

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

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185291 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/13/2012 |
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| NAME OF PROVIDER OR SUPPLIER REDBANKS COLONIAL TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE 142 ROGER POWELL RD SEBREE, KY 42455 |
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| F 000 | INITIAL COMMENTS | F 000 | This plan of correction is submitted in accordance with the requirements of state and federal participation, and does not confirm that deficiencies existed, but provides an allegation of compliance based upon stated deficiencies. | |
| F 281 SS=D | <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality related to following the physician's order for one resident (#1), in the selected sample of three (3) residents. Resident #1 was ordered a blood pressure medication twice daily; however, the resident received the medication once daily from 08/01/12 through 09/28/12 (59 days).</p> <p>Findings include:</p> <p>A review of the policy/procedure for Medication Administration-General Guidelines, undated, revealed medications would be administered in accordance with written orders of the attending physician.</p> <p>A record review revealed Resident #1 was admitted to the facility on 11/21/11 with diagnoses to include Hypertension (high blood pressure),</p> | F 281 | <p>The facility shall assure compliance with noted and approved practices by the following.:</p> <ol style="list-style-type: none"> 1. The error for resident #1 of the sample was corrected on 9/29/12 with MD and family notification, prior to survey. 2. Ms. Lisa Wright, LPN and team leader completed a 100% audit of all medication records to ensure no other residents were affected. 3. All licensed nurses and Kentucky medication aides were re-trained on 12/13/12, 1/5/13 and 1/20/13 by C. Jordan, DON, regarding the administering of medications in accordance with written orders. 4. The CQI tool #N-16 will be completed every month times 3 months and then quarterly; the pharmacy (Junior Wright) will complete an audit of orders to medication record monthly times 3 months and quarterly thereafter. 5. This plan of correction will be reviewed at each CQI meeting, monthly for the next 3 months. The Medical Director has approved this corrective plan. | 1/22/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Pick* TITLE *Administrator* (X6) DATE 1-10-13

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

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| F 281 | <p>Continued From page 1</p> <p>Pacemaker, and Atrial Fibrillation. A review of the quarterly Minimum Data Set (MDS), dated 10/02/12, revealed the facility assessed the resident as moderately cognitively impaired.</p> <p>A review of the Physician's Orders, dated November 2012, revealed an order for Hydrochlorothiazide (HCTZ) 12.5 milligrams (mg) twice daily for the diagnosis of Hypertension. The order date on the medication was 06/08/12. A review of the Medication Administration Record (MAR), dated August 2012 and September 2012, revealed the resident's HCTZ 12.5 mg was specified to give once daily and every afternoon. Both MAR's (August and September) revealed the HCTZ was given at 7:00 AM; however, it was not given in the afternoon for 31 days in August and 28 days in September (59 days total).</p> <p>An interview with Kentucky Medication Aide (KMA) #1, on 12/13/12 at 9:55 AM, revealed she passed medications to Resident #1 during August and September. She indicated that the specified time for the resident's second dose of HCTZ was not printed on the MAR, therefore it was missed. She stated she was supposed to ensure the medication was given per the physician's order.</p> <p>An interview with KMA #2, on 12/13/12 at 10:45 AM, revealed the time was not indicated on the MAR to give the HCTZ to the resident in the afternoon; therefore, the dose was missed. She revealed the error was caught on 09/29/12 after reading the order in detail. She passed medications during August and September to Resident #1; however, she did not notice the error.</p> | F 281 | | | |

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| F 281 | Continued From page 2 An interview with Licensed Practical Nurse (LPN) #1, on 12/13/12 at 10:25 AM, revealed she passed medication to Resident #1 on 08/06/12. She indicated that she goes by the "time" indicated on the MAR when passing medications; however, the afternoon time for the resident's HCTZ was not printed. She stated "I try to read the whole order, it was just an error on my part that day." An interview with the Primary Physician, on 12/13/12 at 1:30 PM, revealed HCTZ was used for blood pressure control; therefore, that would be the only potential concern of not receiving the medication as ordered. An interview with the Director of Nursing (DON), on 12/13/12 at 1:40 PM, revealed she expected staff to read each medication order on the MAR prior to giving the medication. She indicated the standard of practice for medication administration was the facility's policy (Medication Administration-General Guidelines); therefore, she expected staff to follow the policy. | F 281 | | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident was free of significant medication errors for one resident (#1) in the selected sample of three (3) residents. | F 333 | | | |

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| F 333 | <p>Continued From page 3</p> <p>Resident #1 was ordered a blood pressure medication twice daily; however, the resident only received the medication daily from 08/01/12 through 09/28/12 (59 days).</p> <p>Findings include:</p> <p>A review of the policy/procedure for Medication Administration-General Guidelines, undated, revealed medications would be administered in accordance with written orders of the attending physician. At the end of each medication pass, the person who administered medications reviews the MAR to ensure necessary doses were administered and documented.</p> <p>A record review revealed Resident #1 was admitted to the facility on 11/21/11 with diagnoses to include Hypertension (high blood pressure), Pacemaker, and Atrial Fibrillation. A review of the quarterly Minimum Data Set (MDS), dated 10/02/12, revealed the facility assessed the resident as moderately cognitively impaired.</p> <p>A review of the Physician's Orders, dated November 2012, revealed an order for Hydrochlorothiazide (HCTZ) 12.5 milligrams (mg) twice daily for the diagnosis of Hypertension. The order date on the medication was 06/08/12. A review of the Medication Administration Record (MAR), dated August 2012 and September 2012, revealed the resident's HCTZ 12.5 mg was specified to give once daily and every afternoon. Both MAR's (August and September) revealed the HCTZ was given at 7:00 AM; however, it was not given in the afternoon for 31 days in August and 28 days in September (59 days total).</p> | F 333 | <p>The facility shall assure compliance with noted and approved practices by the following:</p> <ol style="list-style-type: none"> 1. The error for resident #1 of the sample was corrected on 9/29/12 with MD and family notification prior to survey. 2. Ms. Lisa Wright, LPN and a team of Med Care Pharmacy completed a 100% audit of all medication records on 12/17/12 to ensure no other residents were affected. 3. All licensed nurses and Kentucky medication aides were re-trained by C. Jordan, DON and Junior Wright, LPN of Med Care Pharmacy, on administering medications in accordance with written orders. Dates of in-service were 12/13/12, 1/5/13, and 1/21/13. Medical records and office aides of that department were trained to check orders as well by C. Jordan, facility DON, on 1/10/13, regarding checking orders. 4. Medical records or an office aide will complete an end of the month audit of medication records, as a second audit check process, to the next month medication records, to ensure no discrepancies exist. The pharmacy will complete an audit of orders in comparison to medication records monthly times 3 months and then quarterly thereafter. 5. This plan of correction, and CQI tool #N-16, will be further reviewed and evaluated by the CQI team monthly for the next 3 months. The Medical Director has approved this corrective plan. | 1/22/13 |

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| F 333 | <p>Continued From page 4</p> <p>An interview with Kentucky Medication Aide (KMA) #1, on 12/13/12 at 9:55 AM, revealed she passed medications to Resident #1 during August and September. She indicated that the specified time for the resident's second dose of HCTZ was not printed on the MAR, therefore it was missed. She revealed the person passing medications on the first of every month (all three shifts) was supposed to compare the new MAR with the previous MAR; however, it was overlooked.</p> <p>An interview with KMA #2, on 12/13/12 at 10:45 AM, revealed the time was not indicated on the MAR to give the HCTZ to the resident in the afternoon; therefore, the dose was missed. She revealed the error was caught on 09/29/12 after reading the order in detail. She passed medications during August and September to Resident #1; however, she did not notice the error.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 12/13/12 at 10:25 AM, revealed she passed medication to Resident #1 on 08/06/12. She indicated that she goes by the "time" indicated on the MAR when passing medications; however, the afternoon time for the resident's HCTZ was not printed. She stated "I try to read the whole order, it was just an error on my part that day."</p> <p>An interview with the Primary Physician, on 12/13/12 at 1:30 PM, revealed HCTZ was used for blood pressure control; therefore, that would be the only potential concern of not receiving the medication as ordered.</p> <p>An interview with the Director of Nursing (DON),</p> | F 333 | | |
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| F 333 | Continued From page 5. on 12/13/12 at 1:40 PM, revealed pharmacy left off the printed time for the second dose of HCTZ and it was missed for two months. The facility noticed the error on 09/29/12. She revealed the nurse checking the August MAR for accuracy did not catch the error. Also, the staff passing medications on the first of the month were supposed to compare the new MAR with the previous one for accuracy prior to the medication pass. She expected staff to read each medication order on the MAR prior to giving the medication. | F 333 | | | |