

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

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2015
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MAR - 2 2015

NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 244 EAST MAIN STREET BEATTYVILLE, KY 41311
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Division of Health Care
Southern Enforcement Branch

(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
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F 000 INITIAL COMMENTS

An abbreviated standard survey (KY22763) was initiated on 02/02/15 and concluded on 02/03/15. The complaint was substantiated with deficient practice identified at "D" level.

F 000 Lee County Care and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.

F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 157

F157 SS D
1. Resident #1 was assessed for pain, sent to the ER for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Susan Bush NHA 2/27/15

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

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to notify a resident's physician when a significant change in condition occurred which required physician intervention for one (1) of three (3) sampled residents (Resident #1). Interview and record review revealed Resident #1 was admitted to the facility on 12/24/14 and was to receive hospice services for a diagnosis of Lung Cancer. The resident had physician orders for pain medication to be administered as needed. However, the resident arrived at the facility without handwritten prescriptions for the ordered pain medications; therefore, staff was unable to administer medications for pain. Although staff acknowledged the resident's medical condition required physician intervention, facility staff failed to notify Resident #1's physician to obtain the needed handwritten prescriptions for the resident's medications.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Change in Resident's Condition/MD Notification," last revised October 2013, revealed staff was required to notify the resident's physician of changes in a resident's medical condition. Continued review of the policy revealed staff was required to notify the resident's physician when a need to significantly alter the resident's medical treatment was identified.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility</p>	F 157	<p>treatment of pain and Hospital MD/POA notified on 12/24/14 by RN #1.</p> <p>2. All residents have the potential to be affected by the facility failing to notify the resident's physician and if known notify the president's legal representative or an interested family member. All residents' orders were audited by the ADONs, or Unit managers on 2/2/15 to ensure all residents had an order to monitor for verbal and nonverbal S/S of pain. Resident's identified to not have an order to monitor for verbal and nonverbal S/S of pain the Unit Manager or ADON completed a pain assessment and obtained an order to monitor for verbal and nonverbal S/S of pain.</p> <p>All residents' charts will be audited for physician/POA/RP notification with any change of condition over past 90 days by the DON, ADONs, or Unit Managers to be completed by 2/22/15. Any</p>	

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F 167	<p>Continued From page 2</p> <p>on 12/24/14 at 5:00 PM with diagnoses that included Lung Cancer, Chronic Obstructive Pulmonary Disease, and Anxiety. A review of the resident's physician orders revealed the resident had orders to receive Morphine 2 milligrams (mg) by mouth every four hours as needed for pain, and Percocet 5 mg by mouth every four to six hours for chest pain.</p> <p>A review of Resident #1's nurse's notes dated 12/24/14 completed by Registered Nurse (RN) #1 revealed the resident arrived at the facility at 5:00 PM. The nurse's notes further revealed at 5:30 PM staff had contacted the Advanced Practice Registered Nurse (APRN), which was on call for the resident's primary physician. Staff informed the APRN that Resident #1 had no handwritten prescriptions, and therefore staff would not be able to obtain the resident's medications for pain.</p> <p>An interview with RN #1 on 02/02/15 at 11:47 AM revealed she admitted Resident #1 on 12/24/14 at 5:00 PM. RN #1 stated she identified that hospital staff failed to send the resident's handwritten prescriptions for Resident #1's controlled medications. RN #1 further stated she notified the APRN that the resident arrived at the facility without handwritten prescriptions and the APRN stated there was nothing she could do because the office was closed due to the holiday. Continued interview revealed the APRN instructed the nurse to call hospital staff and inform them of the need for handwritten prescriptions. The RN stated she contacted hospital staff, which had discharged the resident, and informed them of the need for handwritten prescriptions to be able to obtain and administer the resident's controlled medications. RN #1 stated hospital staff stated they would "see what</p>	F 157	<p>concerns identified will be addressed.</p> <p>3. Education on the change of resident status policy and procedure, to include MD/POA notification was provided to the ADONs, Unit Managers and MDS Coordinator on 2/3/15 by the Regional Nurse Consultant. Education for all licensed staff will be completed by 2/22/15 by the Unit Managers and Interim Director of Nursing. Education provided contains the policy for Change in Resident's Condition/MD Notification. Emphasis was placed on notifying the resident's physician of changes in a resident's medical condition and the requirement to notify the resident's physician when a need to significantly alter the resident's medical treatment was identified.</p> <p>4. The DON, ADONs, Unit Managers, SDC or MDS Coordinator will review all resident status changes daily</p>		

for 2 weeks to ensure MD/POA notification, then daily M-F during the clinical meeting.

Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director.

5. Date of compliance
2/22/15.

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F 157	Continued From page 3 they could do." The RN stated she had not contacted the resident's physician, because she was awaiting hospital staff to provide the resident's handwritten prescriptions.	F 157	F309 SS D 1. Resident #1 was assessed for pain, sent to the ER for treatment of pain and MD/POA notified on 12/24/14 by RN #1.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being related to pain management for one (1) of three (3) sampled residents (Resident #1). Interview and record review revealed Resident #1 was admitted to the facility on 12/24/14 with a diagnosis of Lung Cancer. The resident was admitted with physician's orders for pain medications; however, there were no handwritten prescriptions for the medications, which were required for staff to administer the pain medications to the resident. Interview with staff revealed Resident #1 complained of pain; however, staff was unable to administer pain medications. The facility failed to provide the necessary care and services to assure the resident received the pain medication	F 309	2. All residents have the potential to be affected by the facility failing to provide necessary care and services to attain or maintain the highest practicable psychosocial well-being related to pain management for resident #1. All residents' orders were audited by the ADONs, or Unit managers on 2/2/15 to ensure all residents had an order to monitor for verbal and nonverbal S/S of pain. Resident's identified to not have an order to monitor for verbal and nonverbal S/S of pain the Unit Manager or ADON completed a pain	

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F 309	<p>Continued From page 4</p> <p>as needed, and the resident had to be transferred back to the hospital to receive treatment for his/her pain.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Pain Management," effective December 2010, revealed facility residents assessed to have pain would have an ongoing assessment and if the resident's pain was not under control the resident's Medical Doctor would be notified.</p> <p>A review of the facility policy titled "Controlled Substance Medication Orders," dated December 2012, revealed the facility pharmacy must be in receipt of a clear, complete, and valid prescription from a person lawfully authorized to prescribe them, before a controlled substance can be dispensed. The policy also stated in case of an emergency a practitioner could speak directly to the pharmacist and provide an emergency authorization for the pharmacy to supply a small quantity of the Schedule II medications until a signed prescription could be provided.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 12/24/14 at 5:00 PM with diagnoses that included Lung Cancer, Chronic Obstructive Pulmonary Disease, and Anxiety. A review of the resident's physician orders revealed the resident had orders to receive Morphine 2 milligrams (mg) by mouth every four hours as needed for pain, and Percocet 5 mg by mouth every four to six hours for chest pain.</p> <p>A review of Resident #1's nurse's notes dated 12/24/14 completed by Registered Nurse (RN) #1</p>	F 309	<p>assessment and obtained an order to monitor for verbal and nonverbal S/S of pain. Care plans were updated.</p> <p>The DON, ADONs, and Unit Managers will complete an audit, by 2/22/14, of resident orders/ resident status changes from December 1, 2014 to current date to ensure all residents admitted from 12/1/14 to current had been provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>The DON, ADON'S and Unit Managers will review MD orders, 24 shift report and SBAR to ensure any resident identified with pain the physician has been notified, orders obtained</p>		

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F 309	Continued From page 5 revealed the resident arrived at the facility at 5:00 PM without handwritten prescriptions, which were required for staff to receive and administer pain medications as ordered. The nurse's notes further revealed at 5:30 PM staff contacted the Advanced Practice Registered Nurse (APRN), which was on call for the resident's primary physician. Staff informed the APRN that Resident #1 did not have handwritten prescriptions and therefore staff would not be able to obtain the resident's medications for pain. The APRN provided no resolution to ensure the resident was able to receive pain medications as ordered. An interview with RN #1 on 02/02/15 at 11:47 AM revealed she admitted Resident #1 on 12/24/14 at 5:00 PM. RN #1 stated she identified that hospital staff failed to send the resident's handwritten prescriptions for Resident #1's controlled medications. RN #1 further stated she notified the APRN that the resident arrived at the facility without handwritten prescriptions and the APRN stated there was nothing she could do because the office was closed due to the holiday. Continued interview revealed the APRN instructed the nurse to call hospital staff and inform them of the need for handwritten prescriptions. The RN stated she had contacted hospital staff, which had discharged Resident #1, and informed them of the need for handwritten prescriptions, in order to obtain and administer the resident's controlled medications for pain. The RN stated hospital staff stated they'd "see what they could do." RN#1 stated her shift had ended at approximately 7:30 PM. RN #1 revealed facility staff had not obtained the required handwritten prescriptions for pain medications when she left the facility (approximately two and one-half hours after	F 309	and the resident has received his or her pain medication as ordered. Any concerns identified will be addressed. 3. Education for all licensed staff was started on 2/03/15 by the Unit Managers and Interim Director of Nursing. The education will be completed by 2/22/15. Education provided was to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being related to pain management. Licensed Staff will be educated by DON, ADONs, or Unit Managers starting 2/19/15 to follow a check list that includes asking the discharging hospitals attending physician for a faxed copy of a handwritten prescription for pain		

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F 309	<p>Continued From page 6</p> <p>Resident #1's arrival at the facility). The RN stated she had not contacted the resident's physician because she was awaiting hospital staff to provide the resident's handwritten prescriptions.</p> <p>An interview with RN #2 on 02/02/15 at 3:00 PM revealed she provided care to Resident #1 after 7:00 PM on 12/24/14. RN #2 stated she was told in report the facility was awaiting hospital staff to fax prescriptions to the pharmacy so the resident's medications could be obtained. The RN stated the resident complained of pain at 10:00 PM and she contacted the pharmacy to check the status of the resident's medications. Pharmacy staff informed the RN no prescriptions had been received for the resident. RN #2 notified the on-call APRN of Resident #1's complaints of pain, and the APRN again directed staff to contact hospital staff to obtain handwritten prescriptions (five hours after the resident had been admitted to the facility). RN #2 stated Resident #1 complained of pain again at 11:30 PM on 12/24/14 (six and one-half hours after admission to the facility). RN #2 stated she was again unable to provide the pain medications to the resident. RN #2 stated she notified the APRN and was directed at that time to transfer the resident to the hospital for pain management. The resident's physician was never contacted for interventions to treat Resident #1's pain.</p> <p>An interview with Paramedic #1 on 02/02/15 at 3:15 PM revealed she transported Resident #1 from the facility to the hospital on 12/24/14. She stated the resident was visibly in pain and "whined the whole time." The Paramedic stated the resident was experiencing pain to the extent she was uncomfortable transporting the patient</p>	F 309	<p>prior to the resident being discharged from the hospital. If a copy of the handwritten prescription is not available the resident will not be accepted.</p> <p>Furthermore the facility has ensured alternative pain medication will be kept in the E kit and will be administered, as needed, to any resident that exhibits break through pain once verbal order is obtained and approval from pharmacy to disperse from E kit is received. If the nurse is unable to obtain an order to remove the pain medication from the e-kit the resident will be sent to the Emergency room for pain management.</p> <p>This will ensure the facility can provide necessary care and services to attain or maintain the highest practicable physical,</p>	

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F 309	<p>Continued From page 7</p> <p>without treating the resident's pain. The Paramedic stated, "I broke protocol and called the Emergency Room Doctor myself and got orders" to administer the resident pain medication. She stated she received an order to administer Morphine intravenously (IV) but was unable to obtain IV access, therefore the resident had to be transported to the hospital without treating his/her pain.</p> <p>An interview with the APRN on 02/03/15 at 1:00 PM confirmed she was on call for Resident #1's primary physician on 12/24/14. The APRN acknowledged she was aware Resident #1 arrived at the facility without handwritten prescriptions, and without the prescriptions staff was unable to obtain or administer any medication to the resident. The APRN stated, "The transferring physician should have made the resident's prescriptions available," and stated she "did not have prescribing authority." She acknowledged she could have contacted the resident's primary physician to obtain the needed prescriptions for the resident but failed to do so because "this was the hospital's problem." The APRN acknowledged the resident had to be transferred back to the hospital to receive care and treatment related to pain.</p> <p>An interview with Resident #1's physician on 02/03/15 at 12:25 PM confirmed facility residents required a handwritten prescription from a physician to obtain and administer controlled substances. The resident's physician stated the on-call APRN could have called him and he would have provided the needed prescriptions for the resident. The physician stated he would have provided the facility pharmacy with the needed prescriptions for Resident #1's pain medications.</p>	F 309	<p>mental, and psychosocial well-being related to pain management for all residents. Education will be completed by 2/22/15</p> <p>4. The DON, ADONs, and Unit Managers will audit Physician orders, new admission, and readmission resident charts daily for 2 weeks, then M-F during the clinical meeting to ensure the admission check list was followed and a copy of handwritten prescription was obtained prior to admission to the facility.</p> <p>The DON, ADON'S and Unit Mangers will audit Physician orders and medications forms pulled from the E-Kit daily for 2 weeks. Then M-F during the clinical meeting to ensure residents identified to have breakthrough pain or a change in a pain medication has been identified and addressed</p>		

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F 309	Continued From page 8 An interview with the Administrator on 02/03/15 at 3:50 PM revealed nursing staff had been trained to contact the resident's physician when a change in condition occurred which required an intervention by the physician. The Administrator further stated staff should have contacted Resident #1's physician when they were unable to obtain prescriptions required for the resident's medications to be administered.	F 309	to ensure pain management needs are met. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director. 5. Date of compliance 2/22/15.		