

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

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/06/2014
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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(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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(F 000)	INITIAL COMMENTS	(F 000)		
(F 333) SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures it was determined the facility failed to ensure one (1) of seven (7) sampled residents (Resident #15) was free of significant medication errors. Resident #15 did not receive two (2) doses of Lyrica (medication for nerve pain) and one (1) dose of Klonopin (medication for anxiety) as ordered by the physician due to the medication not being available for administration.</p> <p>The findings include: Review of the facility's policy and procedure titled, "Medication Availability Protocol", not dated, revealed if staff were unable to provide the physician ordered medication, the physician should be notified and the notification should be</p>	(F 333)	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>U. Edward Foley</i>	TITLE <i>Director Administrator</i>	(X6) DATE <i>09/20/14</i>
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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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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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{F 333}	<p>Continued From page 1</p> <p>documented. Additionally, when medications were not available to be administered, the time on the MAR should be circled and the omitted medication documented on the Medication Notes form. Any missed dose of medication except for medication refusals required an incident report to be completed, and the physician, resident's family should have been notified.</p> <p>Record review revealed the facility readmitted Resident #15 on 08/14/14 with diagnoses which included Hypertension, Diabetes Mellitus, Alcohol Persistent Dementia, Mood Disorder, Depression Disorder, Chronic Pain, and Neuropathy in Diabetes. Review of an Annual Minimum Data Set (MDS) assessment dated 10/13/14, revealed the facility assessed Resident #15's cognition as moderately impaired with a Brief Interview Mental Status (BIMS) score of ten (10), indicating he/she was interviewable.</p> <p>Review of a Readmission Physician's Order, dated 08/14/14, revealed an order for Lyrica fifty (50) milligrams (mg) two (2) times daily and Klonopin one-half (0.5) mg every evening.</p> <p>Review of the August 20014 Medication Administration Record (MAR), revealed documentation that the Lyrica 50 mg was not administered to Resident #15 on 08/14/14 at 9:00 PM; and, on 08/15/14 at 9:00 AM. Further review revealed Klonopin 0.5 mg was not administered at 9:00 PM on 08/14/14.</p> <p>Review of the Medication Notes, dated 08/14/14 at 9:00 PM, revealed Lyrica 50 mg, and Klonopin 0.5 mg were unavailable, and the pharmacy and physician had been notified. Review of the Nursing Notes and Physician's orders revealed</p>	{F 333}	<p>F333</p> <ol style="list-style-type: none"> 1. Lyrica fifty (50) mg and Klonopin 0.5mg written prescription was received on 08/15/2014 and was administered as ordered for the 9pm dose on 08/15/2014 as indicated on the Medication Administration Record as noted by the Director of Nursing. 2. On 09/08/14 an audit of all current resident's medications was conducted by the Pharmacist or pharmacy representative and all medications were present in the cart. In addition on 09/09/14 the Director of Nursing conducted an audit of all medication Administration Records and noted that all medications were documented and given per physician order. 3. All Licensed Nurses re-educated on the facility policy of medication availability to include that if a medication is omitted the nurse must notify the physician and complete a medication error report and document any further directions if the physician gives further direction and use of the Emergency drug kit and Narcotic Emergency Drug Kit (EDK and NEDK). This re-education will be completed by the Director of Nursing or Assistant Director of Nursing with no licensed staff working after 09/13/14 without having received this re-education. 		

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{F 333}	Continued From page 2 there was no documented evidence of what the physician's instructions were when notified. Additional review revealed on 08/15/14 at 9:00 AM, the Lyrica 50 mg was unavailable; however, there was no documentation that the physician or the pharmacy had been notified per the facility's policy and procedures. Interview with the Director of Nursing (DON), on 09/08/14 at 11:15 AM and at 4:15 PM, revealed an incident report was not completed for the medications that were not administered on 08/14/14 and 08/15/14. The DON stated when the nurse identified the Lyrica and Klonopin had not been received from the pharmacy an incident report should have been completed. In addition, the DON stated the Physician's directions related to the missed doses of medication should have been documented. The DON revealed the medication had not been sent by the pharmacy because the pharmacy had not received the original signed written script from the physician. Interview with the Administrator, on 09/08/14 at 4:30 PM, revealed the omitted doses of medication was a medication error and the facility's policy and procedure should have been followed for medication errors which included notifying the physician as well as completing an incident report. He stated this should have been completed and it was not done.	{F 333}	In addition a system of reconciliation has been added in which the Assistant Director of Nursing will within 72 hours of admission or readmission validate that all prescriptions for narcotics have been received and are present in the facility for that resident. The Assistant Director of Nursing was educated on this process by the Director of Nursing on 09/24/14. The facility contracted the services of a new Medical Director on 08/19/14 who has Drug Enforcement Agency (DEA) privileges to write prescriptions for narcotics. 4. A pharmacy representative will audit all medication carts to Medication Administration Records weekly for twelve (12) weeks and alternate auditors at least every two weeks to assure medications are available as ordered. The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse will audit all Medication carts to Medication Administration Records three (3) times per week for twelve (12) weeks to assure all medication are available as ordered and that any medication omitted has a medication error report completed and any directions if given from the physician has been documented. Results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months for further		
{F 425} SS=D	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	{F 425}			

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(F 425)	<p>Continued From page 3</p> <p>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>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.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to provide pharmaceutical services to meet the needs of one (1) of seven (7) sampled residents (Resident #15); and, for one (1) unsampled resident (Resident F) related to the unavailability of medications for administration. Resident #15 was not administered two (2) doses of Lyrica (medication for nerve pain) and one (1) dose of Klonopin (medication for anxiety); and Unsampled Resident F had a physician's order for Norco (pain medication); however, the Norco was not available for administration.</p> <p>The findings include:</p>	(F 425)	<p>recommendations as needed. If at any time concerns are identified the committee with convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Social Service Director, Maintenance Director and Dietary Service Manager with the Medical Director participating at least quarterly</p> <p>F425</p> <ol style="list-style-type: none"> 1. Lyrica fifty (50) mg and Klonopin 0.5mg written prescription was received on 08/15/2014 and was administered as ordered for the 9pm dose on 08/15/2014 as indicated on the Medication Administration Record by the Director of Nursing. An order was received on 09/05/14 to discontinue the Norco for resident F due to nonuse as verified by the Director of Nursing. 2. On 09/08/14 an audit of all current resident's medications was conducted by the Pharmacist or pharmacy representative and all medications were present in the cart. In addition on 09/09/14 the Director of Nursing conducted an audit of all medication Administration Records 	09/29/14	

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(F 425)	<p>Continued From page 4</p> <p>Review of a facility protocol titled, "Medication Availability Protocol" not dated, revealed the physician's order should be followed to include administration of prescribed medication. If at any time staff was unable to follow the physician's order including having medications available, the staff should notify the physician for further guidance. Further review revealed the policy for maintaining medications included obtaining the medication from the Emergency Drug Kit (EDK) or notifying the after-hours pharmacy and request for medications to be sent stat (immediately). Additionally, the protocol stated any missed dose of medication excluding refusals required an incident report for a medication error and the physician, family, and Director of Nursing (DON) should be notified.</p> <p>1. Record review revealed the facility re-admitted Resident #15 on 08/14/14 with diagnoses which included Hypertension, Diabetes Mellitus, Alcohol Persistent Dementia, Mood Disorder, Depression Disorder, Chronic Pain, and Neuropathy in Diabetes.</p> <p>Review of a Physician's Order, dated 08/14/14, revealed an order for Lyrica 50 milligrams (mg) two (2) times daily and Klonopin one half (0.5) mg every evening. However, review of the August 2014 Medication Administration Record (MAR), revealed Lyrica 50 mg was not administered on 08/14/14 at 9:00 PM and on 08/15/14 at 9:00 AM; and, Klonopin 0.5 mg was not administered on 08/14/14 at 9:00 PM. Review of the Medication Notes, dated 08/14/14 at 9:00 PM, revealed Lyrica 50 mg, and Klonopin 0.5 mg were unavailable, and the pharmacy and physician were notified. On 08/15/14 at 9:00 AM, it was documented Lyrica 50 mg was unavailable;</p>	(F 425)	<p>and noted that all medications were documented and given per physician order.</p> <p>3. All Licensed Nurses re-educated on the facility policy of medication availability to include that if a medication is omitted the nurse must notify the physician and complete a medication error report and document any further directions if the physician gives further direction and use of the Emergency drug kit and Narcotic Emergency Drug Kit (EDK and NEDK). This re-education will be completed by the Director of Nursing or Assistant Director of Nursing with no licensed staff working after 09/13/14 without having received this re-education. In addition a system of reconciliation has been added in which the Assistant Director of Nursing will within 72 hours of admission or readmission validate that all prescriptions for narcotics have been received and are present in the facility for that resident. The Assistant Director of Nursing was educated on this process by the Director of Nursing on 09/24/14. The facility contracted the services of a new Medical Director on 08/19/14 who has Drug Enforcement Agency (DEA) privileges to write prescriptions for narcotics.</p>	

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(F 425)	<p>Continued From page 5</p> <p>however, there was no documentation that the physician or the pharmacy was notified per the facility's policy and procedures.</p> <p>Interview with the Director of Nursing, on 09/06/14 at 11:15 AM and at 4:15 PM, revealed Resident #15 had returned from a psychiatric hospitalization with new admission orders. However, the physician did not send the original, signed prescription which is required to obtain the controlled substances, Lyrica and Klonopin, from the pharmacy. She further stated she was notified of the unavailable medications however, there was no documentation the staff followed protocol to obtain the unavailable medications.</p> <p>Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy could not fill an order for a controlled substance without a "hard copy" of the physician's order and the pharmacy did not receive the hard copy of the orders until 08/15/14.</p> <p>2. Record review revealed the facility admitted Unsampled Resident F on 08/12/14. Review of the Admission Physician's Order, dated 08/12/14, revealed an order for Norco (controlled narcotic used for pain) 5-325 mg one (1) tablet every six (6) hours as needed (PRN) for pain.</p> <p>Observation during a MAR to medication cart audit, on 09/05/14 at 5:00 PM, revealed Unsampled Resident F's September 2014 MAR revealed an order for Norco 5-325 mg one (1) tablet every six (6) hours as needed (PRN) for pain. Further observation of the medication cart revealed the Norco was not available on the medication cart.</p>	(F 425)	<p>4. A pharmacy representative will audit all medication carts to Medication Administration Records weekly for twelve (12) weeks and alternate auditors at least every two weeks to assure medications are available as ordered. The Director of Nursing, Assistant Director of Nursing, Unit Manager or MDS Nurse will audit all Medication carts to Medication Administration Records three (3) times per week for twelve (12) weeks to assure all medication are available as ordered and that any medication omitted has a medication error report completed and any directions if given from the physician has been documented. Results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months for further recommendations as needed. If at any time concerns are identified the committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Social Services Director, Maintenance Director, and Dietary Service Manager with the Medical Director participating at least quarterly.</p>	09/29/14

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(F 425)	Continued From page 6 Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy had received the new admission orders for Unsampld Resident F. However, Norco (narcotic) required an original copy of the signed Physician's Order and the pharmacy stated this was why the medication was not dispensed. Further Interview revealed the pharmacy faxed a request for the signed copy of the medication order on 08/12/14; however, they never received a response from the facility and therefore did not dispense the medication. Further interview revealed he was not aware of any system in place to follow up on the faxed request sent to the facility. Interview with the DON, on 09/06/14 at 4:15 PM, revealed she was not aware of the issue of not having the medication available. Interview with the Administrator, on 09/08/14 at 4:30 PM, revealed there were audits being performed by the pharmacy to ensure the medications were available for each resident according to their Physician's Orders and this should have been identified. He further stated, in addition to the pharmacy audits, audits were being performed by the Nursing Department to ensure accuracy of the MAR and Physlcian's Orders and this should have been identified.	(F 425)	F490 1.) R-15's Lyrica fifty (50) mg and Klonopin 0.5 mg written prescription was received on 08/15/14 and was administered as ordered for the 9 pm dose on 08/15/14 as indicated on the Medication Administration Record as verified by the Director of Nursing. An order was received on 09/05/2014 to discontinue the Norco for Resident F due to nonuse as verified by the Director of Nursing. On 09/18/2014, the RDO made an observation that the Administrator was administering the facility in accordance with professional standards and per job description including ensuring a system was in place for monitoring pharmacy services and that medications were available and documentation of any omitted medications accordingly. All Licensed Nurses re-educated on the facility policy of medication availability to include that if a medication is omitted the nurse must notify the physician and complete a medication error report and document any further directions. If the physician gives further direction and use of the emergency drug kit and Narcotic Emergency Drug Kit (EDK and NEDK). This re-education will be completed by the Director of Nursing or Assistant Director of Nursing with no licensed staff working after 09/13/14 without having received this re-education. In addition a system of reconciliation has been		
(F 490) SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	(F 490)			

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(F 490)	<p>Continued From page 7 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of the Administrator Job Description, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (1) of seven (7) sampled residents (Resident #15) and one (1) unsampled residents (Resident F). The facility failed to have an effective system in place to ensure medications were available and/or administered according to the physician's orders. In addition, the Administrator failed to ensure the facility's Plan of Correction was Implemented, as alleged.</p> <p>Resident #15 did not receive two (2) doses of Lyrica (medication for nerve pain) on 08/14/14 and 08/15/14 and one (1) dose of Klonopin (medication for anxiety) on 08/14/14 as ordered by the physician due to the facility not providing the appropriate documentation to the pharmacy for administration.</p> <p>Unsampled Resident F had a physician's order for Norco (pain medication); however, the facility failed to provide the appropriate documentation to the pharmacy to ensure the medication was available for administration per the facility's policy.</p> <p>The findings include:</p>	(F 490)	<p>added in which the Assistant Director of Nursing will within 72 hours of admission or readmission validate that all prescriptions for narcotics have been received and are present in the facility for that resident. The Assistant Director of Nursing was educated on this process by the Director of Nursing on 09/24/14. The facility contracted the services of a new Medical Director on 08/19/14 who has Drug Enforcement Agency (DEA) privileges to write prescriptions for narcotics.</p> <p>2.) On 09/18/2014, the RDO made an observation that the Administrator was administering the facility in accordance with professional standards and per job description including ensuring a system was in place for monitoring pharmacy services and that medications were available as well and documentation of any omitted medications accordingly.</p> <p>3.) On 09/10/2014, the Regional Director of Operations re-educated the Administrator on the requirements of a functional Quality Assurance process to include delegation of action items for identified concerns including oversight of the entire Plan of Correction and implementation of systems and follow up to assure corrections are made and reviewed with the interdisciplinary team.</p>		

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(F 490)	<p>Continued From page 8</p> <p>Review of the Job Description for the Administrator (no date) revealed the purpose was to direct the day to day functions of the facility in accordance with current Federal, State and Local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care can be provided to the residents at all times. Essential functions of the position included: Ensure excellent care for residents is maintained by overseeing and monitoring patient care services delivered.</p> <p>Review of the facility's Plan of Correction for the survey dated 06/13/14 with an alleged compliance date of 07/11/14, revealed the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager would complete medication administration observations three (3) times per week to assure medications were administered correctly and to ensure medications were available. In addition, the Plan of Correction stated the Pharmacy would audit all current residents' Medication Administration Records (MARs) and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two (2) weeks for eight (8) weeks beginning on 06/09/14. Further review revealed the DON, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Nurse or the Unit Managers would complete an audit of all MARs to ensure professional standards of practice for clinical record documentation were followed five (5) times per week for twelve (12) weeks. The results of the audits would be forwarded to the facility QAPI committee for review.</p> <p>1. Review of Resident #15 's August 2014 MAR revealed the resident did not receive two (2)</p>	(F 490)	<p>4.) Starting the week of 09/28/14 The Regional Director of Operations or Regional Nurse Consultant will visit and document weekly visits for (4) four weeks then every (2) two weeks for eight weeks to ensure the Administrator follows the professional standards and job description that identifies ensuring a system is in place for monitoring pharmacy services to ensure medications are available to be administered according to physician order and are available as documentation of any omitted medications accordingly. The results of these audits will be forwarded to the facility Quality Assurance performance Improvement Committee for at least monthly for three (3) month. If at any time concerns are identified the QAPI committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Dietary Services manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	09/29/14	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/06/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 490)	Continued From page 9 doses of Lyrica on 08/14/14 and 08/15/14 and one (1) dose of Klonopin on 08/14/14 as ordered by the physician. Interview with the Director of Nursing, on 09/06/14 at 11:15 AM and at 4:15 PM, revealed Resident #15 had returned from a hospitalization with new admission orders on 08/14/14; however, the physician did not send the original, signed prescription which was required to obtain the controlled substances, Lyrica and Klonopin, from the pharmacy. 2. Record review revealed Unsampled Resident F had a physician's order for Norco; however, there was no Norco available in the medication cart for the resident.	(F 490)	F520 1.) An Ad-Hoc Quality Assurance meeting (QPI) was conducted on 09/06/14 to review the remaining alleged deficient practice with the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager MDS Nurse, Social Service Director, Housekeeping Supervisor, Dietary Supervisor and , Maintenance Director. The Regional Director of Operations observed the Ad-Hoc Quality Assurance meeting (QPI) on 09/06/14 and noted that the QPI meeting was established as a system that is functional and meeting the identified needs of the facility.		
(F 520)	Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy had received the new admission orders for Unsampled Resident F. However, Norco (narcotic) required an original copy of the signed physician's order and the pharmacy stated this was why the medication was not dispensed. Interview with the Administrator on 09/06/14 at 4:30 PM, revealed the facility had audits in place to identify when medications were not available for administration per physician's order and staff who conducted the audits failed to identify the medications were not available for administration. He further stated the facility's system had not been effective in identifying the issues; however, he was working to put new tools in place to monitor for the future. 483.75(o)(1) QAA	(F 520)	2.) The Regional Director of Operations observed the Ad-Hoc Quality Assurance meeting (QPI) on 09/06/14 and noted that the QPI meeting was established as a system that is functional and meeting the identified needs of the facility. 3.) On 09/10/14, the Regional Director of Operations re-educated the Administrator on the requirements of a functional Quality Assurance process to include delegation of action items for identified concerns including oversight of the entire Plan Of Correction and implementation of systems and follow up to assure corrections are made and reviewed with the Interdisciplinary Team. In addition a system of reconciliation has been added in		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 520) SS=D	<p>Continued From page 10 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Quality Assurance Policy, it was determined the facility failed to monitor its plans of action to correct identified quality deficiencies. The facility failed to identify, during their audits, that medications were not available for one (1) of seven sampled residents (Resident #15) and for one (1) unsampled resident (Resident F).</p>	(F 520)	<p>which the Assistant Director of Nursing will within 72 hours of admission or readmission validate that all prescriptions for narcotics have been received and are present in the facility for that resident. The Assistant Director of was educated on this process by the Director of Nursing on 09/24/14. The facility contracted the services of a new Medical Director on 08/19/14 who has Drug Enforcement Agency (DEA) privileges to write prescriptions for narcotics.</p> <p>4.)</p> <p>Starting the week of 09/28/14 the Regional Director of Operations will observe the Quality Assurance process monthly, including audit tools for at least (3) three months to assure the Quality Assurance Performance Improvement Committee is functional and meeting the identified needs of the facility. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee at least monthly for (3) three months. If at any time concerns are identified the QAPI committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Dietary Services manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	09/29/14	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 520}	Continued From page 11 The findings include: Review of the facility's policy and procedure titled, "Quality Assurance Policy", last revised 01/11, revealed the Administrator's purpose was to ensure an interdisciplinary approach to all residents' needs and to provide the highest level of care possible all the while keeping the Interdisciplinary Team (IDT), physician and responsible party informed of their condition changes and interventions implemented as they occur and when necessary. The interdisciplinary Team will meet at least weekly and consist of at minimum the Administrator, Director of Nursing or Nursing Representative, Social Services, Therapy, Dietary and Activities. Review of the facility's Plan of Correction for the survey dated 06/13/14 with an alleged compliance date of 07/11/14, revealed medication administration observations would be conducted three (3) times per week to assure medications were administered correctly were available. The results of these audits would be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review at least monthly for three (3) months. In addition, the Plan of Correction stated the Pharmacy would audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two (2) weeks for eight (8) weeks beginning on 06/09/14. Further review revealed the DON, ADON, Minimum Data Set (MDS) Nurse or the Unit Managers will complete an audit of all MARs to ensure professional standards of practice for clinical record	{F 520}			

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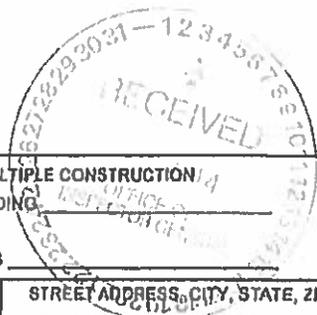
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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{F 520}	<p>Continued From page 12</p> <p>documentation were followed five (5) times per week for twelve (12) weeks. The results of the audits would be forwarded to the facility QAPI committee for review.</p> <p>1. Record review revealed Resident #15 did not receive two (2) doses of Lyrica (nerve medication) on 08/14/14 and 08/15/14 and one (1) dose of Klonopin (nerve medication) on 08/14/14 as ordered by the physician due to the failure of the facility to send the appropriate documentation to the pharmacy to ensure medication was available for administration.</p> <p>2. Record review revealed Usampled Resident F had a physician's order for Norco (pain medication). However, the facility failed to send the appropriate documentation to the pharmacy to ensure the medication was available for administration.</p> <p>Interview with the Director of Nursing (DON), on 09/06/14 at 4:15 PM, revealed the audits were completed by the pharmacy to compare the MAR with the medication available in the medication cart. In addition she stated that she and other staff completed the audits of medication administration observations to ensure medications were administered correctly and ordered medications were available which was done three (3) times per week; however, they failed to identify the medication was not available.</p> <p>Interview with the Administrator, on 09/06/14 at 4:30 PM, revealed the audits were in place and the facility should have identified the errors.</p>	{F 520}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 000	<p>INITIAL COMMENTS</p> <p>**Amended SOD**</p> <p>A Recertification, an Abbreviated Survey and an Extended Survey were conducted on 05/21/14 through 06/13/14 with deficiencies cited at a Scope and Severity of "L". An Abbreviated Survey was conducted to investigate complaints #KY21692, #KY21693 and #KY21727. Complaint #KY21692 and #KY21727 were substantiated with related deficiencies and complaint #KY21693 was unsubstantiated.</p> <p>Immediate Jeopardy (IJ) was identified in the areas of CFR 483.10 Resident Rights; F167, CFR 483.20 Resident Assessment; F281 and F282, CFR 483.26 Quality of Care; F333, CFR 483.60 Pharmacy Services; F425, and, CFR 483.75 Administration at F490, F514 and F520 at a Scope and Severity of a "L". Substandard Quality of Care was identified at CFR 483.26 Quality of Care F333. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.</p> <p>The facility failed to to have an effective system in place to ensure medications were available and administered according to the physician's orders for eleven (11) of seventeen (17) sampled residents.</p> <p>On 05/29/14, a Physician's Order was received for Resident #10 to receive Potassium forty (40) milliequivalents (meq) by mouth "Now" due to a Potassium level of 2.2 (normal 3.5 to 5.0) and to recheck the Potassium level in twenty-four (24) hours. However, the nurse failed to transcribe</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Edward Foley TITLE: Intervenor Administrator (X6) DATE: 09/09/14

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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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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F 000	<p>Continued From page 1</p> <p>the order onto the Medication Administration Record (MAR). The Potassium was not administered until 05/30/14 at 9:00 AM. Resident #10 was admitted to the hospital on 05/30/14 at 8:50 PM with a diagnosis of Acute Hypokalemia (low Potassium) with fluids and Potassium given to increase the resident's Potassium level.</p> <p>On 05/21/14 at 10:57 PM, Licensed Practical Nurse (LPN) #6 assessed Resident #11 and noted the resident was experiencing labored breathing. A "stat" (Immediately) order was received to administer Solu-Medrol (steroid) 40 milligrams (mg) intramuscularly (IM), Levaquin (antibiotic) 500 mg intravenous (IV) every 24 hours and Prednisone (steroid) 40 mg by mouth for two (2) doses and chest x-ray. However, the Solu-Medrol, and Levaquin were not administered until 05/22/14 at 5:49 PM, seventeen (17) hours later. The nurse failed to obtain the Solu-Medrol from the EDK (emergency drug kit). The chest x-ray results revealed "Defined infiltrative shadows in the left infrahilar and lower lobe suggestive of Pneumonia". On 05/24/14 at 6:24 PM, the resident expired.</p> <p>On 05/03/14, Resident #12 was hospitalized due to a seizure. The resident returned to the facility on 05/05/14 with an order for Keppra (anti-convulsant) 500 mg twice daily. Record review revealed no documented evidence Resident #12 received the Keppra from 05/05/14 through 05/08/14; the facility failed to provide the resident six (6) doses of this medication. On 05/08/14, the resident experienced another seizure and was admitted to the hospital. The resident returned to the facility on 05/13/14 with an order to increase Keppra to 1000 mg twice a day. However, the order was not transcribed</p>	F 000		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
(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	<p>Continued From page 2</p> <p>correctly and the resident only received 500 mg twice a day from 05/14/14 through 06/31/14, for a total of thirty five (35) incorrect doses.</p> <p>On 04/21/14, Resident #14 was re-ordered Pancrellpase (digestive enzyme) 5000 units, one (1) cap at meals and one (1) before bedtime. The facility failed to provide Resident #14 this medication on 05/19/14, 05/21/14, 05/22/14 and 05/28/14 (fourteen (14) doses) due to the medication not being available for administration due to the resident's physician Medicaid Provider number not being renewed.</p> <p>On 05/20/14, Resident #15 was ordered to receive Fentanyl (narcotic pain reliever) 25 micrograms (mcg)/hr patch every seventy-two (72) hours. However, the resident was not administered the Fentanyl patch on 05/05/14, 05/14/14 and 05/29/14 resulting in the resident not having a pain patch in place for eight (8) days. In addition, the surveyor observed the resident did not have a Fentanyl patch on 05/30/14. The Fentanyl patches were not available for administration on 05/30/14.</p> <p>Resident #3 was ordered to receive Norvasc (anti-hypertensive) 10 mg every day. The facility failed to provide this medication for Resident #3 from 05/23/14 - 05/29/14, for a total of seven (7) doses, due to the medication not being available for administration.</p> <p>Resident #16 was ordered to receive Torsemide (diuretic) 30 mg every day, Allopurinol (gout) 50 mg every day, Aspirin (heart) 81 mg every day, Neurontin (Neuropathy) 400 mg three times a day, K-Dur (renal failure) 40 meq three times a day, Clindamycin (antibiotic) 300 mg three times</p>	F 000			

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F 000	<p>Continued From page 3</p> <p>a day, Vancomycin (antibiotic) one gram/200 cc IV and Percocet (narcotic pain med) 10/325 mg every eight (8) hours. However, there was no documented evidence Resident #16 received Torsemide 30 mg on 05/18/14, 05/26/14 and 05/31/14 (three doses); Allopurinol 50 mg on 05/14/14 and 05/26/14 (two doses); Aspirin 81 mg on 05/11/14 and 05/20/14 (two doses); Neurontin 400 mg on 05/17/14 at 8:00 AM, 05/20/14 at 2:00 PM and 05/31/14 at 2:00 PM and 10:00 PM (four (4) doses); K-Dur 40 meq one dose on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14 and 05/19/14, all three (3) doses on 05/20/14, one (1) dose on 06/27/14 and two (2) doses on 05/31/14 for a total of twelve (12) doses; Clindamycin 300 mg on 05/02/14 and 05/08/14 at 5:00 PM (two (2) doses); Vancomycin on 05/20/14 (one dose) and Percocet on 05/17/14 at 6:00 AM, 05/20/14 at 2:00 PM and 05/31/14 at 2:00 PM and 10:00 PM (four (4) doses).</p> <p>Resident #13 was ordered to receive Buspar (anti-anxiety) five (5) mg per feeding tube twice daily. However, there was no documented evidence the medication was administered from 05/24/14 at 9:00 PM through 05/27/14 at 9:00 AM. The facility failed to provide the resident six (6) doses of this medication.</p> <p>Observation during a medication pass revealed Resident #17 had a blood sugar reading of 229 (normal 70-100). LPN #1 was observed to draw up seven (7) units of insulin and prepared to administer it to Resident #17, but the licensed staff with her stopped the LPN from administering the medication. Review of the Physician's Order revealed the amount that should have given was five (5) units and not seven (7) units.</p>	F 000		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 000	Continued From page 4 An acceptable Allegation of Compliance (AOC) was received on 06/10/14, alleging the removal of Immediate Jeopardy on 06/05/14. The State Survey Agency validated, on 06/12-13/14 that the Immediate Jeopardy was removed on 06/13/14. The Scope and Severity was lowered to a "F" at 483.10 Resident Rights; F157, 483.20 Resident Assessment; F281 and F282, 483.25 Quality of Care; F333, 483.60 Pharmacy Services; F425, and 483.75 Administration; F490, F514, and F520 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance Committee monitors the effectiveness of the systemic changes. In addition, F323 remained at a Scope and Severity of a "G"; and, F164, F332 and F602 remained at a Scope and Severity of a "D".	F 000			
F 157 SS=L	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	<p><u>F 157</u> 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p><u>The corrective action accomplished to correct the alleged deficient practice:</u></p> <p>On 4/3/2014, the physician was notified by a LPN of a suspected injury of Resident #1 resulting in a new order to have an x-ray completed.</p> <p>On 6/4/2014, the physician was notified by the Director of Nursing (DON) of medications not administered according to physicians order for Residents #2, 3, 10, 11, 12, 13, 14, 15, and 16.</p> <p>Resident #11 expired in the facility on May 24, 2014. Resident #12 was discharged home on May 31, 2014.</p> <p>On 5/19/2014, the physician was notified by DON the treatments for Resident #6 had not been completed according to physicians order.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 5/31/2014, the Director of Nursing, a consulting Director of Nursing, and the</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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F 157 Continued From page 6

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.16(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on interview, observation, record review, and review of the facility's policy and procedure, it was determined the facility failed to consult with the physician for eleven (11) of seventeen (17) sampled residents (Residents #1, #2, #3, #8, #10, #11, #12, #13, #14, #15 and #16). The facility failed to consult with the physicians when medications were not available for administration or when not administered for Residents #2, #3, #10, #11, #12, #13, #14, #15 and #16; and, when treatments were not provided for Resident #6. The physician was not notified when Resident #1 had an accident, which resulted in injury.

The facility failed to notify the physician when Resident #10 did not receive a "now" dose of Potassium 40 milliequivalents (meq) which was ordered to be administered on 05/29/14, but was not given until 05/30/14. Resident #11 did not receive Solu-Medrol (steroid) 40 milligrams (mg) intramuscularly (IM) and Levaquin (antibiotic) 500 mg intravenously (IV) which was ordered "stat" (to be given immediately) on 05/21/14, but wasn't

F 157

Regional Nurse Consultant audited physician orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.

On 6/2/2014, two representatives from Omnicare Pharmacy completed a Medication Administration Record (MAR) to Medication Cart Audit for all current residents to ensure all medications are available for administration per physicians order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.

On 6/3/2014, the DON audited TARs (Treatment Administration Record) for all current residents to ensure all treatments were completed per physicians order. Physician was immediately notified for any treatment that had not been completed per physicians order.

On 7/7/2014, the Director of Nursing audited incidents for the previous thirty (30) days to assure the MD had been notified of the occurrence. No incidents were identified where the physician was not notified.

The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:

On 6/1/2014, Regional Nurse Consultant (RNC) re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered per physicians order, and post test completed.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 157	Continued From page 8 given until 05/22/14. Resident #12, who had a seizure disorder, did not receive Keppra (anti-seizure medication) 500 mg by mouth twice daily from 05/05/14 through 05/08/14 for a total of six (6) doses and experienced a seizure and required hospitalization. Resident #14 did not receive a total of fourteen (14) doses of Pancrellpase (digestive enzyme) 5000 Units from 05/19/14 through 05/28/14; Resident #15, who had a diagnosis of Chronic Pain, did not receive a Fentanyl (pain narcotic) patch 25 micrograms/hour (mcg/hr), to be changed every 72 hours, on 05/05/14, 05/26/14 and 05/29/14 which resulted in the resident going eight (8) days without a pain patch in place. The resident presented with complaints of severe pain. Resident #16 did not receive Torsemide (diuretic) 30 mg daily, Allopurinol (Gout) 50 mg daily, Aspirin (heart) 81 mg daily, Neurontin (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivalents three (3) times daily, Clindamycin (antibiotic) 300 mg three (3) times daily for 10 days, Vancomycin (antibiotic) one (1) Gram twice daily for seven (7) days and Percocet (analgesic) 10-325 mg every eight (8) hours routine on multiple occasions according to the resident's Medication Administration Record (MAR). Resident #3 did not receive seven (7) doses of Norvasc (blood pressure medication) 10 mg every day from 05/23/14 - 05/29/14. Resident #2's Diflucan (antifungal) 100 milligrams (mg) by mouth every day for five (5) days for a yeast rash was not administered from 05/18-20/14; and, the facility failed to notify the physician when Resident #13 did not receive Buspar (anti-anxiety) 5 mg per PEG tube twice daily routine from 05/24/14 at 9:00 PM through 05/27/14 at 9:00 AM for a total of six (6) doses.	F 157	On 6/1/2014, the DON initiated re-education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability", which states the procedure to follow for physician notification when medications are not available to be administered per physicians order or physician orders were unable to be followed including treatments. This training will be completed with all licensed nurses by the DON. The DON will re-educate and validate competency with Assistant Director of Nursing (ADON), MDS Nurse (MDS) or Unit Manager before they initiate re-education with the licensed nurses. No licensed nurse will work after 6/4/2014 without having had this re-education and competency test. On 6/13/2014, the protocol titled "Medication Availability" and post test were added by the DON to the new hire packets for Licensed Nurses to educate them during orientation on the system in place to follow for physician notification when medications are not available to be administered per physicians order or physician orders are unable to be followed including treatments. On 7/7/2014 the DON re-educated all Certified Nursing Assistants of the chain of notification required for all falls or incidents which includes reporting incidents to the Charge Nurse who would notify the physician. No Certified Nursing Assistants will work after 07/08/14 without having received this education. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 7</p> <p>Additionally, the facility failed to notify the physician on 03/30/14, when Resident #1's legs became tangled in the metal pieces on the lift while being transferred with a lift. The State Registered Nurse Aide (SRNA) failed to notify the nurse to ensure the physician was notified of the incident. Resident #1 complained of pain to the right foot; an x-ray was completed on 04/03/14 which identified that Resident #1 had sustained right acute nondisplaced fractures of the distal tibia and fibula (leg).</p> <p>The facility's failure to consult with the physician when medications were not available for administration and when a resident had an incident with a lift that caused possible injury caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 08/02/14 and determined to exist on 06/05/14. The facility was notified of the Immediate Jeopardy on 08/02/14.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Medication Shortages /Unavailable Medications, last revised on 01/01/13, revealed if medication was not available for administration and if an emergency delivery of medication was unavailable, the facility nurse should have contacted the attending physician to obtain orders or directions. The facility should have collaborated with pharmacy and the physician/prescriber to determine a suitable therapeutic alternate.</p> <p>1. Record review revealed the facility admitted Resident #10 on 06/16/14 with diagnoses which included Diarrhea, Diabetes and Psychosis.</p> <p>Review of the resident's medical record revealed</p>	F 157	<p>Beginning the week of 6/9/14, Omnicare Pharmacy audited all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks on 6/9/2014, 6/16/2014, 6/23/2014, and 6/30/2014 and then will be completed every two weeks for eight (8) weeks by Omnicare to assure all medications are available. Any deficiency identified will be corrected immediately. Beginning the week of 6/9/2014, the DON, ADON, MDS Nurse or Unit Manager will audit Treatment Administration Records (TARs) five (5) times a week to ensure that treatments are completed per physicians' order. Any deficiency identified will be corrected immediately to include notification of physician. The Director of Nursing or Assistant Director of Nursing or Unit Manager will complete five questionnaires per week with Certified Nursing Assistants for twelve (12) weeks to assure ongoing understanding of reporting of incidents involving equipment or falls to the Nurse. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review and recommendation for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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F 157	<p>Continued From page 8</p> <p>a routine laboratory test was conducted on 05/20/14 which revealed the resident's Potassium level was 3.2 millimoles/L (or (mmol/L), which was low (normal value was between 3.5-5.50 mmol/L).</p> <p>On 05/29/14 at 9:40 AM, Licensed Practical Nurse (LPN) #3 received an order from the Physician to medicate the resident with Potassium 40 meq by mouth (po) "now" meaning immediately. Review of the May 2014 MAR revealed the Potassium dose was not administered until 05/30/14 at 9:00 AM by LPN #4. Further review of Resident #10's medical record revealed no documented evidence the Physician was made aware that the dose of Potassium was not administered on 05/29/14, as ordered.</p> <p>Interview, on 05/31/14 at 3:00 PM with LPN #3, revealed she forgot to put the medication order on the MAR and did not administer the Potassium as ordered.</p> <p>Review of a Laboratory Report, revealed a repeat potassium level was obtained on 05/30/14 at 1:45 PM and the result was 2.4 mmol/L (low). The result was phoned to the Physician's Assistant (PA) at 6:09 PM by the lab staff. Review of a Nurse's Note, revealed on 05/30/14 at 8:30 PM an order was received to send the resident to the emergency room for evaluation. Review of the Hospital History and Physical revealed the resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and was subsequently admitted into the hospital with a diagnoses of Hypomagnesia and Hypokalemia.</p> <p>Interview with Resident #10's Physician, on 06/12/14 at 2:30 PM, revealed he had not been</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 157	<p>Continued From page 9</p> <p>made aware that the resident had not received his/her Potassium. He stated Hypokalemia was low Potassium and depending on how low, it could be life threatening. He stated he expected medications to be given as ordered.</p> <p>2. Closed record review revealed the facility admitted Resident #11 on 07/01/12 with diagnoses which included Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of Nursing Notes, dated 05/21/14 at 10:57 PM, revealed LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practitioner Registered Nurse (APRN) was notified on 05/21/14 at 11:30 PM and "stat" (indicating immediately) orders were received to medicate the resident with Solu-Medrol (steroid) 40 mg intramuscularly (IM) and Levaquin 500 mg IV every 24 hours.</p> <p>Review of the May 2014 MAR and Nurse's Notes revealed the medication was not administered until 05/22/14 at 5:49 PM; however, further review of Resident #11's medical record revealed no documented evidence the Physician was notified the medication was not administered on 05/21/14 "stat", as ordered.</p> <p>Review of the Nursing Notes, dated 05/24/14 at 8:24 PM, revealed the resident expired.</p> <p>3. Record review revealed the facility admitted Resident #12 on 04/30/14 with diagnoses which included Post Traumatic Seizures.</p> <p>Review of the Nursing Notes, dated 05/02/14 at</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>11:45 AM, revealed the resident experienced a seizure and was sent to the hospital and admitted. Review of Nurse's Notes, dated 05/06/14 at 5:38 PM, revealed Resident #12 was readmitted to the facility.</p> <p>Review of the Admission Orders, dated 05/08/14, revealed to administer Keppra (anti-seizure) 500 mg by mouth twice dally.</p> <p>Review of the May 2014 MAR revealed the first dose of Keppra should have been administered on 05/05/14 at 9:00 PM, but there was no documented evidence the Keppra was given after readmission to the facility on 05/06/13 through 05/08/14 (seven (7) doses) and there was no evidence the physician was notified the medication was not available for administration.</p> <p>Review of the Nurse's Notes revealed on 05/08/14, the resident experienced another seizure and was transported back to the emergency room and was admitted again.</p> <p>Interview with the Director of Nursing (DON), on 06/01/14 at 10:10 AM, revealed there was no way to verify the resident was administered the Keppra as ordered from 05/05/14 through 05/08/14.</p> <p>4. Record review revealed the facility admitted Resident #15 on 07/03/12 with the diagnosis of Chronic Pain. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 04/02/14, revealed the facility assessed Resident #15 as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) indicating the resident was interviewable.</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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F 157	<p>Continued From page 11</p> <p>Review of the May 2014 Physician Orders revealed an order for Fentanyl patch 26 mcg/hr, to be changed every 72 hours.</p> <p>Review of the May 2014 MAR revealed the resident did not receive his/her Fentanyl patch on 05/05/14, 05/14/14 and 05/29/14 (a total of eight (8) days without a pain patch). However, further review of Resident #15's medical record revealed no documented evidence the Physician was notified the Fentanyl patch was not available for administration.</p> <p>Interview with Resident #15, on 06/30/14 at 11:30 AM, revealed he/she was currently hurting "bad". The Assistant Director of Nursing, at that time, was observed to assess the resident and verified there was no Fentanyl patch in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 05/31/14 at 3:00 PM, revealed she had called the Advanced Practical Registered Nurse (APRN) on 05/29/14 and was told the resident had been on Fentanyl for some time and the APRN did not want to switch to Morphine as the Pharmacy had recommended. LPN #3 stated she did not know if the physician had been notified when the Fentanyl patch was not available to be administered on 05/05/14 and 05/14/14.</p> <p>Interview with the APRN, on 06/02/14 at 1:30 PM, revealed she did not recall being made aware Resident #15 had not been administered his/her Fentanyl patch three (3) different times in the month of May. The APRN stated there had been problems with Medicaid "kicking me and the Physician" out of the system but felt that was resolved.</p>	F 157		
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F 167	<p>Continued From page 12</p> <p>5. Record review revealed the facility admitted Resident #13 on 07/01/12 with diagnoses which included Impulse Control Disorder.</p> <p>Review of a Physician's Order, dated 05/24/14, revealed an order for Buspar 5 mg per PEG (tube feeding) tube twice daily routine.</p> <p>Review of the May 2014 MAR revealed staff initials were circled on the MAR for 05/24/14 through 05/26/14, indicating the medication was not given, per the Director of Nursing. There was no entry for the 9:00 PM dose on 05/26/14. The 9:00 AM dose on 05/27/14 had a circled initial on the MAR. Review of the back of the MAR revealed the pharmacy was called on 05/27/14 at 9:00 AM to inquire about the medication and was told it would be in that night. Review of the May 2014 MAR revealed the medication was given on 05/27/14 at 9:00 PM; however, further review of Resident #13's Medical Record revealed there was no documented evidence the physician had been notified that the medication was not available for administration.</p> <p>6. Record review revealed the facility admitted Resident #14 on 10/11/13, with diagnoses which included Diarrhea and Colon Resection. Review of the Quarterly MDS assessment, dated 04/24/14, revealed the facility assessed the resident as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable.</p> <p>Review of the Physician's Orders for May 2014, revealed Pancrelipase 5000 unit capsule at meals and before bedtime. Review of the May 2014 MAR revealed the resident did not receive a total of fourteen (14) doses of Pancrelipase (enzyme)</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 13</p> <p>5000 units on 05/19/14, 05/21/14, 05/22/14 and 05/28/14. However, there was no documented evidence the physician was notified the medication was not available for administration.</p> <p>Interview with Resident #14, on 05/28/14 at 2:26 PM, revealed the facility had not given him/her the medication and he/she did not understand why as he/she has been on it for years. The resident stated he/she was told that the medical card would not pay for it.</p> <p>Observation of the medication cart, on 05/28/14 at 2:55 PM revealed there was no Pancrellpase available to be administered.</p> <p>Interview with the Director of Nursing (DON), on 05/28/14 at 3:35 PM, revealed she was currently investigating the situation and that he/she had authorized the pharmacy to fill the medication and bill it to the facility.</p> <p>7. Record review revealed the facility admitted Resident #16 on 09/19/13, with diagnoses which included Gout, Diabetes, Below the Knee Amputation and Generalized Pain. Review of a Quarterly MDS assessment, dated 05/01/14, revealed the facility assessed Resident #16 as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of May 2014 Physician Orders revealed orders for Torsemide (diuretic) 30 mg daily, Allopurinol (Gout) 50 mg daily, Aspirin (heart) 81 mg daily, Neurontin (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivalents three (3) times daily, Clindamycin (antibiotic) 300 mg three (3) times daily for 10 days (to end on 05/09/14),</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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)	(X6) COMPLETION DATE	
F 157	<p>Continued From page 14</p> <p>Vancomycin (antibiotic) one (1) Gram twice dally for seven (7) days (with last dose on 05/23/14) and Percocet (analgesic) 10-325 mg every eight (8) hours routine.</p> <p>Review of the May 2014 MAR revealed the following omissions from the MAR: Torsemide 30 mg on 05/18/14, 05/25/14 and 05/31/14 (three doses); Allopurinol 60 mg on 05/14/14 and 05/26/14 (two doses); Aspirin 81 mg on 05/11/14 and 05/20/14 (two doses); Neurontin 400 mg on 05/17/14 at 6:00 AM, 05/20/14 at 2:00 PM and 05/31/14 at 2:00 PM and 10:00 PM (four (4) doses); K-Dur 40 meq one dose on 05/01/14, 05/08/14, 05/08/14, 05/09/14, 05/13/14 and 05/19/14, all three (3) doses on 06/20/14, one (1) dose on 05/27/14 and two (2) doses on 05/31/14 for a total of twelve (12) doses; Clindamycin 300 mg on 05/02/14 and 05/08/14 at 5:00 PM (two (2) doses); Vancomycin on 05/20/14 (one dose) and Percocet on 05/17/14 at 6:00 AM, 05/20/14 at 2:00 PM and 05/31/14 at 2:00 PM and 10:00 PM (four (4) doses). However, review of Resident # 16's medical record revealed no documented evidence the Physician was notified these medications were not administered.</p> <p>Interview with Resident #16, on 06/02/14 at 2:23 PM, revealed the resident reported the presence of pain while not receiving his/her medications as ordered.</p> <p>8. Record review revealed the facility admitted Resident #2 on 07/01/12 with diagnoses which included Spina Bifida and Obesity. Review of the Quarterly MDS assessment, dated 03/19/14, revealed the facility assessed the resident as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable.</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 157	<p>Continued From page 15</p> <p>Review of the Order Sheet, dated 05/16/14, revealed an order for Dilucan 100 mg by mouth every day for five (5) days for a yeast rash. Review of the May 2014 Medication Administration Record (MAR) revealed the medication was not given on 05/18/14-05/20/14. Review of the Shipment Detail Report from the pharmacy revealed the medication was not delivered until 05/19/14 at 11:57 PM, three (3) days after the medication was ordered. Further review of Resident #2's medical record revealed no documented evidence the physician was made aware the medication was not available for administration, as ordered.</p> <p>Interview with Resident #2, on 05/31/14 at 4:00 PM, revealed he/she did not receive his/her medication.</p> <p>9. Record review revealed the facility admitted Resident #3 on 07/01/12, with diagnoses which included Hypertension (high blood pressure).</p> <p>Review of a Physician's Order, dated May 2014, revealed an order to administer Norvasc (blood pressure medication) 10 milligrams (mg) every day. Review of the May 2014 MAR revealed this medication was initialed and circled from 05/23/14 through 05/29/14 (seven (7) doses) which indicated the medication was not given. However, further review of Resident #3's medical record revealed no documented evidence the Physician was notified the medication was not available for administration.</p> <p>10. Record review revealed the facility admitted Resident #6 on 05/13/14 with diagnoses which included Hypertension. Review of a Physician's</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 16</p> <p>Order, dated 05/13/14, revealed the Jackson Pratt (JP) drain sites were to be cleansed with normal saline/soap and pat dry every shift. Review of the May 2014 Treatment Administration Record (TAR) revealed there was no documented evidence the treatments were completed on the 6:00 AM-6:00 PM shift on 05/13/14 through 05/18/14. Further record review revealed there was no documented evidence the physician was notified of the failure to provide these treatments.</p> <p>Interview with LPN #1, on 05/28/14 at 3:25 PM, revealed the order for the cleansing of the JP drain site was not on the original TAR and it wasn't done.</p> <p>Interview with the DON, on 05/29/14 at 1:10 PM, revealed medications could be ordered "STAT" and the pharmacy could send medications from the back up pharmacy as needed. The DON further reported if a medication or treatment wasn't documented, it wasn't done and the Physician should be notified. In further interview, the DON stated the Medical Director was made aware on 05/27/14, by the Administrator, of the concerns of medications not being available.</p> <p>Interview with the Administrator, on 05/30/14 at 3:20 PM, revealed when staff was unable to carry out a physician's order, he/she would expect the staff to report to the nurse in charge and/or to the Physician.</p> <p>11. Review of the facility policy titled, "Safe Handling and Movement Policy", last revised 10/31/13, revealed that injuries from patient handling and movement should be reported.</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 157	<p>Continued From page 17</p> <p>Record review revealed the facility admitted Resident #1 on 02/13/14 with diagnoses which included Bi-polar Disorder, Post Traumatic Stress Disorder, Chronic Pain, Paraplegia, Phantom Limb Syndrome and Hypertension. Review of the Admission MDS assessment, dated 02/20/14, revealed the facility assessed Resident #1 as cognitively intact with a BIMS score of fifteen (15), which indicated the resident was interviewable.</p> <p>Review of the facility's final report of the investigation revealed Resident #1 was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance on 03/30/14. While being transferred, the resident's right foot became tangled, and due to the resident's paraplegia, he/she was unable to feel pain to his/her leg. The SRNA did not report the incident to nursing staff to ensure the Physician was notified of the incident. Resident #1 had complaints of foot pain and an x-ray of the right foot was ordered on 04/03/14 and completed on 04/04/14 by the mobile x-ray service.</p> <p>Review of the Radiology Report, dated 04/04/14, revealed a reading of right acute nondisplaced fractures of the distal tibia and fibula.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 05/22/14 at 3:51 PM, revealed she had been notified by the DON the resident was having leg pain. The LPN stated the physician was notified and an order was received for a radiograph (x-ray) of the right foot. The LPN stated the physician was not notified until the resident complained of pain to the foot because the SRNA had not notified anyone of the fall with the lift.</p>	F 157		
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F 157	<p>Continued From page 18</p> <p>Interview with the Assistant Director of Nurses (ADON), on 05/29/14 at 4:33 PM, revealed if medications weren't available from the pharmacy he/she would expect the staff to notify the DON, ADON and the Physician.</p> <p>Interview with the DON, on 05/29/14 at 1:10 PM, revealed if a medication or treatment wasn't documented, it wasn't done.</p> <p>Interview with the Administrator, on 05/29/14 at 1:10 PM and on 05/30/14 at 3:20 PM, revealed when staff was unable to carry out a physician's order, he/she would expect the staff to report to the nurse in charge and/or to the Physician. She stated on 05/23/14, nurses started doing administrative MAR and TAR reviews; and, a conference call Quality Assurance meeting was held with the Medical Director on 05/27/14 related to the medications not being available for administration or not administered. Further interview with the Administrator, on 06/02/14 at 4:30 PM, revealed she could not say the Physician was notified each time, about every resident who did not receive his/her medication as ordered.</p> <p>During the interview with the Medical Director, on 06/02/14 at 2:15 PM, he stated "nurses should know their duties, know what they are doing and the supervisors should know what is going on." He stated, "Can't wait twenty-four (24) hours to find out a medication was not given."</p> <p>*The facility implemented the following actions to remove the immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the</p>	F 157		

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F 157	<p>Continued From page 19</p> <p>Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 08/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed.</p> <p>On 08/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 08/04/14 without having had this re-education and competency test.</p> <p>On 08/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not</p>	F 157		
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F 157	<p>Continued From page 20</p> <p>In the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 21</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy</p>	F 157			

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F 157	<p>Continued From page 22</p> <p>should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be</p>	F 157			

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F 157	<p>Continued From page 23</p> <p>followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 08/12/14 at 11 :46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 24</p> <p>plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 08/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 08/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 08/12/14 at 12:08 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
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F 157	<p>Continued From page 25</p> <p>could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 157	<p>Continued From page 26</p> <p>licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by an RN and SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or Administration should be notified.</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for</p>	F 157			

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F 157	<p>Continued From page 27</p> <p>additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lortab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levohydroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p>	F 157			

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F 157	<p>Continued From page 28</p> <p>Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p> <p>Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work.</p> <p>Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed</p>	F 157			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 167	Continued From page 29 the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 167	F 164 483.10(E), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 5/28/2014, the DON observed the closed MARs of Resident #6 and 14 and determined their right to personal privacy and confidentiality of their clinical records had been protected. On 5/28/2014, LPN #2 and LPN #1 were re-educated on protecting residents' personal privacy and confidentiality of their clinical records, per Director of Nursing. <u>Other residents had the potential to be affected.</u> On 5/28/2014, the DON observed the MARs of all residents to ensure resident's rights are protected for personal privacy and confidentiality of their clinical records. No concerns were identified. <u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u> Beginning 5/28/2014, the DON re-educated all licensed nurses on protecting each residents' right to personal privacy and confidentiality of their clinical records. No licensed nurse will work after 07/08/2014 without having this re-education by the Director or Nursing, Assistant Director of Nursing or Unit Manager. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u>		
F 164 SS=D	483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164			

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F 164	<p>Continued From page 30 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure each resident's right to personal privacy and confidentiality of their clinical records for two (2) of seventeen (17) sampled residents (Resident #6 and #14). Resident #6 and #14's Medication Administration Record (MAR) was left open and in plain view on the medication cart.</p> <p>The findings include:</p> <p>Review of an undated policy, titled Medication Administration, revealed to provide privacy as appropriate.</p> <p>Review of a policy titled Quality of Life - Dignity, last revised October 2009, revealed staff shall maintain an environment in which confidential clinical information is protected.</p> <p>1. Observation, on 05/28/14 at 10:47 AM, revealed a medication cart on Hall #2 with the MAR open and on top of the cart. Resident #6's MAR was in plain view of staff and visitors that were passing by the medication cart. Licensed Practical Nurse (LPN) #2 was passing medications and was in a resident's room with the door closed.</p> <p>Interview with LPN #2, on 05/28/14 at 10:50 AM, revealed she did not normally leave the resident's MARs open to view due to resident privacy. She stated, "It was a fluke on my part", the MAR should never be left in view. She stated she</p>	F 164	<p>Beginning the week of 6/26/2014, the DON, ADON, MDS Nurse or Unit Manager will observe MARs five (5) times per week for twelve (12) weeks to ensure resident's rights are protected for personal privacy and confidentiality of their clinical records. Results of these observations will be forwarded to the facility Quality Assurance Performance Improvement Committee for review and recommendation for at least three months. If at any time concerns are identified, the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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F 164	Continued From page 31 usually covered the MARs when she was away from the medication cart. 2. Observation, on 05/28/14 at 11:15 AM, revealed LPN #1 passing medications. LPN #1 prepared Insulin for administration to Resident #14 and entered the resident's room leaving the resident's MAR exposed and in full view of residents and staff that were in the area. Interview with LPN#1, at the time, revealed resident information on MARs was not to be left in view and she should have closed the MAR book or covered the resident's MAR. Interview with the Assistant Director of Nursing (ADON), on 05/30/14 at 10:15 AM, revealed she expected the residents' MARs to be kept private and not left in full view of anyone passing by the cart.	F 164			
F 281 SS=L	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 interview, record review, and facility policy review, and review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, it was determined the facility failed to provide services, in accordance with acceptable standards of practice related to following physician's orders, for ten (10) of seventeen (17) sampled residents (Residents #2, #3, #6, #10, #11, #12, #13, #14, #15 and #16), and one (1)	F 281	<u>F 281</u> 483.20(K)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS <u>The corrective action accomplished to correct the alleged deficient practice:</u> Resident #11 expired on 05/24/2014 at the facility. Resident #12 discharged home from the facility on 05/31/2014. On 6/4/2014, an observation of the MARs and medication observation for Residents #2, 3, 6, 10, 13, 14, 15, and 16 and Resident A noted medications were administered as ordered and treatments were administered per physicians' order for resident #6. These observations were made per Director of Nursing.		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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F 281	<p>Continued From page 32</p> <p>unsampled resident (Unsampled Resident A). Physician's orders had not been consistently followed related to medication administration and physician ordered treatments. It was determined the facility failed to ensure medications were administered as prescribed by their physician and according to acceptable standards of practice for nine (9) residents; and, the facility failed to provide a treatment as per the Physician's Order for a wound drain site for one resident.</p> <p>On 05/29/14, the physician ordered Resident #10 to receive a "now" dose of Potassium 40 milliequivalents (meq). However, the facility failed to administer the medication until 05/30/14. The resident was sent to the hospital on 05/30/14 and diagnosed with Hypokalemia (low potassium).</p> <p>On 05/21/14, the physician ordered Resident #11 to receive Solu-Medro (steroid) 40 milligrams (mg) intramuscular (IM) and Levaquin (antibiotic) 500 mg intravenously (IV) every 24 hours "stat" (immediately). However, the facility failed to administer the medication until 05/22/14. The resident expired on 05/24/14.</p> <p>On 05/05/14, Resident #12, who had a seizure disorder, was readmitted to the facility with a physician's order for Keppra (anti-seizure medication) 500 mg twice a day. However, the facility failed to administer the medication from 05/05/14 through 05/08/14 for a total of six (6) doses. The resident had another seizure on 05/08/14 and was hospitalized. The resident returned to the facility on 05/13/14, with a Physician's Order to change the milligrams from 500 mg to 1000 mg twice a day. The facility administered 500 mg (should have been 1000 mg) twice a day from 05/13/14 through 05/31/14</p>	F 281	<p><u>Other residents had the potential to be affected.</u></p> <p>On 5/31/2014, the Director of Nursing, a consulting Director of Nursing, and the Regional Nurse Consultant audited physician orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 6/2/2014, two representatives from Omnicare Pharmacy completed a Medication Administration Record (MAR) to Medication Cart Audit for all current residents to ensure all medications are available for administration per physicians order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>On 6/3/2014, the DON audited TARs for all current residents to ensure all treatments were completed per physicians' order. All treatments were completed as ordered.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur.</u></p> <p>On 6/1/2014, Regional Nurse Consultant (RNC) re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered per physicians order, and post test completed.</p>	
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 281	<p>Continued From page 33 (total of thirty five doses).</p> <p>The physician ordered Resident #14 to receive Pancrelipase 5000 Units every meal and prior to bedtime. However, the facility failed to administer the medication on 05/19/14, 05/21/14, 05/22/14 and 05/28/14 for a total of fourteen (14) missed doses.</p> <p>Resident #15, who had a diagnosis of chronic pain had a Physician's Order to receive Fentanyl Patch (narcotic pain reliever) 25 micrograms/hour (mcg/hr), to be changed every seventy-two (72) hours. The facility failed to administer the patches on 05/05/14, 05/26/14 and 05/29/14 which resulted in the resident not having a pain patch in place for eight (8) days. The resident voiced complaints of severe pain.</p> <p>The physician ordered Resident #16 to receive Torsemide (diuretic) 30 mg daily, Allopurinol (for Gout) 50 mg daily, Aspirin (salicylate) 81 mg daily, Neurontin (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 meq three (3) times daily, Clindamycin (antibiotic) 300 mg three (3) times daily for ten (10) days (to end on 05/09/14), Vancomycin (antibiotic) one (1) gram twice daily for seven (7) days (with last dose on 05/23/14) and Percocet (analgesic) 10-325 mg every eight (8) hours routine. However, the facility failed to administer the medication consistently.</p> <p>On 05/16/14, Resident #2's physician ordered Diflucan 100 mg by mouth every day for five (5) days for a yeast rash. The facility failed to administer the medication from 05/19/14 through 05/22/14.</p>	F 281	<p>On 6/1/2014, the DON initiated re-education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability", which states the procedure to follow for physician notification when medications are not available to be administered per physicians order or physician orders were unable to be followed including treatments. This training will be completed with all licensed nurses by the DON. The DON will re-educate and validate competency with Assistant Director of Nursing (ADON), MDS Nurse (MDS) or Unit Manager before they initiate re-education with the licensed nurses. No licensed nurse will work after 6/4/2014 without having had this re-education and competency test.</p> <p>On 6/13/2014, the protocol titled "Medication Availability" and post test were added by the DON to the new hire packets for Licensed Nurses to educate them during orientation on the system in place to follow for physician notification when medications are not available or treatments are unable to be completed per physicians order.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, Omnicare Pharmacy audited all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks on 6/9/2014, 6/16/2014, 6/23/2014, and 6/30/2014 and then will be completed every two weeks for eight (8) weeks by Omnicare to assure all medications are available. Any deficiency identified will be corrected immediately. Beginning the week of 6/9/2014, the DON, ADON, MDS Nurse or Unit Manager will audit Treatment Administration Records (TARs) five (5) times a week for twelve weeks</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42288	
(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 34</p> <p>The physician ordered Resident #3 to receive Norvasc (blood pressure) 10 mg every day. The facility failed to administer the medication from 05/23/14 - 05/29/14 for a total of seven (7) missed doses.</p> <p>The physician ordered Resident #13 to receive Buspar (antianxiety) 6 mg per PEG tube twice daily routine. The facility failed to administer the medication from 05/24/14 through 05/27/14, for a total six (6) missed doses.</p> <p>The Physician ordered Unsampled Resident A to receive Amlodipine Besylate (blood pressure medication) 10 mg Tablet, give one tablet by mouth daily. However, observation of a medication pass on 05/29/14 revealed the medication was not available for administration and the physician order was not followed.</p> <p>On 05/13/14, the physician ordered Resident #6's wound drainage sites to be cleansed with normal saline/soap and pat dry every shift. The facility failed to provide the treatments 05/13/14 through 05/18/14 on the 6a-8p shift.</p> <p>The facility's failure to administer medication and provide treatment per professional standards of quality of care and per Physician's Orders has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 06/02/14 at 4:35 PM, revealed the facility based their</p>	F 281	<p>to ensure that treatments are completed per physicians' order. Any deficiency identified will be corrected immediately to include consultation/notification of physician. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review and recommendation for at least three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
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F 281	Continued From page 35 standards of practice on the Kentucky Board of Nursing as well as the facility's policy, titled Medication Shortages/Unavailable Medications. Review of the facility policy and procedure titled, "Medication Shortages/Unavailable Medications" last revised 01/01/13, revealed actions to take upon discovery that the facility has an inadequate supply of medication to administer to a resident included staff taking immediate action to obtain the medication. If a medication shortage was discovered during normal Pharmacy hours, the nurse should call the pharmacy to determine the status of the order. If the medication has not been ordered, place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, obtain the medication from the Emergency Medication Supply to administer the dose. If the medication was not available in the Emergency Medication Supply, notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, staff should obtain the ordered medication from the Emergency Medication Supply and if it was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. The action may include emergency delivery or the use of an emergency (back-up) third party pharmacy. If an emergency delivery is unavailable, the nurse should contact the attending physician to obtain orders or directions. If the nurse was unable to obtain a response from the attending physician/prescriber in a timely manner, the nurse should notify the nursing supervisor and contact the facility's Medical Director for orders/direction	F 281			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 281	<p>Continued From page 36</p> <p>while making sure to explain the circumstances of the medication shortage. When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the MAR or Treatment Administration Record (TAR) and in the Nurse's Notes per facility policy. Such documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken.</p> <p>Review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, last revised 10/20/10, revealed "Registered Nursing Practice" and "Licensed Practical Nurse" were expected to administer medication and treatment as prescribed by physician, physician assistant, dentist or advanced practice registered nurse. Components of medication administration include, but are not limited to: Preparing and giving medication in the prescribed dosage, route, and frequency, including dispensing medications".</p> <p>1. Record review revealed the facility admitted Resident #10, on 05/16/14, with diagnoses which included Diarrhea and Diabetes.</p> <p>Review of routine laboratory test results, conducted on 05/20/14, revealed the resident's Potassium level was 3.2 millimoles/Liter (mmol/L) and the normal value was between 3.5-5.50 mmol/L. On 05/21/14, the resident was placed on intravenous fluids (IVFs) at 75 ml/hour to end on 05/27/14 and a "now" dose of Potassium 40 milliequivalent (meq) was administered. The Potassium level was rechecked on 05/22/14 with a result of 3.5 mmol/L.</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 281	<p>Continued From page 37</p> <p>Review of a Physician's Order, dated 05/29/14 at 9:40 PM, revealed an order from the physician to medicate the resident with Potassium 40 meq "now". Review of the May 2014 MAR revealed the Potassium dose was not administered on 05/29/14, according to the physician's order. Further review revealed the Potassium was not administered until 05/30/14 at 9:00 AM by LPN #4.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 05/31/14 at 3:30 PM, revealed she was responsible to transcribe Physician's Orders onto the MAR and to administer medications per the Physician's Orders. She stated she should have placed the medication order on the MAR and administered the medication at that time because it was a "now" order but she forgot.</p> <p>Record review revealed a repeat potassium level was obtained on 05/30/14 at 1:45 PM and the result was 2.4 mmol/L (normal 3.5 to 5.0). The lab result was phoned to the Physician's Assistant (PA) at 6:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. The resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and was subsequently admitted into the hospital with diagnoses of Hypomagnesemia and Hypokalemia.</p> <p>2. Closed record review revealed the facility admitted Resident #11 on 07/01/12 with diagnoses which included Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>On 05/21/14 at 10:57 PM, per Nursing Notes,</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286	
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F 281	<p>Continued From page 38</p> <p>LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practitioner Registered Nurse (APRN) was notified on 05/21/14 at 11:30 PM and "stat" orders were received to medicate the resident with Solu-Medrol 40 mg intramuscularly (IM), and Levaquin 500 mg IV every 24 hours. Review of the May 2014 MAR and Nursing Notes, revealed the medication was not administered stat on 05/21/14 as per the physician's order but was administered on 05/22/14 at 5:49 PM approximately seventeen (17) hours later.</p> <p>Further review of the Nurse's Notes, dated 05/24/14 at 6:24 PM, revealed the resident was noted to have a fixed facial expression. Cardiopulmonary resuscitation(CPR) was initiated and continued until Emergency Medical Services (EMS) arrived. Resuscitation was unsuccessful and the resident expired.</p> <p>Interview conducted with the Administrator, on 06/30/14 at 3:20 PM, revealed the oncoming licensed staff failed to obtain the stat Solu Medrol which was in the EDK box and administer the medication.</p> <p>3. Record review revealed the facility admitted Resident #12 on 04/30/14 with a diagnosis of Post Traumatic Seizures.</p> <p>According to a Nurse's Note, dated 05/02/14 at 7:27 PM, Resident #12 had a seizure at 11:45 AM (same date). Review of a Nurses Note, dated 05/05/14 at 6:53 AM, revealed a new order was received from the APRN to transport the resident to the emergency room for evaluation and treatment. The resident was transported by Emergency Medical Services (EMS) at 6:46 PM.</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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F 281	<p>Continued From page 39</p> <p>Resident #12 was admitted to the hospital. Review of a Nurse's Note, dated 05/08/14 at 5:38 PM, revealed Resident #12 was readmitted to the facility with readmission orders to administer Keppra 500 mg by mouth twice daily.</p> <p>Review of the May 2014 MAR revealed the order was handwritten on the MAR as Keppra (levetiracetam) 500 mg by mouth twice daily and to receive the first dose at 9:00 PM on 05/05/14. However, further review revealed there was no documentation on the MAR that the Keppra was administered twice daily per the physician's order after the resident's readmission to the facility on 05/05/14 through 05/08/14 (a total of seven (7) doses) and no documentation as to why the medication was not administered according to the physician's order or if the pharmacy was notified. Further review of the Nurse's Notes revealed on 05/08/14, the resident experienced another seizure and was transported back to the emergency room and was admitted again.</p> <p>Interview with the Administrator, on 08/01/14 at 10:30 AM, revealed after reviewing the MAR that it appeared the Keppra wasn't given.</p> <p>Review of the Admission Orders, dated 05/13/14, revealed an order for Keppra 500 mg tablets, 1000 mg twice daily on readmission; however, review of the May 2014 MAR revealed the resident received Keppra 500 mg twice a day from 05/13/14 through 05/31/14 (thirty-five (35) doses) instead of the 1000 mg twice a day per physician's order.</p> <p>Interview with the Advanced Practical Registered Nurse (APRN), on 06/02/14 at 1:26 PM, revealed on 06/13/14 the discharge medications were</p>	F 281		
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F 281	<p>Continued From page 40 written by the APRN for Keppra 1000 mg PO twice a day.</p> <p>Interview with the Director of Nursing, on 06/02/14 at 1:45 PM, revealed the Keppra dosage given 05/14/14 through 05/31/14 was incorrect. The MAR was printed to read Keppra 500 mg by mouth twice a day instead of Keppra 1000 mg by mouth twice daily.</p> <p>4. Record review revealed the facility admitted Resident #15 on 07/03/12 with a diagnosis of Chronic Pain. Review of a quarterly MDS assessment, dated 04/02/14, revealed the facility assessed Resident #15's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable.</p> <p>Review of the May 2014 Physician Orders revealed an order for Fentanyl (analgesic) patch 25 mcg/hr, to be changed every 72 hours. However, review of the May 2014 MAR revealed the resident did not receive his/her Fentanyl patch every three (3) days as ordered on 05/05/14, 05/14/14 and 05/29/14 which resulted in the resident not having a pain patch in place to control his/her pain for a total of eight (8) days.</p> <p>Interview with Resident #15, on 05/30/14 at 11:30 AM, revealed he/she was currently hurting "bad". Assessment at the time, by the Assistance Director of Nursing revealed there was no Fentanyl patch in place. Resident #15 was unaware he/she did not have a patch in place. The resident stated the patch helped as he/she always had pain.</p> <p>Interview with LPN #3, on 05/31/14 at 3:00 PM,</p>	F 281			

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F 281	<p>Continued From page 41</p> <p>revealed Resident # 15 did not have the prescribed Fentanyl patches available in the medication cart drawer on 05/29/14 and another time at the beginning of the month. She stated she called the pharmacy and was told the Fentanyl patch was not covered by the resident's insurance but Morphine was covered. LPN #3 stated she called the ARNP, who said the resident had been on the Fentanyl for some time and she wanted him/her to have the Fentanyl patch. LPN #3 stated Resident #16 had "Hit me at the door complaining of pain and had never complained of pain like that before and that's how I knew it was missed." She stated, "the pharmacy will not send a medication if it's not covered by insurance and the residents go a day or two without".</p> <p>5. Record review revealed the facility admitted Resident #14 on 10/11/13 with diagnoses which included Diarrhea and Colon Resection. Review of the Quarterly MDS assessment, dated 04/24/14, revealed the facility assessed Resident #14 as cognitively intact with a BIMS score of fourteen (14) which indicated the resident was interviewable.</p> <p>Review of the May 2014 Physician's Order, revealed an order for Pancrealga 5000 units at meals and before bedtime. However, review of the May 2014 MAR revealed the resident did not receive a total of fourteen (14) doses of Pancrellpase (enzyme) 5000 units on 05/19/14, 05/21/14, 05/22/14 and 05/28/14 per the physician's orders.</p> <p>Interview with Resident #14, on 05/28/14 at 2:25 PM, revealed he/she had not received the medication and he/she did not know why as</p>	F 281			

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F 281	<p>Continued From page 42</p> <p>he/she had received this medication for years. The resident stated he/she was told that the medical card would not pay for it.</p> <p>Interview with the DON, on 05/28/14 at 3:35 PM revealed she was currently investigating the situation and he/she had authorized the pharmacy to fill the medication and bill it to the facility.</p> <p>6. Record review revealed the facility admitted Resident #13 on 07/01/12 with diagnosis of Impulse Control Disorder. Review of a Physician's Order, dated 05/24/14, revealed an order to administer Buspar (antianxiety agent) 5 mg per PEG tube twice daily routine. Review of the May 2014 MAR revealed staff initials were circled on the MAR for 05/24/14 through 05/26/14 which indicated the medication was not given, with no entry for the 9:00 PM dose on 05/28/14. The 9:00 AM dose on 05/27/14 had an initialed circle on the MAR. However, review of the back of the MAR with LPN #2, revealed the pharmacy was called on 05/27/14 at 9 AM to inquire about the medication and was told it would be in that night but there was no documentation indicating the pharmacy had been called prior to this or documentation as to why the medication was not given. Review of the May 2014 MAR revealed the medication was given on 05/27/14 at 9:00 PM.</p> <p>7. Record review revealed the facility admitted Resident #16 on 09/19/13 with diagnoses which included Gout, Diabetes, Below the Knee Amputation and Generalized Pain. Review of a Quarterly MDS assessment, dated 05/01/14 revealed the facility assessed Resident #16 as cognitively intact with a BIMS score of fifteen (15)</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION-CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 281	<p>Continued From page 43 which indicated the resident was Interviewable.</p> <p>Review of the May 2014 Physician's Orders revealed orders for Torsemide (diuretic) 30 mg daily, Allopurinol (for Gout) 50 mg daily, Aspirin (salicylate) 81 mg daily, Neurontin (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivalent three (3) times daily, Clindamycin (antibiotic) 300 mg three (3) times daily for 10 days (to end on 05/09/14), Vancomycin (antibiotic) one (1) Gram twice daily for seven (7) days (with last dose on 05/23/14) and Percocet (analgesic) 10-325 mg every eight (8) hours routine. Review of the May 2014 MAR revealed the boxes were blank and there was no documentation to indicate if the medication was given or not on the MAR for these medications on these dates: Torsemide 30 mg on 05/18/14, 05/26/14 and 05/31/14, Allopurinol 50 mg on 05/14/14 and 05/28/14, Aspirin 81 mg on 05/11/14 and 05/20/14, Neurontin 400 mg on 05/17/14, 05/20/14 and 05/31/14, K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14, Clindamycin 300 mg on 05/02/14 and 05/08/14, Vancomycin on 05/20/14 and Percocet on 05/18/14, 05/20/14 and 05/31/14.</p> <p>Interview with Resident #16, on 06/02/14 at 2:23 PM, revealed the resident reported the presence of pain while not receiving his/her medications as ordered.</p> <p>Interview with the DON, on 05/29/14 at 1:10 PM, revealed if a medication or treatment wasn't documented, it wasn't done.</p> <p>8. Observation of a medication pass performed</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 44</p> <p>by Licensed Practical Nurse (LPN) #3, on 05/29/14 at 8:40 AM, revealed Amlodipine (blood pressure medication) 10 mg was not administered to Resident #18 as ordered because the medication was not available in the medication cart.</p> <p>Review of Resident #18's Physician's Orders, dated 05/2014, revealed Amlodipine Besylate 10 mg Tablet, give one tablet by mouth daily.</p> <p>Review of the May 2014 MAR revealed Amlodipine 10 mg on 05/15/14, 05/18/14, 05/19/14, 05/23/14, 06/24/14, 05/25/14, 05/26/14, 05/27/14, 05/28/14 and 05/29/14 (total of ten doses) was initial and circled. There was no documentation on the back of the MAR to indicate the rationale for the medication not being administered or if the pharmacy was notified. Additionally, Resident #18 did not receive Pantoprazole 20 mg eleven (11) times per the May 2014 MAR. The MAR revealed initials circled indicating not received on 05/12/14, 05/13/14, 05/16/14, 05/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14 and 05/28/13. The back of the MAR revealed six (6) days documentation for Pantoprazole not available on May 13th, 23rd, 24th, 26th, 28th and 27th. The five (5) remaining missed doses had no documentation to indicate the reason the medication was not administered. There was no documentation indicating if pharmacy was notified the medication was not available for administration.</p> <p>Interview conducted with LPN #3, on 05/29/14 at 9:30 AM and 10:25 AM, revealed she was not aware the resident was out of this medication until she was doing the medication pass. She</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 281	<p>Continued From page 45</p> <p>stated she would check the Emergency Drug Kit (EDK) box to see if it would be in there to give, then call the pharmacy to see what the issue was. LPN #3 revealed after checking with the Pharmacy she was informed the last time Amlodipine was delivered was on 04/06/14.</p> <p>9. Record review revealed the facility admitted Resident #3 on 07/01/12 with a diagnosis of Hypertension. Review of a Physician's order, dated May 2014, revealed an order to administer Norvasc (blood pressure) 10 milligrams (mg) every day. However, review of the May 2014 MAR revealed this medication was initiated and circled from 05/23/14 through 05/29/14 (seven (7) doses) which indicated the medication was not given and no documentation on the back of the MAR to indicate why it was not given and if the pharmacy had been notified.</p> <p>10. Record review revealed the facility admitted Resident #2, on 07/01/12, with diagnoses which included Spina Bifida and Obesity. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of fifteen (15) indicating the resident was interviewable.</p> <p>Review of the Physician's Order, dated 05/16/14, revealed an order for Diflucan 100 mg by mouth every day for five (5) days for a yeast rash. However, a review of the May 2014 Medication Administration Record (MAR) revealed the medication was not initiated/documented as given on 05/19/14 through 05/22/14 and there was no documentation indicating the pharmacy was notified.</p>	F 281			

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F 281	<p>Continued From page 46</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/28/14 at 11:15 AM, verified the medication was not available for administration and that it was not available for administration the last time she passed medications a few days ago.</p> <p>Interview with Resident #2, on 05/31/14 at 4:00 PM, revealed he/she had not received the medication.</p> <p>11. Record review revealed the facility admitted Resident #6 on 05/13/14 with diagnoses which included Hypertension. Review of a Physician's Order, dated 05/13/14, revealed the Jackson Pratt (JP) drain sites were to be cleansed with normal saline/soap and pat dry every shift. However, review of the May 2014 Treatment Administration Record (TAR) revealed no documented evidence the treatments were performed on the 6a-6p shift on 05/13/14 through 05/18/14.</p> <p>Interview with LPN #1, on 05/28/14 at 3:25 PM, revealed the order for the cleansing of the wound drainage site was not on the original TAR and she did not do it. He/she reported that the TAR was corrected the following Monday morning (05/19/14).</p> <p>Post Survey Interview conducted on 07/02/14 at 3:35 PM with LPN #4 revealed nurses should follow the six (6) rights of medication administration related to right resident, right medication, right time, right dose, right route, and right to receive. The LPN stated when they identify a medication is getting low they have to peel off the sticker from the label and send it to the pharmacy. The LPN revealed the medication should come in that night's tote unless there were</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286
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F 281	<p>Continued From page 47</p> <p>insurance or prescription issues and then the pharmacy would fax a paper stating the medication could not be delivered. The LPN stated if a medication was not available for administration the pharmacy would be called and the Unit Manager would be notified. She stated she would document by initialing the MAR and circling her initials and write the reason not given on the back of the MAR. The LPN stated the way she would find out if a medication was in the EDK box was by getting the list of medications that was in the box and see if it was on the list.</p> <p>Post Survey Interview conducted on 07/02/14 at 3:45 PM with LPN #3 revealed nurses should follow the eight (8) rights of medication administration related to right resident, right medication, right time, right dose, right route, right documentation, right to refuse and right to receive. The LPN stated when they identify a medication is getting low, they remove the sticker on the box and place it on a fax sheet and fax to the pharmacy. The LPN revealed if a medication was not available to administer the pharmacy would be called and the Physician would be notified. She stated she would go on the computer and document in the Nurse's Notes which medication were not given and would initial and circle her initials on the MAR. The LPN stated she would look at the list kept in the EDK box to identify if a medication was in the box.</p> <p>Interview with the DON, on 05/29/14 at 1:10 PM, revealed if medications were not available for administration for a resident, the pharmacy should be called. She stated medications could be ordered STAT and the pharmacy could send them from the back up pharmacy as needed. The DON further reported that if a medication or</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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F 281	<p>Continued From page 48 treatment wasn't documented, it wasn't done.</p> <p>A Post Survey Interview with the DON, on 07/02/14 at 9:20 AM, revealed the nurses should have initialed and circled the box on the MAR if the medication was not available for administration and should have documented on the back of the MAR why the medication was not given. In addition, she stated the nurses should have notified the pharmacy the medication was not available for administration and documented the pharmacy was notified on the back of the MAR. The DON stated some of the residents' medications were not available due to the physician's Medicaid number not being renewed but others were because the nurses had failed to order the medication.</p> <p>Interview with the Administrator, on 05/30/14 at 3:20 PM, revealed the facility had been having a problem with some of the resident's medications not being delivered from the pharmacy due to a Physician needing to update his provider number. She stated the protocol was for the pharmacy to continue to send the medications until the problem was resolved and the facility was currently working with the pharmacy on that. However, when staff was unable to carry out a physician's order, he/she would have expected the staff to report to the nurse in charge, and stated staff should have called the pharmacy and checked the EDK box to ensure medications were available for administration.</p> <p>A Post Survey interview with the Administrator, on 07/04/14 at 9:45 AM, revealed the staff should have documented on the MAR why a medication was not given and if the medication was not available for administration the staff should have</p>	F 281		
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F 281	<p>Continued From page 49</p> <p>documented this on the back of the MAR and also documented that pharmacy was made aware.</p> <p>*The facility implemented the following actions to remove the immediate jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physician's order, and post test completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work</p>	F 281			

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F 281	<p>Continued From page 60 after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director,</p>	F 281			

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F 281	<p>Continued From page 51</p> <p>Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education</p>	F 281			

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F 281	<p>Continued From page 52 regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the</p>	F 281			

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F 281	<p>Continued From page 53</p> <p>medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to obtain the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is</p>	F 281			

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F 281	<p>Continued From page 54</p> <p>an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 06/12/14 at 11 :46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post</p>	F 281			

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F 281	<p>Continued From page 55 test on the covered inservice material.</p> <p>On 08/12/14 at 12:08 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 08/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 08/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 08/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the</p>	F 281			

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F 281	<p>Continued From page 56</p> <p>resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p>	F 281			

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F 281	<p>Continued From page 57</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The slicker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #6 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lorlab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was</p>	F 281			

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F 281	<p>Continued From page 58 pending related to the omission on the MAR.</p> <p>On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 06/12/14 at 5:15 PM, with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM, with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p>	F 281			

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F 281	Continued From page 69 Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 281		
F 282 SS=L	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 facility's policy and procedures, it was determined the facility failed to ensure care was provided in accordance with the plan of care for eight (8) of seventeen (17) sampled residents (Residents #1, #3, #10, #11, #13, #14, #15 and #16). Resident #1, who was a paraplegic, was care	F 282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 4/16/2014, SRNA #1 was terminated from employment. Resident #11 expired on 05/24/2014 in the facility. On 6/3/2014, the care plans of the following residents were reviewed and revised, as indicated, by an Interdisciplinary Team consisting of DON, MDS, Dietary Manager, Social Service Director (SSD) and Activities Director and validated that all interventions were in place as indicated to include administer medications per physicians' orders for Resident #3, 10, 13, 14, 15, and 16. On 6/3/2014, an observation by the Director of Nursing noted that resident # 1 was being transferred per the plan of care.	

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F 282	<p>Continued From page 60</p> <p>planned to be transferred by one staff manually; however, on 03/30/14, State Registered Nurse Aide (SRNA) #1 transferred Resident #1 with a lift. The resident was not assessed or care planned for the use of the lift. Resident #1's foot became caught between two steel pieces of the lift and the resident sustained fractures involving the distal tibia and fibula.</p> <p>Residents #3, #10, #11, #13, #14, #15, and #16 were care planned to receive medications as ordered; however, the facility failed to administer the medications.</p> <p>Resident #10 did not receive a now dose of Potassium on 05/29/14 and was hospitalized with a diagnosis of Hypokalemia. Resident #11 did not receive Solu-Medro (steroid) intramuscular (IM) and Levaquin (antibiotic) Intravenous (IV) until 05/22/14 although the order was received as a "stat" order on 05/21/14. Resident #13 did not receive a total of six (6) doses of Buspar (antianxiety) 5 mg. Resident #14 did not receive a total of fourteen (14) doses of Pancrelipase (digestive enzyme) 5000 Units from 05/19/14 through 05/28/14. Resident #15, who had a diagnosis of chronic pain did not receive Fentanyl (narcotic pain) patches as prescribed on 05/05/14, 05/28/14 and 05/29/14 which resulted in the resident going eight (8) days without a pain patch in place. Resident #16 did not consistently receive Torsemide (diuretic), Allopurinol (gout), Aspirin (heart), Neurontin (Neuropathy), K-Dur (Renal Failure), Cilindamycin (antibiotic), Vancomycin (antibiotic) and Percocet (pain) according to the resident's Medication Administration Record (MAR). Resident #3 did not receive seven (7) doses of Norvasc (blood pressure medication).</p>	F 282	<p><u>Other residents had the potential to be affected.</u></p> <p>On 6/3/2014, the care plans of all current residents were reviewed and revised as indicated by an Interdisciplinary Team (consisting of DON, MDS, Dietary Manager, Social Service Director (SSD) and Activities Director) and validated that all interventions were in place as indicated to include administer medications per physicians' orders. Any intervention identified on the care plan and not in place was immediately implemented.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 6/3/2014, Regional Nurse Consultant (RNC) re-educated the DON on development, revision and implementation of the care plan to include administration of medications per MD orders and documentation of omission of medication as well as the requirement to follow the care plan, including the nursing assistant reporting to a nurse and the nurse reporting to the Physician if unable to make a determination.</p> <p>On 6/3/2014, DON re-educated an Interdisciplinary Team consisting of DON, MDS, Dietary Manager, Social Service Director (SSD) and Activities Director on development, revision and implementation of the care plan to include administration of medications per MD orders and documentation of omission of medication.</p> <p>On 6/3/2014, the DON began re-education with all Certified Nursing Assistants and licensed nurses regarding following the care</p>		

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F 282	<p>Continued From page 61</p> <p>The facility's failure to provide care according to the resident's care plan has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 08/02/14 and determined to exist 05/05/14. The facility was notified of the Immediate Jeopardy on 08/02/14.</p> <p>The findings include:</p> <p>Review of an undated policy, titled Resident Comprehensive Care Plan, revealed the care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility and should always have realistic goals and approaches/interventions to address the residents' needs.</p> <p>1. Record review revealed the facility admitted Resident #1 on 02/13/14 with diagnoses which included Paraplegia and Chronic Pain. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/20/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) of fifteen (15) which indicated the resident was interviewable. The facility also assessed the resident as requiring the extensive assistance of two (2) staff for transfers.</p> <p>Review of the Comprehensive Care Plan for Activities of Daily Living, dated 04/24/14, revealed an intervention for one (1) person physical assist manually. Further review revealed there was no intervention to use a lift for transfers.</p>	F 282	<p>plan and what actions to take when the care plan can not be followed including notification of the physician if the Nurse is unable to make a determination. This training will be completed with all licensed nurses and Certified Nursing Assistants by the DON. The DON will re-educate and validate competency with Assistant Director of Nursing (ADON), MDS Nurse (MDS) or Unit Manager before they initiate re-education with the licensed nurses and CNAs. No licensed nurse or Certified Nursing Assistant will work after 6/4/2014 without having had this re-education and competency test.</p> <p>On 6/13/2014, the protocol for following the care plan and what actions to take when the care plan can not be followed including notification of the physician if the Nurse is unable to make a determination and post test were added by the DON to the new hire packets for Licensed Nurses and CNAs to educate them during orientation on the system in place to follow the care plan for each resident to include administer medications per MD orders.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, The DON, ADON, MDS, or Unit Manager will audit five (5) records per week for twelve (12) weeks to ensure all interventions care planned are in place to include administer medications per physicians' order. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review</p>	

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F 282	<p>Continued From page 62</p> <p>Review of the facility's final report of the investigation, dated 04/10/14, revealed Resident #1 was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance. Further review of the investigation revealed while being transferred, the resident's right foot became tangled in the metal frame of the lift. Due to the resident's paraplegia, he/she was unable to feel pain to the leg. The resident's family member, who was present to take the resident out for the day, witnessed and assisted the SRNA to untangle the resident's leg. The incident was not reported by the SRNA. Record review revealed an x-ray of the right foot was ordered on 04/03/14 and completed on 04/04/14 by the mobile x-ray service which revealed the resident had a right fractured tibia and fibula. Following the investigation, it was determined the SRNA did not follow the resident's plan of care and did not have assistance operating a mechanical lift.</p> <p>Review of a Physician's Order Sheet, dated 04/04/14 at 8:30 PM, revealed an order was received from the physician to send the resident to the emergency room for evaluation of the fractured tibia/fibula. An x-ray of the right lower leg on 04/04/14 at 10:30 PM, revealed a radiologist interpretation of diffuse severe osteopenia with oblique comminuted, minimally displaced fractures involving the distal tibia and fibula.</p> <p>Interview with Resident #1, on 05/21/14 at 9:00 AM, revealed while being transferred with the lift, his/her leg got caught. The resident reported he/she should have been transferred using two (2) assist.</p>	F 2E	<p>for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	7/11/14	

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F 282	<p>Continued From page 63</p> <p>A telephone interview with a family member, on 05/22/14 at 10:22 AM, revealed on 03/30/04, he/she was at the facility to take the resident out for a while. Further interview revealed the staff person picked him/her up with the lift and caught the resident's leg between the two (2) steel pieces. He/she had to raise the lift to get the resident's foot out. She further stated the staff was working alone.</p> <p>Interview with the Administrator, on 05/21/14 at 11:10 AM, revealed the resident was not care planned for the use of a lift, according to the care plan the resident was to have the manual assistance of one person.</p> <p>2. Record review revealed the facility admitted Resident #10 on 05/16/14 with diagnoses which included Diarrhea, Diabetes and Psychosis. Review of the Admission MDS assessment, dated 05/23/14, revealed the facility assessed the resident to have severe cognitive impairment.</p> <p>Review of the Comprehensive Care Plan for Alteration in Nutrition, dated 05/16/14, revealed "Meds/labs as ordered".</p> <p>Review of a Physician's Order, dated 05/29/14 at 9:40 AM, revealed an order from the physician written by Licensed Practical Nurse (LPN) #3, to medicate the resident with Potassium 40 meq "now" (Immediately) and recheck Potassium level four (4) to twenty-four (24) hours after administration.</p> <p>Review of the May 2014 Medication Administration Record (MAR) revealed the Potassium was not administered until 05/30/14 at 9:00 AM by another nurse, Licensed Practical</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 282	<p>Continued From page 64</p> <p>Nurse (LPN) #4. Interview with Licensed Practical Nurse (LPN) #3, the nurse who received the order, on 05/31/14 at 3:30 PM, revealed she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. The missed potassium dose was not administered until 05/30/14 at 9:00 AM by LPN #4.</p> <p>Review of a Laboratory Report for a repeat Potassium level which was obtained on 05/30/14 at 1:46 PM revealed the result was 2.4 mmol/L (normal 3.5 to 5.0). The result was phoned to the Physician's Assistant (PA) at 8:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. Record review revealed the resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and subsequently admitted into the hospital with a diagnosis of Hypokalemia (low Potassium).</p> <p>3. Record review revealed the facility admitted Resident #11 on 07/01/12 with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of the Comprehensive Care Plan for Nutrilion related to COPD, dated 05/03/14, revealed an Intervention to provide "medication and treatment as ordered".</p> <p>Review of a Nurse's Note, dated 05/21/14 at 10:57 PM, revealed LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practice Registered Nurse (APRN) was notified on 05/21/14 at 11:30 PM and an order was received to medicate the resident with Solu-Medrol 40 mg</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 65</p> <p>Intramuscularly (IM), Levaquin 500 mg IV every 24 hours, Prednisone 40 mg by mouth times two (2) doses, DuoNeb every 4 hours, check vital signs every 4 hours, a chest radiograph (x-ray) and a complete blood count (CBC) stat. However, review of the May 2014 MAR and Nurse's Notes revealed the resident did not receive the Solu-Medrol 40 mg IM and the Levaquin 500 mg IV until 05/22/14 at 5:49 PM (next day) after it was taken from the emergency drug kit (EDK) by LPN #1.</p> <p>Review of the radiology report of the chest x-ray, dated 05/22/14, revealed defined infiltrative shadows in the left Infrahilar and lower lobe suggestive of Pneumonia.</p> <p>4. Record review revealed the facility admitted Resident #16 on 07/03/12 with diagnoses which included Chronic Pain.</p> <p>Review of the Comprehensive Care Plan for Pain, dated 04/02/14, revealed an intervention to "administer pain medications as ordered".</p> <p>Review of the May 2014 Physician Orders revealed an order for Fentanyl patch 25 mcg/hr, to be changed every seventy-two (72) hours. Review of the May 2014 MAR revealed the resident did not receive his/her Fentanyl patch on 05/05/14, 05/14/14 and 05/28/14 which caused the resident to go without a patch in place for eight (8) days.</p> <p>5. Record review revealed the facility admitted Resident #14 on 10/11/13 with diagnoses which included Diarrhea and Colon Resection. Review of the Quarterly MDS assessment, dated 04/24/14, revealed the facility assessed Resident</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 66</p> <p>#14 as cognitively intact with a BIMS score of fourteen (14) indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Risk for Alteration in Nutrition, dated 04/24/14, revealed an intervention to receive medications as ordered. Review of the May 2014 Physician's Order revealed an order for Pancrelipase (digestive enzyme) 5000 units to be taken at meals and before bedtime.</p> <p>Review of the May 2014 MAR revealed the resident did not receive Pancrelipase on 05/19/14, 05/21/14, 05/22/14 and 05/28/14 for a total of fourteen (14) missed doses.</p> <p>Interview with Resident #14, on 05/28/14 at 2:26 PM, revealed he/she had been missing the medication but did not understand why as he/she has been on it for years. The resident stated he/she was told that the medical card would not pay for the medication.</p> <p>Interview with the Director of Nursing (DON), on 06/28/14 at 3:35 PM, revealed she was investigating the situation and that she had authorized the pharmacy to fill the medication and bill it to the facility.</p> <p>G. Record review revealed the facility admitted Resident #13 on 07/01/14 with diagnoses which included Impulse Control Disorder.</p> <p>Review of the Comprehensive Care Plan related to Impulse Control, dated May 2014, revealed an intervention to give medications as ordered.</p> <p>Review of the Physician's Order, dated 06/24/14,</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 67</p> <p>revealed an order was received from the APRN for Buspar 5 mg per Percutaneous Endoscopic Gastrostomy (PEG) tube twice daily routine. Review of the May 2014 MAR revealed the medication was not given 06/24/14 through 06/27/14 at 9:00 AM.</p> <p>Interview, on 06/02/14 at 2:38 PM, with the Pharmacy Account Representative, revealed the Buspar order was received on 05/24/14 and if it was faxed before 3:30 PM, it would have been delivered that night. He stated after 3:30 PM, a call should have been placed as well as the fax to have the medication available. Further interview revealed for normal delivery, the medication would have been delivered on the night of 05/28/14.</p> <p>7. Record review revealed the facility admitted Resident #3 on 07/01/12 with diagnosis which included Hypertension. Review of the Annual MDS assessment, dated 04/10/14, revealed the resident had a Brief Interview of Mental Status (BIMS) score of fourteen (14) and was assessed by the facility to be cognitively intact.</p> <p>Review of the Comprehensive Care Plan for Hypertension, dated 04/10/14, revealed the resident should receive medications as ordered. Review of the Physician's order, dated May 2014, revealed an order to administer Norvasc (blood pressure) 10 milligrams (mg) every day.</p> <p>Review of the May 2014 MAR revealed the Norvasc 10 mg. was Initialed and circled from 05/23/14 through 06/29/14 (seven doses) which indicated the medication was not given.</p> <p>8. Record review revealed the facility admitted</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286	
(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 68</p> <p>Resident #16 on 09/19/13 with diagnoses which included Gout, Diabetes, Below the Knee Amputation and Generalized Pain. Review of a Quarterly MDS assessment, dated 06/01/14, revealed the facility assessed the resident as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Alteration Of Comfort, last revised on 05/27/14, revealed an intervention for "medications as ordered".</p> <p>Review of May 2014 Physician's Orders revealed orders for Torsemide 30 mg daily, Allopurinol 50 mg daily, Aspirin 81 mg daily, Neurontin 400 mg by mouth three (3) times daily, K-Dur 40 meq three (3) times daily, Clindamycin 300 mg three (3) times daily for 10 days (to end on 05/09/14), Vancomycin one (1) Gram twice daily for seven (7) days (with last dose on 05/23/14) and Percocet 10-325 mg every eight (8) hours routine.</p> <p>Review of the May 2014 MAR revealed the following omissions from the MAR: Torsemide 30 mg on 05/18/14, 05/26/14 and 05/31/14, Allopurinol 50 mg on 05/14/14 and 05/26/14, Aspirin 81 mg on 05/11/14 and 05/20/14, Neurontin 400 mg on 05/17/14, 05/20/14 and 05/31/14, K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14, Clindamycin 300 mg on 05/02/14 and 05/08/14, Vancomycin on 05/20/14 and Percocet on 05/18/14, 05/20/14 and 05/31/14.</p> <p>Interview with Resident #16, on 06/02/14 at 2:23 PM, revealed he/she reported the presence of pain while not receiving his/her medications as</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268	
(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 69 ordered.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 06/02/14 at 4:30 PM, revealed the care plan interventions were developed from assessments and the DON was to ensure the care was provided per the plan of care and was monitored by the Administrator.</p> <p>A Post Survey interview with the DON, on 07/02/14 at 9:20 AM, revealed licensed staff conducted rounds to ensure care plans were being followed and if they identified any concerns it should be reported to her.</p> <p>A Post Survey interview with the Administrator, on 07/02/14 at 9:45 AM, revealed the licensed staff and Unit Managers on the floor observe to ensure staff are following the care plans and Administrative staff conduct clinical rounds to ensure staff are following the care plans. In addition, she stated the Administrative staff interview staff to ensure they have the supplies they need to provide the residents' care according to the care plan. No one had identified the medications were not available for administration during interviews.</p> <p>*The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 282	<p>Continued From page 70</p> <p>Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 71</p> <p>week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 72</p> <p>one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 73</p> <p>education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 282	<p>Continued From page 74</p> <p>education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 75</p> <p>through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 06/12/14 at 12:06 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42260		
(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 76</p> <p>change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 77</p> <p>to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 282	<p>Continued From page 78</p> <p>the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 08/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 08/02/14 and 08/09/14.</p> <p>On 08/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 08/06/14 at 3:00 PM of a dose of Lorab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 08/11/14 at 6:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 08/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 6:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 08/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p>	F 282			

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F 282	<p>Continued From page 79</p> <p>Interview on 06/12/14 at 6:24 PM with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p> <p>Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work.</p> <p>Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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F 282	Continued From page 80 delivery.			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one (1) of seventeen (17) sampled residents (Resident #1) was provided adequate supervision to prevent accidents during a transfer with a mechanical lift. On 03/30/14, State Registered Nurse Aide (SRNA) transferred Resident #1 with a mechanical lift without assistance, as per facility policy and the resident's right foot became stuck between the (2) two metal bars on the lift. The SRNA failed to report the incident. On 04/03/14, the resident complained of pain to the right foot and an x-ray was ordered. The resident was diagnosed with a fractured tibia/fibula. The resident had not been assessed or care planned for the use of a mechanical lift. The findings include: Review of the facility's policy titled Safe Handling and Movement Policy, last revised 10/31/13,	F 282 F 323	<u>F 323</u> 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The corrective action accomplished to correct the alleged deficient practice: On 6/3/2014 the Director of Nursing observed that the resident identified as resident # 1 was transferred per the plan of care with correct level of supervision. <u>Other residents had the potential to be affected.</u> On 4/7/2014, the Director of Nursing observed all mechanical lift transfers and noted that the correct level of supervision was provided. The number of observations were ten in total and were done by the certified nurses aides. <u>The measures or systematic changes were made to ensure that the alleged deficient practice will not recur:</u> Beginning 4/4/2014, all nursing staff were re-educated on the requirement for two persons to provide assistance with a mechanical lift transfer. This competency test and education was added to the General Orientation program and no nursing staff will work after 07/07/14 without having had this re-education and competency test. This education was conducted per the Director of Nursing. This will be completed annually. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u> The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete five (5) observations per week of a mechanical lift	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 323	<p>Continued From page 81</p> <p>revealed all patient transfers with mechanical lifts will be done with a minimum of two (2) persons or as specified in the patient's plan of care. Additionally, the policy revealed that injuries from patient handling and movement should be reported.</p> <p>Record review revealed the facility admitted Resident #1 on 02/13/14, with diagnoses which included Paraplegia and Chronic pain. Review of the Admission Minimum Data Set (MDS) assessment, dated 02/20/14, revealed the facility assessed Resident #1 as cognitively intact with a score of fifteen (15) which indicated the resident was interviewable. Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers. Further record review revealed no documented evidence of an assessment for the use of a mechanical lift for Resident #1.</p> <p>Review of the Comprehensive Care Plan for Activities of Daily Living (ADL), dated 04/24/14, revealed Resident #1's level of physical functioning required for transfers to be a one person assist and there was no intervention for staff to use a mechanical lift for transfers.</p> <p>Review of the facility's Final Report of the investigation, dated 04/10/14, revealed the resident was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance. While being transferred, the resident's right foot became tangled and due to the resident's paraplegia, the resident was unable to feel pain to his/her leg. The resident's family member was present and witnessed and assisted the SRNA to untangle the resident's leg. The incident was not reported by the SRNA. An</p>	F 323	<p>transfer to assure staff use the correct level of supervision. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
(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)	(X4) COMPLETION DATE	
F 323	<p>Continued From page 82</p> <p>x-ray of the resident's right foot was ordered on 04/03/14 and completed on 04/04/14 by the mobile x-ray service. Following the investigation, it was determined the SRNA did not follow the resident's plan of care and did not have assistance with operating a mechanical lift, as required by facility policy. The SRNA was terminated on 04/16/14.</p> <p>Review of the Radiology Report, dated 04/04/14, revealed the resident had nondisplaced fractures of the right distal tibia and fibula. The physician was notified of the result on 04/04/14 at 3:00 PM by Licensed Practical Nurse #7. Orders were received to make an orthopedic appointment which was scheduled for 04/10/14 at 1:00 PM. An order was received from the physician on 04/04/14 at 8:30 PM to send the resident to the emergency room for evaluation of the fractured tibia/fibula. An x-ray of the right lower leg done on 04/04/14 at 10:30 PM revealed a radiologist interpretation of diffuse severe osteopenia with oblique comminuted, minimally displaced fractures involving the distal tibia and fibula.</p> <p>Interview with Resident #1, on 05/21/14 at 9:00 AM, revealed he/she was transferred by a mechanical lift resulting in a leg fracture and deformity to the resident's leg. Further interview revealed the resident had no sensation so he/she could not feel any pain. He/she stated while being transferred, his/her leg got caught. The resident stated he/she should have been transferred using two (2) staff.</p> <p>A telephone interview with the family member, on 05/22/14 at 10:22 AM, revealed on Sunday, 03/30/14, he was at the facility to take the resident out for a while. He stated the staff</p>	F 323			

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F 323	Continued From page 83 person picked the resident up with the lift and caught the resident's leg between the two (2) steel places. He revealed the staff person had to raise the lift to get the resident's foot out. He stated the staff person was working alone and he was not sure if the staff normally used a lift with the resident. Further interview revealed there was no obvious injury and he didn't know the resident was hurt. He stated he was not sure if the staff person reported the incident. A telephone interview with Licensed Practical Nurse (LPN) #7, on 05/22/14 at 3:51 PM, revealed she was made aware the resident was reporting pain; however, record review revealed there was no documented evidence of the resident's complaints of pain. The physician was notified on 04/03/14 at 5:13 PM and an order received for an x-ray of the right foot. Interview with the Director of Nursing, on 05/23/14 at 10:48 AM, revealed the facility did conduct assessments of staff to ensure they were competent with the use of the lift. Further interview revealed the Interdisciplinary Team (IDT) determined which lift was to be used for which resident. Interview with the Administrator, on 05/21/14 at 11:10 AM, revealed Resident #1 sustained an injury to the right lower leg while being transferred by SRNA #1 using a mechanical lift. The Administrator revealed the resident was not care planned for the use of a lift.	F 323	<u>F 332</u> 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 6/4/2014, the Director of Nursing observed insulin administration for resident # 17 and noted the correct amount of insulin was administered. On 6/12/2014, LPN # 1 was terminated from employment. On 6/4/2014, the DON observed medication administration for Resident # 10 and noted that medications were available and that medications were administered per physician order. On 06/04/14, the DON observed medication administration for Resident #18 and noted that medications were available and that medications were administered per physician order. <u>Other residents had the potential to be affected.</u> On 6/4/2014, Director of Nursing observed medication administration on all current residents to ensure medications were available and administered per physicians order. All medications were available and given per physician's order. On 6/2/2014, two representatives from Omnicare Pharmacy completed a Medication Administration Record (MAR) to Medication Cart Audit for all current residents to ensure all medications are available for administration per physicians		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332			

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F 332	<p>Continued From page 84 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of medication pass, interview, record review and review of the facility's policy and procedures, it was determined the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater. A total of thirty (30) opportunities were observed with two (2) errors observed resulting in an error rate of 6.7%.</p> <p>Licensed Practical Nurse (LPN) #1 was observed to draw up seven (7) units of Novolin regular insulin (for Resident #17) instead of the five (5) units as per the physician's order for sliding scale insulin. The LPN was about to administer the seven (7) units of insulin when LPN #6, who was in orientation and shadowing LPN #1, pointed out the resident should only receive five (5) units. In addition, observation revealed Resident #10's Amlodipine (blood pressure medication) 10 milligrams (mg) was not available for administration.</p> <p>The findings include:</p> <p>Review of a facility policy and procedure, titled General Dose Preparation and Medication Administration, last revised 01/01/13, revealed staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident.</p>	F 332	<p>order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 6/2/2014, Human Resource Manager (HR) initiated Silverchair Learning Education (Electronic Education System) with all Licensed Nurses regarding Medication Administration "MED - Medication Pass". This training will be completed by all licensed nurses with no licensed nurse working after 07/07/2014 without having had this re-education and competency test.</p> <p>On 6/2/2014, Human Resource Manager (HR) initiated Silverchair Learning Education with all Licensed Nurses upon hire to be completed.</p> <p>This will include the "MED - Medication Pass" training and competency test.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, The DON, ADON, MDS Nurse or Unit Manager will observe medication administration to ensure medications were available and administered per physicians order three (3) times a week for twelve (12) weeks. Beginning the week of 6/9/14, Omnicare Pharmacy audited all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks on 6/9/2014, 6/16/2014, 6/23/2014,</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 332	<p>Continued From page 86</p> <p>1. Observation of a medication pass performed by Licensed Practical Nurse (LPN) #3, on 05/29/14 at 8:40 AM, revealed Amlodipine (blood pressure medication) 10 mg was not administered to Resident #18.</p> <p>Review of Resident #18's May 2014 Physician's Orders revealed an order for Amlodipine Besylate 10 mg tablet, give one (1) tablet by mouth daily.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #3, on 05/29/14 at 9:30 AM and 10:25 AM, revealed she was not aware the resident was out of this medication until she was doing the medication pass. She stated she would check the Emergency Drug Kit (EDK) box to see if the medication was available to administer, then call the pharmacy to see why the medication was not available. LPN #3 revealed after checking with the Pharmacy she was informed the last time Amlodipine was delivered was on 04/06/14. Review of the May 2014 MAR revealed the resident had not received the medication for nine (9) days prior to this observation.</p> <p>2. Observation of a second medication pass performed by LPN #1, on 06/29/14 at 11:00 AM, revealed LPN #1 obtained a 229 blood sugar reading for Resident #17 and drew up seven (7) units of Regular insulin and prepared to administer it to the resident. LPN #6, who was in orientation and shadowing LPN #1, informed LPN #1 that she thought the Insulin amount should be five (5) units and not the seven (7) units LPN #1 had prepared. LPN #1 then re-checked the resident's MAR and determined the resident was to have five (5) and not seven (7) units of insulin.</p> <p>Review of Resident #17's May 2014 Physician's</p>	F 33	<p>and 6/30/2014 and then will be completed every two weeks for eight (8) weeks by Omnicare to assure all medications are available. Any deficiency identified will be corrected immediately. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review weekly until the Jeopardy is removed and then at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 332	Continued From page 86 Orders revealed the amount of Regular Insulin to be administered when the blood sugar reading was between 101-250 would be five (5) units. Interview with LPN #1, on 05/29/14 at 11:00 AM, revealed she had another resident's sliding scale insulin orders and had drawn up and prepared to administer the wrong amount of Insulin to Resident #17. She stated she would have to fill out a medication error report. Interview conducted with the Director of Nursing (DON), on 05/29/14 at 1:10 PM, revealed she expected nurses to go by the orders on the resident's Medication Administration Record and thought the nurse would have double checked.	F 332	recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. <u>F 333</u> <u>483.25(M)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</u> <u>The corrective action accomplished to correct the alleged deficient practice:</u> Resident # 11 expired on 05/24/2014 at the facility. Resident # 12 discharged home from the facility on 05/31/2014.	7/11/2014	
F 333 SS=L	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 observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure nine (9) of seventeen (17) sampled residents (Residents #2, #3, #10, #11, #12, #14, #15, #13 and #17) and one (1) unsampled resident (Resident A) were free from significant medication errors. Resident #10 did not receive a "now" dose of Potassium that was ordered on 05/29/14, until	F 333	On 6/4/2014, the Director of Nursing observed medication administration for Residents #2, 3, 10, 13, 14, 15, and 17 and Resident A noted that all medications were available and that medications were administered per physicians order. <u>Other residents had the potential to be affected.</u> On 6/2/2014, two representatives from Omnicare Pharmacy completed a Medication Administration Record (MAR) to Medication Cart Audit for all current residents to ensure all medications are available for administration per physicians order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. On 6/4/2014, Director of Nursing observed medication administration on all current residents to ensure medications were available and administered per physicians order. All		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 333	<p>Continued From page 87 05/30/13 and required hospitalization for Hypokalemia.</p> <p>Resident #11 did not receive Solu-Medro (steroid) Intramuscular (IM) "stat" (immediately), and Levaquin (antibiotic) Intravenously (IV) "stat" as ordered on 05/21/14 until 05/22/14.</p> <p>Resident #12, who had a seizure disorder, did not receive Keppra (anti-seizure medication) for six (6) doses and experienced a seizure requiring hospitalization. Additionally, after returning to the facility on 05/13/14, with a physician's order to change the Keppra milligrams (mg) from 500 mg to 1000 mg twice a day, the resident only received 500 mg for a total of thirty five (35) doses.</p> <p>Resident #14 did not receive a total of fourteen (14) doses of Pancrelipase (digestive enzyme) 5000 Units from 05/19/14 through 05/28/14 due to the Physician's Medicaid number being expired and the pharmacy not sending the medication.</p> <p>Resident #15 who had diagnoses of chronic pain did not receive Fentanyl patches as prescribed on 05/05/14, 05/28/14 and 05/29/14, for a total of eight (8) days.</p> <p>Resident #3 did not receive seven (7) doses of Norvasc (blood pressure medication).</p> <p>Resident A did not receive ten (10) doses of Amlodipine (anti- angina) and eleven (11) doses of Pantoprazole (gastrointestinal medication).</p> <p>Resident #13 did not receive Buspar (anti-anxiety medication) for a total of six (6) doses.</p>	F 333	<p>medications were available and given per physicians order.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 6/1/2014, Regional Nurse Consultant (RNC) re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered per physicians order, and post test completed.</p> <p>On 6/1/2014, the DON began re-education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physicians order. This training will be completed with all licensed nurses by the DON. The DON will re-educate and validate competency with Assistant Director of Nursing (ADON), MDS Nurse (MDS) or Unit Manager before they initiate re-education with the licensed nurses. No licensed nurse will work after 6/4/2014 without having had this re-education and competency test.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, Omnicare Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8)</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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F 333	<p>Continued From page 88</p> <p>Resident #2 did not receive four (4) doses of Diflucan (yeast rash) from 06/19/14 through 06/22/14.</p> <p>Additionally, during a medication pass observation, Licensed Practical Nurse (LPN) #1 was observed to draw up seven (7) units of Novolin regular insulin instead of the five (5) units as per the physician's order for sliding scale insulin for Resident #17. The LPN was about to administer the seven units of insulin but another LPN (#8), who was in shadowing LPN #1 pointed out the resident should only receive five (5) units. A second medication pass revealed Resident #18 did not receive Amlodipine (anti-hypertensive) 10 mg and had not received the medication for nine (9) days prior.</p> <p>The facility's failure to ensure residents were free from significant medication errors caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.</p> <p>The findings include:</p> <p>Review of the facility policy and procedure titled, "Medication Shortages/Unavailable Medications" last revised 01/01/13, revealed actions to take upon discovery that the facility has an inadequate supply of medication to administer to a resident included staff taking immediate action to obtain the medication. If a medication shortage was discovered during normal Pharmacy hours, the nurse should call the pharmacy to determine the status of the order. If the medication has not been ordered, place the order or reorder for the</p>	F 333	<p>weeks by Omnicare to assure all medications are available. Any deficiency identified will be corrected immediately. The DON, ADON or Unit Manager will complete medication administration observations three times per week for twelve (12) weeks to assure medications are administered correctly and medications are available. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 333	Continued From page 89 next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, obtain the medication from the Emergency Medication Supply to administer the dose. If the medication was not available in the Emergency Medication Supply, notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, staff should obtain the ordered medication from the Emergency Medication Supply and if it was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. The action may include emergency delivery or the use of an emergency (back-up) third party pharmacy. If an emergency delivery is unavailable, the nurse should contact the attending physician to obtain orders or directions. If the nurse was unable to obtain a response from the attending physician/prescriber in a timely manner, the nurse should notify the nursing supervisor and contact the facility's Medical Director for orders/direction while making sure to explain the circumstances of the medication shortage. When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the MAR or Treatment Administration Record (TAR) and in the Nurse's Notes per facility policy. Such documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken. 1. Record review revealed Resident #10 was admitted on 05/16/14 with diagnoses which	F 333			

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F 333	<p>Continued From page 90 Included Psychosis, Diarrhea and Diabetes.</p> <p>Review of a Laboratory Report revealed a routine laboratory test was conducted on 05/20/14 and revealed the resident's Potassium level was 3.2 millimoles/Liter (mmol/L) and normal value was between 3.5-5.60 mmol/L. On 05/21/14, the resident was placed on Intravenous Fluids (IVFs) at 75 ml/hour to end on 05/27/14 and a "now" dose of Potassium 40 milliequivalents (meq) was administered. The Potassium level was rechecked on 05/22/14 with a result of 3.5 mmol/L.</p> <p>On 05/29/14, Licensed Practical Nurse (LPN) #3 received an order to administer Potassium 40 meq by mouth now and recheck Potassium level in twenty-four (24) hours. However, review of the May 2014 MAR revealed the order for the Potassium 40 meq was not documented on the MAR until 05/30/14 at 9:00 AM (one day later) at which time it was administered.</p> <p>Record review revealed a repeat Potassium level was obtained on 05/30/14 with a Panic Level of 2.4 mmol/L. The Physician Assistant was notified and the resident was sent to the emergency room. Resident #10 was admitted to the hospital on 05/30/14 at 8:50 PM with diagnosis of Hypokalemia (low potassium). The licensed staff (LPN #3) failed to transcribe the order to the MAR and failed to administer the medication when ordered on 05/29/14.</p> <p>Review of Hospital Admission History and Physical, dated 05/30/14, revealed Resident #10 was admitted to the hospital because of a Potassium level of 2.4 and was diagnosed with Hypokalemia and would be treated with IV</p>	F 333			

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F 333	<p>Continued From page 91 hydration and Potassium replacement.</p> <p>Interview conducted with LPN #3, on 05/31/14 at 3:00 PM, revealed on 05/29/14 she had not notified the physician about Resident #10 but the nurse for Resident #10's physician had called the facility and gave her an order for a one (1) time dose of 40 meq Potassium but gave her no other specifics. LPN #3 revealed she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. She faxed the order to the pharmacy and also called the pharmacy about the Potassium order sometime before lunch on 05/29/14. She stated she did not know if the Potassium was in the Emergency Drug Kit (EDK) as she was unaware of what medications were available in the EDK and she did not look in there for the medication.</p> <p>Interview with the Director of Nursing (DON), conducted on 05/31/14 at 9:30 AM, revealed LPN #3 had failed to place the order for the one (1) time dose of Potassium on Resident #10's MAR and had forgotten to administer it on 05/29/14 when it was ordered. The DON revealed the resident's Potassium level was at "Panic Level" of 2.4 on 05/30/14 and the resident was sent to the hospital and admitted for treatment of Hypokalemia. The Potassium was available in the EDK box; however, LPN #3 failed to obtain the medication from the EDK.</p> <p>Interview with Resident #10's Physician on 06/12/14 at 2:30 PM, revealed Resident #10's Potassium was low and depending on how low "could be life threatening". He expected the Potassium to have been given when ordered.</p> <p>2. Record review revealed the facility admitted</p>	F 333		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 333	<p>Continued From page 92</p> <p>Resident #11 on 07/01/12 with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>On 05/21/14, Resident #11 had a change in condition and was having respiratory distress and a "stat" order for Solu Medrol IM and IV antibiotics was obtained. The medications were not administered until the following day, seventeen (17) hours later. The resident continued to decline and expired in the facility on 05/24/14.</p> <p>Review of Nursing Notes, dated 05/21/14 at 10:57 PM, revealed Resident #11 was noted to have labored breathing and an oxygen saturation of 91% on 2/Liters of oxygen. Lung sounds were diminished bilateral lower lobes and the Advanced Practice Registered Nurse (APRN) was notified and orders were received.</p> <p>Review of the Physician's Order, dated 05/21/14 at 11:30 PM, revealed administer "stat" (Immediately) Solu Medrol 40 milligrams (mg) IM and IV (intravenous) Levaquin 500 mg, however, review of the May 2014 MAR revealed the medication was not administered until 05/22/14 at 5:49 PM.</p> <p>Interview with LPN #6, on 06/02/14 at 3:20 PM, revealed she received the stat order, wrote it out and put it in the computer. The oncoming nurse was already on duty and it was time for LPN #5 to leave and she gave report to the oncoming nurse. LPN #5 revealed she felt the Physician had ordered Solu Medrol as a stat order because it helped with breathing and it works in twenty to thirty minutes.</p> <p>Review of Nursing Notes, dated 05/22/14 at 5:49</p>	F 333			

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F 333	<p>Continued From page 93</p> <p>PM, revealed documentation by Licensed Practical Nurse (LPN) #1 to include the antibiotic was taken from EDK box and a peripheral IV was started with antibiotic administered. The residents lungs had rhonchi noted in the upper lobes.</p> <p>Interview conducted with the Administrator, on 05/30/14 at 3:20 PM, revealed LPN #5 had noted Resident #11 having respiratory distress on 05/21/14 prior to her leaving the facility from a split shift. LPN #5 had written the stat order and given report to LPN #8, who was picking up the split shift. LPN #8 failed to obtain the stat Solu Medrol which was in the EDK box. Solu Medrol was obtained from the back up pharmacy sometime around 4:00 AM, but the vial was reported to be compromised and was not used and another one was ordered. She further stated LPN #8 still did not obtain the Solu Medrol from the EDK box and should have. LPN #1 administered the medication on 05/22/14 at 5:49 PM (approximately seventeen hours later) after retrieving the medication from the EDK box. The Administrator stated she expected if a stat order was not available on the medication cart, that staff would follow procedure and obtain that medication from the EDK box if it was available there. LPN #8 did not check the EDK box. The Administrator suspended LPN #8 by phone on 05/22/14 and recommended she be terminated.</p> <p>Interview with Resident #11's Physician, on 05/30/14 at 4:35 PM, revealed a stat order was for a special need and meant "now". He stated a routine order would be provided with routine orders. He additionally stated he expected medications and treatments that were ordered "stat" would be provided "stat".</p>	F 333			