

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/22/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-MAPLE			STREET ADDRESS, CITY, STATE, ZIP CODE 515 GREENE DRIVE GREENVILLE, KY 42345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 07/24/15, as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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F 323	<p>Continued From page 1 revealed oxygen cylinders must be chained individually or secured in stand.</p> <p>Review of the facility's policy titled, "Life Safety Management Plan", dated 12/11/04, revealed exits are kept clear to include areas directly affected, as well as all other exits.</p>	F 323	<p>IV. Monitoring:</p> <p>Facility rounds will be made daily for 1 month, Monday through Friday, twice a week for 1 month, and once a week for 1 month, by the Director of Nursing, or the Executive Director (as backup), to ensure proper storage of the oxygen cylinders/tanks, and that exits are kept clear. The observation rounds will be reviewed by the Executive Director and/or the Director of Nursing to ensure ongoing compliance in the daily Stand Up meeting Monday through Friday. Findings will be reviewed by the Performance Improvement committee for 3 months. The Performance Improvement Committee consists of, but is not limited to, the Executive Director, Director of Nursing, Staff Development Coordinator, Medical Director, Social Services Director, and Nutritional Services Manager.</p>	7/22/15
	<p>Observation during general tour of the "C" hall, on 06/24/15 at 5:20 AM, revealed a green "D" size oxygen cylinder was standing freely on the floor and unsecured in the hallway outside room #40. Additionally, there was a recliner blocking the emergency exit door and a liquid oxygen portable tank was standing unsecured beside a "D" oxygen cylinder both located just inside the emergency exit door beside room #40.</p> <p>Interview with Registered Nurse (RN) #1, on 06/24/15 at 5:40 AM, revealed the oxygen cylinder was there when she arrived to work on 06/23/15 at 6:00 PM. She indicated that she had moved the cylinders into room #40. She stated the recliner had been in front of the exit door earlier that shift.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 06/24/15 at 6:15 AM, revealed she was new and had never been told what to do with or how to use oxygen cylinders. She stated she had only been shown how to use the Liquid Portables which are to be secured to the back of the resident wheelchair when in use or stored in the oxygen room when not in use.</p> <p>Interview with the Director Of Nursing (DON), on 06/25/15 at 2:42 PM, revealed she expected all oxygen cylinders to be kept secured and all exits to be kept clear at all times.</p>			

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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, medication shipment log review and facility policy review, it was determined the facility's system to ensure pharmacy services were provided to meet the needs of one (1) of five (5) sampled residents was effective (Resident #2). Resident #2 was admitted to the facility on 06/04/15 and the facility failed to ensure Intravenous Medication (an antibiotic) was available for administration which caused the resident to miss two (2) doses.</p> <p>The findings include:</p>	F 425	<p>Resident #2 no longer resides in the facility.</p> <p>I. Immediate action taken: An audit was conducted by the Unit Managers on June 24, 2015 to ensure that all medications for each resident residing in the facility on the stated date was available for administration as ordered by the physician. No additional concerns were found at that time.</p> <p>II. Potential to effect others: All residents have the potential to be effected.</p> <p>III. Action taken to prevent re-occurrence. The license nurses were re-educated on faxing a copy of IV medications to the pharmacy as well as transmitting the computerized orders to the pharmacy on 6/25/15 by the Staff Development Coordinator. Nurses will not be allowed to work again until they have received the education.</p> <p>Education was provided to the licensed nurses to notify the physician if the medication is not available to be administered as scheduled for further direction or orders on 6/25/15 by the Staff Development Coordinator. Nurses will not be allowed to work again until they have received the education.</p> <p>IV. Monitoring: The Unit Managers/Director of Nursing will review the medication record of each new admission on the next business day after admission to ensure that each medication was delivered and administered timely, or that physician notification was made if the medication can not be given as ordered. Findings will be brought to the Performance Improvement Committee for 3 months.</p>	7/22/15
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F 425	<p>Continued From page 3</p> <p>Review of the facility policy titled, "Physician Orders", dated 11/12/12, revealed an appropriate copy of orders should be transmitted to the pharmacy for dispensing.</p> <p>Review of the facility policy titled, "Delivery and Receipt of Routine Deliveries", dated 01/01/13, revealed the pharmacy and facility should coordinate to determine the delivery dates and times as soon as possible after the execution of the Pharmacy Services Agreement or pharmacy Consult Agreement.</p> <p>Record review revealed the facility admitted Resident #2 on 06/04/15 at 6:00 PM with diagnoses to include Acute Mental Status change, Headache, Diabetes Mellitus Type II, History of Pancreatitils, Spinal Surgery, Right Knee Arthroscopic Surgery, Appendectomy, Acute Meningoencephalitis, Herpes Simplex Encephalitis vs West Nile Virus, GERD and Depression.</p> <p>Review of the Physician Admission Orders, dated 06/04/15, revealed Resident #1 was ordered Acyclovir (antibiotic) 800 milligrams (mg) intravenously (IV), every eight (8) hours for infection to be started upon admission to the facility. Review of the transferring hospital Medication Reconciliation Sheet revealed Resident #2 received his/her last dose of Acyclovir at 2:00 PM on 06/04/15 and should have received the next dose at 10:00 PM on 06/04/15. However, review of the June 2015 Medication Administration Record (MAR) revealed Acyclovir 800 mg IV was scheduled to be started on 06/05/15 at 7:00 AM instead of 06/04/15 at 10:00 PM which would cause this resident to have missed two (2) doses of the</p>	F 425			

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F 425	<p>Continued From page 4 Acyclovir.</p> <p>Review of the Admission Physician Orders that were faxed from the transferring hospital revealed the orders were received into the facility at 1:44 PM on 06/04/15; however, review of the Nursing Notes, revealed the Licensed Practical Nurse (LPN) documented the orders were faxed to pharmacy on 06/04/15 at 6:31 PM.</p> <p>Review of the Pharmacy Shipment Detail Report, dated 06/05/15 at 2:49 AM, revealed the Acyclovir 800 mg was not shipped from the pharmacy.</p> <p>Interview with the Unit Manager for the A and C halls, on 06/24/15 at 8:53 AM, revealed the computer system was down one (1) time during June 2015 but it was not while this resident was here. She stated Intravenous (IV) orders were faxed over to the pharmacy and if not available they arrange for the backup pharmacy to deliver the ordered medications. She stated Resident #2 was only here over night and left Against Medical Advice (AMA) the next morning on 06/05/15. She stated the resident left AMA at approximately 7:00 AM on 06/05/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/25/15 at 10:55 AM, revealed she was working on 06/04/15 when the orders were faxed to the facility. She stated the orders were reconciled with the physician and placed in the computer on hold because all orders require two (2) nurses to review them before releasing them to the pharmacy. Once the orders are confirmed, all narcotics and IV medications orders are faxed to the pharmacy and the pharmacy should be notified of the admission. She confirmed Resident #2 had not arrived to the facility prior to</p>	F 425			

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F 425	<p>Continued From page 5 her shift ending.</p> <p>Interview with LPN #3, on 06/25/15 at 7:57 AM, revealed she was working the night Resident #2 was admitted and the orders had been faxed over to pharmacy upon arrival. She stated the medications did not arrive on the shipment, so she called the pharmacy and was informed that it was coming from the backup pharmacy; however, she never followed up on the delivery. She confirmed she never notified the physician that the medication was never given as ordered.</p> <p>Interview with the facility's Chief Pharmacist, on 06/24/15 at 11:25 AM, revealed there was never an order faxed to pharmacy for Acyclovir 800 mg to be given IV. He stated all IV medications ordered should be faxed to the pharmacy to be dispensed. Additionally, he confirmed a call had been placed to the pharmacy at 8:15 PM on 06/04/15 by LPN #3 to inform them Resident #2 had been admitted to the facility and that all medications including controlled medications needed to be sent.</p> <p>Interview with the Attending Physician, on 06/25/15 at 8:50 AM, revealed he had never seen Resident #2 due to his/her short stay in the facility but was made aware that the resident had been admitted on 06/04/15. He stated he had not been notified the resident had not received his Acyclovir 800 mg as ordered. He revealed he expected all medications to be administered and he was to be notified if not given as ordered.</p>	F 425			