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SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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F 225	Continued From page 12 100 percent would be educated on the spot and retested. Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from the discharge summary, resident history or POA history, verification of allergy orders from the physician, as well as places on the MAR or medical record for placement of allergies will be included in the orientation for licensed nurses and KMAs. A follow-up questionnaire would be completed by the Administrator, DON, ADONs, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplain, Medical Records, Human Resources Director, SDC, Business Office Manager, Facility Formulary Nurse, or the Environmental Services Manager for ten staff members daily to include all shifts and different staff members until removal of immediacy, then weekly for four weeks, to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process to include reporting concerns to the Administrator, and front line staff participation in the development of QAPI plans. The Social Services Director, DON, ADONs, SDC, and MDS Coordinator conducted interviews on 03/27/14 with residents who had a BIMS score above 8 regarding their knowledge of allergies. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed.	F 225	During the medication pass audit, a questionnaire was completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication. All allergy clarifications for all residents has been sent to pharmacy as of 3/30 in which pharmacy has updated their listing in their computer system. Pharmacy will review all new orders and compare to any allergies listed and notify facility if an allergy exist regarding the new medication at which time the nurse will notify the physician for any new orders. 4. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, weekly for 4 weeks beginning 3/30/14, then monthly. The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits twice weekly for 4 weeks beginning 3/30/14 and report findings	

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F 225	Continued From page 13 The Social Services Director, DON, ADONs, MDS Coordinator, Administrator, or Regional Nurse Consultant conducted interview with the responsible party for residents with a BIMS score of less than 8 by 03/27/14 to identify any allergies or concerns with medications. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed. Allergies will be identified on the day of admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse will document allergies on the resident's medication allergy record that will be placed in the front of the MAR for that resident. The admitting nurse will review the resident's allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on the day of admission/readmission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders; and review of discharge summaries and all paperwork sent by the hospital along with the interview of the resident/POA will also be included in orientation for all new staff. The physician will be notified of any allergies by the charge nurse following review of all documents sent by the hospital, resident, and POA interview. Charts for newly admitted residents and readmitted residents will be reviewed and discussed in the Daily Clinical meeting on weekdays by the DON, MDS Coordinator, Social Services Director, Medical Records, SDC,	F 225	during weekly QA for 4 weeks, for recommendations and further follow-up as indicated. A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 staff members to include all shifts and different staff weekly for 4 weeks beginning 3/30/14, then monthly to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan. DON, ADONs', MDS, SDC or facility formulary nurse will audit 20% weekly	

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F 225	Continued From page 14 ADONs, Activities Director, Dietary Manager, and Chaplain with a comparison review completed at that time of the resident's admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, this review will be completed by the DON, ADONs, SDC, or MDS Coordinator until removal of immediacy. Following removal of immediacy, on weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or readmitted residents to ensure allergies are appropriately identified as well as all paperwork complete and accurate, care plan updated, physician notification complete, and all allergy lists updated or initialed. Allergy stickers and allergy lists were updated for all residents to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, and Regional Nurse Consultant on 03/28/14. Education was provided for licensed nursing staff/Kentucky Medication Aides by the Director of Nursing, Assistant Director of Nursing, the Staff Development Coordinator, and the Regional Nurse Consultant regarding all paperwork forwarded from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listings, physician orders, and MARs. Licensed nursing staff will not be allowed to work prior to receiving the above stated education. Nursing Administration to include the Director of	F 225	for 1 month the Resident Medication Administration Records and Treatment Administration Records for significant medication errors. Concerns identified will be correctly immediately and reported to the administrator. DON, ADONs, or SDC will observe the care delivery for 10% of residents weekly for 1 month for any suspected neglect concerns. Concerns identified will be corrected immediately and reported to administrator to ensure investigation of suspected neglect was investigated/completed and reporting guidelines are met. Social services Director or Chaplain will interview weekly for 1 month, 5% of residents with BIMs > 8 and 5% of residents POA with BIMs < 8 for any suspected neglect concerns. Concerns identified will be corrected immediately and reported to the administrator to ensure investigation of suspected neglect was investigated/completed and reporting guidelines are met. Administrator or DON will review all grievances weekly for 1 month to ensure any suspected neglect/abuse is investigated and reported.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 15 Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators, Facility Formulary Nurse, or Regional Nurse Consultant are reviewing every physician's order daily to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. This will continue daily until immediacy lifted. Once immediacy is lifted a daily review will continue (Monday-Friday) by the above team. During care plan conference for each elder the allergy list will also be reviewed for any updates. Medication pass audits were completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 03/28/14 to ensure that allergies are appropriately identified and medications are administered without significant medication error. Medication pass audits will be completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 03/28/14 until all nurses and certified medication technicians have had a medication pass audit completed. During the medication pass audit, a questionnaire will be completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication. The Assistant Director of Nursing, MDS Coordinator, or the Staff Development Coordinator will audit the Medication	F 225	A Quality Assurance meeting will be held weekly for 4 weeks beginning 3/30/14, then monthly for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.	

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F 225	Continued From page 16 Administration Record daily for newly admitted and readmitted residents to ensure allergies are identified on the resident's medication allergy record and allergy sticker on the outside of the chart. All allergy clarifications for all residents have been sent to Pharmacy as of 03/29/14 in which Pharmacy has updated their listing in their computer system. Pharmacy will review all new orders and compare to any allergies listed and notify facility if an allergy exists regarding the new medication at which time the nurse will notify the physician for any new orders. All incident reports were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any further significant medication errors by 03/29/14. None was identified. All incidents or concerns are reviewed daily during the daily standup meeting to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manger, Chaplain, MDS Coordinators, Plant Operations Director, Medical Records, Admissions Director, Housekeeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager, or Regional Staff to identify any allegation of abuse or neglect. The Administrator has been on-site daily to review all concerns or incidents to ensure abuse or neglect has been appropriately identified and reported. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or the	F 225		

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Chief Operating Officer daily until removal of immediacy, then weekly for four weeks after removal of immediacy, and then monthly.

Education was provided by the Regional Nurse Consultant on 03/28/14 for the Administrator, the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manger, and Admission Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant mediation errors, failure to report neglect, and auditing pharmacy services.

The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits daily until removal of immediacy, and then twice weekly for four weeks and report findings during weekly QA for four weeks, for recommendations and further follow-up as indicated.

A Quality Assurance meeting was held on 03/28/14 with the Medical Director for further recommendations regarding the plan for removal of jeopardy. A Quality Assurance meeting will be held weekly for four weeks, and then monthly for recommendations and further follow-up regarding the above stated plan.

**The surveyors validated the Immediate Jeopardy was removed as follows:

Review of a physician's order for Resident #8 dated 03/11/14, at 9:50 PM, revealed the nurse

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F 225	Continued From page 18 was to administer 120 milligrams (mg) of Solu-Medrol intramuscularly "now," and Benadryl 50 mg orally "now." Review of the MAR for Resident #8 revealed staff administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally on 03/11/14. Interview conducted with RN #2 on 03/27/14, at 4:55 PM, revealed she administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally to Resident #8 after Resident #8 complained of "tightness" of the chest, after learning the resident had an allergy to Macrodantin (antibiotic), and obtained a physician's order. The RN stated the treatment was effective and she continued to monitor the resident throughout the night. Interview conducted with Resident #6's physician on 04/02/14, at 4:30 PM, revealed he had been contacted by ADON #2 regarding the resident's allergy to Morphine. Review of an allergy sheet for Resident #6 on 04/02/14, at 5:00 PM, revealed Morphine was listed on the allergy sheet which was located in the front of the resident's MAR. Review of a care plan dated 03/30/14, revealed interventions to address Resident #6's allergy to Morphine. Review of a chart audit sheet the facility used to audit all residents' medical records for hospital discharge summaries and discharge documentation was reviewed to ensure allergies were identified. The audits were signed by the	F 225		

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F 225	Continued From page 19 DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant as being completed on 03/27/14. The reviews of the medication allergy sheets for all residents were dated 03/27/14. Reviewed physician telephone orders to verify facility staff had contacted physicians to clarify the resident's drug allergies. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had assisted with the chart audits on 03/27/14 to identify medication allergies by reviewing hospital discharge summaries, outside consultation notes, and discharge documentation. The interviews revealed allergy stickers were reviewed for accuracy, and medication allergy sheets were completed for all residents and placed in the front of each resident's MAR. The interview revealed all allergies were then clarified with the resident's physician. The interview also revealed the DON had assisted with the audits; however, she was no longer employed by the facility. Review of an in-service roster dated 03/27/14, revealed nurses and KMAs were in-serviced by the Regional Nurse Consultant, DON, and SDC regarding reviewing all hospital documentation upon admission or readmission to the facility to ensure allergies were appropriately identified. Posttests taken by licensed nurses and KMAs regarding in-service roster dated 03/27/14 were reviewed.	F 225		

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Interview with the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to the licensed nurses and KMAs regarding reviewing all hospital documentation upon each resident admission or readmission to the facility to ensure allergies were appropriately identified.

Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM all revealed they had attended an in-service regarding reviewing all hospital documentation to ensure allergies were appropriately identified with every admission or readmission.

Review of an in-service roster dated 03/28/14 revealed the Medical Director attended an in-service provided by the Regional Nurse Consultant, SDC, and the Administrator regarding appropriately identifying allergies for residents.

Interview conducted with the Medical Director on 04/02/14, at 4:30 PM, revealed he had attended an in-service provided by the facility on 03/28/14, regarding identifying allergies for the residents.

Interview with the SDC on 04/03/14 at 2:40 PM, Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had provided an in-service to the Medical Director on 03/28/14 regarding ensuring resident allergies were appropriately identified.

Review of an in-service syllabus and an email

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confirmation revealed the Consultant Pharmacist had been in-serviced by the Administrator, DON, and Regional Nurse Consultant on 03/28/14, regarding reviewing of all hospital discharge records for residents to ensure allergies were appropriately identified.

Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed he had attended an in-service by phone on 03/28/14 provided by the facility regarding reviewing all hospital discharge documentation to ensure residents' allergies were appropriately identified.

Interview with the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they, along with the former DON, had provided an in-service to the Consultant Pharmacist on 03/28/14 regarding reviewing all hospital discharge documentation to ensure resident allergies were appropriately identified.

Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified.

Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified.

Review of an in-service roster dated 03/28/14, revealed the Administrator, DON, SDC, and ADONs attended an in-service provided by the Regional Nurse Consultant regarding the

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F 225	Continued From page 22 reporting of significant medication errors as neglect. Interview with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had provided an in-service to the Administrator, DON, ADONs, and SDC on 03/28/14 regarding reporting of significant medication errors as neglect to the appropriate state agencies and investigating them as an allegation of neglect. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had attended an in-service provided by the Regional Nurse Consultant regarding reporting of significant medication errors to the state agencies and they were to investigate them as an allegation of neglect. Review of an in-service roster dated 03/28/14, revealed the SDC, DON, ADONs, and the Regional Nurse Consultant provided an in-service for all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of posttests regarding the in-service had been completed by staff. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include	F 225		

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F 225	Continued From page 23 significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had attended an in-service regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. The staff also revealed they had been required to take a posttest on the in-service prior to working. Review of a syllabus for all new licensed nurses and KMAs revealed staff would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus. Review of the follow-up questionnaire revealed	F 225		

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F 225	Continued From page 24 the facility had completed ten questionnaires daily from all shifts and different staff regarding understanding of the Abuse/Neglect policy, appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process, and their participation in the QAPI process, and reporting to the Administrator. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had randomly completed a follow-up questionnaire regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of an interview sheet revealed on 03/27/14, all residents with a BIMS score of greater than 8 had been interviewed by the Social Services Director, DON, ADONs, SDC, and the MDS Coordinator. Review of physician's orders where new allergies were identified was confirmed with the physician. Interviews conducted on 04/02/14, at 4:40 PM with Resident #6, at 4:50 PM with Resident #9, and at 4:55 PM with Resident #8 revealed they had been interviewed by the facility staff and had been asked about their allergies. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, SDC on	F 225		

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F 225	Continued From page 25 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had interviewed all residents who had a BIMS score above 8 regarding their knowledge of their medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy. Record review revealed on 03/27/14, responsible parties of residents with a BIMS score of less than 8 were interviewed about the residents' allergies. The interviews were conducted by the Social Services Director, DON, ADONs, SDC, Administrator, MDS Coordinator, or the Regional Nurse Consultant. Any new allergies that were identified as a result of the interviews were confirmed with the resident's physician. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had interviewed all responsible parties of residents who had a BIMS score of less than 8 regarding their knowledge of the resident's medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy. Interviews conducted with Resident #7's responsible party on 04/02/14, at 5:45 PM, and Resident #14's responsible party on 04/02/14, at 6:00 PM, revealed the facility had contacted them regarding the resident's allergies.	F 225		

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F 225	Continued From page 26 Review of Resident B's medical record revealed the resident was readmitted to the facility on 03/28/14, the resident did not have any known allergies, and the information was documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and was verified with the resident/responsible party. Review of Resident C's medical record revealed the resident was readmitted to the facility on 03/29/14, and the resident was allergic to Aspirin (analgesic) and Tubersol (medication to test for Tuberculosis) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of Resident A's medical record revealed the resident was readmitted to the facility on 04/01/14, and the resident was allergic to Morphine (pain medication) and Levaquin (antibiotic) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of a syllabus for all new staff revealed staff would be provided education regarding allergies and that they would be identified on the day of the resident's admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse would document allergies on the	F 225		

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F 225	Continued From page 27	F 225		

resident's medication allergy record that would be placed in the front of the MAR for that resident. The admitting nurse would review the resident's allergies with the resident and/or the responsible party for confirmation. A care plan would be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The admitting nurse would review any discharge summaries and all paperwork sent by the hospital, along with the interview of the resident/responsible party, and notify the physician of any allergies. The admitting nurse would then document the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders.

Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.

Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who were readmitted to the facility and all three residents' records had been reviewed for allergies being identified, action taken, allergies listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, Nursing Admission Assessment Form, care plan for allergies initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.

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F 225	Continued From page 28 Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited for allergies being identified, any action taken to correct, allergies being listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, and Nursing Admission Assessment Form, a care plan for allergies being initiated, allergy sticker on chart, and allergies listed on the resident's face sheet. Review of the allergy stickers on the front of residents' medical records and review of medication allergy lists revealed they had been updated on 03/28/14. Review of an audit dated 03/28/14, conducted by the DON, ADONs, MDS Coordinator, Staff Development Coordinator, and Regional Nurse Consultant revealed medication allergies for all residents had been updated in the residents' chart. The audit was reviewed and no concerns were identified. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of residents' allergy stickers and Medication Allergy Sheets for all residents had been updated.	F 225		

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F 225	Continued From page 29	F 225		

Review of an in-service roster and syllabus dated 03/28/14 provided by the DON, ADONs, SDC, and Regional Nurse Consultant for licensed nursing staff/KMAs regarding Abuse, Neglect, and Misappropriation of funds, Medication Administration-Medication Discrepancies, Care Plans, Admission Process, Clinical Meeting, and QAPI revealed the Admission Process included reviewing/referencing hospital discharge paperwork, specifically noting allergies and interviewing residents/family to ensure appropriate information was received. It was also noted that if any discrepancies were found the nurse must get clarification from the physician. Also noted under the Admission Process was the Medication Allergy Sheet that was required to be completed upon admission and compared against hospital discharge documentation to check for allergies.

Interview with RN #7 on 04/03/14 at 2:33 PM revealed he reviewed resident allergies on discharge information from the hospital. If the resident was admitted from home, he would contact the resident's physician and family to verify drug allergies. He also indicated that he had been provided with an in-service by the facility on drug allergies last week to include making sure that the resident's drug allergies were listed on the allergy sticker on the front of the chart, on the face sheet, on the MARs, and MD orders. RN #7 also stated that he had taken a posttest after being educated and had to pass it before he was allowed to be on the floor working. A copy of the notice informing the licensed nursing staff that they must be educated and pass the posttest before they would be allowed to work was provided.

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F 225	Continued From page 30	F 225		

Review of audits conducted by the DON, ADONs, MDS Coordinator, SDC, or Regional Nurse Consultant, and which were reviewed daily by the Administrator, regarding checking all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list revealed this was being reviewed daily.

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list. The staff stated this was being done daily and was reviewed daily by the Administrator.

Review of a document titled "2013 Updated Care Conference Agenda" updated on 03/29/14 revealed that allergies would be reviewed during care plan conference.

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed allergies would be discussed as part of the Care Conference Agenda and no Care Conference had

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F 225	Continued From page 31 been done yet. Review of a medication pass audit completed by the DON, ADONs, SDC, and Regional Nurse Consultant for all nurses and KMAs working on 03/28/14 and the questionnaire to ensure nursing staff had knowledge regarding location of a resident's allergies prior to administering medication and without a significant medication error revealed all licensed nurses and KMAs been observed during medication administration and had a completed questionnaire. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted medication audits for all nurses and KMAs working on 03/28/14, and had the employees complete a questionnaire regarding allergies and where to locate allergies prior to administering medications. The staff stated all nurses and KMAs had been observed during medication administration and had completed a questionnaire regarding allergies. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM, revealed they had all been observed during medication administration and had completed a questionnaire regarding allergies. Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who had been readmitted to the facility and all three residents' records had been reviewed for Medication Allergy Record and an	F 225		

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F 225	Continued From page 32 allergy sticker being on the chart. Review of all resident medical records on 04/03/14, revealed all residents had an allergy sticker on the front of the resident's medical record. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited the Medication Allergy Sheet and the allergy sticker being on the resident's chart. Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified and a copy sent to the pharmacy. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified. Review of an audit of incident reports conducted on 03/29/14, by the DON, ADONs, SDC, or Regional Nurse Consultant to verify that no further significant medication errors had occurred revealed none had been identified by the facility. Interview with ADON #1 on 04/03/14 at 1:40 PM,	F 225		

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F 225	Continued From page 33 ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted the audits on 03/29/14 of incident reports to verify that no further significant medication errors had occurred and none was identified. Review of documentation of incidents reviewed in the Daily Clinical Meeting to identify any allegations of abuse or neglect revealed the Administrator had documented he had reviewed them daily. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meeting and had reviewed all incidents or concerns to identify any allegations of abuse or neglect and there were none. The Administrator revealed he had reviewed the incidents daily. Review of a sign-in sheet verified that the Chief Operating Officer (COO) was present at the facility on 03/29/14, 03/30/14, 03/31/14, 04/01/14, and 04/02/14. Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits and been present for facility meetings. Review of an in-service roster dated 03/28/14	F 225		

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F 225	Continued From page 34 revealed the Administrator, DON, ADONs, SDC, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager, and Admissions Director attended an in-service regarding the QAPI process; appropriate methods to identify significant medication errors; failure to report neglect; and auditing of pharmacy services. The in-service was provided by the Regional Nurse Consultant. Interview conducted with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had conducted an in-service on 03/28/14 regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had attended an in-service regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services. All audits were being reviewed by the Administrator, DON, COO, or Regional Nurse Consultant daily. Interview conducted with the Administrator on 04/03/14, at 2:55 PM, revealed he had reviewed the audits completed by the staff daily. Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was	F 225		

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F 225	Continued From page 35 identified. The COO stated he was providing oversight to the facility and had reviewed audits daily. Review of a QAPI meeting agenda dated 03/28/14, revealed the Medical Director was in attendance. The agenda revealed the committee addressed issues related to administering medications for which a resident had an allergy. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned. Interview conducted with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Medical Director on 04/02/14 at 4:30 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended a QAPI meeting on 03/28/14, and issues were addressed regarding administering a medication to a resident with an allergy to the medication. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned.	F 225	F 282 1. Resident #5, 6, AND #16 medical record was reviewed by the Assistant Director of Nursing or Director of Nursing for documentation related to any signs of related issues regarding of self-manipulation of increasing oxygen administration. Resident/POA was educated on the risk of manipulating oxygen administration rate by the Director of Nursing. Residents' #5, #6, and #16 was assessed by the Nurse and the oxygen setting was immediately corrected/set as per the Physicians orders along with care plan updated to reflect physician ordered oxygen settings. 2. All residents receiving Oxygen were reviewed by May 13, 2014 to ensure oxygen rate was set as to physician orders. All care plans will be reviewed for all residents to ensure that care was being provided as it related to the individual needs and	5/13/14
F 282 SS=E	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	F 282		

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F 282	Continued From page 36 care..	F 282	physician orders by May 13, 2014.	

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure services were provided in accordance with the written plan of care and physician's orders for three (3) of twenty-one (21) sampled residents (Residents #5, #6, and #16). Residents #5, #6, and #16 had physician's orders to receive oxygen and each resident had interventions on the Comprehensive Care Plan addressing the use of oxygen. However, observations during the survey revealed Residents #5, #6, and #16 were not receiving oxygen as prescribed or per interventions on the Comprehensive Plan of Care.

The findings include:

Review of the "Care Planning-Interdisciplinary Team" policy (dated October 2013) revealed Care Plan interventions were designed to address the underlying problems, and were to incorporate risk factors associated with identified problems.

1. Review of Resident #5's medical record revealed the facility admitted Resident #5 on 11/22/10 with diagnoses that included Chronic Obstructive Pulmonary Disease, Coronary Artery Disease with a Carotid Artery Bypass and Graft, Diabetes, and Hypertension. Review of the Minimum Data Set (MDS) quarterly assessment dated 10/25/13 revealed facility staff had assessed the resident to have a Basic Interview for Mental Status (BIMS) score of 15, which revealed the resident's cognition was intact. A

3. Education was proved to nursing staff regarding providing services related to care plan, services provided by qualified persons and carrying out physician orders by Staff Development Coordinator and completed by May 13, 2014. A posttest was given in which 100% was obtained by each staff member or further education would be needed. Nursing staff were also educated to report to charge nurse and or Assistant Directors of Nursing, Director of Nursing, MDS Coordinators', or Facility Formulary/Infection Control Nurse of any resident who may be manipulating any oxygen or any other type of device that requires setting.

If staff report such findings the charge nurse and or Assistant Directors of Nursing, Director of Nursing, MDS Coordinators', or Facility Formulary/Infection Control Nurse will notify Social Service Director and physician

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SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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F 282	Continued From page 37 review of physician's orders dated 03/14/14 revealed an order for 2 liters of oxygen "per minute" to be administered to Resident #5 as needed. Review of Resident #5's Comprehensive Care Plan dated 08/12/13 revealed staff had assessed the resident to have difficulty breathing and had developed a care plan, with interventions, to address pulmonary conditions/diagnoses. Review of the identified interventions revealed staff was to review the resident's oxygen saturation levels "as needed" and to ensure oxygen was administered as ordered. Observations of Resident #5 on 03/25/14 at 9:45 AM revealed the resident's oxygen was set at 3 liters per minute; on 03/25/14 at 10:10 AM, 11:30 AM, 12:00 PM, and 1:45 PM, the resident's oxygen setting was on 4 liters per minute; on 03/25/14 at 3:00 PM, the oxygen setting was observed to be on 3.5 liters per minute; and on 03/25/14 at 4:00 PM the oxygen setting was observed to be on 4 liters per minute. On 03/26/14, the resident's oxygen setting was observed to be on 4 liters per minute at 6:15 AM, 8:00 PM, and 12:45 PM. In addition, the oxygen setting was observed to be on 3 liters per minute at 1:30 PM. Observations during the survey on 03/25/14 and 03/26/14 revealed Resident #5 wore the oxygen continuously. There was no documentation in the medical record that the facility had evaluated the resident for the continuous oxygen usage or that the physician had been notified that the resident was wearing the oxygen continuously. Interview with Resident #5 on 03/26/14 at 1:30 PM revealed the resident believed the physician	F 282	for further instructions. Resident and/or POA will be educated on the risk of manipulation of any device setting. The care plan will reflect resident's behavior. Licensed staffs are to document on the TAR and verify the correct administration of oxygen as well as any other treatment orders. If staff find any concerns with settings , provision of services by qualified personnel or care plan not being followed it will be reported to the charge nurse and/ or Assistant Directors of Nursing, Director of Nursing at which time the issue will be reviewed and corrected to include notification of physician and resident/POA. 4. The Director of Nursing, Assistant Directors of Nursing, MDS Coordinators', Facility Formulary Nurse or Nursing Supervisors will audit 10% of care plans per month for	

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F 282	Continued From page 38 had prescribed oxygen at 3 liters per minute and he/she changed the oxygen flow rate to 3 or 4 liters per minute when he/she got out of bed into the wheelchair and when the resident went from the wheelchair to the bed. Resident #5 said, "I thought the oxygen rate was ordered at 3 liters per minute, and the staff know I turn the oxygen on and off all the time." However, further review of the resident's care plan revealed the approaches did not address the resident self-adjusting the oxygen flow or how the facility would monitor that the resident was receiving the accurate oxygen flow. Interview with State Registered Nurse Aide (SRNA) #8 on 03/27/14 at 1:40 PM revealed she thought the oxygen for Resident #5 should be set at 3 liters per minute. SRNA #8 stated even though they can look at the care plans to see what the oxygen setting should be, the nurses adjusted the flow rates of the oxygen in accordance with physician's orders. SRNA #8 was aware that Resident #5 self-adjusted his/her oxygen flow rate "all the time" and had reported the resident's actions to the nursing staff, but was unable to recall the nurse. Interview with Registered Nurse (RN) #4 on 03/27/14 at 1:45 PM revealed she was unaware of what Resident #5's oxygen flow rate was, and stated staff could review the physician's orders and care plans to determine the setting. According to RN #4, nursing staff adjusted oxygen settings as ordered by the physician and stated SRNAs were not permitted to adjust the oxygen flow rates. RN #4 said she did not know that Resident #5 adjusted his/her oxygen flow rate and had never observed it to be on the wrong setting. According to RN #4, Clinical	F 282	adherence as well as perform room rounds on a daily basis (Monday-Friday) to check for proper settings of devices or any concerns related to provision of services by a qualified person in accordance with the written plan of care. Results of these audits will be reported to the QA committee monthly to evaluate responses in order to determine further need of education or revision of plan. At that time based upon evaluation the QA Committed will determine at what frequency the audits will need to continue.	

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F 282	Continued From page 39 Coordinators were to observe residents when they made "rounds" to ensure staff provided resident care, including oxygen flow rates, in accordance with physician's orders and the plan of care. Interview with the Clinical Coordinator on 03/27/14 at 2:58 PM revealed nurses should monitor the oxygen settings when they made rounds to ensure the rate was accurate. The Clinical Coordinator stated the physician had prescribed Resident #5's oxygen to be administered at 2 liters per minute and was unaware Resident #5 adjusted his/her oxygen setting him/herself. According to the Clinical Coordinator, staff should ensure the resident's care plan addressed the resident's behavior of changing the oxygen rate and how the facility would ensure the proper oxygen rate would be maintained. 2. A review of the medical record for Resident #16 revealed the resident was admitted to the facility on 03/14/14. The resident's diagnoses included Congestive Heart Failure, Coronary Artery Disease, and Congestive Obstructive Pulmonary Disease. Observations of Resident #16 on 03/27/14 at 1:05 PM and at 2:10 PM revealed the resident was being administered oxygen at 2 liters per minute via a nasal cannula. Review of Resident #16's physician's orders revealed the resident was ordered to have oxygen administered at 4 liters per minute, every shift, on an as needed basis. A review of the Comprehensive Plan of Care for	F 282		

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F 282	Continued From page 40 Resident #16, dated 03/18/14, revealed interventions for oxygen to be administered as ordered by the physician. An interview conducted with Licensed Practical Nurse (LPN) #3 on 03/27/14 at 3:16 PM revealed the LPN had documented Resident #16's oxygen as being administered at 4 liters per minute. The LPN stated she had not noticed the oxygen was set on 2 liters per minute instead of 4 liters per minute as ordered. An interview conducted with the Unit Manager on 03/27/14 at 3:20 PM revealed the Unit Manager made rounds every two hours to ensure oxygen was administered as ordered and care planned. According to the Unit Manager, she had not identified that Resident #16's oxygen was set on 2 liters per minute or that the resident was not receiving oxygen as ordered by the physician. 3. A medical record review for Resident #6 revealed the facility admitted the resident on 11/18/14 with the diagnoses that included Bronchitis, Chronic Obstructive Pulmonary Disease, Chronic Pain, and Anxiety. Review of the Minimum Data Set (MDS) for Resident #6 dated 02/08/14 revealed the Brief Interview for Mental Status (BIMS) was 15, indicating Resident #6 was cognitively intact. Observations of Resident #6 on 03/24/14 at 7:15 PM revealed the resident's oxygen was being administered at 3.5 liters per minute via a nasal cannula. Observations on 03/25/14 at 9:55 AM, 11:00 AM, 12:00 PM, and 1:35 PM, revealed Resident #6 received oxygen at 3 liters per minute per nasal cannula. On 03/26/14 at 6:30 AM and 9:00 AM, Resident #6 was observed to	F 282		

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F 282	Continued From page 41 receive oxygen at 3 liters per minute per nasal cannula. Interview with Resident #6 on 03/27/14 at 2:40 PM revealed he/she turned up the oxygen when he/she "smothers real bad." Resident #6 stated the doctor knew he/she "changes" her/his own oxygen. Review of the physician's orders dated 03/01/14 revealed Resident #6 was to receive oxygen at 2 liters per minute, every shift, as needed. Review of the Comprehensive Care Plan dated February 2014 revealed Resident #6 was to have oxygen administered as ordered by the physician. Interview with Licensed Practical Nurse (LPN) # 1 on 03/27/14 at 2:30 PM revealed she checked the oxygen when administering medication in the morning, and randomly throughout the day. LPN #1 had documented Resident #6's oxygen as being administered at 2 liters per minute and was not aware the oxygen was administered at 3 or 3.5 liters on 03/24/14, 03/25/14, and 03/26/14. Interview conducted with RN #4, the Manager on the South Unit, on 03/27/14 at 3:30 PM revealed the nurses check the oxygen settings throughout the day to ensure the correct amount is being administered. RN #4 stated the Unit Managers make rounds every two hours and randomly throughout the shift. The Unit Manager stated she had not checked Resident #6's oxygen and was unaware the amount being administered was incorrect. Interview with the Minimum Data Set (MDS) Coordinator on 03/27/14 at 3:05 PM revealed she was not aware Resident #5 changed the rate of	F 282		

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F 282	Continued From page 42 his/her oxygen administration. According to the MDS Coordinator, staff should update/revise the care plan to reflect the resident's behaviors of adjusting the oxygen rate. The MDS Coordinator also stated the care plan should reflect approaches required to ensure that Resident #6's oxygen rate was set at the prescribed setting.	F 282		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure 3 of twenty-one (21) sampled residents (Residents #5, #16, and #6) received proper treatment and care for special services. Resident #5 and Resident #6 had physician's orders for staff to administer 2 liters of oxygen per minute to each resident; however, observation on 03/24/14, 03/25/14, and/or 03/26/14, revealed the residents' oxygen was set to be administered at 3 to 4 liters per minute via nasal cannula (a tube that delivers oxygen to the nose). Resident #16 had physician's orders for	F 328	F 328 1. Residents' #5, #6, and #16 was assessed by the Nurse and the oxygen setting was immediately corrected as per the Physicians orders. Residents #5, #6 and #16's Physician was notified on 4/25/14 by ADONs. 2. An audit will be completed by the DON, ADONs, SDC, or MDS on residents receiving injections, gastric tube feedings, respiratory care, suctioning, foot care and prostheses to ensure residents are receiving appropriate treatment and care and that no other resident was affected by deficient practice by 5/13/14. 3.An In-service will be completed by the SDC for all nursing staff, related to	5/13/14

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F 328	Continued From page 43 staff to administer 4 liters of oxygen per minute to the resident; however, on 03/27/14, the resident's oxygen was observed to be administered at 2 liters per minute via nasal cannula. The findings include: Review of the "Oxygen Administration" policy (dated December 2010) revealed the physician's orders should be checked for the liter flow and method of oxygen administration. 1. Review of the medical record revealed the facility admitted Resident #5 on 11/22/10 with diagnoses that included Chronic Obstructive Pulmonary Disease. Based on review of the Minimum Data Set (MDS) quarterly assessment, dated 10/25/13, staff assessed Resident #5 to have a Basic Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Continued review of Resident #5's medical record revealed physician's orders dated 03/14/14 for staff to administer 2 liters of oxygen per minute "as needed" by means of a nasal cannula. Further review of the medical record revealed a nurse aide care plan, and comprehensive care plan, dated February 2014, that revealed Resident #5's oxygen was to be administered at 2 liters per minute as needed. On 03/25/14 Resident #5 was observed to receive oxygen at 3 liters per minute by means of a nasal cannula at 9:45 AM, 10:10 AM, 11:30 AM, and 12:00 PM; and at 1:45 PM, the resident's oxygen was set at 4 liters per minute. On 03/25/14, at 3:00 PM, the resident received oxygen at 3.5 liters per minute; and at 4:00 PM the resident received oxygen at 4 liters per	F 328	residents receiving oxygen therapy, injections, gastric tube feeding, suctioning care, respiratory care, foot care and prosthesis by 5/13/14. All newly hired nursing staff will receive this in-service during the orientation process. 4. The Director of Nursing / Nursing Administration Team, will complete weekly walking rounds for three months, and review 10% of the residents, identified to have special needs such as injections, enteral fluids, colostomy, ileostomy, ureterostomy, tracheostomy, suctioning, respiratory care, trach care, foot care and/or prosthesis, to ensure the residents care plans are appropriately implemented. The Administrative team will monitor the compliance of the walking rounds daily. Any non-compliance will be addressed immediately. All findings will be reported to the Quality Assurance Committee monthly.	

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F 328	Continued From page 44 minute. Observations conducted on 03/26/14 revealed Resident #5 received oxygen at 4 liters per minute at 6:15 AM, 8:00 AM, and 12:45 PM. In addition, the resident's oxygen setting was observed to be on 3 liters per minute at 1:30 PM on 03/27/14. Resident #5 stated in interview conducted on 03/26/14 at 1:30 PM that his/her physician had prescribed oxygen at 2 liters per minute. However, according to Resident #5, the resident often changed the oxygen flow rate to 3 or 4 liters per minute when he/she got out of bed into the wheelchair and when the resident went from the wheelchair to the bed. Resident #5 said the staff was aware of the resident turning the oxygen flow dial on and off and adjusting the oxygen by his/her self. State Registered Nurse Aide (SRNA) #8 stated in interview conducted on 03/27/14 at 1:40 PM that nursing staff adjusted the flow rates of the oxygen in accordance with physician's orders. The SRNA stated she thought the oxygen for Resident #5 should be set at 3 liters per minute and stated Resident #5 adjusted the oxygen flow rate "all the time"; she stated she had reported the resident's actions to the nursing staff. Interview with Licensed Practical Nurse (LPN) #2 on 03/27/14 at 2:00 PM revealed she had provided direct care to Resident #5 on 03/27/14. LPN #2 stated Resident #5's oxygen level should be set at 2 liters per minute. According to LPN #2, nursing staff was to check oxygen settings when they made rounds each day. LPN #2 stated SRNAs could check oxygen flow rates but would need to notify a nurse if the oxygen was not at the correct setting. LPN #2 was unaware	F 328		

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F 328	Continued From page 45 of Resident #5 self-adjusting the oxygen flow rate or of the oxygen being at 3-4 liters per minute until the surveyor notified her. According to LPN #2, Resident #5's oxygen had been set to 2 liters per minute all day. Interview with Registered Nurse (RN) #4 on 03/27/14 at 1:45 PM revealed she was the Unit Manager and stated she was unaware of the rate the physician had prescribed for Resident #5's oxygen administration. She stated she could review the physician's orders or care plan to determine the correct setting. RN #4 said oxygen settings were to be checked for each resident during rounds and was unaware that Resident #5 had self-adjusted the oxygen flow rates until the surveyor notified her. 2. A review of the medical record for Resident #16 revealed the facility admitted the resident on 03/14/14 with diagnoses that included Congestive Heart Failure, Coronary Artery Disease, and Congestive Obstructive Pulmonary Disease. Observations of Resident #16 conducted on 03/27/14 at 1:05 PM and at 2:10 PM revealed the resident's oxygen was being administered at 2 liters per minute via a nasal cannula. Additional observation of the resident on 03/27/14 at 3:15 PM revealed Resident #16 was eating cake in the dining room with a family member but the resident's oxygen was off. A review of the physician's orders for Resident #16 revealed facility staff was to administer the resident's oxygen at 4 four liters per minute, every shift, on an as needed basis. A review of the medication administration record	F 328		

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for March 2014 revealed facility staff had documented the resident's oxygen was administered at 4 liters per minute on the 7:00 AM to 3:00 PM shift on 03/27/14.

An interview conducted with Licensed Practical Nurse (LPN) #3 on 03/27/14 at 3:16 PM revealed the LPN had documented the oxygen as being administered at 4 liters per minute and had not noticed the oxygen was set on 2 liters per minute.

An interview conducted with the Unit Manager on 03/27/14 at 3:20 PM revealed the Unit Manager made rounds every two hours to ensure oxygen was administered as ordered and had not noticed Resident #16's oxygen was set on 2 liters per minute.

3. A review of the medical record for Resident #6 revealed the facility admitted the resident on 11/18/13 with diagnoses of Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Chronic Pain, and Anxiety. Based on review of the Mininmum Data Set (MDS) quarterly assessment dated 02/18/14, Resident #6 was assessed by staff to have a score of 15 on the Basic Interview for Mental Status (BIMS), which indicated the resident's cognition was intact. Continued review of the of Resident #6's medical record revealed physician's orders dated 03/01/14 for staff to administer 2 liters of oxygen per minute "as needed" by nasal cannula. Further review of the medical record for Resident #6 revealed a comprehensive care plan dated February 2014 that indicated oxygen was to be administered at 2 liters per minute as needed.

Observations of Resident #6 conducted on 03/24/14 at 7:15 PM revealed the resident's

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oxygen was administered at 3.5 liters per minute via nasal cannula. On 03/25/14, Resident #6 was observed to receive oxygen at 3 liters per nasal cannula at 9:55 AM, 11:00 AM, 12:00 PM, and 1:35 PM. On 03/26/14, Resident #6 was observed to receive oxygen at 3 liters per minute via nasal cannula at 6:30 AM and 9:00 AM.

A review of the Medication Administration Record (MAR) revealed staff had documented Resident #6's oxygen was delivered at 2 liters per nasal cannula on 03/24/14, 03/25/14, and 03/26/14.

Interview with Resident #6 on 30/27/14 at 2:40 PM revealed that he/she was aware that his/her oxygen was ordered at 2 liters per minute, and stated, "When I start smothering I turn it up."

Interview with SRNA #7 on 03/27/14 at 2:20 PM revealed he/she provided direct care for Resident #6. He/she stated the SRNAs do not adjust the amount of oxygen being administered to the resident. SRNA #7 stated he/she had seen Resident #6 change the amount of oxygen being administered when he/she "is short of breath." SRNA #7 stated he/she would tell the nurse when the resident's oxygen was not on the correct setting. SRNA #7 was unsure if he/she had informed the nurse about Resident #6 changing the amount of oxygen being administered on 03/27/14.

Interview with Licensed Practical Nurse (LPN) #1 on 03/27/14 at 2:30 PM revealed he/she had provided direct care for Resident #6 on 03/26/14 and 03/27/14. LPN #1 stated she checked the setting of the resident's oxygen during the morning medication pass and during rounds throughout the day. LPN #1 stated he/she was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 48 unaware Resident #6's oxygen had been administered incorrectly throughout the day, and was unaware Resident #6 had ever changed the amount of oxygen being administered. Interview with the Clinical Coordinator on 03/27/14 at 2:58 PM revealed the nurses should make rounds and check the oxygen settings for all residents. The Clinical Coordinator stated Resident #5 and Resident #6 should receive oxygen at 2 liters per minute and Resident #16 should receive oxygen at 4 liters per minute. The Clinical Coordinator stated he did not know why the nurses had not identified Residents #5, #6, and #16 had not received oxygen in accordance with physician's orders or that the resident had adjusted the oxygen rate himself/herself. According to the Clinical Coordinator, the nurses were the only ones to adjust the oxygen rate.	F 328	F - 333 1. The Physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to administration of Macrodantin. Physician's orders were obtained immediately and intramuscular Solumedrol along with Benadryl by mouth was administered by the staff nurse on 3/11/14 to treat her symptoms. The Physician was notified by the Assistant Director of Nursing for Resident #6 on 3/28/14, to clarify her allergy to Morphine. An allergy sheet was added in front of her MAR (medication administration record) to identify her allergy to Morphine. A care plan was initiated with interventions to decrease the risk of allergic reaction. 2. Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing and/or Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, or	5/13/14
F 333 SS=J	3. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of the facility's policy, it was determined the facility failed to ensure two (2) of twenty-one (21) sampled residents (Resident #8	F 333		

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F 333	Continued From page 49 and Resident #6) were free from significant medication errors. Review of Resident #8's History and Physical report from an acute care facility, dated 08/27/13 revealed Resident #8 was allergic to Macrodantin (antibiotic). Interview on 03/26/14, at 2:25 PM with Resident #8 revealed the resident had informed Registered Nurse (RN) #1 on the day of admission to the facility that he/she was allergic to Macrodantin. However, review of the resident's admission assessment completed by RN #1 dated 09/09/13, revealed facility staff failed to document the resident's allergy to Macrodantin in the resident's medical record and/or on the resident's Medication Administration Record (MAR). Review of documentation on the MAR revealed facility staff administered seven (7) doses of Macrodantin to Resident #8 from 03/08/14 through 03/11/14. Interview with the facility's Medical Director revealed Resident #8 could have been harmed as a result of receiving Macrodantin. In addition, review of the medical record revealed the facility admitted Resident #6 on 11/08/13 with a documented allergy to Morphine (narcotic analgesic). Record review revealed documentation on the front of Resident #6's medical record that the resident had an allergy to Morphine. However, review of Resident #6's MAR for December 2013 and January, February, and March 2014 revealed staff failed to document the resident's allergy to Morphine and had noted Resident #6 had no known allergies. Review of Physicians Orders for March 2014 revealed the physician and/or facility staff had failed to document the resident's allergy to Morphine and noted Resident #6 had no known allergies. The facility's failure to ensure residents were free	F 333	Regional Nurse Consultant on 3/27/14 for all residents to ensure allergies are appropriately identified. During the audit, allergy stickers on the outside of resident's charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 3/27/14 by the Director of Nursing and/or Assistant director of Nursing, Staff development coordinator, MDS coordinator or Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician. All MARS/TARS were reviewed by DON, ADONs, SDC, MDS, and Facility formulary nurse to determine if any medication errors had occurred. All incident reports from January 2014 to April 2014 have been reviewed by the Director of Nursing and/or the Assistant Director of Nursing, Staff Development Coordinator or Regional nurse consultant to identify any further significant medication error. None were identified.	

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F 333	Continued From page 50 from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 03/08/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) at a Scope and Severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.25 Quality of Care (F333). The facility was notified of the Immediate Jeopardy on 03/28/14. An acceptable Allegation of Compliance (AOC) was received on 04/01/14, which alleged removal of the Immediate Jeopardy on 03/31/14. The State Survey Agency determined the Immediate Jeopardy was removed on 03/31/14, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's Admission Standard of Practice policy, effective date of December 2010, revealed that nurses would obtain clinical resident information to assist in the completion of Admission Assessments on all new admissions and readmissions.	F 333	The Pharmacy Consultants were on site on 3/29/14 and reviewed all resident records on 3/29/14 to ensure allergies have been appropriately identified. All residents' allergy stickers and allergy list were updated to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, and Regional Nurse Consultant on 3/28/14. Interviews were completed on 3/27/14 by the Social Services Director and/or the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or MDS Coordinators for residents with a BIMS score above 8 regarding their knowledge of allergies. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed. Residents with a BIM score less than 8, responsible party interviews were completed on 3/27/14 by	

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F 333	Continued From page 51 Review of the facility's "Medication Administration-New Orders, Reorders, Receiving" policy, effective date of December 2010, revealed the Medication Order Form was to be completed for all new medication orders for all residents and the information on the form included the resident's name, room number, name of medication, dosage, frequency, physician's name, and the name of the nurse ordering. Further review of the policy revealed the medications were to be called into the pharmacy with the following information: nurse's name, resident's full name, physician's name, location of resident, Medicaid number if necessary, and medication strengths and full directions. 1. Review of Resident #8's medical record revealed the facility admitted the resident on 09/09/13, with diagnoses that included Chronic Ischemic Heart Disease, Atrial Fibrillation, and Coronary Artery Disease. Review of a History and Physical (H&P) report from an acute care facility dated 08/27/13, revealed Resident #8 had a drug allergy to Macrodantin. Review of the Nursing Admission Information Report dated 09/09/13, revealed staff had listed and identified the resident's allergies to Codeine (analgesic), Influenza Vaccine, Elavil (anti-depressant), Darvocet (analgesic), and Tussionex (cough syrup) but had failed to include the resident's allergy to Macrodantin (antibiotic). Further review of the H&P revealed the resident's attending physician, who was also the facility's Medical Director, had initialed and dated the report on 09/12/13 with no time documented. However, review of the resident's Record of Admission to the facility revealed facility staff failed to include information related to the resident's allergy to Macrodantin or other allergies.	F 333	Social Services Director and/or Director of Nursing, MDS Coordinators, Assistant Directors of Nursing, Administrator, or Regional Nurse Consultant to identify any allergies or concerns with medications. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed. 3. Education was initiated for licensed staff/Kentucky Medication Aide on 3/27/14 by the Regional Nurse Consultant and/or Director of Nursing, or the Staff Development Coordinator regarding reviewing the hospital documentation upon admission or re-admission to ensure that allergies are appropriately identified. Licensed nursing staff/Kentucky Medication Aide must obtain a score of 100% on post test. Staff not obtaining a passing score of 100% will be educated on the spot and re-tested. The Medical Director received education from the Administrator	

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F 333	Continued From page 52 Review of a Significant Change Minimum Data Set (MDS) assessment dated 12/25/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Review of Resident #8's Comprehensive Care Plan dated 12/31/13 revealed the resident had allergies and the potential for injury and discomfort. Further review revealed the resident was allergic to Codeine (analgesic), Tussionex (cough syrup), Darvocet (analgesic), Penicillin (antibiotic), Influenza Vaccine, History of positive PPD (Purified Protein Derivative), and Pneumonia Vaccine. However, facility staff failed to include the resident's allergy to Macrodantin (antibiotic) on the care plan. Review of Resident #8's Physician Orders dated 03/08/14, revealed the physician had prescribed 100 milligrams (mg) of "Nitrofurantoin" (generic form of Macrodantin) to be administered every 6 hours by mouth for ten days to treat the resident's Urinary Tract Infection (UTI). Continued review of the physician's orders, also dated 03/08/14, revealed staff was to discontinue the previous order for "Nitrofurantoin" and to administer 100 mg of "Macrobid" (same medication as Nitrofurantoin and Macrodantin) twice a day by mouth for ten days to treat the Urinary Tract Infection. Review of Resident #8's Medication Administration Record (MAR) revealed from 03/08/14 to 03/11/14, facility staff administered seven doses of "Macrobid" to the resident. The MAR indicated the resident received one dose on 03/08/14, two doses on 03/09/14, two doses on 03/10/14, and two doses on 03/11/14. Further	F 333	and/or the Staff Development Coordinator, and the Regional Nurse Consultant on 3/28/14 regarding appropriately identifying allergies for residents. The Pharmacy Consultant received education on 3/28/14 from the Administrator and/or Director of Nursing, and Regional Nurse Consultant regarding reviewing of hospital discharge records for all residents to ensure that allergies are appropriately identified. Education was provided by the Regional Nurse Consultant on 3/28/14 for the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager and Admissions Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant medication errors, and auditing of pharmacy services.	

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F 333	Continued From page 53 review of the MAR revealed the Macrobid was discontinued on 03/11/14 after the resident complained of "tightness" in the chest. Observation of Resident #8 on 03/26/14 at 2:45 PM revealed the resident was lying in bed watching television. Interview with Resident #8 on 03/26/14 at 2:45 PM revealed facility staff had administered Macrodantin to him/her "about two weeks ago." Resident #8 stated that he/she had informed the facility upon admission that he/she was allergic to Macrodantin. Resident #8 stated he/she started having "tightness in my chest" and thought that staff might have given him/her something he/she was allergic to. The resident stated he/she notified staff of his/her symptoms and learned he/she had received Macrodantin. According to the resident, he/she had experienced tightness in the chest when he/she had taken Macrodantin in the past, prior to admission to the facility, and had learned he/she was allergic to Macrodantin. Interview with Resident #8's attending physician on 03/27/14 at 3:37 PM revealed he was not aware Resident #8 had a drug allergy to Macrodantin when he prescribed the medication. The physician stated the resident could have suffered harm from the Macrodantin as a result of the resident's allergy. Interview with RN #1 on 03/27/14 at 4:00 PM revealed she failed to review the allergies from the acute care facility's H&P when Resident #8 was admitted to facility. Interview with RN #2 on 03/27/14 at 4:55 PM revealed Resident #8 had complained of tightness in his/her chest after she administered	F 333	Education was completed for the Administrator, Director of Nursing, Staff Development Coordinator and Assistant Director of Nurses were educated by the Regional Nurse Consultant on 3/28/14 regarding reporting of neglect for any significant medication error. Education for all staff was initiated on 3/28/14 by the Staff Development Coordinator and/or Director of Nursing, Assistant Directors of Nursing or the Regional Nurse Consultant regarding reporting significant medication errors, the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. A post test is given at completion of education in which staff must make 100% . If passing score not made the staff will be re-educated on the spot and tested again. Education regarding reporting of significant medication errors, obtaining allergies from discharge summary, resident history or POA history , verification of allergy	

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F 333	Continued From page 54 the evening dose of Macrodantin on 03/11/14. RN# 2 stated that she learned at that time Resident #8 had experienced an allergic reaction to Macrodantin in the past. She notified the Assistant Director of Nursing (ADON), the resident's physician, and the resident's family member. Interview with the facility's Consultant Pharmacist on 03/27/14 at 4:40 PM, revealed at the time the facility admitted Resident #8, the pharmacist reviewed the resident's medical record, including the History and Physical, dated 08/27/13, to determine if the resident had any drug allergies. Although the Pharmacist stated he had identified the resident's allergies to Antibiotics, Penicillin, Opioids, and Darvocet, he failed to identify the resident's allergy to Macrodantin. Interview with the Administrator on 03/28/14 at 8:45 AM revealed the facility had addressed Resident #8 being administered a medication that he/she had an allergy to in the daily Quality Assurance meeting on 03/28/14 and had a plan in place on 03/27/14 to prevent significant medication errors for other residents. However, the facility failed to provide any proof that a plan to protect residents was in place. 2. Review of Resident #6's medical record revealed the facility admitted the resident on 11/08/13 and documented the resident had an allergy to Morphine (narcotic analgesic). Record review also revealed facility staff had noted on the front of the resident's medical record that the resident had an allergy to Morphine. Review of the most recent Minimum Data Set (MDS) quarterly assessment dated 02/08/14 revealed the facility assessed the resident to have a Brief	F 333	orders from physician as well as places on Medication Administration Record or medical record for placement of allergies will be included in orientation for licensed nursing and Certified Medication Techs. Education was provided for Licensed Nursing Staff/Kentucky Medication Aide by the Director of Nursing and/or Assistant Director of Nursing, the Staff Development Coordinator, and the Regional Nurse Consultant regarding the above stated plan on 3/28/14 to include admitting nurse reviewing all paperwork forward from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listing, physician orders, and MARS. During care plan conference for each resident the allergy list will also be reviewed for any updates. Allergies will be identified on day of admission and/or re-admission by the admitting nurse on the nursing admission information document. The admitting nurse will document	

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F 333	Continued From page 55 Interview for Mental Status (BIMS) of 15, which indicated the resident's cognition was intact. Review of the resident's MAR for December 2013 and January, February, and March 2014 revealed staff had failed to document the resident's allergy to Morphine on the MAR. The facility indicated the resident had no known allergies. Further record review revealed the Physicians Orders for March 2014 identified Resident #6 as having no known allergies. Interview with Resident #6 on 03/27/14 at 2:40 PM, revealed the resident was allergic to Morphine. Resident #6 stated he/she had informed the facility on the day of admission that he/she was allergic to Morphine. Interview with Licensed Practical Nurse (LPN) #1 on 03/27/14 at 3:20 PM revealed staff obtained the information related to allergies at the time a resident was admitted to the facility. The LPN stated the list of allergies could be located in the resident's admission packet. LPN #1 stated if a resident was admitted to a hospital and returned to the facility with a documented change in allergies, staff would investigate the cause of the change, notify the resident's physician, and obtain an order for what should be listed for the resident's allergies. Interview with the Corporate Nurse Consultant on 03/28/14 at 8:30 AM, revealed staff was to ask the resident, or his/her representative, of his/her allergies at the time of admission and document the information in the admission packet. The Nurse Consultant also stated a record of the resident's medication allergy was completed upon	F 333	allergies on the resident's medication allergy record that will be placed in the front of the Medication Administration Record for that resident. The admitting nurse will review the residents allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on day of admission/re-admission by the admitting nurse along with documenting the allergies on the medication allergy record , the nursing admission assessment and physician orders and a review of discharge summaries and all paperwork sent by the hospital, along with interview of resident/POA will also be included in orientation for new staff. All allergy clarifications for all residents have been sent to pharmacy as of 3/30/14 in which pharmacy has updated their listing in their computer system. Pharmacy will review all new orders and compare to any allergies listed and	

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F 333	Continued From page 56 admission and taken to the daily meeting with administrative staff for review. Further interview revealed the Corporate Nurse Consultant stated if the resident was discharged to the hospital and returned to the facility with a change in allergies, staff was to research the reported allergy and take the report to the daily meeting with administrative staff for review. The Corporate Nurse Consultant stated the nurse "should follow the orders on the discharge paperwork" if staff was unable to clarify the discrepancy. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/01/14. The facility implemented the following actions to remove the Immediate Jeopardy: The physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to the administration of Macrodantin. Physician's orders were obtained immediately and intramuscular Solu-Medrol along with Benadryl by mouth was administered by the staff nurse on 03/11/14 to treat the resident's symptoms. The treatment was effective as evidenced by every shift assessment along with supporting documentation. The resident was monitored by staff nurses to ensure continued effectiveness. The physician was notified by the Assistant Director of Nursing (ADON) for Resident #6 on 03/28/14 to clarify the resident's allergy to Morphine. A sheet was added in front of the resident's medication administration record (MAR) to identify the resident's allergy to Morphine. A care plan was initiated with interventions to decrease the risk of an allergic reaction.	F 333	notify facility. If an allergy exist regarding the new medication, the nurse will notify the physician for any new orders. All incidents or concerns are reviewed daily (Monday – Friday) during the daily stand up meeting to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Chaplin, MDS coordinators, Plant Operations Director, Medical Records, Admission Director, House Keeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager or Regional staff to identify any significant medication errors. Charts for newly admitted residents and re-admitted residents will be reviewed and discussed in the Daily Clinical Meeting on weekdays attended by the Director of Nursing, MDS Coordinators, Social Service Director, Medical Records, Staff Development Coordinator, Assistant Directors of Nursing, Activities Director, Dietary Manager and Chaplain, with a comparison review completed at that time of	

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F 333	Continued From page 57 Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), MDS Coordinators, and Regional Nurse Consultant on 03/27/14 for all residents to ensure allergies were appropriately identified. During the audit, allergy stickers on the outside of residents' charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 03/27/14 by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician. The Regional Nurse Consultant, DON, and SDC initiated education for licensed staff and Kentucky Medication Aides (KMAs) on 03/27/14 and advised staff to review hospital documentation upon each resident admission or readmission to ensure allergies were appropriately identified. Licensed nursing staff/KMAs were not allowed to work prior to receiving the above stated education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of 100 percent would be educated on the spot and retested. Resident #8's attending physician, who is also the facility's Medical Director, received education from the Administrator, SDC, and the Regional Nurse Consultant on 03/28/14 regarding appropriately identifying resident allergies.	F 333	the resident's nursing admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or re-admitted residents to ensure allergies are appropriately identified as well as paperwork is completed accurately, care plan is updated, Physician notification completed and all allergy lists is updated or initiated. The Director of Nursing and/or the Assistant Director of Nursing, Staff Development Coordinator, or the MDS Coordinator will review the new admission charts from the weekend to ensure accuracy of the residents record. This will be an on-going practice. 4. Nursing Administration to include the Director of Nursing, and/or Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinator's, Facility Formulary	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 58 The Administrator, DON, and Regional Nurse Consultant provided education to the Pharmacy Consultant on 03/28/14 regarding reviewing hospital discharge records for all residents to ensure allergies were appropriately identified. The Pharmacy Consultants were on-site on 03/29/14 and reviewed all resident records to ensure allergies were appropriately identified. The Regional Nurse Consultant provided education to the Administrator, DON, SDC, and ADONs on 03/28/14 regarding reporting of neglect for any significant medication error. The SDC, DON, ADONs, and the Regional Nurse Consultant initiated staff education on 03/28/14 regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement (QAPI) process to include reporting of concerns to the Administrator, and front line staff participation in development of QAPI plans. Staff was not permitted to work prior to receiving the education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of 100 percent would be educated on the spot and retested. Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from the discharge summary, resident history or POA history, verification of allergy orders from the physician, as well as places on the MAR or medical record for placement of allergies will be included in the orientation for licensed nurses and	F 333	Nurse or Regional Nurse Consultant are reviewing every physician order Monday - Friday to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. This practice will be on-going. A follow-up questionnaire will be completed by the Administrator, and/or Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental Services Manager for 10 staff members weekly to include all shifts and different staff for 4 weeks beginning 3/30/14, to ensure continued understanding of the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the Quality Assurance Performance Improvement process	

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F 333	Continued From page 59 KMAs. A follow-up questionnaire would be completed by the Administrator, DON, ADONs, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplain, Medical Records, Human Resources Director, SDC, Business Office Manager, Facility Formulary Nurse, or the Environmental Services Manager for ten staff members daily to include all shifts and different staff members until removal of immediacy, then weekly for four weeks, to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process to include reporting concerns to the Administrator, and front line staff participation in the development of QAPI plans. The Social Services Director, DON, ADONs, SDC, and MDS Coordinator conducted interviews on 03/27/14 with residents who had a BIMS score above 8 regarding their knowledge of allergies. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed. The Social Services Director, DON, ADONs, MDS Coordinator, Administrator, or Regional Nurse Consultant conducted interview with the responsible party for residents with a BIMS score of less than 8 by 03/27/14 to identify any allergies or concerns with medications. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed.	F 333	to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. DON, ADONs' MDS, SDC and facility formulary nurse will audit 20% weekly for 1 month theResident Medication Administration Records and Treatment Administration Records for significant medication errors. Concerns identified will be correctly immediately and reported to the administrator. Medication pass audits were completed by the Director of Nursing and/or Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 3/28/14 to ensure that allergies are appropriately identified and that all medications are administered without significant medication error. Medication pass audits, to include residents with enteral feedings, was completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 3/28/14 until all nurses and	

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F 333	Continued From page 60 Allergies will be identified on the day of admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse will document allergies on the resident's medication allergy record that will be placed in the front of the MAR for that resident. The admitting nurse will review the resident's allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on the day of admission/readmission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders; and review of discharge summaries and all paperwork sent by the hospital along with the interview of the resident/POA will also be included in orientation for all new staff. The physician will be notified of any allergies by the charge nurse following review of all documents sent by the hospital, resident, and POA interview. Charts for newly admitted residents and readmitted residents will be reviewed and discussed in the Daily Clinical meeting on weekdays by the DON, MDS Coordinator, Social Services Director, Medical Records, SDC, ADONs, Activities Director, Dietary Manager, and Chaplain with a comparison review completed at that time of the resident's admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, this review will be completed by the DON, ADONs, SDC, or MDS Coordinator until removal of immediacy. Following removal of	F 333	certified medication technicians have had a medication audit completed. During the medication pass audit, a questionnaire will be completed by the Director of Nursing and/or Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, and/ or the Chief Operating Officer weekly for 4 weeks beginning on 3/30/14, then monthly. The Administrator and/or Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits twice weekly for 4 weeks beginning 3/30/14 and report findings during weekly QA for 4 weeks beginning 3/30/14, for recommendations and further follow-up as indicated.	

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

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F 333	Continued From page 61 immediacy, on weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or readmitted residents to ensure allergies are appropriately identified as well as all paperwork complete and accurate, care plan updated, physician notification complete, and all allergy lists updated or initialed. Allergy stickers and allergy lists were updated for all residents to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, and Regional Nurse Consultant on 03/28/14. Education was provided for licensed nursing staff/Kentucky Medication Aides by the Director of Nursing, Assistant Director of Nursing, the Staff Development Coordinator, and the Regional Nurse Consultant regarding all paperwork forwarded from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listings, physician orders, and MARs. Licensed nursing staff will not be allowed to work prior to receiving the above stated education. Nursing Administration to include the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators, Facility Formulary Nurse, or Regional Nurse Consultant are reviewing every physician's order daily to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. This will continue daily until immediacy lifted. Once immediacy is lifted a daily review will continue (Monday-Friday) by the above	F 333	Results of the audit will be reported to the QA committee monthly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audits will need to continue.	

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F 333	Continued From page 62 team. During care plan conference for each elder the allergy list will also be reviewed for any updates. Medication pass audits were completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 03/28/14 to ensure that allergies are appropriately identified and medications are administered without significant medication error. Medication pass audits will be completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 03/28/14 until all nurses and certified medication technicians have had a medication pass audit completed. During the medication pass audit, a questionnaire will be completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication. The Assistant Director of Nursing, MDS Coordinator, or the Staff Development Coordinator will audit the Medication Administration Record daily for newly admitted and readmitted residents to ensure allergies are identified on the resident's medication allergy record and allergy sticker on the outside of the chart. All allergy clarifications for all residents have been sent to Pharmacy as of 03/29/14 in which Pharmacy has updated their listing in their computer system. Pharmacy will review all new	F 333		

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F 333	Continued From page 63 orders and compare to any allergies listed and notify facility if an allergy exists regarding the new medication at which time the nurse will notify the physician for any new orders. All incident reports were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any further significant medication errors by 03/29/14. None was identified. All incidents or concerns are reviewed daily during the daily standup meeting to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manger, Chaplain, MDS Coordinators, Plant Operations Director, Medical Records, Admissions Director, Housekeeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager, or Regional Staff to identify any allegation of abuse or neglect. The Administrator has been on-site daily to review all concerns or incidents to ensure abuse or neglect has been appropriately identified and reported. Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, then weekly for four weeks after removal of immediacy, and then monthly. Education was provided by the Regional Nurse Consultant on 03/28/14 for the Administrator, the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records	F 333		

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F 333	Continued From page 64 Coordinator, Dietary Manger, and Admission Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant mediation errors, failure to report neglect, and auditing pharmacy services. The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits daily until removal of immediacy, and then twice weekly for four weeks and report findings during weekly QA for four weeks, for recommendations and further follow-up as indicated. A Quality Assurance meeting was held on 03/28/14 with the Medical Director for further recommendations regarding the plan for removal of jeopardy. A Quality Assurance meeting will be held weekly for four weeks, and then monthly for recommendations and further follow-up regarding the above stated plan. **The surveyors validated the Immediate Jeopardy was removed as follows: Review of a physician's order for Resident #8 dated 03/11/14, at 9:50 PM, revealed the nurse was to administer 120 milligrams (mg) of Solu-Medrol intramuscularly "now," and Benadryl 50 mg orally "now." Review of the MAR for Resident #8 revealed staff administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally on 03/11/14. Interview conducted with RN #2 on 03/27/14, at	F 333		

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F 333	Continued From page 65 4:55 PM, revealed she administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally to Resident #8 after Resident #8 complained of "tightness" of the chest, after learning the resident had an allergy to Macrodantin (antibiotic), and obtained a physician's order. The RN stated the treatment was effective and she continued to monitor the resident throughout the night. Interview conducted with Resident #6's physician on 04/02/14, at 4:30 PM, revealed he had been contacted by ADON #2 regarding the resident's allergy to Morphine. Review of an allergy sheet for Resident #6 on 04/02/14, at 5:00 PM, revealed Morphine was listed on the allergy sheet which was located in the front of the resident's MAR. Review of a care plan dated 03/30/14, revealed interventions to address Resident #6's allergy to Morphine. Review of a chart audit sheet the facility used to audit all residents' medical records for hospital discharge summaries and discharge documentation was reviewed to ensure allergies were identified. The audits were signed by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant as being completed on 03/27/14. The reviews of the medication allergy sheets for all residents were dated 03/27/14. Reviewed physician telephone orders to verify facility staff had contacted physicians to clarify the resident's drug allergies.	F 333		

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F 333	Continued From page 66	F 333		

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had assisted with the chart audits on 03/27/14 to identify medication allergies by reviewing hospital discharge summaries, outside consultation notes, and discharge documentation. The interviews revealed allergy stickers were reviewed for accuracy, and medication allergy sheets were completed for all residents and placed in the front of each resident's MAR. The interview revealed all allergies were then clarified with the resident's physician. The interview also revealed the DON had assisted with the audits; however, she was no longer employed by the facility.

Review of an in-service roster dated 03/27/14, revealed nurses and KMAs were in-serviced by the Regional Nurse Consultant, DON, and SDC regarding reviewing all hospital documentation upon admission or readmission to the facility to ensure allergies were appropriately identified.

Posttests taken by licensed nurses and KMAs regarding in-service roster dated 03/27/14 were reviewed.

Interview with the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to the licensed nurses and KMAs regarding reviewing all hospital documentation upon each resident admission or readmission to the facility to ensure allergies were appropriately identified.

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F 333	Continued From page 67 Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM all revealed they had attended an in-service regarding reviewing all hospital documentation to ensure allergies were appropriately identified with every admission or readmission. Review of an in-service roster dated 03/28/14 revealed the Medical Director attended an in-service provided by the Regional Nurse Consultant, SDC, and the Administrator regarding appropriately identifying allergies for residents. Interview conducted with the Medical Director on 04/02/14, at 4:30 PM, revealed he had attended an in-service provided by the facility on 03/28/14, regarding identifying allergies for the residents. Interview with the SDC on 04/03/14 at 2:40 PM, Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had provided an in-service to the Medical Director on 03/28/14 regarding ensuring resident allergies were appropriately identified. Review of an in-service syllabus and an email confirmation revealed the Consultant Pharmacist had been in-serviced by the Administrator, DON, and Regional Nurse Consultant on 03/28/14, regarding reviewing of all hospital discharge records for residents to ensure allergies were appropriately identified. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed he had attended an in-service by phone on 03/28/14	F 333		

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F 333	Continued From page 68 provided by the facility regarding reviewing all hospital discharge documentation to ensure residents' allergies were appropriately identified. Interview with the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they, along with the former DON, had provided an in-service to the Consultant Pharmacist on 03/28/14 regarding reviewing all hospital discharge documentation to ensure resident allergies were appropriately identified. Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified. Review of an in-service roster dated 03/28/14, revealed the Administrator, DON, SDC, and ADONs attended an in-service provided by the Regional Nurse Consultant regarding the reporting of significant medication errors as neglect. Interview with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had provided an in-service to the Administrator, DON, ADONs, and SDC on 03/28/14 regarding reporting of significant medication errors as neglect to the appropriate state agencies and investigating them as an allegation of neglect.	F 333		

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F 333	Continued From page 69	F 333		

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had attended an in-service provided by the Regional Nurse Consultant regarding reporting of significant medication errors to the state agencies and they were to investigate them as an allegation of neglect.

Review of an in-service roster dated 03/28/14, revealed the SDC, DON, ADONs, and the Regional Nurse Consultant provided an in-service for all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of posttests regarding the in-service had been completed by staff.

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator.

Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14

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F 333	Continued From page 70 at 2:10 PM, all revealed they had attended an in-service regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. The staff also revealed they had been required to take a posttest on the in-service prior to working. Review of a syllabus for all new licensed nurses and KMAs revealed staff would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus. Review of the follow-up questionnaire revealed the facility had completed ten questionnaires daily from all shifts and different staff regarding understanding of the Abuse/Neglect policy, appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process, and their participation in the QAPI process, and reporting to the Administrator. Interviews conducted with RN #6 on 04/03/14 at	F 333		

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SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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F 333	Continued From page 71 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had randomly completed a follow-up questionnaire regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of an interview sheet revealed on 03/27/14, all residents with a BIMS score of greater than 8 had been interviewed by the Social Services Director, DON, ADONs, SDC, and the MDS Coordinator. Review of physician's orders where new allergies were identified was confirmed with the physician. Interviews conducted on 04/02/14, at 4:40 PM with Resident #6, at 4:50 PM with Resident #9, and at 4:55 PM with Resident #8 revealed they had been interviewed by the facility staff and had been asked about their allergies. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had interviewed all residents who had a BIMS score above 8 regarding their knowledge of their medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy. Record review revealed on 03/27/14, responsible	F 333		

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F 333	Continued From page 72 parties of residents with a BIMS score of less than 8 were interviewed about the residents' allergies. The interviews were conducted by the Social Services Director, DON, ADONs, SDC, Administrator, MDS Coordinator, or the Regional Nurse Consultant. Any new allergies that were identified as a result of the interviews were confirmed with the resident's physician. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had interviewed all responsible parties of residents who had a BIMS score of less than 8 regarding their knowledge of the resident's medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy. Interviews conducted with Resident #7's responsible party on 04/02/14, at 5:45 PM, and Resident #14's responsible party on 04/02/14, at 6:00 PM, revealed the facility had contacted them regarding the resident's allergies. Review of Resident B's medical record revealed the resident was readmitted to the facility on 03/28/14, the resident did not have any known allergies, and the information was documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and was verified with the resident/responsible party.	F 333		

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F 333	Continued From page 73 Review of Resident C's medical record revealed the resident was readmitted to the facility on 03/29/14, and the resident was allergic to Aspirin (analgesic) and Tubersol (medication to test for Tuberculosis) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of Resident A's medical record revealed the resident was readmitted to the facility on 04/01/14, and the resident was allergic to Morphine (pain medication) and Levaquin (antibiotic) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of a syllabus for all new staff revealed staff would be provided education regarding allergies and that they would be identified on the day of the resident's admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse would document allergies on the resident's medication allergy record that would be placed in the front of the MAR for that resident. The admitting nurse would review the resident's allergies with the resident and/or the responsible party for confirmation. A care plan would be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The admitting nurse would review any discharge summaries and all paperwork sent by the hospital, along with the interview of the	F 333		

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F 333	Continued From page 74	F 333		

resident/responsible party, and notify the physician of any allergies. The admitting nurse would then document the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders.

Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.

Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who were readmitted to the facility and all three residents' records had been reviewed for allergies being identified, action taken, allergies listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, Nursing Admission Assessment Form, care plan for allergies initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.

Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited for allergies being identified, any action

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F 333	Continued From page 75 taken to correct, allergies being listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, and Nursing Admission Assessment Form, a care plan for allergies being initiated, allergy sticker on chart, and allergies listed on the resident's face sheet. Review of the allergy stickers on the front of residents' medical records and review of medication allergy lists revealed they had been updated on 03/28/14. Review of an audit dated 03/28/14, conducted by the DON, ADONs, MDS Coordinator, Staff Development Coordinator, and Regional Nurse Consultant revealed medication allergies for all residents had been updated in the residents' chart. The audit was reviewed and no concerns were identified. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of residents' allergy stickers and Medication Allergy Sheets for all residents had been updated. Review of an in-service roster and syllabus dated 03/28/14 provided by the DON, ADONs, SDC, and Regional Nurse Consultant for licensed nursing staff/KMAs regarding Abuse, Neglect, and Misappropriation of funds, Medication Administration-Medication Discrepancies, Care Plans, Admission Process, Clinical Meeting, and QAPI revealed the Admission Process included reviewing/referencing hospital discharge	F 333		

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F 333	Continued From page 76 paperwork, specifically noting allergies and interviewing residents/family to ensure appropriate information was received. It was also noted that if any discrepancies were found the nurse must get clarification from the physician. Also noted under the Admission Process was the Medication Allergy Sheet that was required to be completed upon admission and compared against hospital discharge documentation to check for allergies. Interview with RN #7 on 04/03/14 at 2:33 PM revealed he reviewed resident allergies on discharge information from the hospital. If the resident was admitted from home, he would contact the resident's physician and family to verify drug allergies. He also indicated that he had been provided with an in-service by the facility on drug allergies last week to include making sure that the resident's drug allergies were listed on the allergy sticker on the front of the chart, on the face sheet, on the MARs, and MD orders. RN #7 also stated that he had taken a posttest after being educated and had to pass it before he was allowed to be on the floor working. A copy of the notice informing the licensed nursing staff that they must be educated and pass the posttest before they would be allowed to work was provided. Review of audits conducted by the DON, ADONs, MDS Coordinator, SDC, or Regional Nurse Consultant, and which were reviewed daily by the Administrator, regarding checking all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list revealed this was being reviewed daily.	F 333		

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F 333	Continued From page 77 Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list. The staff stated this was being done daily and was reviewed daily by the Administrator. Review of a document titled "2013 Updated Care Conference Agenda" updated on 03/29/14 revealed that allergies would be reviewed during care plan conference. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed allergies would be discussed as part of the Care Conference Agenda and no Care Conference had been done yet. Review of a medication pass audit completed by the DON, ADONs, SDC, and Regional Nurse Consultant for all nurses and KMAs working on 03/28/14 and the questionnaire to ensure nursing staff had knowledge regarding location of a resident's allergies prior to administering medication and without a significant medication error revealed all licensed nurses and KMAs	F 333		

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F 333	Continued From page 78 been observed during medication administration and had a completed questionnaire. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted medication audits for all nurses and KMAs working on 03/28/14, and had the employees complete a questionnaire regarding allergies and where to locate allergies prior to administering medications. The staff stated all nurses and KMAs had been observed during medication administration and had completed a questionnaire regarding allergies. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM, revealed they had all been observed during medication administration and had completed a questionnaire regarding allergies. Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who had been readmitted to the facility and all three residents' records had been reviewed for Medication Allergy Record and an allergy sticker being on the chart. Review of all resident medical records on 04/03/14, revealed all residents had an allergy sticker on the front of the resident's medical record. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on	F 333		

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F 333	Continued From page 79 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited the Medication Allergy Sheet and the allergy sticker being on the resident's chart. Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified and a copy sent to the pharmacy. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified. Review of an audit of incident reports conducted on 03/29/14, by the DON, ADONs, SDC, or Regional Nurse Consultant to verify that no further significant medication errors had occurred revealed none had been identified by the facility. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted the audits on 03/29/14 of incident reports to verify that no further significant medication errors had occurred and none was identified. Review of documentation of incidents reviewed in the Daily Clinical Meeting to identify any	F 333		

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F 333	Continued From page 80 allegations of abuse or neglect revealed the Administrator had documented he had reviewed them daily. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meeting and had reviewed all incidents or concerns to identify any allegations of abuse or neglect and there were none. The Administrator revealed he had reviewed the incidents daily. Review of a sign-in sheet verified that the Chief Operating Officer (COO) was present at the facility on 03/29/14, 03/30/14, 03/31/14, 04/01/14, and 04/02/14. Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits and been present for facility meetings. Review of an in-service roster dated 03/28/14 revealed the Administrator, DON, ADONs, SDC, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager, and Admissions Director attended an in-service regarding the QAPI process; appropriate methods to identify significant medication errors; failure to report neglect; and auditing of pharmacy services. The in-service was provided by the Regional Nurse Consultant.	F 333		