

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

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PRINTED: 08/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2014
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER		STREET ADDRESS DIVISION OF HEALTH CARE 67 Commonwealth Center SALYERSVILLE, KY 41466	

(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 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY21945) was initiated on 07/15/14. Immediate Jeopardy was identified on 07/18/14. After supervisory review, a recertification survey was initiated on 07/21/14 and concluded on 07/25/14. An extended survey was initiated on 07/24/14 and concluded on 07/25/14. The complaint was substantiated. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>Review of physician's orders for May 2014 revealed the physician had prescribed 8 milligrams (mg) of Coumadin (anticoagulant) to be administered to Resident #8 at night, and for a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) to be completed weekly. Documentation revealed the facility administered the Coumadin on a daily basis at night. A PT/INR was obtained on 05/05/14 and review of a verbal physician's order dated 05/05/14 revealed the physician wrote an order for staff to decrease the 6 mg of Coumadin to 5 mg of Coumadin. Another PT/INR was obtained on 05/12/14 and revealed the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds), and the resident's INR was 2.2 (reference range 0.9 to 1.1). Based on the results of the PT/INR obtained on 05/12/14, the physician increased the resident's dosage of Coumadin to 6 mg.</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Elaine Jones* TITLE: *Administrator* (X4) DATE: *8/26/14*

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 SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 000	Continued From page 1 Documentation revealed facility staff administered 6 mg of Coumadin to Resident #8 at night; however, staff failed to ensure the PT/INR was collected on a weekly basis. Review of documentation revealed a PT/INR was not obtained for Resident #8 from 05/12/14 until 07/02/14 (a timeframe of seven weeks), at which time the resident's PT was 85.1 seconds (73.5 seconds above reference range), the INR was 7.0 (5.9 above the reference range) and, based on the laboratory report, the resident's PT and INR levels were "Critical." Review of the nurse's notes revealed Resident #8's physician was notified of the abnormal lab results, and the resident was admitted to a hospital where he/she was placed on telemetry and diagnosed with "Coumadin Toxicity." The facility's failure to ensure facility staff provided adequate monitoring of drugs and laboratory testing and that the facility was free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. Prior to exit on 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14 as alleged by the facility, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000			
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225			

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F 225
SS=D

Continued From page 2
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F 225

"Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation."

F225 483.13(c)(1)(ii)-(iii),(c)(2) - 94
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

- The Director of Nursing reported misappropriation to the state survey agency on 7/15/2014 for Residents C, D, and E
- The administrator reviewed all internal investigations and grievances on 8/11/2014 to see if there was any other investigation that should have been reported. No other issues were identified.
- The Regional Director of Operations re-educated the Administrator on allegations of abuse, neglect, misappropriation of resident's property and other items on 8/5/2014.

The Administrator re-educated the Director of Nursing on allegations of abuse, neglect, misappropriation of resident's property and other items on 8/5/2014.

The Director of Nursing or the Administrator is responsible for notifying the state survey agency of any reportable investigation or incident.

- The Director of Nursing and or Administrator will review all allegations and grievances as they occur to determine if they are reportable or not reportable. Results will be brought to the Quality Assurance Committee and reviewed again on a monthly basis for three months for further recommendation.

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F 225	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the facility's investigation, it was determined the facility failed to ensure an allegation of misappropriation of resident property was reported to state agencies as required by state law and the facility's policy for three (3) of three (3) unsampled residents (Residents C, D, and E). On 04/30/14, Resident C reported to Registered Nurse (RN) #2 that Licensed Practical Nurse (LPN) #10 attempted to administer an unknown "white pill" to the resident instead of a narcotic pain medication. In addition, staff reported that LPN #10 did not administer Residents D and E's narcotic pain medication on 04/30/14. The facility initiated an investigation and suspended LPN #10. However, the facility failed to report the allegation to state agencies.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Prevention and Reporting Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property," which was undated, revealed the facility would report all alleged violations and substantiated incidents to the State Agencies as required, and take all corrective actions depending on the results of the investigation. The policy also revealed the facility was required to report the results of their investigation to the State Survey Agency within five calendar days.</p> <p>Review of the facility's policy titled, "Medication Administration," undated, revealed the licensed nurse or medication assistant was required to</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>check the following prior to administering a resident's medication: the right medication, the right dosage, the right dosage form, the right route, the right resident, and the right time.</p> <p>Review of the medical record revealed on 04/28/14, Resident C's physician prescribed Percocet (a narcotic pain medication that contains 7.5 of Oxycodone and 325 milligrams of Acetaminophen), orally for Resident C every six hours, as needed for pain. The facility assessed Resident C on 04/22/14, to have a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired.</p> <p>Interview conducted on 07/17/14, at 4:40 PM, with Resident C revealed LPN #10 attempted to give the resident a "white pill" after the resident requested a "pain pill." Resident C stated he/she knew the pill the LPN gave the resident was not his/her "pain pill" and questioned LPN #10. The LPN threw the "white pill" in the trash and brought the resident the correct medication. Resident C stated he/she got the "white pill" out of the trash, gave the pill to RN #2, and told the RN that LPN #10 attempted to give the resident the pill instead of his/her pain pill.</p> <p>Review of an investigation completed by the Director of Nursing (DON) revealed on 04/30/14, at approximately 5:00 AM, Resident C requested something for pain and LPN #10 attempted to administer 10 milliequivalents of Potassium Chloride (the "white pill" was identified as Potassium Chloride, used to treat low potassium levels) to Resident C instead of the Percocet that was prescribed by the resident's physician. The investigation revealed Resident C told LPN #10</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>that the medication the LPN handed to the resident was not his/her pain pill. The LPN threw the pill into the resident's trash, left the resident's room, and administered the pain medication that was prescribed by the physician to the resident.</p> <p>Continued review of the investigation revealed Resident C retrieved the medication LPN #10 had disposed of from the trash and gave the pill to Registered Nurse (RN) #2. RN #2 reported the allegation to the DON, and an investigation was initiated. According to the facility's investigation, Residents D and E stated that LPN #10 administered their narcotic pain medication and had no concerns. Based on review of documentation, the DON immediately suspended LPN #10 pending the outcome of the facility's investigation. However, the facility failed to report the allegations regarding LPN #10 on 04/30/14 to the appropriate State Agencies until 07/15/14 (76 days after the allegation was made), after the State Survey Agency initiated an abbreviated survey.</p> <p>LPN #10's employment at the facility was terminated on 05/13/14 due to appearing to be under the influence of drugs and she could not be contacted for interview.</p> <p>The DON acknowledged in interview on 07/18/14, at 10:00 AM, that she had been notified of the allegations on 04/30/14 regarding LPN #10. The DON stated based on the facility's investigation of the allegations, the allegations did not need to be reported to the State Agency because she had not considered them to be allegations of abuse, neglect, or misappropriation of resident property. However, the DON stated "looking back on it" she should have reported the allegations to the State</p>	F 225		

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F 225	Continued From page 6 Survey Agency.	F 225		
F 263 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observations revealed bedside fall mats with carpeted top surfaces in four (4) of seventy-six (76) resident rooms (resident room numbers 118, 215, 308, and 315) that had stains, food crumbs, and lint on the carpeted areas and needed to be cleaned. Resident room 215 had two bedside mats that were in need of cleaning.</p> <p>The findings include:</p> <p>A request was made on 07/17/14 at 10:19 AM for the facility's housekeeping policy. The facility</p>	F 253	<p>F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>1. The carpeted floor mats in rooms 118, 215, 308, and 315 were shampooed on 7/18/2014 and they were sprayed with scotch guard. The carpeted floor mats in rooms 118, 215, 308, and 315 were vacuumed daily by housekeeping. The carpeted fall mats in rooms 118, 215, 308, and 315 were replaced by vinyl fall mats on 8/1/2014 by the housekeeping supervisor.</p> <p>2. On 7/28/14 all fall mats were inspected by the housekeeping supervisor for cleanliness. Any issue identified was immediately addressed and all fall mats were cleaned by housekeeping department.</p>	

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F 253	<p>Continued From page 7</p> <p>provided a document entitled "Housekeeping In-Service" with a date of "01/01/2000" located at the bottom of the page. Interview with the facility's Housekeeping Supervisor on 07/17/14 at 9:44 AM revealed the facility did not have a policy related to maintaining cleanliness of carpeted surfaces, including the bedside fall mats. Interview with the facility's Administrator on 07/17/14 at 10:19 AM, also revealed the facility did not have a written policy to address proper cleaning/sanitizing of carpeted surfaces in resident rooms.</p> <p>Observations of resident room 118 on 07/16/14 at 4:34 PM, and on 07/17/14 at 9:18 AM revealed one carpeted bedside fall mat that was stained, had food crumbs and lint on it, and was in need of cleaning. Observation conducted on 07/17/14 at 9:35 AM of resident rooms 308 and 315 also revealed each room had a carpeted bedside mat that was stained, had food crumbs and lint on them, and that were in need of cleaning. Continued observation conducted on 07/17/14 at 9:35 PM revealed resident room 215 had two carpeted bedside fall mats that were stained, had food crumbs on them, and were in need of cleaning.</p> <p>Interview with the Housekeeper on 07/17/14 at 9:24 AM revealed the fall mats in resident rooms should be vacuumed and/or cleaned only when dirty and stated the facility did not have a "set time" to vacuum and/or clean the mats. The Housekeeper stated that she did not know when the fall mats had been vacuumed or cleaned.</p> <p>Interview with the Housekeeping Supervisor on 07/17/14 at 9:44 AM revealed housekeeping staff was to clean resident rooms on a daily basis.</p>	F 253	<p>3. Re education was completed by the housekeeping supervisor for all housekeeping staff regarding cleaning fall mats on 7/17/2014</p> <p>Beginning the week of 8/11/2014 the housekeeping supervisor and or administrator will check all floor mats for cleanliness 3 days a week for four weeks. Then the housekeeping supervisor/designee will check all floor mats for cleanliness weekly for three months. Results will be reviewed through the Quality Assurance Committee for further recommendation.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, and Housekeeping Supervisor will meet monthly for three months to review audit findings and revise plan as needed this plan will be ongoing until this issue is resolved.</p>	8/26/14	

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F 253	<p>Continued From page 8</p> <p>According to the Housekeeping Supervisor, housekeeping staff was to clean and/or vacuum rugs, including the carpeted bedside fall mats, every time housekeeping staff cleaned a resident room. The Housekeeping Supervisor stated she had instructed housekeeping staff to use disinfectant spray on the carpeted bedside fall mats for spot cleaning. Further interview with the Housekeeping Supervisor revealed that she had attempted to contact the manufacturer of the carpeted bedside fall mats to determine what the manufacturer's recommendations were for cleaning/sanitizing the fall mats but she had been unsuccessful. The Supervisor stated she was not aware staff had failed to vacuum and/or clean the carpeted bedside fall mats. Continued interview with the Housekeeping Supervisor on 07/17/14 at 4:08 PM revealed facility staff had never deep cleaned the carpeted bedside fall mats and stated she was not aware that the mats could be deep cleaned.</p> <p>Interview on 07/17/14 at 3:30 PM with a representative of the company that provided the carpeted bedside mats to the facility revealed the carpeted bedside mats should be vacuumed daily and spot cleaned as necessary. Further interview with the representative revealed the mats may be deep cleaned using any method that would normally be used to clean any other carpet.</p> <p>Interview with the Administrator of the facility on 07/17/14 at 10:19 AM revealed that housekeeping staff was required to clean everything in the resident rooms on a daily basis. Continued interview with the Administrator on 07/17/14 at 6:40 PM revealed staff had never deep cleaned the carpeted bedside fall mats and stated she was not aware that they could be deep</p>	F 253			

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F 253	Continued From page 9: cleaned. The Administrator also stated the Housekeeping Supervisor had informed staff to clean each resident room on a daily basis, including carpeted surfaces, and she was not aware that housekeeping staff had not vacuumed the carpeted bedside fall mats on a daily basis as instructed.	F 253			
F 282 SS=J	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, review of the facility's laboratory contract, and review of the facility's policy entitled, "Using The Care Plan," it was determined the facility failed to ensure services were provided in accordance with a written plan of care for one (1) of thirty-four (34) sampled residents (Resident #8). Review of the plan of care for Resident #8 dated 01/30/14, and revised 05/08/14, revealed facility staff had developed a plan of care related to the resident's diagnosis of Atrial Fibrillation and the use of Coumadin (anticoagulant). The care plan included an intervention to obtain a "Prothrombin Time (PT) with an International Normalized Ratio (INR) as ordered" (a test to check for bleeding time). Review of the Physician's Orders for May 2014 revealed an order to administer Coumadin on a daily basis and to obtain a PT with INR every week. Record review revealed facility staff had administered the medications as ordered.	F 282	F282 483.20(k) (3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Resident # 8 has a Care Plan for Anticoagulants which stated to obtain a PT/INR as ordered, at least monthly. However the PT with INR labs for Resident # 8 was not drawn weekly as ordered by their physician or as care planned from May 12, 2014 to July 2, 2014. The PT/INR was drawn on July 2, 2014 by Medlab with results being reported on July 2, 2014 to the physician and responsible party by the LPN. 2. One hundred percent of all anti-coagulant care plans were reviewed and/or updated by the RNC for Preferred Care, MG as necessary on 7/20/2014. One hundred percent of the care plans have been reviewed and/or updated for labs on 7/21/2014 by Members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.		

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F 282	<p>Continued From page 10</p> <p>However, the facility failed to ensure the laboratory test had been conducted as ordered and as required by the resident's plan of care. Further review revealed a PT with INR had been obtained on 05/12/14; however, the next PT with INR was not conducted until 07/02/14, a timeframe of seven weeks after the previous test, at which time the PT was 85.1 seconds (reference range 9.5 to 11.6 seconds), and the INR was 7.0 (reference range 0.9 to 1.1). Documentation on the laboratory report revealed the PT and INR levels were "critical." Review of the Nurse's Notes on 07/02/14 revealed the resident's physician was notified of the abnormal PT and INR levels and the resident was transferred to the hospital. Review of the hospital medical record revealed Resident #8 had been admitted to the facility on 07/02/14, with a diagnosis of "Coumadin Toxicity."</p> <p>The facility's failure to ensure residents received services in accordance with the resident's written plan of care caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. Prior to exit on 07/25/14, the State Survey Agency</p>	F 282	<p>3. The Regional Nurse Consultant for Preferred Care Partners, MG in serviced the DON and the Staff Development Nurse on the lab policy and protocol on 7/19/2014.</p> <p>Licensed Nursing staff was in-serviced on the Comprehensive Care Plan use in directing resident care by 7/21/2014. In-servicing was conducted by Staff Development Nurse, DON or designee. In-service included documentation required of the use of the interventions on those Care Plans. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>Members of the QA Committee developed a policy on 7/19/2014 to validate that Labs are being obtained as ordered by the physician and results are received and followed up on timely per policy protocol. This was implemented 7/19/2014 and is ongoing. The unit managers will compare the lab calendar to the labs listed on the lab tracking sheet to verify that they match prior to morning meeting. The unit manager will then follow up to ensure that labs were drawn as listed, results have been received, and they have been followed up on timely prior to morning meeting. During morning meeting Monday through Friday any resident with a new lab order will have their care plan reviewed and updated as needed per a member of the care plan team including: the DON, Unit manager, MDS, Dietary Manager, Social Services. The Administrator or DON or designee will be present to ensure that this process takes place. Any issues identified are corrected immediately. This practice became effective 7/19/2014</p>		

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F 282	<p>Continued From page 11</p> <p>determined the Immediate Jeopardy was removed on 07/24/14 as alleged by the facility, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Using the Care Plan," with a revision date of August 2006, revealed the care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had the responsibility to provide care or services to the resident.</p> <p>Review of the facility's contract with the laboratory, dated 05/15/06, revealed chart audit reviews of physician-ordered laboratory testing would be conducted on a monthly basis. The contract did not specify a timeframe for when a physician's order for standing orders for laboratory testing would expire. However, interview on 07/22/14, at 2:00 PM with the laboratory's Corporate Manager revealed all routine standing laboratory orders expired 400 days after the initial receipt of the order. According to the Corporate Manager, the standing orders would need to be updated in the laboratory's computer system prior to the expiration date of the laboratory orders.</p> <p>Record review revealed the facility admitted Resident #8 on 09/07/12 with diagnoses including Atrial Fibrillation.</p>	F 282	<p>4. In clinical meeting Monday through Friday all new physician orders will be reviewed by the Interdisciplinary team including readmission and admission physician orders. Care plans will be updated as necessary for any new physician orders.</p> <p>The interdisciplinary care plan team will review all care plans at least quarterly on each resident who has a scheduled care conference meeting that day. Care plans will be updated and revised as needed during this meeting. Any discrepancies noted will be investigated and addressed, results will be reviewed through the QA process.</p> <p>The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>QA Meetings can be held with two or more team members in attendance daily 5 days a week and PRN for review of data to ensure compliance including: any findings of labs not completed per physician order, any abnormal lab results found without physician notification, or critical lab results.</p>		

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F 282	<p>Continued From page 12</p> <p>Further review of Resident #8's medical record revealed on 04/10/13 the resident's physician ordered a "PT with INR Q (every) week." Review of the May 2014 Physician's Orders revealed an order to obtain a "PT with INR Q (every) week." Continued review of Physician's Orders dated May 2014 revealed staff was to administer 6 milligrams of Coumadin (anticoagulant) to Resident #8 every night. On 05/05/14, the physician gave a verbal order to staff to reduce the resident's Coumadin to 5 milligrams every night. On 05/12/14, the physician gave a verbal order to discontinue the 5 milligrams of Coumadin and to administer 6 milligrams of Coumadin every night.</p> <p>Review of the Comprehensive Plan of Care, dated 01/30/14, revealed staff had developed a plan of care to address Resident #8's diagnosis of Atrial Fibrillation and the use of anticoagulants and had reviewed the plan of care on 05/08/14. According to the plan of care, the resident was at risk for bleeding related to the use of Coumadin and the interventions included to obtain a "PT/INR" as ordered and to notify the physician of the "PT/INR" results.</p> <p>Review of Resident #8's laboratory records revealed on 05/12/14, the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds) and his/her INR level was 2.2 (reference range 0.9 to 1.1). However, continued review of Resident #8's medical record revealed staff failed to ensure the PT with INR laboratory tests were obtained on a weekly basis as ordered by the physician and in accordance with the plan of care. Record review revealed the next PT with an INR for Resident #8 was not completed until 07/02/14 (seven weeks after the previous test) at which</p>	F 282	<p>QA Committee members will review QA topics minimally 5 days a week and PRN for 30 days or additionally as necessary until 9/30/2014; then monthly thereafter or as needed. The Regional Clinical Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings minutes five time weekly or as needed until September 30, 2014.</p>	8/26/14	

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F 282	<p>Continued From page 13</p> <p>time the resident's PT was 85.1 seconds (73.5 seconds above reference range) and the INR was 7.0 (5.9 above the reference range). Review of the laboratory report revealed both levels were "Critical." The resident's physician was notified of the abnormal lab results. On 07/02/14, the facility transferred Resident #8 to a hospital for further assessment and treatment in accordance with physician's orders.</p> <p>Review of the hospital record for Resident #8 revealed the resident was admitted to the hospital on 07/02/14, placed on telemetry, and was diagnosed with "Coumadin Toxicity."</p> <p>Interview with Unit Manager #1 on 07/18/14 at 9:05 AM, revealed staff was to review the plan of care on a monthly basis to ensure care was provided in accordance with the plan of care. According to the Unit Manager, she became aware that a PT and INR had not been obtained on a weekly basis for Resident #8 when she was in the process of transcribing the monthly Physician Orders on 06/30/14. The Unit Manager stated she had only been in the position as the Unit Manager "a couple of months" and had not been aware that the Unit Manager's responsibilities included monitoring laboratory tests to ensure the tests were completed as ordered. The Unit Manager also stated after the incident with Resident #8, she learned the company that obtained laboratory tests discontinued the orders for routine laboratory tests 400 days after the tests were initially ordered and required a new physician's order to continue the laboratory testing. According to the Unit Manager, the initial order for the PT with INR for Resident #8 had been ordered by the physician on 04/10/13 and staff had transcribed</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>the laboratory tests to the resident's Physician's Orders on a monthly basis; however, according to the Unit Manager, she learned after the incident that, even though the laboratory request had been transcribed to the physician's orders on a monthly basis, the contracted laboratory service had discontinued Resident #8's PT and INR laboratory test 400 days from the time the test had been initially ordered, which would have been on 05/15/14, three days after the PT and INR had been obtained on 05/12/14.</p> <p>An interview on 07/22/14, at 2:00 PM, conducted with the laboratory's Corporate Manager, revealed the laboratory sent an auditor once a month to verify the facility's laboratory orders. The Corporate Manager stated the auditor updated orders at that time and left reports of any identified concerns for the facility to follow up on. According to the Corporate Manager, ultimately it was the facility's responsibility to monitor to ensure laboratory orders were updated and the laboratory process had not changed. The Corporate Manager revealed the auditor had been to the facility on 05/12/14, and had updated the order for Resident #8's PT with INR to be collected on a weekly basis. However, the Corporate Manager stated the auditor had entered a start date of 07/01/14, instead of 05/19/14, for the PT and INR, which caused the laboratory orders to be missed from 05/19/14 until 07/02/14.</p> <p>Interview conducted with the Laboratory Auditor on 07/22/14, at 3:15 PM, revealed she had been responsible for updating Resident #8's PT with INR orders in the computer system and had inadvertently placed the wrong start date in the computer. The Laboratory Auditor stated she had</p>	F 282		

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F 282	<p>Continued From page 15</p> <p>placed 07/01/14, as the start date for the PT with INRs and should have put 05/19/14, as the start date. The Laboratory Auditor stated she reviewed physician's orders and compared them with the laboratory orders in the computer system to ensure laboratory orders were completed as ordered by the physician. The Laboratory Auditor stated she then provided a report to the DON of any discrepancies.</p> <p>Interview with the Director of Nursing on 07/18/14 at 1:15 PM revealed Unit Managers were responsible for monitoring to ensure residents' laboratory orders had been completed as ordered by the physician and that care had been provided in accordance with the resident's comprehensive plan of care. The DON stated she forwarded any reports left by the Laboratory Auditor to the Unit Managers to follow through. The DON stated she made rounds several times throughout the day to ensure care was being provided as directed in the plan of care, reviewed the residents' plans of care at random, and had not identified any problems related to laboratory tests not conducted as ordered by the physician.</p> <p>The Administrator acknowledged in interview conducted on 07/18/14, at 2:30 PM that she became aware that staff had failed to ensure the PT and INR laboratory tests had not been conducted as ordered by the physician. The Administrator stated the facility had not taken any action after the incident to ensure care was provided as planned in each resident's plan of care and in accordance with physician's orders.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the</p>	F 282		

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F 282	<p>Continued From page 16 Immediate Jeopardy:</p> <p>-Resident #8 had a physician's order for a routine PT with 1NR to be drawn every week. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained On 06/30/14 to obtain a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14.</p> <p>-All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has</p>	F 282			

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F 282	<p>Continued From page 17</p> <p>been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner.</p> <p>-The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely.</p> <p>-A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness.</p> <p>-The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff.</p> <p>-All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving</p>	F 282			

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F 282	<p>Continued From page 18</p> <p>this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work.</p> <p>-Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order clarification, and putting lab results on the chart.</p> <p>-The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday.</p> <p>-The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any "stat" laboratory tests were ordered on the</p>	F 282			

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F 282	<p>Continued From page 19 weekend. If "stat" laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend.</p> <p>-All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>-The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed</p>	F 282			

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F 282	Continued From page 20 Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend "stat" laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician	F 282			

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F 282	<p>Continued From page 21</p> <p>order, any abnormal lab results found without physician notification, or any critical lab results.</p> <p>-Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner.</p> <p>-Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol.</p> <p>-The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders. However, the neither Administrator nor DON was made aware of this issue by the Pharmacy Consultant and neither the Administrator nor DON had access to Omniview. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk.</p> <p>-The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p>	F 282			

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F 282	<p>Continued From page 22</p> <p>-The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the Pharmacy Consultant must exit with the Administrator and/or DON, go over the consultant reports, and leave a hard copy of his consultant report.</p> <p>-On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports.</p> <p>-The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education.</p> <p>-The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the</p>	F 282			

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F 282	<p>Continued From page 23</p> <p>Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received.</p> <p>-Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14.</p> <p>-Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff.</p> <p>-Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident</p>	F 282			

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F 282	<p>Continued From page 24</p> <p>care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work.</p> <p>-One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14.</p> <p>-One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.</p> <p>-The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders.</p> <p>-The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>-Review of the laboratory reports for Resident #8</p>	F 282			

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F 282	<p>Continued From page 25</p> <p>revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0.</p> <p>-Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital.</p> <p>-Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital.</p> <p>-Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14.</p> <p>-Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses.</p> <p>-Review of an In-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect,</p>	F 282			

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F 282	<p>Continued From page 26 resident rights, and care plans.</p> <p>-Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff.</p> <p>-Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff.</p> <p>-Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory</p>	F 282			

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F 282	<p>Continued From page 27</p> <p>order into the computer, the tracking process, and documentation required.</p> <p>-Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>medical record and the results reported to the physician as necessary.</p> <p>-Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit.</p> <p>-Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call.</p> <p>-Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday</p>	F 282			

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F 282	<p>Continued From page 29</p> <p>and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any "stat" laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program.</p> <p>-An in-service roster dated 07/20/14, regarding</p>	F 282		

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F 282	<p>Continued From page 30</p> <p>Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service.</p> <p>-Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest.</p> <p>-Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans.</p> <p>-Review of a list of Quality Assurance Team Committee members was conducted.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning</p>	F 282			

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F 282	<p>Continued From page 31</p> <p>meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools.</p> <p>-Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted.</p> <p>-Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified.</p> <p>-Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician.</p> <p>-Review of Care Plan Protocol staff were informed where care plans were located at each nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care.</p> <p>-Review of an in-service roster dated 07/21/14,</p>	F 282		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 282	<p>Continued From page 32</p> <p>regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM, verified they had attended an in-service regarding the required use of the care plan, and had completed a posttest.</p> <p>-Review of an audit completed by the Regional Corporate Nurse on 07/20/14, revealed all care plans for residents who were on anticoagulant therapy had been reviewed.</p> <p>-Interview conducted with the Regional Corporate Nurse Consultant on 07/25/14, at 4:45 PM, revealed she had conducted an audit on 07/20/14 of all care plans for residents who were on anticoagulant therapy, to ensure their plans of care were being followed as directed.</p> <p>-Review of an audit completed by the DON, Unit Managers, Minimum Data Set (MDS) Coordinator, and Social Services revealed 100 percent of the resident care plans were audited to ensure laboratory orders were documented on the care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had assisted in the audit of all residents' care plans to ensure care was being provided as directed in the care plans.</p> <p>-Review of a letter sent to the facility's pharmacy</p>	F 282			

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F 282	<p>Continued From page 33</p> <p>regarding the Pharmacist not identifying and bringing it to the facility's attention that Resident #8, who was on Coumadin therapy, had not been having the physician-ordered PT with INRs was reviewed. The letter revealed the future expectation of the facility was that the Consultant Pharmacist would review all residents on an anticoagulant as well as any other medication that required laboratory levels to be drawn. The letter also revealed the Pharmacist was expected to exit with the DON and the Administrator going forward and review any consultant reports with them and to leave a hard copy of the findings.</p> <p>-Interview conducted with the DON on 07/25/14, at 4:40 PM, revealed she had spoken with the Consultant Pharmacist on 07/18/14, and was informed he would no longer be doing the pharmacy reviews for the facility and a new Consultant Pharmacist would be completing the facility's pharmacy reviews.</p> <p>-Review of an education syllabus to be taught to the new Consultant Pharmacist before their next regular review revealed the Consultant Pharmacist would be required to monitor laboratory tests for critical levels, drug-to-drug interactions, and recommended drug alternatives. In addition, the Consultant Pharmacist would be required to exit with the Administrator and or the DON upon completion of the pharmacy review and to leave a hard copy of the consultant reports with the Administrator and DON and must be reviewed during the exit conference.</p> <p>-Observation on 07/25/14, at 3:50 PM, of the Administrator accessing the Consultant Pharmacist computer system with access to the reports was conducted.</p>	F 282			

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F 282	Continued From page 34 -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had contacted the General Manager of the pharmacy regarding the concern that Consultant Pharmacist had not identified and notified the Administrator nor the DON regarding the PT with INRs not being done as ordered for Resident #8. The Administrator stated she then sent the information in a letter to the pharmacy. The Administrator stated the General Manager was informed the new Consultant Pharmacist would have to attend an in-service by either her or the DON when coming to the facility on their next scheduled visit. The Administrator stated she attended all Quality Assurance Committee meetings and would be reviewing all data obtained from all the audits. -Interviews conducted with the Regional Corporate Nurse Consultant and the Regional Director of Operations, on 07/25/14, at 4:45 PM, revealed either one or both of them had provided oversight to the facility and would continue to do so until the jeopardy was abated, and then would provide oversight on a weekly basis. The interview also revealed they would continue to review all Quality Assurance minutes.	F 282			
F 323 SS=D	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.	F 323	F323 483.25(h)FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1 Resident # 12 was placed in a wheelchair with anti-rollback devices and bilateral leg rests on 7/ 24/2014 by the Occupational therapist.		

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F 323	<p>Continued From page 35</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review, and review of the facility's Incidents and Accidents policy, it was determined the facility failed to ensure one (1) of thirty-four (34) sampled residents (Resident #12) received adequate assistive devices to prevent accidents. A review of Resident #12's care plan revealed the resident's wheelchair required anti-rollback devices and bilateral leg rests because the resident was at risk for injury from falling. Observations of Resident #12 sitting in his/her wheelchair on 07/21/14, 07/22/14, and 07/23/14 revealed there were no anti-rollback devices or leg rests attached to the wheelchair.</p> <p>The findings include:</p> <p>Review of the facility's "Incidents and Accidents Policy," with a revision date of 10/16/12, revealed the policy did not address the prevention of accidents. Interview with the Administrator on 07/24/14 at 1:30 PM, revealed the facility did not have a policy related to assistive devices.</p> <p>Record review revealed the facility admitted Resident #12 on 08/25/13 with diagnoses including General Muscle Weakness, Hypertension, Diabetes Mellitus, History of Falls, and Lack of Coordination.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 06/17/14, revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severely impaired</p>	F 323	<p>2. DON, Unit Manager, Dietary Supervisor, and Social Services completed an audit of one hundred percent of all assistive devices that were listed on the resident's physicians orders and the care plan on 8/7/2014. Communication forms were filled out and given to maintenance and/or therapy as needed and updates were made as necessary.</p> <p>3. In clinical meeting Monday through Friday all new physician orders will be reviewed by the Interdisciplinary team. Any new physician orders for an assistive device will be verified to ensure that they have been placed appropriately.</p> <p>The Administrator in serviced the interdisciplinary team on 8/14/2014 that during the interdisciplinary careplan meeting that is done on each resident at least quarterly they will check the residents assistive devices and verify that they match the residents physicians orders and the residents care plan., any discrepancies will be addressed and taken through the QA process.</p> <p>Beginning the week of 8/11/2014 the DON and/or unit managers will audit 10% of residents with physician's orders for assistive devices weekly for four weeks. Then the DON/designee will audit 15% of residents with assistive devices monthly for three months or ongoing until this issue is resolved.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, unit managers to meet monthly to review audit findings and revise plan as needed this plan will be ongoing until this issue is resolved.</p>	8/26/14

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F 323	<p>Continued From page 36 cognition.</p> <p>Review of the Comprehensive Plan of Care with a revision date of 06/24/14, revealed the facility developed a care plan intervention for anti-rollback devices (device to prevent the wheelchair from rolling back when the resident attempts to stand) and bilateral leg rests (attachment placed on the wheelchair to allow the resident's legs to rest on and aid in mobility) to be on Resident #12's wheelchair to prevent falls.</p> <p>Observations of Resident #12 on 07/21/14 at 4:50 PM, on 07/22/14 at 11:28 AM, and on 07/23/14 at 9:36 AM revealed the resident was sitting in a wheelchair in the dining room. The resident's wheelchair revealed staff failed to ensure the anti-rollback devices and bilateral leg rests were in place on the wheelchair.</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #10 on 07/23/14 at 10:16 AM revealed she was responsible for the care of Resident #12 on 07/23/14. Further interview revealed she was to review the resident's care plan daily. However, the SRNA stated she was unaware what "anti-rollback to the wheelchair" meant, or if Resident #12's wheelchair had anti-rollbacks or leg rests.</p> <p>Interview conducted with SRNA #11 on 07/23/14 at 10:19 AM revealed she was also responsible for the care of Resident #12 on 07/23/14. She stated she was required to review the care plan of the residents that she provided care for each day, as the care plan would include information about the resident's care needs. However, SRNA #11 also stated she was unaware if Resident #12 had anti-rollbacks and leg rests to the resident's</p>	F 323			

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F 323	<p>Continued From page 37 wheelchair.</p> <p>Registered Nurse (RN) #1 acknowledged in an interview conducted on 07/23/14 at 10:27 AM that Resident #12 did not have anti-rollbacks or leg rests on the resident's wheelchair. The RN stated therapy staff was responsible for placing attachments onto wheelchairs.</p> <p>Interview conducted with the Physical Therapist (PT) on 07/23/14, at 1:31 PM, revealed the Therapy Department was responsible for placing attachments on wheelchairs. The PT stated she was unsure why the attachments were not on Resident #12's wheelchair or if the attachments had ever been placed on the wheelchair. The PT stated nursing staff monitored the care of residents to ensure care was provided.</p> <p>Further interview with RN #1 on 07/23/14 at 2:22 PM revealed she was the Unit Manager for the Green Wing and Resident #12 resided on her unit. RN #1 stated she made rounds frequently throughout the unit to monitor to ensure residents were being provided the care they required. However, the RN stated she had not identified that the anti-rollbacks or the bilateral leg rests were not on the resident's wheelchair.</p> <p>Interview with the Director of Nursing (DON) on 07/25/14 at 1:17 PM revealed the facility monitored residents to ensure they were provided with adequate supervision to prevent accidents when they conducted resident care rounds randomly throughout the facility. The DON stated Therapy staff was required to place attachments on wheelchairs, but nursing staff was responsible to ensure the attachments were in place or to notify the Therapy Department to place them on</p>	F 323		

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F 323	Continued From page 38 the wheelchairs.	F 323			
F 329 SS=J	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies entitled "Lab and Diagnostic Test Results-Clinical Protocol" and "Medication Administration," and a review of the facility's contract for Laboratory Services, it was determined the facility failed to ensure nursing	F 329	P329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1. Resident #8 had a physician's order for routine PT with INR every week. Resident #8 had a PT with INR drawn on 5/12/2014. On May 12, 2014 the lab auditor was doing her review and saw that the PT with INR for Resident # 8 was going to expire on July 31, 2014 so she went in to renew the lab in the Medlab system. She mistakenly changed the start date to July 1, 2014 through July 31, 2014 which deleted out of the system until that date therefore there would be no PT with INR order in the system for resident # 8 from May 12, 2014 until July 1, 2014. The unit manager discovered that a PT with INR wasn't being drawn during changeover on 6/30/2014. The physician was notified by the unit manager and a clarification order was obtained to get a PT with INR weekly on 6/30/2014. The unit manager put the PT with INR in the Medlab computer system to be drawn on the next lab day which was 7/1/2014. The PT with INR was drawn on Resident #8 on 7/2/2014. The PT was 85.1 and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer the Resident #8 to the hospital for direct admission. Resident # 8 was admitted to the hospital from 7/2/2014 to 7/4/2014.		

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F 329	<p>Continued From page 39</p> <p>staff effectively monitored medications and laboratory results for one (1) of thirty-four (34) sampled residents (Resident #8). Review of physician's orders for May 2014 revealed the physician had prescribed 6 milligrams (mg) of Coumadin (anticoagulant) to be administered to Resident #8 at night, and for a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) to be completed weekly.</p> <p>A review of Resident #8's medical record revealed the facility administered Coumadin on a daily basis at night and a PT and INR was obtained on 05/05/14 and on 05/12/14. The PT/INR that was obtained on 05/12/14 revealed the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds), and the resident's INR was 2.2 (reference range 0.9 to 1.1). Documentation revealed facility staff continued to administer 6 mg of Coumadin to Resident #8 at night; however, staff failed to ensure the PT and INR was collected on a weekly basis as ordered by the resident's physician. Review of the resident's medical record revealed a PT and INR was not obtained for Resident #8 again until 07/02/14 (seven weeks after the previous test on 05/12/14) at which time the resident's PT was 85.1 seconds (73.5 seconds above reference range), the INR was 7.0 seconds (5.9 above the reference range), and was identified by the laboratory to be at a "Critical" level. Review of the Nurse's Notes dated 07/02/14, revealed Resident #8's physician was notified of the abnormal lab results and the resident was transported and admitted to a hospital where he/she was placed on telemetry (heart monitoring) and diagnosed with "Coumadin Toxicity."</p>	F 329	<p>2. Administrative Nursing Staff completed a 100 percent audit of all labs on 7/22/2014 to ensure that labs were drawn per physician's order; any issues identified were addressed and taken through QA. Based on the information provided to me in QA follow-up included completion of S-Bars and physician order clarification and putting lab results on the chart</p> <p>The facility will have one pharmacy consultant who will come to the facility each month to conduct a pharmacy review on 100% of the residents in the facility</p> <p>The Director of Nursing will review the pharmacy recommendations monthly. Any recommendation that needs physician approval will be sent to the physician. The unit managers will receive the recommendations after the physician reviews them and will write orders or follow up on as needed. The Director of Nursing will ensure that all pharmacy recommendations are followed up on and addressed. These results will be taken through the Quality Assurance process.</p> <p>3. A lab policy and protocol was developed by the Quality Assurance team on July 19, 2014 to be used for all labs. This new policy and protocol includes the steps to take starting from receiving a lab order all the way to getting the results and monitoring for timeliness.</p>	

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F 329	<p>Continued From page 40</p> <p>The facility's failure to ensure facility staff provided adequate monitoring of drugs and laboratory testing and failure to ensure residents were free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. Prior to exit on 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14 as alleged by the facility, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Lab and Diagnostic Test Results-Clinical Protocol," with a revision date of October 2010, revealed the physician would identify and order diagnostic and laboratory testing based on diagnostic and monitoring needs. The policy stated nursing staff would process the test requisition and arrange for</p>	F 329	<p>The Regional Nurse Consultant for Preferred Care Partners, MG in serviced the DON, and Staff Development Nurse on the lab policy on July 19, 2014 prior to them in servicing the Licensed Nursing Staff and Unit Managers. All of the nurses as well as the unit managers was in-serviced by the DON, Staff Development nurse or designee on the new lab policy and protocol. New protocol has been developed to ensure that labs are drawn as ordered and that results are received in a timely manner to prevent residents from missing any ordered labs.</p> <p>The administrator drafted a letter to the manager of Medlab on 7/22/2014 stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the Medlab system they must notify the Administrator and DON as well as provide education on those changes.</p> <p>Also stated in the letter from July 22, 2014 is the expectation that no Medlab auditor will renew any labs at all, the facility will be responsible for that. Medlab is also expected during their monthly audits will provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that the building can renew the lab orders in the Medlab system timely.</p> <p>The Regional Nurse Consultant for Preferred Care Partners, MG in serviced the DON and the Staff Development Nurse on the lab policy and protocol on 7/19/2014 before they in serviced the licensed nursing staff.</p>		

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F 329	<p>Continued From page 41 the tests to be completed by the laboratory.</p> <p>Review of the facility's policy titled, "Medication Administration," which was undated, revealed nursing staff would evaluate if the medication was implicated in an adverse consequence and had achieved the therapeutic goal. However, the policy failed to address monitoring medication/medication errors.</p> <p>Review of the facility's contract titled, "Laboratory Contract Addendum," dated 05/15/05, revealed the laboratory "will provide chart audit services for facility on a monthly basis." However, the contract did not address a specific amount of time in which a laboratory test order would expire/stop being collected.</p> <p>Review of the facility's contract titled, "Pharmacy Consultant Agreement," dated 02/01/99, revealed the Pharmacist (RPh) would review the drug regimen of each resident in the facility and would report in writing any irregularity to the facility's Administrator, Medical Director, the resident's physician, and the DON.</p> <p>Record review revealed the facility initially admitted Resident #8 to the facility on 09/07/12 following a hospitalization, and was readmitted on 03/21/13. The resident's diagnoses included Atrial Fibrillation.</p> <p>Review of Resident #8's May 2014 Physician's Orders revealed an order for 6 milligrams of Coumadin to be administered daily. The Physician's Orders also included an order for a Prothrombin Time (PT) with an International Normalized Ratio (INR) to be completed weekly. Resident #8's medical record revealed facility</p>	F 329	<p>All licensed nursing staff as well as the unit managers was educated on the new lab policy and protocol by 7/20/2014 by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education.</p> <p>All staff has been in serviced on abuse, what it is, and the reporting. Education was conducted by DON, Staff Development Nurse or designee with a completion date of 7/20/2014. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>All staff was in serviced on Resident Rights. Education was conducted by DON, Staff Development Nurse or designee with a completion date of 7/20/2014. No agency in use at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p>		

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F 329	<p>Continued From page 42</p> <p>staff administered 8 mg of Coumadin to the resident nightly; however, staff failed to ensure the PT/INR was collected on a weekly basis from 05/12/14 through 07/02/14 (a timeframe of seven weeks). A PT and INR laboratory test was conducted on 07/02/14, which revealed Resident #8's PT was 85.1 seconds (73.5 seconds above the reference range), his/her INR was 7.0 seconds (5.9 above the reference range), and the laboratory results revealed the levels were "Critical." Review of the Nurse's Notes dated 07/02/14, revealed Resident #8's physician was notified of the "Critical" lab results and the resident was transported to a hospital. Review of the Hospital record revealed Resident #8 was admitted to the hospital, placed on telemetry, and diagnosed with "Coumadin Toxicity." (According to the Occupational Safety and Health Administration [n.d.], the signs and symptoms of Coumadin toxicity include bloody nose; bleeding gums; muscle and joint pain; hematomas of the arms, legs, buttocks, and/or joints; frank blood in the urine and feces; anorexia, nausea, vomiting, diarrhea or abdominal pain; pallor and fatigue caused by anemia; paralysis caused by intracranial hemorrhage; blurry vision, eye pain, and blindness; skin lesions and petechiae, necrosis, or gangrene). A review of the resident's facility and hospital medical records and interviews with staff revealed Resident #8 did not exhibit any outward signs or symptoms of Coumadin Toxicity.</p> <p>Interview with Unit Manager #1, on 07/18/14 at 9:05 AM, revealed she was responsible to ensure laboratory orders were completed. However, according to the Unit Manager, on 08/30/14 she discovered the PT with INR had not been collected for Resident #8 since 05/12/14. The</p>	F 329	<p>The unit managers will compare the lab calendar to the labs listed on the lab tracking sheet before morning meeting to verify that they match Monday through Friday. The unit manager will then follow up prior to morning meeting to ensure that labs were drawn as listed, results have been received, and they have been followed up on timely Monday through Friday. During morning meeting Monday through Friday the Administrator or DON or designee will check the Lab book as well as the lab calendar to ensure that labs have been drawn as physician ordered and results have been received. Any issues identified are corrected immediately. These results will be taken through QA. This practice became effective 7/19/2014. If there are any weekend stat labs ordered the Nurse on call will call the Administrator or DON and will QA any Labs ordered and received on Saturday and Sunday.</p> <p>The Nurse on the rotating call schedule was in serviced on the weekend lab monitoring log on 7/22/2014 by the Administrator. The weekend nurse on call will call the facility on Saturday and Sunday at 9am, 1pm, 5pm, and 9pm to see if any stat labs were ordered on the weekend. If stat labs have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. The Nurse on call will then call the DON or Administrator and review the weekend labs.</p>		

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F 329	<p>Continued From page 43</p> <p>Unit Manager stated she contacted the laboratory on 06/30/14, and was told the order for Resident #8's PT with an INR had "expired." According to the Unit Manager, the Corporate Manager for the laboratory informed her standing orders for laboratory tests expired after 400 days. The Unit Manager stated she was not aware of the date the laboratory request had expired.</p> <p>Interview on 07/18/14 at 1:20 PM with Resident #8's physician revealed the failure to ensure Resident #8's PT and INR levels were obtained and reported weekly could have caused the resident harm. The physician stated he assessed the resident on 06/21/14, and had documented Resident #8's PT with INRs were being monitored weekly in his Progress Notes, but stated he had just reviewed the laboratory reports that were on the resident's medical record and had not identified the PT with INRs had not been completed weekly for Resident #8 as he had ordered.</p> <p>Interview conducted on 07/22/14, at 2:00 PM with the Corporate Manager for the laboratory utilized by the facility revealed the laboratory sent an Auditor to the facility once a month to verify laboratory orders. The Corporate Manager stated the Auditor would update an order at that time, but it was ultimately the facility's responsibility to ensure laboratory orders were updated and the process had not changed. The Corporate Manager stated when the Auditor verified Physician Orders on 05/12/14, she had attempted to update the physician's order for Resident #8's PT/INR, but had mistakenly entered a "start" date for the laboratory tests of 07/01/14, instead of 05/19/14, and that had caused the laboratory orders to be missed from 05/19/14 until 07/02/14.</p>	F 329	<p>All new orders for medications as well as admission and readmission medication orders is reviewed and will continue to be reviewed during morning meeting Monday through Friday for efficacy. All lab and pharmacy consultant reports will be reviewed monthly for any recommended changes or follow up. Results will be taken through QA.</p> <p>4. The Director of Nursing will review the pharmacy recommendations monthly. The Director of Nursing will ensure that all pharmacy recommendations are followed up on and addressed. These results will be reviewed at the Quality Assurance meeting times three months.</p> <p>The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>QA Meetings can be held with two or more team members in attendance daily 5 days a week and PRN for review of data to ensure compliance including: any findings of labs not completed per physician order, any abnormal lab results found without physician notification, or critical lab results.</p>		

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F 329	<p>Continued From page 44</p> <p>Interview with the Director of Nursing (DON) on 07/18/14 at 1:15 PM revealed the Laboratory the facility utilized to perform laboratory testing maintained standing orders for laboratory tests for a timeframe of 400 days, and then discontinued the order unless it was reordered by the physician. According to the DON, the Laboratory had conducted the PT and INR for Resident #1 in accordance with the physician's initial order, but had discontinued the test the first day after the standing order expired (the 400th day). The DON stated facility staff was required to update standing orders for the Laboratory to continue to conduct laboratory tests. The DON stated until the incident with Resident #8, neither she nor the facility had been aware of the expiration of a laboratory order after 400 days, nor was it specified in the contract between the facility and the laboratory. The DON stated the facility had not put any monitors in place other than the Laboratory Auditor until after Resident #8's PT with INRs had been missed.</p> <p>Interview with the Administrator on 07/18/14, at 2:30 PM, revealed she was informed of the facility's failure to obtain PT and INR laboratory tests for Resident #8 on 07/01/14. The Administrator stated the facility had not taken any action after the incident to ensure care was provided in accordance with physician's orders.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-Resident #8 had a physician's order for a routine PT with 1NR to be drawn every week. Resident</p>	F 329	<p>QA Committee members will review QA topics minimally 5 days a week and PRN for 30 days or additionally as necessary until 9/30/2014; then monthly thereafter or as needed. The Regional Clinical Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings minutes five time weekly or as needed until September 30, 2014.</p>	8/20/14	

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F 329	<p>Continued From page 45</p> <p>#8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained On 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14.</p> <p>-All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner.</p>	F 329			

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F 329	<p>Continued From page 46</p> <p>-The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely.</p> <p>-A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness.</p> <p>-The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff.</p> <p>-All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return</p>	F 329			

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F 329	<p>Continued From page 47 to work.</p> <p>-Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order clarification, and putting lab results on the chart.</p> <p>-The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday.</p> <p>-The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any "stat" laboratory tests were ordered on the weekend. If "stat" laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders</p>	F 329			

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F 329	<p>Continued From page 48</p> <p>have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend.</p> <p>-All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>-The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided</p>	F 329			

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F 329	<p>Continued From page 49 on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use.</p> <p>-Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend "stat" laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received.</p> <p>-Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results.</p> <p>-Quality Assurance Committee members will</p>	F 329			

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F 329	<p>Continued From page 50</p> <p>review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner.</p> <p>-Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol.</p> <p>-The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders. However, the neither Administrator nor DON was made aware of this issue by the Pharmacy Consultant and neither the Administrator nor DON had access to Omniview. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk.</p> <p>-The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p> <p>-The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the</p>	F 329		

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F 329	<p>Continued From page 51</p> <p>minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the Pharmacy Consultant must exit with the Administrator and/or DON, go over the consultant reports, and leave a hard copy of his consultant report.</p> <p>-On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports.</p> <p>-The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education.</p> <p>-The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on</p>	F 329			

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F 329	<p>Continued From page 52</p> <p>the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received.</p> <p>-Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14.</p> <p>-Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff.</p> <p>-Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work.</p> <p>-One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14.</p> <p>-One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.</p> <p>-The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders.</p> <p>-The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>-Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0.</p>	F 329			

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F 329	<p>Continued From page 54</p> <p>-Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital.</p> <p>-Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital.</p> <p>-Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14.</p> <p>-Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses.</p> <p>-Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans.</p> <p>-Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had</p>	F 329			

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F 329	<p>Continued From page 55</p> <p>attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff.</p> <p>-Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff.</p> <p>-Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required.</p> <p>-Review of the letter sent to the laboratory dated</p>	F 329			

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F 329	<p>Continued From page 56</p> <p>07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2.02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary.</p> <p>-Review of the laboratory calendars for each</p>	F 329			

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F 329	<p>Continued From page 57</p> <p>nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit.</p> <p>-Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call.</p> <p>-Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any "stat" laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the</p>	F 329			

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F 329	<p>Continued From page 58</p> <p>results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/28/14.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program.</p> <p>-An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service.</p>	F 329			

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F 329	<p>Continued From page 59</p> <p>-Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:48 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest.</p> <p>-Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans.</p> <p>-Review of a list of Quality Assurance Team Committee members was conducted.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the</p>	F 329			

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F 329	<p>Continued From page 60</p> <p>abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools.</p> <p>-Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted.</p> <p>-Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified.</p> <p>-Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician.</p> <p>-Review of Care Plan Protocol staff were informed where care plans were located at each nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care.</p> <p>-Review of an in-service roster dated 07/21/14, regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest.</p>	F 329			

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F 329	Continued From page 61 -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM, verified they had attended an in-service regarding the required use of the care plan, and had completed a posttest. -Review of an audit completed by the Regional Corporate Nurse on 07/20/14, revealed all care plans for residents who were on anticoagulant therapy had been reviewed. -Interview conducted with the Regional Corporate Nurse Consultant on 07/25/14, at 4:45 PM, revealed she had conducted an audit on 07/20/14 of all care plans for residents who were on anticoagulant therapy, to ensure their plans of care were being followed as directed. -Review of an audit completed by the DON, Unit Managers, Minimum Data Set (MDS) Coordinator, and Social Services revealed 100 percent of the resident care plans were audited to ensure laboratory orders were documented on the care plans. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had assisted in the audit of all residents' care plans to ensure care was being provided as directed in the care plans. -Review of a letter sent to the facility's pharmacy regarding the Pharmacist not identifying and bringing it to the facility's attention that Resident #8, who was on Coumadin therapy, had not been having the physician-ordered PT with INRs was	F 329			

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F 329	<p>Continued From page 62</p> <p>reviewed. The letter revealed the future expectation of the facility was that the Consultant Pharmacist would review all residents on an anticoagulant as well as any other medication that required laboratory levels to be drawn. The letter also revealed the Pharmacist was expected to exit with the DON and the Administrator going forward and review any consultant reports with them and to leave a hard copy of the findings.</p> <p>-Interview conducted with the DON on 07/25/14, at 4:40 PM, revealed she had spoken with the Consultant Pharmacist on 07/18/14, and was informed he would no longer be doing the pharmacy reviews for the facility and a new Consultant Pharmacist would be completing the facility's pharmacy reviews.</p> <p>-Review of an education syllabus to be taught to the new Consultant Pharmacist before their next regular review revealed the Consultant Pharmacist would be required to monitor laboratory tests for critical levels, drug-to-drug interactions, and recommended drug alternatives. In addition, the Consultant Pharmacist would be required to exit with the Administrator and or the DON upon completion of the pharmacy review and to leave a hard copy of the consultant reports with the Administrator and DON and must be reviewed during the exit conference.</p> <p>-Observation on 07/25/14, at 3:50 PM, of the Administrator accessing the Consultant Pharmacist computer system with access to the reports was conducted.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had contacted the General Manager of the pharmacy</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 871 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 329	Continued From page 83 regarding the concern that Consultant Pharmacist had not identified and notified the Administrator nor the DON regarding the PT with INRs not being done as ordered for Resident #8. The Administrator stated she then sent the information in a letter to the pharmacy. The Administrator stated the General Manager was informed the new Consultant Pharmacist would have to attend an in-service by either her or the DON when coming to the facility on their next scheduled visit. The Administrator stated she attended all Quality Assurance Committee meetings and would be reviewing all data obtained from all the audits. -Interviews conducted with the Regional Corporate Nurse Consultant and the Regional Director of Operations, on 07/25/14, at 4:45 PM, revealed either one or both of them had provided oversight to the facility and would continue to do so until the jeopardy was abated, and then would provide oversight on a weekly basis. The interview also revealed they would continue to review all Quality Assurance minutes.	F 329			
F 428 SS=J	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 483.60 (c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 1. The pharmacy consultant reviewed resident #8's medical record on 5/19/2014 and on 6/26/2014. The pharmacist did note in Omniview on their 6/26/2014 review that Resident # 8 hadn't been having their PT with INR drawn weekly per physician's orders. However neither the Administrator nor the DON was made aware of this issue by the pharmacy consultant and neither the Administrator nor the DON had access to Omniview.		

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F 428	<p>Continued From page 64</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's contract with the pharmacy, it was determined the facility failed to ensure the pharmacist reported irregularities to the attending physician and to the Director of Nursing (DON) in order for the reports to be acted upon for one (1) of thirty-four (34) sampled residents (Resident #8).</p> <p>Resident #8 had Physician's Orders for Coumadin (anticoagulant) and for a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) laboratory tests to be completed weekly. Review of Resident #8's May 2014 monthly Physician Orders revealed an order for staff to administer 8 milligrams (mg) of Coumadin every night. On 05/05/14, the facility received a verbal order from the physician to decrease the Coumadin to 5 milligrams every night and on 05/12/14, the physician ordered that the Coumadin be increased to 8 milligrams every night. Record review revealed a PT and INR was obtained on 05/12/14 and revealed the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds), and the INR was 2.2 (reference range 0.9 to 1.1). However, the next PT with an INR for Resident #8 was not completed until 07/02/14 (seven weeks after the previous PT/INR had been obtained on 05/12/14) and the resident's PT was 85.1 seconds (73.5 seconds above reference) and the INR was 7.0 (5.9 above the reference range). Review of the Laboratory report revealed the resident's PT and INR at that time was "Critical." Resident #8 was admitted to the hospital on 07/02/14, was placed on telemetry,</p>	F 428	<p>The DON spoke with the current pharmacy consultant on July 18, 2014 who had conducted the pharmacy review for Resident # 8 in May and June 2014 and he stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p> <p>2. The Administrator drafted a letter to the manager of the pharmacy on July 23, 2014 stating that during the pharmacist's monthly review at the facility the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the pharmacy consultant must exit with the Administrator and/or DON and go over the consultant reports and leave a hard copy of his consultant report.</p> <p>The administrator called and spoke with John Smith (General Manager of Omnicare of Beattyville) and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports on July 21, 2014.</p> <p>The Administrator and/ or DON will educate the pharmacy consultant before their next regular review on the ensuring that they assess the following areas: monitoring labs for critical levels, drug to drug interactions, and recommended drug alternatives. The education will also include that the pharmacy consultant must exit with the Administrator and/or DON upon completion of their review to go over consultant reports and provide the facility with a hard copy of the consultant reports. The pharmacy consultant will be required to sign verification of education.</p>		

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F 428	<p>Continued From page 65</p> <p>and diagnosed with Coumadin Toxicity. Review of the Pharmacist (RPh) notes revealed the RPh had reviewed Resident #8's medical record on 05/19/14 and 06/26/14. However, there was no evidence the pharmacist had notified the physician or the DON that the resident's PT and INR had not been obtained as ordered by the physician.</p> <p>The facility's failure to ensure residents received adequate drug monitoring and was free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "I." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. On 07/26/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14, as alleged, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p>	F 428	<p>The administrator and DON now has access to Omniview effective July 23, 2014 so we can go in and look at the consultant reports as well as any notes that has been made. The Administrator and DON will review the reports in the Omniview system when they become available after the pharmacy consultant has did his exit. The Administrator and DON will check the Omniview system daily after the pharmacy consultant has exited to see if the reports are on Omniview. When the reports are available on Omniview the Administrator and DON will compare Omniview to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p><u>The Director of Nursing printed all of the pharmacy recommendations for July's pharmacy consultant review and sent them to the physician. On 8/26/2014 the Director of Nursing audited 100% of the pharmacy recommendation to ensure that they were addressed. No issues were identified.</u></p> <p>3. The facility will have one pharmacy consultant who will come to the facility each month to conduct a pharmacy review on 100% of the residents in the facility.</p> <p>The Director of Nursing will review the pharmacy recommendations monthly. Any recommendation that needs physician approval will be sent to the physician. The unit managers will receive the recommendations after the physician reviews them and will write orders or follow up on as needed. The Director of Nursing will ensure that all pharmacy recommendations are followed up on and addressed. These results will be taken through Quality Assurance.</p>		

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F 428	<p>Continued From page 68</p> <p>Review of the facility's contract with the pharmacy entitled, "Pharmacy Consultant Agreement," dated 02/01/99, revealed the Pharmacist (RPh) would review the drug regimen of each resident in the facility and would report in writing any irregularity to the facility's Administrator, Medical Director, the resident's physician, and the DON.</p> <p>Record review revealed the facility admitted Resident #8 on 09/07/12 with a diagnosis of Atrial Fibrillation.</p> <p>Further review of Resident #8's medical record revealed Physician's Orders for May 2014 that revealed Resident #8 was to receive 8 milligrams of Coumadin (anticoagulant) every night, and a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check for bleeding time) every week.</p> <p>Review of Physician Orders for Resident #8 revealed a verbal order dated 05/05/14 to decrease the resident's Coumadin dosage to 5 milligrams every night. In addition, the physician gave a verbal order dated 05/12/14 for the resident's Coumadin to be increased to 6 milligrams every night.</p> <p>Review of Resident #8's laboratory records dated 05/12/14 revealed the PT was 24.6 seconds with the normal range being 9.5 to 11.6 seconds. The INR was 2.2 with the normal range being 0.9 to 1.1 seconds. Further review of laboratory results for Resident #8 revealed the laboratory testing had not been completed on a weekly basis as ordered. Review of laboratory reports revealed a PT and INR was conducted on 07/02/14, seven weeks after the most recent tests on 05/12/14, and the resident's PT was 85.1 seconds (73.5</p>	F 428	<p>A lab policy and protocol was developed on July 19, 2014 by the quality assurance committee to be used for all labs. This new policy and protocol includes the steps to take starting from receiving a lab order all the way to getting the results and monitoring for timeliness.</p> <p>The Regional Nurse Consultant for Preferred Care Partners, MG in serviced the DON and the Staff Development Nurse on the lab policy and protocol on 7/19/2014 before they began in servicing Licensed Nursing Staff.</p> <p>All licensed nursing staff as well as the unit managers has been educated on the new lab policy and protocol by 7/20/2014 by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education.</p> <p>The unit managers have a lab calendar which has all routine labs scheduled to be drawn for the rest of the year in it. They will compare their lab calendar to the labs in the lab book prior to morning meeting Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed any issues found will be addressed and brought through the QA process. The Administrator and/or DON or designee will monitor use of the lab book five days a week Monday through Friday prior to morning meeting to ensure that labs have been drawn as ordered and results has come back and has been addressed, results will be taken through QA.</p>	

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F 428	<p>Continued From page 67</p> <p>seconds above the reference range) and the INR was 7.0 (5.9 above the reference range). The laboratory report indicated both levels were "Critical." A hand written note on the laboratory report revealed a Registered Nurse (RN) notified the resident's physician of the abnormal lab results and Resident #8 was transported to a hospital.</p> <p>Review of the hospital record for Resident #8 revealed the resident was admitted to the hospital on 07/02/14, placed on telemetry, and was diagnosed with Coumadin Toxicity (Increased bleeding time which can be potentially fatal from too high dosage of Coumadin, an anticoagulant).</p> <p>Review of the Medication Regimen Review revealed the RPh had reviewed the medication regimen for Resident #8 on 05/19/14 and 08/26/14. However, there was no documented evidence the RPh had identified and/or notified the Administrator, DON, Medical Director, or the resident's physician that the weekly PT and INR laboratory tests had not been conducted as prescribed for Resident #8.</p> <p>Interview conducted with the RPh on 07/18/14, at 1:40 PM, revealed he conducted monthly medication regimen reviews, and reviewed laboratory reports of those residents that received Coumadin (anticoagulant). The RPh stated he had not recorded Resident #8's PT with INR on 08/28/14, and that he had "missed" the fact that the resident had not had a PT with INR completed since 05/12/14.</p> <p>Interview with the Director of Nursing on 07/18/14 at 1:15 PM revealed she had not received any communication from the RPh that the weekly PT</p>	F 428	<p>If there are any weekend stat labs ordered the Nurse on call will call the Administrator or DON and will QA any labs ordered and received.</p> <p>4. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>QA Meetings can be held with two or more team members in attendance daily 5 days a week and PRN for review of data to ensure compliance including: any findings of labs not completed per physician order, any abnormal lab results found without physician notification, or critical lab results.</p> <p>QA Committee members will review QA topics minimally 5 days a week and PRN for 30 days or additionally as necessary until 9/30/2014; then monthly thereafter or as needed. The Regional Clinical Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings minutes five time weekly or as needed until September 30, 2014.</p>	8/26/14	

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F 428	<p>Continued From page 68</p> <p>and INR that had been ordered by Resident #8's physician had not been done. The DON stated she would have expected the pharmacist to notify her.</p> <p>Interview on 07/18/14 at 1:20 PM with the Medical Director revealed he was also Resident #8's physician. According to the Medical Director, he expected the pharmacist that conducted the monthly drug regimen reviews at the facility to notify him of any drug irregularities and that the weekly PT and INRs that he had ordered for Resident #8 had not been completed as ordered.</p> <p>Interview conducted with the Administrator on 07/18/14, at 2:30 PM, revealed the pharmacist conducted drug regimen on a monthly basis and the pharmacist was to notify her of any drug irregularities as the result of his monthly drug regimen review. The Administrator stated the pharmacist had conducted a monthly drug regimen review for Resident #8 on 05/19/14 and 06/26/14. However, according to the Administrator, the pharmacist had not notified her of any drug irregularities or that the laboratory tests used to monitor Resident #8's Coumadin use had not been conducted as ordered by the physician.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-Resident #8 had a physician's order for a routine PT with 1NR to be drawn every week. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so</p>	F 428			

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F 428	<p>Continued From page 69</p> <p>she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained On 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14.</p> <p>-All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner.</p> <p>-The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in</p>	F 428			

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F 428	<p>Continued From page 70</p> <p>renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely.</p> <p>-A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness.</p> <p>-The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff.</p> <p>-All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work.</p> <p>-Administrative Nursing Staff completed a 100</p>	F 428			

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41485		
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F 428	<p>Continued From page 71</p> <p>percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order clarification, and putting lab results on the chart.</p> <p>-The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday.</p> <p>-The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any "stat" laboratory tests were ordered on the weekend. If "stat" laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend.</p>	F 428			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/25/2014
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 428	Continued From page 72 -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use.	F 428			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/25/2014
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 428	<p>Continued From page 73</p> <p>-Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend "stat" laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received.</p> <p>-Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results.</p> <p>-Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any</p>	F 428			