

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/25/2014
NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466		
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F 428	<p>Continued From page 74</p> <p>critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner.</p> <p>-Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol.</p> <p>-The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders. However, the neither Administrator nor DON was made aware of this issue by the Pharmacy Consultant and neither the Administrator nor DON had access to Omniview. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk.</p> <p>-The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p> <p>-The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the Pharmacy</p>	F 428			

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F 428	<p>Continued From page 75</p> <p>Consultant must exit with the Administrator and/or DON, go over the consultant reports, and leave a hard copy of his consultant report.</p> <p>-On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports.</p> <p>-The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education.</p> <p>-The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy</p>	F 428			

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F 428	<p>Continued From page 76</p> <p>pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received.</p> <p>-Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14.</p> <p>-Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff.</p> <p>-Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been</p>	F 428			

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F 428	<p>Continued From page 77</p> <p>in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work.</p> <p>-One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14.</p> <p>-One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.</p> <p>-The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders.</p> <p>-The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>-Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0.</p> <p>-Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results</p>	F 428			

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F 428	<p>Continued From page 78</p> <p>of the resident's PT with INR, and the resident was sent to the hospital.</p> <p>-Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital.</p> <p>-Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14.</p> <p>-Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses.</p> <p>-Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans.</p> <p>-Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans.</p>	F 428			

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F 428	<p>Continued From page 79</p> <p>The DON and SDN stated they had then provided the in-service to the nursing staff.</p> <p>-Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff.</p> <p>-Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required.</p> <p>-Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all</p>	F 428			

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F 428	<p>Continued From page 80</p> <p>renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary.</p> <p>-Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on</p>	F 428			

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F 428	<p>Continued From page 81 their unit.</p> <p>-Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call.</p> <p>-Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any "stat" laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log</p>	F 428		

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F 428	<p>Continued From page 82 beginning 07/26/14.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program.</p> <p>-An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service.</p> <p>-Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation.</p>	F 428		

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F 428	<p>Continued From page 83</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest.</p> <p>-Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans.</p> <p>-Review of a list of Quality Assurance Team Committee members was conducted.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4.40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools.</p>	F 428			

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F 428	Continued From page 84  -Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted.  -Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified.  -Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician.  -Review of Care Plan Protocol staff were informed where care plans were located at each nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care.  -Review of an in-service roster dated 07/21/14, regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest.  -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical	F 428			

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F 428	<p>Continued From page 85</p> <p>Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM, verified they had attended an in-service regarding the required use of the care plan, and had completed a posttest.</p> <p>-Review of an audit completed by the Regional Corporate Nurse on 07/20/14, revealed all care plans for residents who were on anticoagulant therapy had been reviewed.</p> <p>-Interview conducted with the Regional Corporate Nurse Consultant on 07/25/14, at 4:45 PM, revealed she had conducted an audit on 07/20/14 of all care plans for residents who were on anticoagulant therapy, to ensure their plans of care were being followed as directed.</p> <p>-Review of an audit completed by the DON, Unit Managers, Minimum Data Set (MDS) Coordinator, and Social Services revealed 100 percent of the resident care plans were audited to ensure laboratory orders were documented on the care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had assisted in the audit of all residents' care plans to ensure care was being provided as directed in the care plans.</p> <p>-Review of a letter sent to the facility's pharmacy regarding the Pharmacist not identifying and bringing it to the facility's attention that Resident #8, who was on Coumadin therapy, had not been having the physician-ordered PT with INRs was reviewed. The letter revealed the future expectation of the facility was that the Consultant Pharmacist would review all residents on an</p>	F 428			

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 428	<p>Continued From page 86</p> <p>anticoagulant as well as any other medication that required laboratory levels to be drawn. The letter also revealed the Pharmacist was expected to exit with the DON and the Administrator going forward and review any consultant reports with them and to leave a hard copy of the findings.</p> <p>-Interview conducted with the DON on 07/25/14, at 4:40 PM, revealed she had spoken with the Consultant Pharmacist on 07/18/14, and was informed he would no longer be doing the pharmacy reviews for the facility and a new Consultant Pharmacist would be completing the facility's pharmacy reviews.</p> <p>-Review of an education syllabus to be taught to the new Consultant Pharmacist before their next regular review revealed the Consultant Pharmacist would be required to monitor laboratory tests for critical levels, drug-to-drug interactions, and recommended drug alternatives. In addition, the Consultant Pharmacist would be required to exit with the Administrator and or the DON upon completion of the pharmacy review and to leave a hard copy of the consultant reports with the Administrator and DON and must be reviewed during the exit conference.</p> <p>-Observation on 07/25/14, at 3:50 PM, of the Administrator accessing the Consultant Pharmacist computer system with access to the reports was conducted.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had contacted the General Manager of the pharmacy regarding the concern that Consultant Pharmacist had not identified and notified the Administrator nor the DON regarding the PT with INRs not</p>	F 428			

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F 428	Continued From page 87 being done as ordered for Resident #8. The Administrator stated she then sent the information in a letter to the pharmacy. The Administrator stated the General Manager was informed the new Consultant Pharmacist would have to attend an in-service by either her or the DON when coming to the facility on their next scheduled visit. The Administrator stated she attended all Quality Assurance Committee meetings and would be reviewing all data obtained from all the audits.  -Interviews conducted with the Regional Corporate Nurse Consultant and the Regional Director of Operations, on 07/26/14, at 4:45 PM, revealed either one or both of them had provided oversight to the facility and would continue to do so until the jeopardy was abated, and then would provide oversight on a weekly basis. The interview also revealed they would continue to review all Quality Assurance minutes.	F 428			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policies entitled "Medication Administration" and "Lab and Diagnostic test results-Clinical Protocol," and the Administrator's	F 490	F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  1. Resident #8 had a physician's order for routine PT with INR every week. Resident #8 had a PT with INR drawn on 5/12/2014. On May 12, 2014 the lab auditor was doing her review and saw that the PT with INR for Resident # 8 was going to expire on July 31, 2014 so she went in to renew the lab in the Medlab system. She mistakenly changed the start date to July 1, 2014 through July 31, 2014 which deleted out of the system until that date therefore there would be no PT with INR order in the system for resident # 8 from May 12, 2014 until July 1, 2014. The unit manager discovered that a PT with INR wasn't being drawn during changeover on June 30, 2014. The physician was notified by the unit manager and a clarification order was obtained to get a PT with INR weekly on 6/30/2014. The unit manager put the PT with INR in the Medlab computer system to be drawn on the next lab day which was 7/1/2014. The PT with INR was drawn on Resident #8 on 7/2/2014. The PT was 85.1 and the INR was 7.0. The physician was notified by an LPN and new orders were received to transfer the Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 7/2/2014 to 7/4/2014.		

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41468	

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F 490	Continued From page 88 position description, it was determined the facility's Administration failed to ensure its resources were used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (1) of thirty-four (34) sampled residents (Resident #8). The facility admitted Resident #8 on 09/07/12 with diagnoses that included Atrial Fibrillation. A review of the physician's orders for May 2014 revealed the physician had written an order for staff to administer 6 milligrams (mg) of Coumadin to Resident #8 every night and to obtain a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests routinely ordered for patients that receive Coumadin to check bleeding time) to be drawn weekly. Review of Resident #8's physician's orders revealed although the medications had been administered as ordered, the laboratory tests had not been conducted on a weekly basis for Resident #8 as ordered. Review of laboratory reports revealed a PT with INR had been conducted on 05/12/14; however, the next PT with INR had not been conducted until 07/02/14, a timeframe of seven weeks. Review of the laboratory report for the PT and INR conducted on 07/02/14 revealed Resident #8's PT and INR levels were "Critical," and the resident was transferred and admitted to a hospital, placed on telemetry, and diagnosed with "Coumadin Toxicity." Interview conducted with the Administrator revealed the Director of Nursing (DON) informed her on 07/01/14 that the routine laboratory tests used to monitor Resident #8's Coumadin use had not been conducted as ordered by the physician since 05/12/14, even though it had been ordered to be conducted on a weekly basis. The Administrator stated the Unit Managers and DON were present on 07/01/14, when the incident was discussed. According to	F 490	<p>2. All residents who have routine labs ordered by the physician are at risk. All of the License nursing staff as well as the unit managers has been in-serviced on the new lab policy and protocol by the DON, Staff Development Nurse or designee by 7/20/2014. New protocol has been developed to ensure that labs are drawn as ordered and that results are received in a timely manner to prevent residents from missing any ordered labs.</p> <p>3. The administrator drafted a letter to the manager of Medlab on 7/22/2014 stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the Medlab system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from July 22, 2014 is the expectation that no Medlab auditor will not renew any labs at all, the facility will be responsible for that. Medlab is also expected during their monthly audits will provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that the building can renew the lab orders in the Medlab system timely.</p> <p>The Regional Director of Operations or the Clinical Nurse Consultant for Preferred Care Partners, MG will be in the facility to provide management oversight throughout the survey process at least weekly.</p> <p>A lab policy and protocol was developed on July 19, 2014 by the quality assurance committee to be used for all labs. This new policy and protocol includes the steps to take starting from receiving a lab order all the way to getting the results and monitoring for timeliness.</p>	

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F 490	<p>Continued From page 89</p> <p>the Administrator, because the Unit Managers were required to monitor laboratory tests to ensure the tests were done and were present when the DON was notified of the incident, the facility had not conducted staff in-services related to the incident and had not monitored any other resident records, including physician orders and laboratory reports, to ensure other residents' medications and laboratory tests were provided in accordance with physician's orders.</p> <p>The facility's failure to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for its residents caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.60 Pharmacy Services (F428), 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J."</p> <p>Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. On 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14, as alleged, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness</p>	F 490	<p>The Regional Nurse Consultant for Preferred Care Partners, MG In serviced the DON and the Staff Development Nurse and the Administrator on the lab policy and protocol on 7/19/2014 before they in serviced the licensed nursing staff.</p> <p>All licensed nursing staff as well as the unit managers has been educated on the new lab policy and protocol by 7/20/2014 by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education.</p> <p>The unit managers have a lab calendar which has all routine labs scheduled to be drawn for the rest of the year in it. They will compare their lab calendar to the labs in the lab book prior to morning meeting Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. This process began 7/19/2014. The Administrator and/or DON or designee will monitor use of the lab book five days a week Monday through Friday in morning meeting to ensure that labs have been drawn as ordered and results has come back and has been addressed. Routine labs are Monday through Thursday. Any issues identified are corrected immediately. Results will be taken to the QA meeting.</p> <p>The Nurse on the rotating call schedule was inserviced on the weekend lab monitoring log on 7/22/14 by the Administrator. The weekend nurse on call</p>		

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F 490	<p>Continued From page 90 of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the Administrator's "Position Description" dated and signed by the Administrator on 02/12/13, revealed the Administrator was responsible for directing the day to day functions of the facility in accordance with current federal, state, and local guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times. The position description also revealed it was the Administrator's responsibility to ensure excellent care was maintained for residents by overseeing and monitoring patient care services delivered.</p> <p>Review of an undated facility policy titled, "Medication Administration," revealed the nursing staff would evaluate medications to determine if a resident had an adverse consequence such as an abnormal laboratory test result, or had achieved the therapeutic drug level (within the desired level), or a level that was too high or too low.</p> <p>Review of the facility's policy titled, "Lab and Diagnostic test results-Clinical Protocol," with a revision date of October 2010, revealed the physician would identify and order diagnostic and laboratory testing based on diagnostic and monitoring needs. The policy revealed nursing staff would process the test requisitions and arrange for the tests to be completed by the laboratory.</p> <p>Review of the contract between the laboratory and the facility dated 10/02/06, revealed the</p>	F 490	<p>will call the facility on Saturday and Sunday at 9am, 1pm, 5pm, and 9pm to see if any stat labs were ordered on the weekend. If stat labs have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. If there are any weekend stat labs ordered the Nurse on call will call the Administrator or DON and will QA any labs ordered and received during the weekend.</p> <p>The Administrator drafted a letter to the manager of the pharmacy on July 23, 2014 stating that during the pharmacist's monthly review at the facility the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the pharmacy consultant must exit with the Administrator and/or DON and go over the consultant reports and leave a hard copy of his consultant report.</p> <p>The administrator called and spoke with John Smith (General Manager of The administrator called and spoke with John Smith (General Manager of Omnicare of Beatyville) and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports on July 21, 2014.</p>		

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F 490	<p>Continued From page 91</p> <p>contract did not specify an amount of time at which a physician's routine laboratory order would expire. The contract revealed the laboratory would furnish to the facility the results of all routine tests as outlined in the physician's order in a reasonable time to the facility.</p> <p>Medical record review revealed the facility initially admitted Resident #8 on 09/07/12, with a diagnosis that included Atrial Fibrillation.</p> <p>Review of the monthly May 2014 Physician's Orders for Resident #8 revealed an order for 6 milligrams of Coumadin (anticoagulant) to be administered every night and for a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) to be conducted every week. Review of Resident #8's laboratory results revealed a PT with INR had been conducted on 05/12/14; however, no further PT with INR had been conducted until 07/02/14, at which time the resident's PT was 85.1 seconds (73.5 seconds above the reference range of 9.5 to 11.6 seconds) and his/her INR was 7.0 (5.9 above the reference range of 0.9 to 1.1). According to the laboratory report, both levels were "Critical." Documentation in the Nursing Notes revealed on 07/02/14, at 5:41 PM, facility staff notified the resident's physician of the elevated PT and INR laboratory results and the resident was transported to a hospital for further evaluation and treatment.</p> <p>Documentation in the resident's hospital record revealed Resident #8 was admitted to the hospital on 07/02/14, placed on telemetry to monitor his/her vital signs, and the physician at the hospital diagnosed Resident #8 to have "Coumadin Toxicity."</p>	F 490	<p>The Administrator and/ or DON will educate the pharmacy consultant before their next regular review on the ensuring that they assess the following areas: monitoring labs for critical levels, drug to drug interactions, and recommended drug alternatives. The education will also include that the pharmacy consultant must exit with the Administrator and/or DON upon completion of their review to go over consultant reports and provide the facility with a hard copy of the consultant report. The pharmacy consultant will be required to sign verification of education.</p> <p>The administrator and DON now has access to Omniview effective July 23, 2014 so we can go in and look at the consultant reports as well as any notes that has been made. The Administrator and DON will review the reports in the Omniview system when they become available after the pharmacy consultant has did his exit. The Administrator and DON will check the Omniview system daily after the pharmacy consultant has exited to see if the reports are on Omniview. When the reports are available on Omniview the Administrator and DON will compare Omniview to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p>		

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F 490	Continued From page 92  Interview conducted with the Administrator on 07/18/14, at 2:30 PM, revealed the Director of Nursing (DON) had informed her on 07/01/14 that the routine laboratory tests used to monitor Resident #8's Coumadin use had not been conducted as ordered by the physician since 05/12/14 even though it had been ordered to be conducted on a weekly basis. The Administrator stated the pharmacist and nursing staff failed to identify and/or report that the routine laboratory tests for Resident #8 had not been conducted as ordered by the physician. The Administrator stated a Unit Manager had learned on 08/30/14 that the laboratory tests had not been conducted as ordered by the physician for Resident #8 and contacted the resident's physician. According to the Administrator, the Unit Manager that learned the laboratory tests had not been conducted notified the DON on 07/01/14 in the presence of the facility's Unit Managers, who were responsible to monitor the laboratory requests to ensure they had been completed. According to the Administrator, because the Unit Managers were present when the DON was notified of the omission of the laboratory tests for Resident #8, the Administrator had not taken any action to educate staff of the facility's policies related to the incident and had not monitored any other resident records, including physician orders and laboratory reports, to ensure other residents medications and laboratory tests were provided in accordance with physician orders. In addition, the Administrator stated that prior to 07/01/14 she was not aware laboratory orders would expire in the computer system after 400 days nor was that information in the contract between the facility and the laboratory. However, when the Administrator became aware on 07/01/14, no	F 490	4. The Regional Director of Operations or Regional Clinical Consultant will review the facility onsite or assist with monitoring administration weekly or as needed times 6 weeks. Results of the visit will be reviewed in the Quality Assurance meeting.  The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.  QA Meetings can be held with two or more team members in attendance daily 5 days a week and PRN for review of data to ensure compliance including: any findings of labs not completed per physician order, any abnormal lab results found without physician notification, or critical lab results.  QA Committee members will review QA topics minimally 5 days a week and PRN for 30 days or additionally as necessary until 9/30/2014; then monthly thereafter or as needed. The Regional Clinical Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings minutes five time weekly or as needed until September 30, 2014.		

*Sheela*

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F 490	<p>Continued From page 93</p> <p>action was taken to ensure laboratory testing orders did not expire and laboratory tests were obtained as ordered by residents' physicians.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-Resident #8 had a physician's order for a routine PT with 1NR to be drawn every week. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained on 06/30/14 to obtain a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14.</p> <p>-All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service</p>	F 490			

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F 490	<p>Continued From page 94</p> <p>for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner.</p> <p>-The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely.</p> <p>-A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness.</p> <p>-The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff.</p>	F 490			

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F 490	<p>Continued From page 95</p> <p>-All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work.</p> <p>-Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order clarification, and putting lab results on the chart.</p> <p>-The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday.</p>	F 490			

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F 490	Continued From page 96  -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any "stat" laboratory tests were ordered on the weekend. If "stat" laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend.  -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.  -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse.  -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.	F 490			

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F 490	<p>Continued From page 97</p> <p>-The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use.</p> <p>-Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend "stat" laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any</p>	F 490			

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F 490	<p>Continued From page 98</p> <p>laboratory tests ordered and received.</p> <p>-Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results.</p> <p>-Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner.</p> <p>-Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol.</p> <p>-The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders. However, the neither Administrator nor DON was made aware of this issue by the Pharmacy Consultant and neither the Administrator nor DON had access to Omniview. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk.</p>	F 490			

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F 490	<p>Continued From page 99</p> <p>-The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p> <p>-The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the Pharmacy Consultant must exit with the Administrator and/or DON, go over the consultant reports, and leave a hard copy of his consultant report.</p> <p>-On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports.</p> <p>-The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education.</p>	F 490			

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F 490	<p>Continued From page 100</p> <p>-The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p> <p>-If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received.</p> <p>-Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14.</p> <p>-Based on the fact that the Care Plan was not</p>	F 490			

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F 490	<p>Continued From page 101</p> <p>followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff.</p> <p>-Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work.</p> <p>-One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14.</p> <p>-One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.</p> <p>-The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders.</p> <p>-The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management</p>	F 490		

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F 490	<p>Continued From page 102 oversight throughout the survey process at least weekly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>-Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0.</p> <p>-Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital.</p> <p>-Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital.</p> <p>-Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14.</p> <p>-Review of the Laboratory Policy and Protocol</p>	F 490			

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F 490	<p>Continued From page 103</p> <p>developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses.</p> <p>-Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans.</p> <p>-Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff.</p> <p>-Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff.</p> <p>-Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights.</p>	F 490			

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F 490	<p>Continued From page 104</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required.</p> <p>-Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM,</p>	F 490		

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F 490	<p>Continued From page 105</p> <p>Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #8 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary.</p> <p>-Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit.</p> <p>-Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Review of the Nurse on Call schedule revealed a</p>	F 490			

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F 490	<p>Continued From page 106</p> <p>nurse was scheduled every weekend to take Administrative call.</p> <p>-Review of an In-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any "stat" laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an In-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record.</p>	F 490			

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F 490	<p>Continued From page 107</p> <p>The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program.</p> <p>-An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service.</p> <p>-Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest.</p> <p>-Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans.</p> <p>-Review of a list of Quality Assurance Team Committee members was conducted.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician.</p>	F 490			

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F 490	Continued From page 108  -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools.  -Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted.  -Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified.  -Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician.  -Review of Care Plan Protocol staff were informed where care plans were located at each	F 490			

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F 490	Continued From page 109 nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care.  -Review of an in-service roster dated 07/21/14, regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest.  -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM, verified they had attended an in-service regarding the required use of the care plan, and had completed a posttest.  -Review of an audit completed by the Regional Corporate Nurse on 07/20/14, revealed all care plans for residents who were on anticoagulant therapy had been reviewed.  -Interview conducted with the Regional Corporate Nurse Consultant on 07/25/14, at 4.45 PM, revealed she had conducted an audit on 07/20/14 of all care plans for residents who were on anticoagulant therapy, to ensure their plans of care were being followed as directed.  -Review of an audit completed by the DON, Unit Managers, Minimum Data Set (MDS) Coordinator, and Social Services revealed 100 percent of the resident care plans were audited to ensure laboratory orders were documented on the care plans.  -Interviews conducted on 07/25/14, with RN #2 at	F 490			

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F 490	<p>Continued From page 110</p> <p>4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had assisted in the audit of all residents' care plans to ensure care was being provided as directed in the care plans.</p> <p>-Review of a letter sent to the facility's pharmacy regarding the Pharmacist not identifying and bringing it to the facility's attention that Resident #8, who was on Coumadin therapy, had not been having the physician-ordered PT with INRs was reviewed. The letter revealed the future expectation of the facility was that the Consultant Pharmacist would review all residents on an anticoagulant as well as any other medication that required laboratory levels to be drawn. The letter also revealed the Pharmacist was expected to exit with the DON and the Administrator going forward and review any consultant reports with them and to leave a hard copy of the findings.</p> <p>-Interview conducted with the DON on 07/25/14, at 4:40 PM, revealed she had spoken with the Consultant Pharmacist on 07/18/14, and was informed he would no longer be doing the pharmacy reviews for the facility and a new Consultant Pharmacist would be completing the facility's pharmacy reviews.</p> <p>-Review of an education syllabus to be taught to the new Consultant Pharmacist before their next regular review revealed the Consultant Pharmacist would be required to monitor laboratory tests for critical levels, drug-to-drug interactions, and recommended drug alternatives. In addition, the Consultant Pharmacist would be required to exit with the Administrator and or the DON upon completion of the pharmacy review and to leave a hard copy of the consultant reports</p>	F 490			

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F 490	Continued From page 111 with the Administrator and DON and must be reviewed during the exit conference.  -Observation on 07/25/14, at 3:50 PM, of the Administrator accessing the Consultant Pharmacist computer system with access to the reports was conducted.  -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had contacted the General Manager of the pharmacy regarding the concern that Consultant Pharmacist had not identified and notified the Administrator nor the DON regarding the PT with INRs not being done as ordered for Resident #8. The Administrator stated she then sent the information in a letter to the pharmacy. The Administrator stated the General Manager was informed the new Consultant Pharmacist would have to attend an in-service by either her or the DON when coming to the facility on their next scheduled visit. The Administrator stated she attended all Quality Assurance Committee meetings and would be reviewing all data obtained from all the audits.  -Interviews conducted with the Regional Corporate Nurse Consultant and the Regional Director of Operations, on 07/25/14, at 4:45 PM, revealed either one or both of them had provided oversight to the facility and would continue to do so until the jeopardy was abated, and then would provide oversight on a weekly basis. The interview also revealed they would continue to review all Quality Assurance minutes.	F 490			
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			

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F 520	Continued From page 112  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy entitled, "Quality Assessment and Assurance Plan," it was determined the facility failed to maintain a Quality Assessment and Assurance Committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies for one (1) of thirty-four (34) sampled residents (Resident #8). Review of the May 2014 Physician Orders for Resident #8 revealed the	F 520	F 520 483.75(b)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  1. Resident #8 had a physician's order for routine PT with INR every week. Resident #8 had a PT with INR drawn on 5/12/2014. On May 12, 14 the lab auditor was doing her review and saw that the PT with INR for Resident # 8 was going to expire on July 31, 2014 so she went in to renew the lab in the Medlab system. She mistakenly changed the start date to July 1, 2014 through July 31,2014 which deleted out of the system until that date therefore there would be no PT with INR order in the system for resident # 8 from May 12, 2014 until July 1,2014. The unit manager discovered that a PT with INR wasn't being drawn during changeover on June 30,2014. The physician was notified by the unit manager and a clarification order was obtained to get a PT with INR weekly on 6/30/2014. The unit manager put the PT with INR in the Medlab computer system to be drawn on the next lab day which was 7/1/2014. The PT with INR was drawn on Resident #8 on 7/2/2014. The PT was 85.1 and the IRN was 7.0. The physician was notified by an LPN and new orders were received to transfer the Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 7/2/2014 to 7/4/2014.		

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F 520	<p>Continued From page 113</p> <p>physician had ordered 6 milligrams of Coumadin (anticoagulant) to be administered every night to the resident and had also ordered a Prothrombin Time (PT) with an International Normalized Ratio (INR), which are laboratory tests to check the resident's bleeding time, to be completed on a weekly basis.</p> <p>On 05/05/14, the physician gave staff a verbal order to decrease Resident #8's Coumadin dosage from 6 milligrams daily to 5 milligrams a day. Review of laboratory results dated 05/12/14, revealed the resident's PT was 24.6 seconds with a reference range of 9.5 to 11.6 seconds. The INR was 2.2 seconds with a reference range of 0.9 to 1.1 seconds. Further review of the laboratory results for Resident #8 revealed after 05/12/14, the facility failed to obtain a PT and INR for Resident #8 until 07/02/14 (a timeframe of seven weeks after the previous PT and INR had been obtained), at which time the resident's PT was 85.1 seconds (73.5 seconds above the normal range of 9.5 to 11.6 seconds) and his/her INR level was 7.0 (5.9 above the normal range of 0.9 to 1.1).</p> <p>Review of the laboratory report revealed the PT and INR levels obtained on 07/02/14 were "Critical." Review of the Nurse's Notes revealed Resident #8's physician was notified of the abnormal lab results on 07/02/14 and the resident was taken to a hospital where he/she was placed on telemetry and diagnosed with "Coumadin Toxicity."</p> <p>Interview revealed the facility failed to identify that a PT and INR had not been conducted on a weekly basis (for a timeframe of seven weeks) as ordered by Resident #8's physician and, as a</p>	F 520	<p>The Quality Assurance Committee failed to put a plan in place after identifying an issue with labs not being drawn for Resident #8 weekly per physician's orders. The Quality Assurance Committee failed to develop a plan of action to correct the problem of labs not being drawn per physician's orders for Resident #8 as well as failed to develop a system to monitor labs.</p> <p>Members of the QA Committee developed a policy on 7/19/2014 to validate that Labs are being obtained as ordered by the physician and results are received and followed up on timely per policy protocol. This was implemented 7/19/2014 and is ongoing. The unit managers will compare the lab calendar to the labs listed on the lab tracking sheet to verify that they match prior to morning meeting. The unit manager will then follow up to ensure that labs were drawn as listed, results have been received, and they have been followed up on timely prior to morning meeting, any issues noted will be addressed and followed up in QA. During morning meeting Monday through Friday the Administrator or DON or designee will check the Lab book as well as the lab calendar to ensure that labs have been drawn as physician ordered and results have been received. Any issues identified are corrected immediately. This practice became effective 7/19/2014. If there are any weekend stat labs ordered the Nurse on call will call the Administrator or DON and will QA any labs ordered and received the Regional Director of Operations or the Regional Nurse Consultant for the Preferred Care Partners Management Group will review any weekend QA lab notes/reports through the QA process.</p>	

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F 520	<p>Continued From page 114</p> <p>result, failed to develop and implement appropriate plans of action through a Quality Assurance Program to correct the identified deficiency to prevent medication and laboratory monitoring errors, the pharmacist's failure to identify and report drug irregularities to the physician and the Director of Nursing, and the facility's failure to be administered in a manner to ensure each resident maintained the highest practicable physical, mental, and psychosocial wellbeing of each resident. (Refer to F282, F329, F428, and F490.)</p> <p>The facility's failure to ensure residents received adequate drug monitoring and was free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. Prior to exit on 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes</p>	F 520	<p>2. A lab policy and protocol was developed on July 19, 2014 by the Quality Assurance Committee and approved by the Quality Assurance Committee to be used for all labs. All residents who have routine labs ordered by the physician are at risk. All of the nurses as well as the unit managers have been in-serviced on the new lab policy and protocol. New protocol has been developed to ensure that labs are drawn as ordered and that results are received in a timely manner to prevent residents from missing any ordered labs</p> <p>One hundred percent of all anti-coagulant care plans were reviewed and/or updated if necessary by the RNC for Preferred Care, MG, on July 20, 2014.</p> <p>One hundred percent of residents who are on Coumadin PT with INR labs were audited by the DON to ensure they were drawn per physicians orders on 7/20/2014. Any issues identified were addressed.</p> <p>3. The administrator drafted a letter to the manager of Medlab on 7/22/2014 stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the Medlab system they must notify the Administrator and DON as well as provide education on those changes.</p> <p>Also stated in the letter from July 22, 2014 is the expectation that no Medlab auditor will not renew any labs at all, the facility will be responsible for that. Medlab is also expected during their monthly audits will provide the Administrator and DON with a list of names for those orders expiring in the</p>		

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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 520	<p>Continued From page 115 and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Quality Assessment and Assurance Plan," with a revision date of December 2009, revealed the facility would develop, implement, and maintain an ongoing, facilitywide Quality Assessment and Assurance Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems. The policy revealed the Administrator was responsible for ensuring the facility's Quality Assessment and Assurance Program complied with federal, state, and local regulatory agency requirements.</p> <p>Record review revealed the facility admitted Resident #8 on 09/07/12, with a diagnosis of Atrial Fibrillation.</p> <p>Review of Resident #8's May 2014 monthly Physician's Orders revealed an order for Coumadin (anticoagulant) 6 milligrams to be administered every night orally and for a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) to be drawn weekly.</p> <p>Review of Resident #8's Physician's Orders revealed a verbal order dated 05/05/14, for the resident's Coumadin to be decreased to 5 milligrams every night; and on 05/12/14, the physician gave a verbal order to increase the resident's Coumadin to 6 milligrams every night. Review of Resident #8's PT with INR results, which were dated 05/12/14, revealed the resident's PT was 24.6 seconds, with a reference</p>	F 520	<p>upcoming month so that the building can renew the lab orders in the Medlab system timely.</p> <p>The Administrator drafted a letter to the manager of the pharmacy on July 23, 2014 stating that during the pharmacist's monthly review at the facility the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the pharmacy consultant must exit with the Administrator and/or DON and go over the consultant reports and leave a hard copy of his consultant report.</p> <p>The administrator called and spoke with John Smith (General Manager of Omnicare of Beautyville) and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports on July 21, 2014.</p> <p>The Administrator and/or DON will educate the pharmacy consultant before their next regular review on the ensuring that they assess the following areas: monitoring labs for critical levels, drug to drug interactions, and recommended drug alternatives. The education will also include that the pharmacy consultant must exit with the Administrator and/or DON upon completion of their review to go over consultant reports and provide the facility with a hard copy of the consultant report. The pharmacy consultant will be required to sign verification of education.</p>		

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F 520	<p>Continued From page 116</p> <p>range of 9.5 to 11.6 seconds and the resident's INR level was 2.2, with a reference range of 0.9 to 1.1. Continued review of the laboratory results for Resident #8 revealed no documented evidence the weekly lab testing had been completed as ordered by the physician until 07/02/14 (a timeframe of seven weeks), at which time the resident's PT level was 85.1 seconds (73.5 seconds above the reference range of 9.5 to 11.8 seconds) and the INR was 7.0 (5.9 above the reference range of 0.9 to 1.1 seconds). According to the lab report dated 07/02/14, the resident's PT and INR levels were "Critical." Review of Resident #8's Nurse's Notes revealed the resident's physician was notified of the abnormal lab results and Resident #8 was transported to a local hospital.</p> <p>Review of Resident #8's hospital record revealed the resident was admitted to on 07/02/14, placed on telemetry, and was diagnosed to have "Coumadin Toxicity."</p> <p>Interview conducted with the Director of Nursing (DON) on 07/17/14, at 6:30 PM, revealed she was responsible for the Quality Assurance Program for the facility. The DON stated even though she became aware on 07/01/14 that Resident #8's laboratory tests (PT and INR) had not been conducted as ordered, no additional education in-services or monitors had been put into place. The DON stated the Unit Managers, who were responsible for monitoring to ensure all residents laboratory testing had been completed as it was ordered by the physician, had been present when she learned of the omission of Resident #8's laboratory tests. According to the DON, she and the Unit Managers discussed the situation and the DON determined they had been</p>	F 520	<p>A lab policy and protocol was developed on July 19, 2014 to be used for all labs. This new policy and protocol includes the steps to take starting from receiving a lab order all the way to getting the results and monitoring for timeliness.</p> <p>The Regional Nurse Consultant for Preferred Care Partners, MG in serviced the DON and the Staff Development Nurse on the lab policy and protocol on 7/19/2014 before they in serviced the licensed nursing staff.</p> <p>All licensed nursing staff as well as the unit managers have been educated on the new lab policy and protocol by 7/20/2014 by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education.</p> <p>The unit managers will have a lab calendar which has all routine labs scheduled to be drawn for the rest of the year in it. They will compare their lab calendar to the labs in the lab book prior to morning meeting Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the lab book five days a week Monday through Friday in morning meeting to ensure that labs have been drawn as ordered and results has come back and has been addressed. Routine labs are Monday through Thursday.</p>	

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F 520	<p>Continued From page 117</p> <p>sufficiently educated on the omission of laboratory tests.</p> <p>The Administrator stated in interview conducted on 07/18/14, at 2:30 PM that the pharmacist had not notified her that the laboratory tests used to monitor Resident #8's Coumadin use had not been conducted as ordered by the physician. The Administrator stated nursing staff had also failed to identify that the routine laboratory tests had not been conducted as ordered by the physician until 06/30/14. The Administrator stated the Unit Manager notified the DON of the incident on 07/01/14 in the presence of the facility's Unit Managers. According to the Administrator, because the Unit Managers were present when the DON was notified of the omission of the laboratory tests for Resident #8, the facility had not conducted staff in-services related to the incident and had not monitored any other resident records, including physician orders and laboratory reports, to ensure other residents' medications and laboratory tests were provided in accordance with physician orders.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>-Resident #8 had a physician's order for a routine PT with 1NR to be drawn every week. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore,</p>	F 520	<p>The Nurse on call will call the facility on Saturday and Sunday at 9am, 1pm, 5pm, and 9pm to see if any stat labs were ordered on the weekend. If stat labs have been ordered they will verbally verify that the results have been received and the physician and the family have been notified. They will write this down on the weekend lab monitoring log</p> <p>The Administrator and DON will review the reports in the Omniview system when they become available after the pharmacy consultant has did his exit. The Administrator and DON will check the Omniview system daily after the pharmacy consultant has exited to see if the reports are on Omniview. When the reports are available on Omniview the Administrator and DON will compare Omniview to the hard copy pharmacy reports to ensure that they match, any discrepancies will be taken through QA.</p> <p>The administrator inserviced the Quality Assurance committee members on Quality Assurance on 8/22/2014. Any member who wasn't at work received an inservices on 8/22/2014 over the phone by the administrator.</p> <p>The facility will have a monthly Quality Assurance Meeting; a plan will be developed for an areas identified. The monthly Quality Assurance plan will be monitored by the Regional Nurse Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group they will review,</p>		

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F 520	<p>Continued From page 118</p> <p>there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with INR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained On 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14.</p> <p>-All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner.</p> <p>-The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the</p>	F 520	<p>comment, recommend and/or approve QA plan monthly or as needed .</p> <p>4. The monitoring results of the regional review will be brought to the Quality Assurance meeting for 3 months.</p> <p>The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>QA Meetings can be held with two or more team members in attendance daily 5 days a week and PRN for review of data to ensure compliance including: any findings of labs not completed per physician order, any abnormal lab results found without physician notification, or critical lab results.</p> <p>QA Committee members will review QA topics minimally 5 days a week and PRN for 30 days or additionally as necessary until 9/30/2014; then monthly thereafter or as needed. The Regional Clinical Consultant or the Regional Director of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings minutes five time weekly or as needed until September 30, 2014.</p>	<p><i>8/26/14</i></p>
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F 520	<p>Continued From page 119</p> <p>letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely.</p> <p>-A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness.</p> <p>-The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff.</p> <p>-All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work.</p> <p>-Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality</p>	F 520			

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F 520	<p>Continued From page 120</p> <p>Assurance follow-up included completion of documentation, Physician order clarification, and putting lab results on the chart.</p> <p>-The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday.</p> <p>-The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any "stat" laboratory tests were ordered on the weekend. If "stat" laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend.</p> <p>-All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff</p>	F 520			

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F 520	<p>Continued From page 121</p> <p>Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse.</p> <p>-The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director.</p> <p>-The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use.</p> <p>-Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the</p>	F 520			

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F 520	<p>Continued From page 122</p> <p>physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend "stat" laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received.</p> <p>-Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results.</p> <p>-Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly</p>	F 520			

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F 520	<p>Continued From page 123 thereafter or as needed sooner.</p> <p>-Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol.</p> <p>-The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders. However, the neither Administrator nor DON was made aware of this issue by the Pharmacy Consultant and neither the Administrator nor DON had access to Omniview. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk.</p> <p>-The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August.</p> <p>-The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for Coumadin must be reviewed every month. The letter also stated that the Pharmacy Consultant must exit with the Administrator and/or DON, go over the consultant reports, and leave a hard copy of his consultant report.</p>	F 520			

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F 520	<p>Continued From page 124</p> <p>-On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports.</p> <p>-The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education.</p> <p>-The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/25/2014
NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 520	Continued From page 125  -The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up.  -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received.  -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14.  -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff.  -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work.	F 520			

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F 520	<p>Continued From page 126</p> <p>-One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14.</p> <p>-One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services.</p> <p>-The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders.</p> <p>-The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>-Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0.</p> <p>-Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital.</p> <p>-Interview conducted with Registered Nurse (RN)</p>	F 520			

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F 520	<p>Continued From page 127</p> <p>#2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital.</p> <p>-Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14.</p> <p>-Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses.</p> <p>-Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans.</p> <p>-Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff.</p> <p>-Interview conducted on 07/25/14, at 4:15 PM,</p>	F 520			

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F 520	<p>Continued From page 128</p> <p>with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff.</p> <p>-Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required.</p> <p>-Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire.</p>	F 520			

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F 520	Continued From page 129  -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration.  -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed.  -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2.02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary.  -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit.  -Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40	F 520			

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F 520	<p>Continued From page 130</p> <p>PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call.</p> <p>-Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any "stat" laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40</p>	F 520			

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F 520	<p>Continued From page 131</p> <p>PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program.</p> <p>-An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service.</p> <p>-Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM,</p>	F 520			

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F 520	<p>Continued From page 132</p> <p>LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest.</p> <p>-Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans.</p> <p>-Review of a list of Quality Assurance Team Committee members was conducted.</p> <p>-Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools.</p> <p>-Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14,</p>	F 520			

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F 520	<p>Continued From page 133 which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted.</p> <p>-Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified.</p> <p>-Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician.</p> <p>-Review of Care Plan Protocol staff were informed where care plans were located at each nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care.</p> <p>-Review of an in-service roster dated 07/21/14, regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest.</p> <p>-Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM, verified they had attended an in-service regarding the required use of the care plan, and had completed a posttest.</p>	F 520			

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F 520	Continued From page 134  -Review of an audit completed by the Regional Corporate Nurse on 07/20/14, revealed all care plans for residents who were on anticoagulant therapy had been reviewed.  -Interview conducted with the Regional Corporate Nurse Consultant on 07/25/14, at 4:45 PM, revealed she had conducted an audit on 07/20/14 of all care plans for residents who were on anticoagulant therapy, to ensure their plans of care were being followed as directed.  -Review of an audit completed by the DON, Unit Managers, Minimum Data Set (MDS) Coordinator, and Social Services revealed 100 percent of the resident care plans were audited to ensure laboratory orders were documented on the care plans.  -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had assisted in the audit of all residents' care plans to ensure care was being provided as directed in the care plans.  -Review of a letter sent to the facility's pharmacy regarding the Pharmacist not identifying and bringing it to the facility's attention that Resident #8, who was on Coumadin therapy, had not been having the physician-ordered PT with INRs was reviewed. The letter revealed the future expectation of the facility was that the Consultant Pharmacist would review all residents on an anticoagulant as well as any other medication that required laboratory levels to be drawn. The letter also revealed the Pharmacist was expected to exit with the DON and the Administrator going	F 520			

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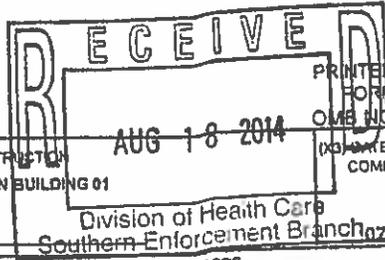
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F 520	<p>Continued From page 135</p> <p>forward and review any consultant reports with them and to leave a hard copy of the findings.</p> <p>-Interview conducted with the DON on 07/25/14, at 4:40 PM, revealed she had spoken with the Consultant Pharmacist on 07/18/14, and was informed he would no longer be doing the pharmacy reviews for the facility and a new Consultant Pharmacist would be completing the facility's pharmacy reviews.</p> <p>-Review of an education syllabus to be taught to the new Consultant Pharmacist before their next regular review revealed the Consultant Pharmacist would be required to monitor laboratory tests for critical levels, drug-to-drug interactions, and recommended drug alternatives. In addition, the Consultant Pharmacist would be required to exit with the Administrator and or the DON upon completion of the pharmacy review and to leave a hard copy of the consultant reports with the Administrator and DON and must be reviewed during the exit conference.</p> <p>-Observation on 07/25/14, at 3:50 PM, of the Administrator accessing the Consultant Pharmacist computer system with access to the reports was conducted.</p> <p>-Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had contacted the General Manager of the pharmacy regarding the concern that Consultant Pharmacist had not identified and notified the Administrator nor the DON regarding the PT with INRs not being done as ordered for Resident #8. The Administrator stated she then sent the information in a letter to the pharmacy. The Administrator stated the General Manager was</p>	F 520			

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F 520	Continued From page 138 informed the new Consultant Pharmacist would have to attend an in-service by either her or the DON when coming to the facility on their next scheduled visit. The Administrator stated she attended all Quality Assurance Committee meetings and would be reviewing all data obtained from all the audits.  -Interviews conducted with the Regional Corporate Nurse Consultant and the Regional Director of Operations, on 07/25/14, at 4:45 PM, revealed either one or both of them had provided oversight to the facility and would continue to do so until the jeopardy was abated, and then would provide oversight on a weekly basis. The interview also revealed they would continue to review all Quality Assurance minutes.	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185221	(X2) MULTIPLE CONSTRUCTION: A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) ON-SITE SURVEY COMPLETED  07/22/2014
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven (7)</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET &amp; DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 07/22/14. The survey began using the (2786S) short form. Concerns were identified effecting egress and complete sprinkler coverage. The survey was then changed to the 2786R standard form. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The census on the day of the survey was 128 residents with a bed capacity of 142.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Edw Jones Admin: 8/18/14* TITLE: \_\_\_\_\_ (X6) DATE: \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466	
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K 000	Continued From page 1	K 000		
K 038 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exit egress paths that could be maintained in all weather conditions, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of seven smoke compartments, 40 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 07/22/14 at 1:54 PM of the designated exit discharge located in the Dining Room revealed the walking surface terminated into a section of grass and rough muddy terrain prior to reaching the public way. Interview with the Maintenance Director revealed the facility was not aware the exit required a hard surface path for travel leading to a public way.</p> <p>The finding was acknowledged by the Administrator during the exit conference.</p>	K 038	<p><b>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>1. No residents were affected; all residents had the potential to be affected.</p> <p>An exit egress path was built and completed on 7/31/14 connecting the dining room exit to the sidewalk in front of the building that could be maintained in all weather conditions.</p> <p>2. The Maintenance Director assessed all other exits to ensure that they had an exit egress path that could be maintained in all weather conditions on 7/23/2014; all other areas had a proper exit path.</p> <p>3. The Maintenance Director/maintenance assistant will assess all exit doors to ensure that they connect to a exit egress path that could be maintained in all weather conditions weekly for four weeks beginning 8/18/2014, then monthly for three months.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, and Maintenance will meet weekly x 4 weeks beginning week of 8/18/2014 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance. 8/25/2014</p>	

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K 038	Continued From page 2  Reference: NFPA 101 (2000 Edition).  7.5.1.1. Exit access shall be arranged that exits are readily accessible at all times.  7.1.10.1. The means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in the case of fire or emergency.  7.7.1. Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 056	K 056 NFPA 101 LIFE SAFETY CODE STANDARD  1. No residents were affected; all residents had the potential to be affected.  Two shower stalls on peach wing had sprinkler heads installed on 8/7/2014 and were added to the automatic sprinkler system.  2. The Maintenance Assistant assessed all other areas of the building to ensure that they had sprinklers as required on 7/23/2014. One other area was found and a sprinkler head was installed in a shower on green wing on 8/7/2014.	

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K 058	<p>Continued From page 3</p> <p>determined the facility failed to ensure automatic sprinkler protection was provided for all areas of the building, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of seven smoke compartments, 26 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 07/22/14 at 1:35 PM, with the Maintenance Director, revealed two shower stalls on the Peach Wing Hall were not protected by the automatic sprinkler. Interview revealed he/she was not aware those areas were not protected by automatic sprinkler protection.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)</p> <p>Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 258, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied</p>	K 058	<p>On 8/15/2014 Ivan Burton from Heritage Fire did a walk through with the maintenance assistant to assess the building to see if any other areas of the building needed to have a sprinkler head. He found 3 areas that he advised us to sprinkler. Heritage Fire will be here the week of August 18, 2014 to install the 3 sprinkler heads.</p> <p>3. The Maintenance Director/maintenance assistant will assess all areas of the building to ensure that they are protected by the automatic sprinkler system weekly for four weeks beginning 8/18/2014, then monthly for three months.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, and Maintenance will meet weekly x 4 weeks beginning week of 8/18= /2014 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance.8/25/2014</p>	

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K 056	Continued From page 4 or protected throughout by an approved automatic sprinkler system.  Table 19.1.6.2 Construction Type Limitations  <table border="1"> <thead> <tr> <th rowspan="2">Construction Type</th> <th colspan="4">Stories</th> </tr> <tr> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>I(443)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>I(332)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(222)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(111)</td> <td>X</td> <td>X*</td> <td>X*</td> <td>NP</td> </tr> <tr> <td>II(000)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(211)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(200)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>IV(2HH)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(111)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>V(000)</td> <td>X*</td> <td>NP</td> <td>NP</td> <td>NP</td> </tr> </tbody> </table> <p>X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.)</p>	Construction Type	Stories				1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	II(000)	X*	X*	NP	NP	III(211)	X*	X*	NP	NP	III(200)	X*	NP	NP	NP	IV(2HH)	X*	X*	NP	NP	V(111)	X*	X*	NP	NP	V(000)	X*	NP	NP	NP	K 056		
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V(000)	X*	NP	NP	NP																																																											
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure fire	K 064	K 064 NFPA 101 LIFE SAFETY CODE STANDARD  1. No residents were affected; all residents had the potential to be affected.  The fire extinguisher near room 320 and room 305 was replaced on 7/30/2014.																																																												

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K 064	<p>Continued From page 5</p> <p>extinguishers were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two of seven smoke compartments, 45 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 07/22/14 at 2:30 PM revealed the fire extinguisher near room 320 did not have a verification of service collar indicating a hydrostatic test had been performed. The fire extinguisher had a manufacture date of 1994. The same was found for a fire extinguisher near room 305 having a manufacture date of 2004. Interview with the Maintenance Director revealed he was unaware of when the fire extinguishers were placed into service. Further interview revealed the facility relies on an outside contractor to ensure the fire extinguishers are inspected and maintained.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers</p>	K 064	<p>2. The Maintenance Assistant assessed all fire extinguishers in the building to ensure that they were inspected according to National Fire Protection or were the proper fire extinguisher that was not outdated. Fifteen fire extinguishers were outdated and replaced on 7/30/2014.</p> <p>3. The Maintenance Director/maintenance assistant will assess all of the fire extinguishers in the building weekly to ensure that they are the proper extinguishers and they have been inspected according to National Fire Protection weekly for four weeks beginning 8/11/2014, then monthly for three months.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, and Maintenance will meet weekly x 4 weeks beginning week of 8/11/2014 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance. 8/25/2014</p>	

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K 064	Continued From page 8 shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. 4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in. (5.1 cm x 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance 4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.	K 064		

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K 064	Continued From page 7 Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999. Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.	K 064		