

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 94</p> <p>Interview conducted with the Assistant Director of Nursing, on 06/02/14 at 1:30 PM, revealed she remembered getting a call from LPN #5 on 05/21/14 sometime before midnight related to Resident #11 who she recalled was having breathing problems. It was almost time for LPN #5 to leave and the ADON instructed LPN #5 to have LPN #8 carry out the orders. She stated she was not aware the resident did not receive the medication until the next day.</p> <p>Interview with Advanced Registered Nurse Practitioner (ARNP), on 06/02/14 at 1:30 PM, revealed she remembered receiving a call from LPN #5 on 05/21/14 and had given LPN #5 orders for the next nurse to carry out as it was time for LPN #5 to leave. She stated Resident #11 was End Stage COPD and was having wheezing so she ordered Solu Medrol "stat" because it works within an hour.</p> <p>3. Record review revealed the facility admitted Resident #12 on 04/30/14 with diagnoses which included Post Traumatic Seizures. Review of the admission MDS assessment, dated 05/20/14, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of the Nurse's Notes, revealed the resident experienced a seizure on 05/02/14 at 11:45 AM. The resident was transported to the Emergency Room for evaluation and admitted for treatment. Record review revealed he/she returned to the facility on 05/06/14 with Physician Orders for Keppra (anti-convulsant) 500 mg by mouth twice daily at 9:00 AM and 9:00 PM.</p>	F 333			

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F 333	<p>Continued From page 85</p> <p>Review of the May 2014 MAR revealed there was no documentation the Keppra was administered as prescribed from 05/05/14 through 05/08/14 (total of seven (7) doses).</p> <p>Further review of the Nurse's Notes, revealed the resident experienced another seizure on 05/08/14 and was transported back to the emergency room and was admitted. Record review revealed Resident #12 was readmitted to the facility on 05/13/14 with Physician's Orders for Keppra 500 mg tablets, 1000 mg twice daily. Review of the resident's May 2014 MAR revealed the resident had been administered Keppra 500 mg twice daily from 05/14/14 through 05/31/14 instead of the 1000 mg twice daily as prescribed on 05/13/14 (a total of thirty-five (35) doses).</p> <p>Interview with the DON, on 06/01/14 at 10:10 AM and on 06/02/14 at 1:45 PM, revealed the Keppra dosage given 05/14/14 through 05/31/14 was incorrect.</p> <p>Interview with the Administrator, on 06/01/14 at 10:30 AM, revealed the MAR indicated Keppra was not given as prescribed for seizure activity and the administration of medications should be accurately recorded in the medical record.</p> <p>4. Record review revealed the facility admitted Resident #14 on 10/11/13 with diagnoses which included Diarrhea and Colon Resection. The resident was ordered Pancrelipase (digestive enzyme) 5000 units, one (1) at meals and one (1) before bedtime. Review of the May 2014 MAR revealed the resident did not receive the medication on 05/19/14, 05/21/14, 05/22/14 and 05/28/14, a total of fourteen (14) doses. The back of the MAR revealed documentation the</p>	F 333			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 333	<p>Continued From page 96</p> <p>pharmacy was notified the medication was not available on 05/19/14 however, the MAR indicated the medication was still not available on 05/23/14.</p> <p>Interview with Resident #14, on 05/28/14 at 2:25 PM, revealed the Pancrelipase had not been available for several days because the insurance would not pay for it even though he/she had been taking the medication for years and it was covered by the insurance.</p> <p>Interview with the DON, on 05/28/14 at 3:35 PM, revealed she was currently investigating why this resident received other medications but did not receive the Pancrelipase. The Pharmacist had informed the DON the Physician's Medicaid number was expired and that was why the medication was not sent. There was no explanation as to why the pill bottle dated 05/21/14 was in the drawer empty.</p> <p>Interview with a Pharmacy Representative, on 06/02/14 at 3:00 PM, revealed the Physician's provider enrollment was not updated in the Medicaid system. She stated when they did an update in their system, that was when they started rejecting. The system notified the physician's license was not updated.</p> <p>5. Record review revealed the facility admitted Resident #15 on 07/03/12 with diagnoses which included Bilateral Above the Knee Amputee and Chronic Pain. Review of a Quarterly MDS assessment revealed the facility assessed the resident with a BIMS score of fourteen (14) which indicated the resident was interviewable.</p> <p>Review of the May 2014 Physician's Order,</p>	F 333		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 333	<p>Continued From page 97</p> <p>revealed the resident was to have Fentanyl 26 mcg/hr patch every 72 hours. However, review of the May 2014 MAR, revealed no Fentanyl patch was administered on 05/05/14, 05/14/14 and 05/29/14.</p> <p>Interview with Resident #15, on 05/30/14 at 11:30 AM, revealed he was currently hurting "bad". Observation of an assessment at the time, by the ADON, revealed there was no Fentanyl patch in place. Resident #15 was unaware there was not a patch in place. The resident stated the patch helped as he/she always had pain.</p> <p>Interview with LPN #3, on 05/31/14 at 3:00 PM, revealed Resident #15 did not have the prescribed Fentanyl patches available in the medication cart drawer on 05/29/14 and another time at the beginning of the month. The LPN stated she called the pharmacy and was told the Fentanyl patch was not covered by the resident's insurance but Morphine would be. The LPN revealed she called the ARNP who said she did not want to change the resident to Morphine because the resident had been on the Fentanyl for some time. LPN #3 stated Resident #15 had "Hit me at the door complaining of pain and had never complained of pain like that before and that's how I knew it was missed". The LPN revealed the pharmacy will not send a medication if it was not covered by insurance and the residents go a day or two without".</p> <p>Interview with Pharmacy Representative #2, on 06/02/14 at 3:20 PM, revealed he verified the facility notified the Pharmacy on 05/26/14, but had not notified the Pharmacy on 05/05/14 or on 05/14/14. The Fentanyl patch was not delivered to the facility, and available for administration, on</p>	F 333		
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F 333	<p>Continued From page 98 05/05/14, 05/14/14 or 05/26/14.</p> <p>6. Observation of a medication pass performed by LPN #1, on 05/29/14 at 11:00 AM, revealed LPN #1 obtained a 229 blood sugar reading for Resident #17 and drew up seven (7) units of Regular Insulin and prepared to administer it to the resident. LPN #6, who was new to the facility and shadowing LPN #1, informed LPN #1 that she thought the Insulin amount should be five (5) units and not the seven (7) units as was prepared. LPN #1 then re-checked the resident's MAR and determined the resident was to have five (5) and not seven (7) units of Insulin. Interview with LPN #1 at the time revealed she had another resident's sliding scale Insulin orders and had drawn up and prepared to administer the wrong amount of Insulin to Resident #17. She stated she would have to fill out a medication error report.</p> <p>Review of Resident #17's May 2014 Physician's Orders, revealed the amount of Regular Insulin to be administered when the blood sugar reading was between 101-250 would be five (5) units.</p> <p>Interview conducted with the DON, on 05/29/14 at 1:10 PM, revealed she expected nurses to go by the orders on the resident's MAR and thought the nurse would have double checked. The DON was not aware of what was in the facility policy related to administration of sliding scale Insulin.</p> <p>7. Record review revealed the facility admitted Resident #3 on 07/01/12 with diagnoses which included Hypertension.</p> <p>Review of the May 2014 Physician's Order, revealed to administer Norvasc (blood pressure)</p>	F 333			

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F 333	<p>Continued From page 99</p> <p>10 mg every day. However, review of the May 2014 MAR revealed this medication was initiated and circled from 05/23/14 through 05/29/14 (seven doses) which indicated the medication was not given. Further review of the back side of the MAR revealed no documentation related to why the medication was not given.</p> <p>8. Record review revealed the facility admitted Resident #2 on 07/01/12 with diagnoses which included Spina Bifida and Obesity. Review of the Quarterly MDS assessment, dated 03/19/14, revealed the facility assessed the resident to have a BIMS score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of a Physician's Order, dated 05/18/14, revealed the Advanced Practice Registered Nurse (APRN) ordered Diflucan 100 mg by mouth every day for five (5) days for a yeast rash. Review of the May 2014 Medication Administration Record (MAR) revealed the medication was not given on 05/18-05/20/14 a total of five days.</p> <p>9. Record review revealed the facility admitted Resident #13 on 07/01/12 with diagnoses to include Impulse Control Disorder and Dementia with Behaviors. Review of an annual MDS assessment dated, 05/07/14, revealed the facility had assessed the resident's cognition as severely impaired with a BIMS score of six (6) and required extensive assistance with activities of daily living.</p> <p>Review of Physician's Order, dated 05/24/14, revealed to administer Buspar 5 mg twice a day. Review of the May 2014 MAR revealed the resident did not receive the Buspar until 05/27/14</p>	F 333			

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F 333	<p>Continued From page 100</p> <p>Indicating six (6) doses were missed. The back of the MAR revealed documentation dated 05/27/14 at 9:00 AM that indicated the Buspar would be available that evening. The first dose was documented as administered on 05/27/14 at 9:00 PM.</p> <p>10. Resident A was observed during a medication pass on 05/29/14 at 9:20 AM. Resident #18 did not receive Amlodipine 10 mg as ordered as it was not available.</p> <p>Review of the May 2014 Physician Orders revealed to administer Amlodipine 10 mg and Pantoprazole 20 mg every day. However, review of the May 2014 MAR revealed the resident did not receive Amlodipine 10 mg on 05/15/14, 06/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14, 05/28/14 and 05/29/14 (total of ten doses). There was no documentation on the back of the MAR to indicate the rationale for the medication not being administered. Additionally, Resident #18 did not receive Pantoprazole 20 mg eleven (11) times per the May 2014 MAR. The MAR revealed initials circled indicating not received on 05/12/14, 05/13/14, 05/16/14, 05/18/14, 05/19/14, 05/23/14, 05/24/14, 05/26/14, 05/28/14, 05/27/14 and 05/28/13. The back of the MAR revealed six (6) days documentation for Pantoprazole not available on May 13th, 23rd, 24th, 25th, 26th and 27th. The five (5) remaining missed doses had no documentation to indicate the reason the medication was not administered.</p> <p>Interview with LPN #3, on 05/29/14 at 10:05 AM and 10:25 AM, who performed the medication pass (05/29/14), revealed she called the Pharmacy and was told the Amlodipine was last</p>	F 333			

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F 333	<p>Continued From page 101 sent from the Pharmacy on 04/08/14.</p> <p>Interview with the DON, on 05/29/14 at 1:10 PM, revealed if medications were not available for administration for a resident, the pharmacy should be called. She stated medications could be ordered STAT and the pharmacy could send them from the back up pharmacy as needed.</p> <p>A Post Survey Interview with the DON, on 07/02/14 at 9:20 AM, revealed the nurses should have have notified the pharmacy the medication was not available for administration and documented the pharmacy was notified on the back of the MAR. The DON stated some of the medications were not given because the nurse failed to reorder the medication and some of the resident's medication was not available due to the physician's Medicaid number not being renewed.</p> <p>Interview with the Administrator, on 05/30/14 at 3:20 PM, revealed some of the resident's medications were not being delivered from the pharmacy due to a Physician needing to update his provider number. She stated the pharmacy should have continued to send the medications until the problem was resolved and the facility was currently working with the pharmacy on that. However, when staff was unable to carry out a physician's order, he/she would have expected the staff to report to the nurse in charge, and stated staff should have called the pharmacy and checked the EDK box to ensure medications were available for administration.</p> <p>Post Survey Interviews with the Administrator, on 07/02/14 at 9:45 AM, 2:55 PM and 6:00 PM, revealed the MAR and TAR reviews were implemented on 05/16/14 due to identifying</p>	F 333		

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F 333	<p>Continued From page 102</p> <p>admission medications were not available for administration, but there was nothing put in place to ensure the MAR and TAR reviews were being conducted to ensure the facility would identify when medications were not available for administration and administered per physician's order.</p> <p>*The facility implemented the following actions to remove the immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed.</p> <p>On 08/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses</p>	F 333			

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F 333	<p>Continued From page 103</p> <p>by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 08/04/14 without having had this re-education and competency test.</p> <p>On 08/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 08/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI)</p>	F 333			

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F 333	<p>Continued From page 104</p> <p>was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the</p>	F 333			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 105</p> <p>pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 08/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 08/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 08/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the</p>	F 333			

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F 333	<p>Continued From page 106</p> <p>ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that</p>	F 333		
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F 333	<p>Continued From page 107</p> <p>he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA</p>	F 333		
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F 333	<p>Continued From page 108</p> <p>Is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 08/12/14 at 12:08 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 08/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 08/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 08/12/14 at 1:37 PM, SRNA #8 verified</p>	F 333		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 333	<p>Continued From page 109</p> <p>through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If</p>	F 333			

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F 333	<p>Continued From page 110</p> <p>a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lortab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was</p>	F 333		
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F 333	<p>Continued From page 111</p> <p>revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 08/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 6:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 08/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM, with LPN #4 revealed that he/she had given the 6:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 6:50 PM, revealed that an additional, 3rd MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at</p>	F 333			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286	
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F 333	Continued From page 112 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan. Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 333	F 425 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH <u>The corrective action accomplished to correct the alleged deficient practice:</u> Resident #11 expired in the facility on May 24, 2014, in facility. On 6/4/2014, Director of Nursing observed medication administration to ensure medications were available and administered per physicians order for Resident #3, 10, 13, 14, 15, 16 <u>Other residents had the potential to be affected.</u> On 6/2/2014, two representatives from Omnicare Pharmacy completed a MAR to Medication Cart Audit to ensure all medications are available for administration per physicians order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. <u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u> On 6/4/2014 Omnicare Pharmacy Adjudication Supervisor educated all Adjudication employees on assuring that Omnicare Pharmacy will dispensed all resident medications ordered by a physician for at least seven (7) days to the facility according to physicians order regardless of residents' payer source.	
F 425 SS=L	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.76(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE 8T PEMBROKE, KY 42288	
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F 425	<p>Continued From page 113</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide pharmaceutical services to meet the needs of seven (7) of seventeen (17) sampled residents (Residents #3, #10, #11, #13, #14, #15 and #18) related to the unavailability of routine and emergency medications for administration.</p> <p>The facility failed to ensure staff followed procedures to obtain a "Stat" order for Solu Medrol (steroid) intramuscular (IM) and Levaquin (antibiotic) intravenous (IV) for Resident #11 when experiencing labored breathing. Resident #10 did not receive Potassium (when prescribed due to a low Potassium level) until the following day and was admitted to the hospital with a diagnosis of Hypokalemia. Resident #15 was not administered a Fentanyl patch (narcotic for pain) for pain three (3) times in May 2014 because the medication was not obtained from the Pharmacy. Residents #3, #13, #14 and #18 did not receive various medications as prescribed due to the unavailability of the medication, and or the failure to administer the medication.</p> <p>The facility's failure to provide pharmaceutical services to meet the needs of the residents caused or was likely to cause serious injury,</p>	F 425	<p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, Omnicare Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks by Omnicare to assure all medications are available. Any deficiency identified will be corrected immediately. Omnicare Pharmacy General Manager will audit ten (10) physician orders weekly for twelve weeks to ensure all resident medications ordered by a physician were dispensed for at least seven (7) days to the facility according to physicians order regardless of residents' payer source. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for at least three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14

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F 425	<p>Continued From page 114</p> <p>harm, impairment or death of a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the immediate Jeopardy on 06/02/14.</p> <p>The findings include:</p> <p>1. Record review revealed the facility admitted Resident #10 on 05/16/14 with diagnoses which included Psychosis, Diarrhea and Diabetes.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 05/23/14, revealed the facility assessed the resident with severe cognitive impairment.</p> <p>Review of the resident's record revealed a routine laboratory test was conducted on 05/20/14, which revealed the resident's Potassium level was 3.2 millimoles/Liter (mmol/L) and normal value was between 3.5-5.50 mmol/L. On 05/21/14, the resident was to receive intravenous fluids and a "Now" dose of Potassium 40 milliequivalents (meq) was administered. The Potassium level was rechecked on 05/22/14 with a result of 3.6 mmol/L.</p> <p>On 05/29/14, Licensed Practical Nurse (LPN) #3 received an order to administer Potassium 40 meq by mouth "Now" and recheck Potassium level in twenty-four (24) hours. Further review of the May 2014 MAR revealed the order for the Potassium 40 meq was not documented on the MAR until 05/30/14 at 9:00 AM (one day later) at which time it was administered.</p> <p>Record review revealed a repeat Potassium level</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 425	<p>Continued From page 115</p> <p>was obtained on 05/30/14 with a Panic Level of 2.4 mmol/L. The Physician Assistant was notified and the resident was sent to the emergency room. Resident #10 was admitted to the hospital on 05/30/14 at 8:50 PM with a diagnosis of Hypokalemia (low potassium). LPN #3 failed to transcribe the order to the MAR; and, failed to administer the medication when ordered on 05/29/14.</p> <p>Review of the Hospital Admission History and Physical, dated 05/30/14, revealed Resident #10 was admitted to the hospital because of a Potassium level of 2.4 indicating Hypokalemia and would be treated with IV hydration and replacement of the Potassium.</p> <p>Interview conducted with LPN #3, on 05/31/14 at 3:00 PM, revealed on 05/29/14, the nurse for Resident #10's physician had called the facility and given her an order for a one time dose of 40 meq Potassium but gave her no other specifics. LPN #3 stated she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. She faxed the order to the pharmacy and also called the pharmacy about the Potassium order sometime before lunch on 05/29/14. She stated she did not know if the Potassium was in the Emergency Drug Kit (EDK) as she was unaware of what medications were available in the EDK and she did not look in there for the medication. The medication was available in the EDK.</p> <p>Interview with the Director of Nursing, conducted on 05/31/14 at 9:30 AM, revealed LPN #3 had failed to place the order for the one time dose of Potassium on Resident #10's MAR and had forgotten to administer it on 05/29/14 when it was</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 425	<p>Continued From page 116</p> <p>ordered. The DON revealed the resident's Potassium level was at Panic Level of 2.4 mmol/L on 05/30/14. The resident was sent to the hospital and admitted for treatment of Hypokalemia.</p> <p>A Post Survey Interview conducted with the Administrator, on 07/02/14 at 2:55 PM, revealed staff was educated during orientation when hired on medication administration and the EDK box, which included where the box was located, the contents and the protocol to follow. She stated the staff was educated that the EDK box was located in the medication room and there was a list kept in the box that listed the medications that were available for administration.</p> <p>Interview with the Medical Director, on 08/02/14 at 2:15 PM, revealed nurses should know their duties, know what they were doing; and, the supervisors needed to know what was going on. He stated, "Can't wait twenty four hours to find out a medication has not been given."</p> <p>2. Record review revealed Resident #11 was admitted to the facility on 07/01/12, with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). A Quarterly Minimum Data Set (MDS) assessment, dated 05/03/14, revealed the facility assessed the resident with moderately impaired cognition. On 05/21/14 at 10:57 PM, LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The APRN was notified on 05/21/14 at 11:30 PM and orders were received to medicate the resident with Solu-Medrol 40 milligrams (mg) intramuscularly (IM), Levaquin 500 mg IV every 24 hours, Prednisone 40 mg by mouth times two</p>	F 425			

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F 426	<p>Continued From page 117</p> <p>(2) doses, DuoNeb every 4 hours, check vital signs every 4 hours, a chest radiograph (x-ray) and a complete blood count (CBC) "Stat". The chest x-ray which was read by the Radiologist revealed there were defined infiltrative shadows in the left infrahilar and lower lobe suggestive of Pneumonia. However, review of the Nursing Notes, and the May 2014 MAR, revealed the resident received the Solu-Medrol 40 mg IM and the Levaquin IV on 05/22/14 at 5:49 PM after the Solu Medrol was taken from the Emergency Drug Kit (EDK) by LPN #1 instead of on 05/21/14. Review of the Nurse's Notes, dated 05/24/14 at 6:24 PM, revealed the resident was noted to have a fixed facial expression. Cardiopulmonary resuscitation (CPR) was initiated by staff and continued until Emergency Medical Services (EMS) arrival. Resuscitation was unsuccessful and the resident expired.</p> <p>Interview with the DON and Administrator, on 05/29/14 at 5:00 PM, revealed they did not know there was a problem with Resident #11 not getting medication until the next day after it was ordered "Stat". They stated the medication was available in the EDK box.</p> <p>3. Record review revealed Resident #3 was admitted to the facility on 07/01/12, with diagnoses which included Hypertension. Review of the Annual MDS Assessment, dated 04/10/14, revealed the resident had a Brief Interview of Mental Status (BIMS) score of fourteen (14), indicating the resident was cognitively intact. Review of the May 2014 Physician's orders revealed to administer Norvasc (blood pressure medication) 10 mg daily; however, review of the May 2014 MAR revealed the resident did not receive Norvasc 10 mg daily from 05/23/14</p>	F 426			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 425	<p>Continued From page 118 through 05/29/14.</p> <p>4. Record review revealed the facility admitted Resident #13 on 07/01/12 with diagnoses which included Impulse Control Disorder. The Annual MDS assessment dated 05/07/14, revealed the facility assessed the resident to have a BIMS score of six (6). The Comprehensive Care Plan, dated 07/16/13, related to impulse control lists an intervention to give medications as ordered. On 05/24/14, an order was received from the APRN for Buspar 5 mg per PEG tube twice daily routine. The medication was not given until 05/27/14 at 9:00 PM after it was unavailable for the first six (6) initial doses.</p> <p>5. Record review revealed Resident #14 was admitted to the facility on 10/11/13, with diagnoses which included Diarrhea and Colon Resection. Review of the Comprehensive Care Plan dated 01/27/14, revealed a comfort intervention to receive medications as ordered. Review of the May 2014 MAR revealed the resident did not receive a total of fourteen (14) doses of Pancrelipase 5000 units on 05/19/14, 05/21/14, 05/22/14 and 05/28/14. Review of Physician's Orders, dated May 2014, revealed the medication was ordered to be taken at meals and before bedtime. Interview with the resident on 05/28/14 at 2:25 PM, revealed he/she had been missing the medication but did not understand why as he/she has been on it for years. He/she was told that the medical card would not pay for it.</p> <p>6. Record review revealed the facility admitted Resident #15 on 07/03/12, with diagnoses which included chronic pain. Review of the Quarterly MDS assessment dated 04/02/14, revealed the</p>	F 425		

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F 425	<p>Continued From page 119</p> <p>facility assessed the resident with a BIMS score of fourteen (14). Review of the Comprehensive Care Plan, dated 04/02/14, revealed to administer medications as ordered. Review of the May 2014 Physician Orders revealed an order for Fentanyl patch 25 mcg/hr, to be changed every 72 hours, with the order start date of 09/10/13. However, review of the May 2014 MAR revealed the resident did not receive his/her Fentanyl patch on 05/05/14, 05/14/14 and 05/29/14.</p> <p>Interview with Pharmacy Account Executive Customer Service Representative, on 06/02/14 at 3:20 PM, revealed he checked to see when the facility notified the Pharmacy related to Resident #16's Fentanyl patch and determined the facility did not notify the Pharmacy on 05/05/14 or on 05/14/14 that the resident's Fentanyl patch was not delivered and was not available for administration and they should have been notified.</p> <p>A Post Survey interview with the Pharmacy Account Executive Customer Service Representative, on 07/15/14 at 10:15 AM, revealed if the facility had notified the pharmacy and they were unable to deliver the medication a fax would have been sent to the facility indicating the reason a medication was not delivered as ordered. The Representative stated, "We don't just not send a medication."</p> <p>7. Record review revealed the facility admitted Resident #16 on 09/19/13, with diagnoses which included Gout, Diabetes, Below the knee amputation and Generalized Pain. Review of a Quarterly MDS assessment dated 05/01/14, revealed the facility assessed the resident with a BIMS score of fifteen (15) indicating the resident</p>	F 425			

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F 425	<p>Continued From page 120</p> <p>was interviewable. Review of the Comprehensive Care Plan, revised on 05/27/14 revealed a pain care plan which included interventions of the resident to receive medications as ordered. Review of the May 2014 Physician Orders revealed orders for Torsemide 30 mg daily, Allopurinol 50 mg daily, Aspirin 81 mg daily, Neurontin 400 mg by mouth three (3) times daily, K-Dur 40 meq three (3) times daily, Cilindamycin 300 mg three (3) times daily for 10 days (to end on 05/09/14), Vancomycin one (1) Gram twice daily for seven (7) days (with last dose on 05/23/14) and Percocet 10-325 mg every eight (8) hours routine. Further review of the May 2014 MAR revealed the following omissions from the MAR: Torsemide 30 mg on 05/18/14, 05/25/14 and 05/31/14, Allopurinol 50 mg on 05/14/14 and 05/26/14, Aspirin 81 mg on 05/11/14 and 05/20/14, Neurontin 400 mg on 05/17/14, 05/20/14 and 05/31/14, K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14, Cilindamycin 300 mg on 05/02/14 and 05/08/14, Vancomycin on 05/20/14 and Percocet on 05/18/14, 05/20/14 and 05/31/14.</p> <p>Interview on 05/30/14 at 2:45 PM with the Pharmacy Account Executive Customer Service Representative, revealed he was not aware of any recent problem with the availability of medications for residents in this facility. The facility staff was to fax orders by 5:30 PM Monday through Friday and by 3:30 PM on Saturday and the medication would be delivered that night. Orders received on Sunday have to be faxed and called to the Pharmacy and the back up Pharmacy would deliver.</p> <p>However, a Post Survey Interview on 07/18/14 at</p>	F 425		
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F 426	<p>Continued From page 121</p> <p>10:07 AM with the Pharmacy Account Executive Customer Service Representative, revealed the pharmacy services main source of communication as the provider of pharmacy services to the facility was facsimile (fax). He stated there were multiple fax numbers that could be utilized to send faxes to various departments within the facility. He further stated, the pharmacy provider relied on the person receiving the fax to ensure it was routed to the appropriate person. There were no pharmacy protocols that necessitated the pharmacy provider to make verbal communication with the facility; however, occasionally it was practice to call the facility if there was a problem. He did not know if the facility was ever contacted other than by the means of a fax. He further stated, the chart reviews which would have been completed by the pharmacy consultant who makes rounds once a month, reviews medication interactions and compatibility and so forth, and the pharmacy consultant would not have identified if there were medications missing or not being delivered because the consultant does not look at the MARs.</p> <p>A Post Survey interview with the General Pharmacy Manager, on 07/02/14 at 10:35 AM, revealed there was an issue with the physician's license number being renewed in the system so Medicaid was rejecting some of the residents' medications. He stated a fax was sent to the facility when this would occur. He revealed the facility had contacted the Pharmacy, he thought sometime after the survey had started, and requested the Pharmacy to send the resident's medications that were rejected by Medicaid and the facility would cover the cost until the issue was resolved. He stated as far as he was aware</p>	F 426			

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F 425	<p>Continued From page 122</p> <p>this had been done. He stated when staff needed to reorder a medication, there were stickers on the labels of the residents' medications and the staff would need to peel the sticker off and place it on a reorder sheet and fax to the pharmacy when a medication was needed.</p> <p>Post Survey interview with the DON, on 07/02/14 at 9:20 AM, revealed the nurses should have checked the Emergency Drug Kit (EDK) and notified the pharmacy when a medication was not available for administration. The DON stated some of the residents' medications were not available due to the physician's Medicaid number not being renewed and the pharmacy faxed the facility to make them aware but the nurses did not give her the faxes. She stated other residents did not have their medication available for administration because the nurses had failed to reorder the medication.</p> <p>Interview with the Administrator, on 05/29/14 at 1:10 PM, revealed she had not been aware of a problem with obtaining medications from the pharmacy until 05/23/14. Further interview with the Administrator, on 05/30/14 at 4:00 PM, and 06/02/14 at 5:20 PM, revealed they had identified one of the Physicians needed to update his/her provider number for Medicaid because it was not showing up as active in the system. The Administrator stated the pharmacy was now supposed to continue to send the medications until the problem was resolved. A Post Survey interview, conducted on 07/02/14 at 2:55 PM, revealed the Pharmacy was sending the faxes to the facility informing the facility the medications would not be sent due to the physician needing to update his provider number but the faxes were</p>	F 425			

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F 425	<p>Continued From page 123</p> <p>going to the nurses on the floor and not to the Administrative staff. She stated they have now changed their system for all pharmacy faxes to be sent to the Administrator.</p> <p>*The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physician's order, and post test completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work</p>	F 425			

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F 425	<p>Continued From page 124 after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director,</p>	F 425			

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F 425	<p>Continued From page 126 Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education</p>	F 425		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 425	<p>Continued From page 126 regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the</p>	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(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 425	<p>Continued From page 127</p> <p>medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 08/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is</p>	F 425		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 425	<p>Continued From page 128</p> <p>an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 425	<p>Continued From page 129 test on the covered Inservice material.</p> <p>On 06/12/14 at 12:08 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the</p>	F 425		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(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 425	<p>Continued From page 130</p> <p>resident's plan of care is through the Accunurse system and staff received printed informallon. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medicallions were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 425	<p>Continued From page 131</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lortab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 425	<p>Continued From page 132 pending related to the omission on the MAR.</p> <p>On 08/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 08/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 08/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 08/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 08/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 08/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 08/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p>	F 425		
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F 426	Continued From page 133 Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 426	F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING <u>The corrective action accomplished to correct the alleged deficient practice:</u> <u>On 06/04/14, the physician was notified by the Director of Nursing of medications not administered according to physicians order for Residents #3, #10 #11, #12, #13, #14, #15, #16 and #17.</u> <u>On 06/04/14, the physician was notified by the Director of Nursing of medications not administered according to physicians order for Residents #13 and #15.</u> <u>On 06/12/14, LPN #3 was counseled regarding proper medication administration per the Director of Nursing.</u> On 6/3/2014, a system was put in place by the Administrator to ensure medications were available and administered per physicians' orders, physicians notification occurred per facility protocol, and professional standards of practice were followed for medication administration and documentation. This system included Omnicare Pharmacy filling all medications without regard to payer source, pharmacy billing communication is now sent to the fax line located in the Administrator's office, and education of staff regarding: "Medication Availability" and post test; development, revision and implementation of the care plan to include administration of medications per physician orders and documentation requirements of omitted medication; Medication Pass Silverchair education; and MAR documentation and what protocol to follow to include when, how and where to document medications not		
F 490 SS=L	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 interview, record review, review of the Administrator Position Description, and review of the facility's policy/procedure, it was determined the facility failed to be 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	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGITS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 490	<p>Continued From page 134</p> <p>well being for residents residing in the facility. The facility failed to provide pharmaceutical services which ensured the availability and timely administration of drugs and biologicals to meet the needs of each resident that included some issues with the Physician's Medical provider number for billing and some administration errors. The facility failed to have an effective system in place to ensure medications were available and/or administered according to physician orders. The facility's census on 05/21/14 was forty one (41) residents, and nine (9) of those residents were affected by medications not administered and/or available to meet their needs.</p> <p>The facility's failure to ensure the facility was administered in a manner that enabled it to provide pharmaceutical services to ensure medications were available for administration caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.</p> <p>The findings include:</p> <p>Review of the Position Description for Administrator (no date) revealed the purpose was to direct the day to day functions of the facility in accordance with current Federal, State and Local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times. Essential Functions of the Position included: Ensure excellent care for residents is maintained by overseeing and monitoring patient</p>	F 490	<p>administered per physician order and what corrective action to implement.</p> <p>On 6/4/2014, the RDO made an observation that the Administrator was administering the facility in accordance with professional standards and per Job Description including ensuring a system was in place for monitoring Pharmacy Services and that medications were available as well as care plan revision and documentation of any omitted medications accordingly.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 6/4/2014, the RDO made an observation that the Administrator was administering the facility in accordance with professional standards and per Job Description including ensuring a system was in place for monitoring Pharmacy Services and that medications were available as well as care plan revision and documentation of any omitted medications accordingly.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 6/4/2014, the Administrator was re-educated regarding professional standards and services provided by the facility by the Regional Director of Operations to include Administrator Job Description and ensuring a system is in place for monitoring Pharmacy Services to ensure medications are available to be administered according to physicians order as well as care plan revision and documentation of any omitted medications accordingly.</p>		

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F 490	<p>Continued From page 136 care services delivered.</p> <p>Review of the facility's policy and procedure titled, "Medication Shortages/Unavailable Medications", last revised 01/01/13, revealed actions to take upon discovery that the facility has an inadequate supply of a medication to administer to a resident included staff taking immediate action to obtain the medication. "When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and in the Nurse's Notes, per facility policy. Such documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken."</p> <p>Record review revealed Resident #13 was to receive Buspar (anti-anxiety) five (5) mg twice daily. However, review of the May 2014 MAR revealed, on 05/24/14 at 9:00 PM through 05/27/14 at 9:00 AM (a total of six doses), staff had not initialed or circled the the medication was administered.</p> <p>Interview with the Administrator, on 05/30/14 at 4:00 PM, and 06/02/14 at 5:20 PM, revealed there was a problem with one of the Physicians needing to update his provider number for Medicaid because it was not showing up as active in the system. The protocol was for the pharmacy to continue to send the medications until the problem was resolved and she was currently working on the problem. She additionally revealed the Director of Nursing (DON) was responsible to ensure medications were administered as prescribed but she was ultimately responsible to monitor the DON for</p>	F 490	<p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>The Regional Director of Operations will visit and document two (2) facility visits per month for three (3) months to ensure the Administrator follows the professional standards and Job Description that identifies ensuring a system is in place for monitoring Pharmacy Services to ensuring medications are available to be administered according to physicians order and are available as well as care plan revision and documentation of any omitted medications accordingly. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 490	<p>Continued From page 136 ensuring facility practice compliance.</p> <p>Further interview with the Administrator, during a Post Survey Interview, on 07/02/14 at 2:55 PM and 5:00 PM revealed she was made aware on 05/19/14, (the survey was initiated on 05/21/14, after the Administrator had been made aware of residents not receiving medications) some resident's were not receiving medications from the pharmacy because the physician's Medicaid provider number needed to be updated. She stated the pharmacy had been sending the faxes informing the facility of this to the nurse's station fax number and Administrative staff had not been made aware of the problem. She stated she contacted the pharmacy and was having the pharmacy send a three (3) day supply of medications and on 05/29/14 she changed it to a seven (7) day supply of medication. She stated on 05/16/14, the facility had initiated weekly MAR and TAR reviews due to identifying documentation problems on the MARs; however, there was nothing in place to monitor to ensure the MAR and TAR reviews were being conducted to identify if medications were available for administration or were being administered as ordered. The facility's failure to have an effective action in place after 05/16/14, (the Administrator was aware there was a problem on 05/16/14) to ensure medications were available for administration and administered as ordered caused the facility to continue to fail to ensure medications were available and administered as ordered, as noted above.</p> <p>Post Survey interviews with the Administrator, on 07/02/14 at 9:45 AM, 2:55 PM and 5:00 PM, revealed the MAR and TAR reviews were</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 490	<p>Continued From page 137</p> <p>implemented on 05/16/14, but there was nothing put in place to ensure the MAR and TAR reviews were being conducted to ensure the facility would identify when medications were not available for administration and administered per physician's order. She stated the facility did not have a QA meeting until 05/27/14 because they did not realize the gravity of the situation until then. She stated at first they thought the medication problem was only related to new admissions and readmissions, then they thought it was due to lack of documentation and then the physician's Medicaid provider number issue was identified. She revealed they took steps to address each of these concerns as identified. The Administrator was unable to provide an explanation as to why medications were still unavailable for administration after the issues were identified.</p> <p>Post Survey Interview with the Director of Nursing, on 07/15/14 at 1:20 PM, revealed the MAR/TAR reviews were conducted on 05/22/14 and 05/23/14 due to the initiation of a complaint survey at the facility and those reviews were not documented. She stated a QA meeting was not conducted until 05/27/14 after the complaint survey was initiated.</p> <p>Post Survey Interview with the Medical Director, conducted on 7/15/14 at 2:50 PM, revealed he could not say the exact date he was aware of there being a problem with his provider number which had not been updated in the Medicaid system. Although a review of a letter dated 06/02/14 from the facility's pharmacy provider, which was addressed to the facility, stated "unable to bill Medicaid for claims written by physician starting the beginning of May due to a license issue with Kentucky Medicaid."</p>	F 490		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 490	<p>Continued From page 138</p> <p>*The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16, and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
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F 490	<p>Continued From page 139</p> <p>Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 490	Continued From page 140 The State Survey Agency validated the corrective actions taken by the facility as follows: On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.	F 490			

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F 490	<p>Continued From page 141</p> <p>On 08/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 08/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 08/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents</p>	F 490			

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F 490	<p>Continued From page 142</p> <p>should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 08/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p>	F 490			

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F 490	<p>Continued From page 143</p> <p>On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 06/12/14 at 12:06 PM, SRNA #5 verified through interview that he/she had received recent</p>	F 490			

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F 490	<p>Continued From page 144</p> <p>education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8</p>	F 490		
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F 490	<p>Continued From page 145</p> <p>also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after</p>	F 490			

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F 490	<p>Continued From page 146</p> <p>receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lortab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding</p>	F 490			

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F 490	<p>Continued From page 147</p> <p>omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 6:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p> <p>Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 490	Continued From page 148 action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 08/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 08/07/14, 08/08/14 and 08/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 08/13/14 appeared to be adequate based on the date of delivery.	F 490	F 502 483.75(j)(1) ADMINISTRATION <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 6/2/2014, the DON obtained an order to discontinue the wound culture order for Resident #16 because the wound had scabbed over. <u>Other residents had the potential to be affected.</u> On 6/24/2014, the consultant Assistant Director of Nursing and Regional Nurse Consultant completed an audit of all current residents' medical records, dating from 05/01/14 to 06/24/14 to assure that any ordered lab was completed. Any lab missed had physician notification and further direction. <u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u> The Director of Nursing, new Assistant Director of Nursing or Unit Manager completed re-education with all Licensed Nurses on the lab process to include completion of labs per MD order. No Licensed Nurse will work after 07/10/14 without having had this re-education. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u> The ADON, DON or UM will audit the lab log five times per week for twelve (12) weeks to assure the lab process is followed. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review weekly at least monthly		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, it was determined the facility failed to provide laboratory services to meet the needs of one (1) of seventeen (17) sampled residents (Resident #16) related to the failure to obtain a wound culture as ordered by the physician. The findings include: Interview on 08/02/14 at 4:30 PM, with the Administrator and Director of Nursing (DON) revealed the facility had no policy related to obtaining laboratory specimens and the facility did not have a log book to document the labs.	F 502			

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F 502	<p>Continued From page 149</p> <p>Further interview revealed the Assistant Director of Nurslng (ADON) was responsible for ensuring the laboratory specimens were obtained.</p> <p>Review of the Delegation of Duties listing, undated, revealed the ADON was responsible for labs daily.</p> <p>Record review revealed the facility admitted Resident #16 on 09/19/13 with diagnoses which included Gout, Diabetes, Below the Knee Amputation and Generalized Pain. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 05/01/14, revealed the facility assessed Resident #16 as cognitively intact with a Brief Interview of Mental Status score of fifteen (15) indicating the resident was Interviewable.</p> <p>Review of a Physician's Order, dated 05/27/14, revealed an order to culture the resident's wound on his/her leg stump.</p> <p>Review of Resident #16's medical record revealed no documented evidence of the results of a culture of the resident's stump.</p> <p>Interview with Resident #16, on 06/02/14 at 2:23 PM, revealed a wound culture was obtained from his/her stump and he/she was told by staff there were no results. The resident further stated staff had told him/her that the specimen had not been sent to the lab.</p> <p>Observation on 06/02/14 at 4:30 PM, revealed a culture tube was retrieved by the Director of Nursing (DON) from the specimen refrigerator. Further observation revealed the culture swab was labeled with Resident #16's name and dated 06/27/14.</p>	F 502	<p>for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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F 502	Continued From page 150 Interview with the DON, on 06/02/14 at 4:30 PM, revealed she was notified on 06/02/14 that the culture was not done on the resident. The DON stated she checked the specimen refrigerator and found the specimen container labeled with Resident #16's information and dated 05/27/14. She reported the facility did not currently have a specimen log book to monitor specimens for collection or results. The Assistant Director of Nursing, who was responsible for the labs, quit her employment at the facility and was unable to be contacted for an interview.	F 502		
F 514 SS=L	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 514	<u>F 514</u> 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 4/2/2014, a LPN completed an incident report on Resident #1. On 4/3/2014, a LPN received orders for x-ray to Resident #1's right foot. On 4/4/2014, a LPN documented pain in Resident #1's nurse's notes and new orders received related to x-ray results obtained. On 5/24/2014, Resident #11 expired in facility on 05/24/14. On 5/31/2014, Resident #12 discharged from the facility to home on 05/31/14. On 6/3/2014, DON audited Medication Administration Records (MARs) of Resident #2, 3, 10, 13, 14, 15, and 16 and Resident A to ensure professional standards of practice for clinical record documentation were followed for the following residents and that all medications given were signed out and if	

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F 514	<p>Continued From page 151</p> <p>the facility's policy/procedure, it was determined the facility failed to maintain clinical records that were complete and accurately documented for ten (10) of seventeen sampled residents (Residents #1, #2, #3, #10, #11, #12, #13, #14, #15, #16) and one (1) unsampled resident (Resident A), related to incomplete documentation of medication administration, treatments, and services provided.</p> <p>The facility failed to document in the clinical record when medications were not given, why and if the pharmacy was notified for Resident #2, #3, #10 #11, #12, #13, #14, #15, #16 and Resident A.</p> <p>The facility's failure to maintain clinical record that were complete and accurately documented caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Medication Shortages/Unavailable Medications" last revised 01/01/13, revealed actions to take upon discovery that the facility has an inadequate supply of medication to administer to a resident. Included staff taking immediate action to obtain the medication. When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and in the Nurse's Notes, per facility policy. Such</p>	F 514	<p>omitted documented on the medication note section the reason why. An incident report for resident # 1 was completed on 4/3/2014 which included and incident and the resident's lack of pain.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 6/3/2014, DON audited MARs of all current residents to ensure professional standards of practice for clinical record documentation were followed and that all omitted medications were documented on the medication note section of the MAR. As of 6/3/2014, any item identified had education or discipline of the staff involved.</p> <p>On 7/7/2014, the Director of Nurses completed a review of all incident reports in the past thirty (30) days to assure documentation of the incident and condition of the resident. No concerns were identified</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur.</u></p> <p>On 6/1/2014, Regional Nurse Consultant (RNC) re-educated the DON on MAR documentation and what protocol to follow to include when, how and where to document medications not administered per physician order and what corrective action to implement.</p> <p>Beginning 6/3/2014 the DON conducted re-education and competency test with licensed nurses regarding MAR documentation and what protocol to follow to include when, how and where to document medications not administered per physician order and what corrective action to implement. The DON will re-educate and validate competency with Assistant Director of Nursing (ADON), MDS Nurse (MDS) or Unit Manager before they</p>	

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F 514	<p>Continued From page 152</p> <p>documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken.</p> <p>1. Record review revealed the facility admitted Resident #10 on 05/18/14 with diagnoses which included Diarrhea and Diabetes. On 05/29/14 at 9:40 AM, Licensed Practical Nurse (LPN) #3 received an order from the physician to medicate the resident with Potassium 40 meq now. Interview with LPN #3 on 05/31/14 at 3:00 PM, revealed that she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. The missed Potassium dose was administered on 05/30/14 at 9:00 AM by LPN #4 after the ADON clarified the order. A repeat Potassium level was obtained on 05/30/14 at 1:45 PM and the result was 2.4 mmol/L. The result was phoned to the Physician's Assistant at 6:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. The resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and subsequently admitted into the hospital with a diagnosis of Hypomagnesia and Hypokalemia. The facility failed to ensure the clinical record was complete as the order for the resident's Potassium was not documented on the MAR.</p> <p>Interview conducted with LPN #3, on 05/31/14 at 3:00 PM, revealed on 05/29/14, she forgot to document the medication order on Resident #10's MAR and did not administer the Potassium as ordered.</p> <p>2. Record review revealed the facility admitted</p>	F 514	<p>initiate re-education with the licensed nurses. No licensed nurse will work after 6/4/2014 without having had this re-education and competency test. The DON conducted re-education will all licensed staff related to completion of an incident report with any fall or incident involving equipment. No licensed staff will work after 07/06/2014 without having had this re-education.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>Beginning the week of 6/9/14, The DON, ADON, MDS Nurse or Unit Manager will complete an audit of all MARs to ensure professional standards of practice for clinical record documentation were followed and that all omitted medications were documented on the medication note section on the MAR five (5) times weekly for twelve (12) weeks. The Director of Nursing or Assistant Director of Nursing will audit all incident reports five (5) times per week to assure that documentation of an incident meets professional standards and includes a description of the resident condition. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee and at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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F 514	<p>Continued From page 153</p> <p>Resident #1 on 02/13/14 with diagnoses which included Bi-polar Disorder, Post Traumatic Stress Disorder, Chronic Pain, Paraplegia, Phantom Limb Syndrome and Hypertension. The Admission Minimum Data Set (MDS) dated 02/20/14, revealed the resident with a Brief Interview for Mental Status (BIMS) of fifteen (15) indicating the resident was interviewable. The Comprehensive Care Plan was not revised to include the transfer needs of the resident. The resident was transferred using a mechanical lift on 03/30/14 by one (1) staff member and received an injury resulting in a fractured right tibia and fibula. The resident was not care planned for the use of a mechanical lift during transfers. The facility failed to document the incident on 03/30/14, or the subsequent event details in the medical record.</p> <p>3. Record review revealed the facility admitted Resident #2 on 07/01/12 with diagnoses which included Spina Bifida and Obesity. Review of the Quarterly MDS dated 03/19/14, revealed the resident to have a BIMS score of fifteen (15). On 05/16/14, the Advanced Practice Registered Nurse (APRN) ordered Diflucan 100 mg by mouth every day for five (5) days for a yeast rash. The shipment detail from the pharmacy revealed the medication was delivered on 05/19/14 at 11:57 PM. An interview with the resident revealed she did not receive the medication. Review of the May 2014 MAR revealed the Diflucan was to be administered at 7:00 AM on 05/17/14 through 05/22/14. Further review of the MAR revealed initials with circles on those dates indicating the medication was not given. The facility failed to ensure the medical record was complete and accurate as there was no documentation on the back of the MAR to indicate the reason the</p>	F 514			

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F 514	<p>Continued From page 154</p> <p>medication was not administered, that pharmacy was notified and their response, as per the policy.</p> <p>4. Record review revealed the facility admitted Resident #3 on 07/01/12 with diagnoses which included Hypertension. Review of the Annual Assessment MDS dated 04/10/14, revealed the facility assessed the resident to have a BIMS score of fourteen (14). Review of the MAR revealed the resident did not receive Norvasc (blood pressure medication) 10 mg daily from 05/23/14 through 05/29/14. The facility failed to ensure the medical record was complete and accurate as there was no documented evidence in the medical record stating the medication was not administered or why it wasn't given.</p> <p>5. Record review revealed the facility admitted Resident #11 on 07/01/12 with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). On 05/21/14 at 10:57 PM, LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The APRN was notified on 05/21/14 at 11:30 PM and orders received to medicate the resident with Solu-Medrol 40 mg intramuscularly (IM), Levaquin 500 mg IV every 24 hours, prednisone 40 mg by mouth times two (2) doses, DuoNeb every 4 hours, check vital signs every 4 hours, a chest radiograph (x-ray) and a complete blood count (CBC) stat. The resident received the Solu-Medrol 40 mg IM on 05/22/14 at 8:49 PM (the next day) after taken from the emergency drug kit (EDK) by LPN #1. The facility failed to ensure the medical record was complete and accurate as they failed to document on the resident's MAR that the medications were not given. LPN #5 failed to</p>	F 514			

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F 514	<p>Continued From page 155</p> <p>document on the back of the resident's MAR, as per the policy, the reason the medications were not administered and response of the pharmacy when notified.</p> <p>6. Resident #12 was admitted to the facility on 04/30/14 with diagnoses which included Post Traumatic Seizures. The resident was admitted to the hospital on 05/02/14 at 11:45 AM, after experiencing seizure activity. On 05/05/14 Resident #12 returned to the facility with a continued order for Keppra (anti-convulsant) 500 mg twice daily. Review of the May 2014 MAR revealed no documented evidence the medication was administered or not administered from the time of readmission on 05/05/14 until 05/08/14 (six doses).</p> <p>7. Record review revealed the facility admitted Resident #13 on 07/01/14 with diagnoses to include Impulse Control Disorder. The Annual MDS assessment dated 05/07/14, revealed the resident to have a BIMS score of six (6). The Comprehensive Care Plan, May 2014, related to Impulse control lists as an intervention to give medications as ordered. On 05/24/14 an order was received from the APRN for Buspar 5 mg per PEG tube twice daily routine. The medication was unavailable for administration until 05/27/14 at 9:00 PM. There was no evidence the facility policy was followed related to documenting why a medication was not administered.</p> <p>8. Record review revealed the facility admitted Resident #14 on 10/11/13, with diagnoses which included diarrhea and colon resection. Review of the May 2014 MAR revealed the resident did not receive a total of fourteen (14) doses of Pancrellpase 5000 units on 05/19/14, 05/21/14,</p>	F 514			

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F 514	<p>Continued From page 156</p> <p>05/22/14 and 05/28/14. The medication was ordered to be taken at meals and before bedtime. An interview with the resident on 05/28/14 at 2:25 PM revealed he/she has been missing the medication but doesn't understand why as he/she has been on it for years. Review of the MAR revealed no documented evidence why the medication was not given, as ordered on 05/21/14, 05/23/14 and 05/28/14 or if pharmacy was notified or their response, as per the facility policy.</p> <p>9. Record review revealed the facility admitted Resident #15 on 07/03/12, with diagnoses which included chronic pain. Review of the Comprehensive Care Plan, revealed no care plan for chronic pain. A review of the May 2014 Physician orders revealed an order for Fentanyl (pain medication) patch 25 mcg/hr, to be changed every 72 hours, with the order start date of 09/10/13. A review of the May 2014 MAR revealed the resident did not receive his/her Fentanyl patch on 05/5/14, 05/14/14 and 05/26/14. The facility failed to ensure the medical record was complete and accurate as there was no documentation on the back of the MAR to indicate why the medication was not given, if the pharmacy had been notified and their response.</p> <p>10. Record review revealed the facility admitted Resident #16 on 09/19/13, with diagnoses to include Gout, diabetes, below the knee amputation and generalized pain. Review of May 2014 Physician's Orders revealed orders for Torsemide 30 mg daily, Allopurinol 50 mg daily, Aspirin 81 mg daily, Neurontin 400 mg by mouth three (3) times daily, K-Dur 40 meq three (3) times daily, Clindamycin 300 mg three (3) times daily for 10 days (to end on 05/09/14),</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 514	<p>Continued From page 167</p> <p>Vancomycin one (1) Gram twice daily for seven (7) days (with last dose on 05/23/14) and Percocet 10-325 mg every eight (8) hours routine. Review of the May 2014 MAR revealed there was no documentation the medications were given or not give on the MAR for these medications on these dates: Torsemide 30 mg on 05/18/14, 05/25/14 and 05/31/14; Allopurinol 60 mg on 05/14/14 and 05/26/14; Aspirin 81 mg on 05/11/14 and 05/20/14; Neurontin 400 mg on 05/17/14, 05/20/14 and 05/31/14; K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14; Clindamycin 300 mg on 05/02/14 and 05/08/14; Vancomycin on 05/20/14; and, Percocet on 05/18/14, 05/20/14 and 05/31/14.</p> <p>11. Observation during a medication pass, on 05/29/14 at 9:20 AM, revealed Resident A did not receive Amlodipine 10 mg as ordered, as it was not available. Review of the May 2014 MAR revealed the resident did not receive Amlodipine 10 mg on 05/15/14, 05/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14, 05/28/14, and 05/29/14 (total of ten doses). There was no documentation on the back of the MAR to indicate the rationale for the medication not being administered. Additionally, Resident #18 did not receive Pantoprazole 20 mg eleven (11) times according to the May 2014 MAR. The MAR revealed initials circled indicating not received on 05/12/14, 05/13/14, 05/15/14, 05/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14, and 05/28/14. The back of the MAR revealed six (6) days documentation for Pantoprazole unavailable on May 13th, 23rd, 24th, 25th, 26th, and 27th. The five (5) remaining missed doses had no documentation to indicate the reason the medication was not administered.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 514	<p>Continued From page 158</p> <p>Interview with the Assistant Director of Nurses (ADON), on 05/30/14 at 10:15 AM, revealed if a medication was not administered, a circled initial was to be placed on the MAR indicating it was not given and the reason also documented.</p> <p>Interview with the Director of Nursing (DON) and the Administrator, on 05/29/14 at 1:10 PM, revealed if medications were not available for administration for a resident, the pharmacy should be called. The nurse should circle the initial and document on the back of the MAR or Nurse's Notes the reason why the medication was not given and would not be accurate if not correctly documented.</p> <p>*The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 06/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test</p>	F 514		

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F 514	<p>Continued From page 159 completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee</p>	F 514			

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F 514	<p>Continued From page 160</p> <p>will convene to review and make further recommendations as needed. The QAPI Commlltee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p> <p>The State Survey Agency validated the corrective acions taken by the facillity as follows:</p> <p>On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavallable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavallable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON</p>	F 514			

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F 514	<p>Continued From page 161</p> <p>has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON.</p> <p>On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the</p>	F 514			

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F 514	<p>Continued From page 162 facility two (2) days ago.</p> <p>On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:16 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and</p>	F 514			

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F 514	<p>Continued From page 163</p> <p>faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavallable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p> <p>On 08/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 08/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If</p>	F 514			

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F 514	<p>Continued From page 164</p> <p>staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 06/12/14 at 12:06 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent</p>	F 514			

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F 514	<p>Continued From page 165</p> <p>education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of Interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are</p>	F 514			

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F 514	<p>Continued From page 166</p> <p>problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p> <p>On 08/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 08/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a</p>	F 514			

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F 514	<p>Continued From page 167</p> <p>MAR to medication cart audits for all residents on 06/02/14 and 08/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #16 on 06/05/14 at 3:00 PM of a dose of Lorlab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 6:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 08/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 6:48 PM,</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 514	Continued From page 168 revealed that training and education were provided to staff as a part of a disciplinary action. Interview with the Administrator, on 06/12/14 at 6:50 PM, revealed that an additional, 3rd MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions. Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan. Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 514			
F 520 SS=L	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520	<u>F 520</u> 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42206	
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F 520	<p>Continued From page 189</p> <p>nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Quality Assurance Policy, it was determined the Quality Assessment and Assurance Committee failed to identify, develop and implement appropriate plans of action to correct quality deficiencies related to pharmacy services. The facility failed to ensure medications were available to be administered, per physician's orders, for eight (8) of seventeen (17) sampled residents (Residents #3, #10, #11, #12, #13, #14, #15 and #17).</p> <p>Resident #10 did not receive a dose of Polassium on 05/29/14 as ordered by the physician and did</p>	F 520	<p><u>The corrective action accomplished to correct the alleged deficient practice:</u></p> <p>An Ad-Hoc Quality Assurance meeting (QPI) was held on 6/3/2014 to review the alleged deficient practice and removal plan with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehab, Dietary Manager, Maintenance Director, and Admissions Coordinator. The Regional Director of Operations observed the Ad-Hoc Quality Assurance meeting (QPI) on 6/3/2014 and noted that the QPI meeting was established as a system that is functional and meeting the identified needs of the facility.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>The Regional Director of Operations observed the Ad-Hoc Quality Assurance meeting (QPI) on 6/3/2014 and noted that the QPI meeting was established as a system that is functional and meeting the identified needs of the facility.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 6/4/2014, the Regional Director of Operations re-educated the Administrator on the requirements of a functional Quality Assurance process to include delegation of action items for identified concerns and follow up to assure corrections are made and reviewed with the Interdisciplinary Team.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 520	<p>Continued From page 170 not receive the Potassium unlll 06/30/14.</p> <p>Resident #11 did not receive a "stat" dose of Solu-Medro (steroid) intramuscular (IM), Levaquin (antibiotic) Intravenous (IV) and Prednisone ordered on 06/21/14, until 06/22/14.</p> <p>Resident #12, who had a seizure disorder did not receive six (6) doses of Keppra (anti-seizure medication) and experienced seizure actively requiring hospitalization. The order was changed on 06/13/14, from 500 mg to 1000 mg twice a day, the resident received only 500 mg for a total of thirty five (35) incorrect doses.</p> <p>Resident #14 did not receive a total of fourteen (14) doses of Pancrellpase 5000 Units from 05/19/14 through 05/28/14 (for seven days).</p> <p>Resident #15 who had chronic pain, did not receive his/her Fentanyl patches as prescribed, on 05/05/14, 05/26/14, and 05/29/14.</p> <p>Resident #3 did not receive seven (7) doses of Norvasc (blood pressure medication).</p> <p>Resident #13 did not receive Buspar (anti-anxiety medication) for a total of six (6) doses.</p> <p>In addition, Licensed Practical Nurse (LPN) #1 was observed to draw up seven (7) units of Novolin regular insulin instead of the five (5) units as per the physician's order for sliding scale insulin for Resident #17.</p> <p>The Administrator become aware beginning on 05/16/14 that there was a problem with residents receiving medications as prescribed, as the medications were not available and/or not</p>	F 520	<p>Beginning the week of 6/9/14, The Regional Director of Operations will observe the Quality Assurance process monthly for at least three (3) months to assure the Quality Assurance process is functional and meeting the identified needs of the facility. The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement Committee at least monthly for three (3) months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p>	07/11/14	

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F 520	<p>Continued From page 171</p> <p>administered as ordered. Even though the facility was aware of these concerns there was no documented evidence the facility's Quality Assurance Committee identified and addressed these concerns to correct this quality deficiency to ensure medications were available. Refer to F333.</p> <p>The QAA committee's failure to identify, develop and implement appropriate plans of action to correct deficiencies related to pharmacy services and medication errors has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and SQC was identified at 483.25 Quality of Care on 06/02/14 and determined to exist on 05/05/14.</p> <p>The findings include:</p> <p>Review of the undated Quality Assurance Policy revealed the purpose was to ensure an interdisciplinary approach to all residents' needs and to provide the highest level of care possible all the while keeping the IDT, physician and responsible party informed of their condition changes and interventions implemented as they occur and when necessary. The interdisciplinary Team will meet at least weekly and consist of at minimum the Administrator, Director of Nursing or Nursing Representative, Social Services, Therapy, Dietary and Activities.</p> <p>Resident #10 did not receive a dose of Potassium on 05/29/14 as ordered by the physician and did not receive the Potassium until 05/30/14.</p> <p>Resident #11 did not receive Solu-Medro (steroid) intramuscular (IM), Levaquin (antibiotic) intravenous (IV) and Prednisone until 05/22/14.</p>	F 520			

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F 520	<p>Continued From page 172 although the order was received as a "stat" order on 05/21/14.</p> <p>Resident #12, who had a seizure disorder and was being treated with Keppra (anti-seizure medication) did not receive six (6) doses and experienced seizure activity requiring hospitalization. Additionally, after returning to the facility on 05/13/14, with a Physician's Order to change the milligrams from 500 mg to 1000 mg twice a day, the resident received only 500 mg for a total of thirty five (35) incorrect doses.</p> <p>Resident #14 did not receive a total of fourteen (14) doses of Pancrelipase 5000 Units from 05/19/14 through 05/28/14 (for seven days).</p> <p>Resident #16 who had a diagnosis of chronic pain did not receive Fentanyl patches as prescribed, the resident was to received patches on 05/05/14, 05/28/14, and 05/29/14.</p> <p>Resident #3 did not receive seven (7) doses of Norvasc (blood pressure medication).</p> <p>Resident #13 did not receive Buspar (anti-anxiety medication) for a total of six (6) doses.</p> <p>Additionally, during a medication pass observation, Licensed Practical Nurse (LPN) #1 was observed to draw up seven (7) units of Novolin regular insulin instead of the five (5) units as per the physician's order for sliding scale insulin for Resident #17. The LPN was about to administer the seven units of insulin but another LPN (#6) who was shadowing LPN #1 pointed out the resident should only receive five (6) units. (Refer to F333).</p>	F 520			

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F 520	<p>Continued From page 173</p> <p>An interview, on 06/02/14 at 6:30 PM, with LPN #4, revealed she circled initials on medications that were unavailable for administration on the MAR and medications had not been arriving from the Pharmacy on a larger scale than normal most of May 2014.</p> <p>Interview with LPN #3, on 06/31/14 at 3:00 PM, revealed medications had not been available on various occasions and nurses had to call the Pharmacy and ask why. She stated "At least daily, there is a medication that is not covered". She additionally stated the Pharmacy will not send a medication if it is not covered and residents go a day or two without.</p> <p>Interview, on 05/28/14 at 11:15 AM, with Licensed Practical Nurse (LPN) #1 revealed medications for Resident #14 were not available at this time and stated the medications were not available the last time she administered medications on this hall. She was not aware Resident #14 had not received a prescribed medication in the past few days until this date (05/28/14). She stated the Pharmacy had informed her the Physician's Medicaid "something" had expired and that was why the Pharmacy did not send the medication. She also stated, "I'm not sure why they are not filling that medication (Pancrellipase)" but they fill the other medications.</p> <p>An interview with the Advanced Practice Registered Nurse (APRN), on 06/02/14 at 1:30 PM, revealed she was only aware of Resident #14 not receiving medications as ordered due to the Pharmacy not delivering them and said there was a problem with Medicaid and she had been "kicked out of the system as well as the Physician".</p>	F 520			

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F 520	<p>Continued From page 174</p> <p>Interview with the Administrator, on 05/30/14 at 4:10 PM, revealed problems with medications being unavailable for administration was an issue related to one of the facility's Physician's need to update his/her provider number for Medicaid as it was not showing active in the system. The Administrator stated the latter part of the previous week (week of 05/23/14) the facility was made aware and implemented weekly Medication Administration Record (MAR) and Treatment Administration Record (TAR) reviews. She further stated there was no policy to address reviewing the MARs or TARs. A QA meeting was not held until 05/27/14.</p> <p>Post Survey interviews with the Administrator, on 07/02/14 at 9:45 AM, 2:55 PM and 5:00 PM, revealed the MAR and TAR reviews were implemented on 05/16/14 but there was nothing put in place to ensure the MAR and TAR reviews were being conducted to ensure the facility would identify when medications were not available for administration and administered per physician's order. She stated the facility did not have a QA meeting until 05/27/14 because they did not realize the gravity of the situation until then. She stated at first they thought the medication problem was only related to new admissions and readmissions, then they thought it was due to lack of documentation and then the physician's Medicaid provider number issue was identified. She revealed they took steps to address each of these concerns as identified. She was unable to provide an explanation as to why medications were still unavailable for administration after the issues were identified.</p>	F 520			

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F 520	<p>Continued From page 175</p> <p>*The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17.</p> <p>On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders.</p> <p>On 06/01/14, the RNC re-educated the DON on "Medication Availability" protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed.</p> <p>On 06/01/14, the DON began education with Licensed Nurses on "Medication Availability" and post test titled "Medication Availability" which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test.</p> <p>On 06/02/14, two representatives from the Pharmacy completed a Medication Administration</p>	F 520			

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F 520	<p>Continued From page 176</p> <p>Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery.</p> <p>Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly.</p> <p>An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made.</p>	F 520			

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F 520	Continued From page 177 The State Survey Agency validated the corrective actions taken by the facility as follows: On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a "STAT" order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON. On 06/12/14 at 10:54 AM, RN #2 verified through	F 520		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
(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 178</p> <p>interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 08/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago.</p> <p>On 08/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 520	<p>Continued From page 179</p> <p>medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse.</p> <p>On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 520	<p>Continued From page 180</p> <p>On 06/12/14 at 11 :46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON.</p> <p>On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse.</p> <p>On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material.</p> <p>On 06/12/14 at 12:06 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a</p>	F 520			

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F 520	<p>Continued From page 181</p> <p>post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved.</p> <p>On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified.</p> <p>On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed.</p> <p>On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
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F 520	<p>Continued From page 182 after Inservice training.</p> <p>On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test.</p> <p>On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified.</p> <p>On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 520	<p>Continued From page 183</p> <p>available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care.</p> <p>On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14.</p> <p>On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of Lortab and a 2:00 PM dose of Lyrica indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of Levothyroxine was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR.</p> <p>On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident</p>	F 520			

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F 520	<p>Continued From page 184</p> <p>#18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of Zantac on 06/09/14 and 5:00 PM doses of Depakote on 06/07/14 and 06/08/14.</p> <p>Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the Zantac to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview.</p> <p>Interview on 06/12/14 at 5:24 PM, with LPN #4 revealed that he/she had given the 5:00 PM Depakote doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview.</p> <p>Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action.</p> <p>Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions.</p> <p>Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan.</p> <p>Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
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F 520	Continued From page 185 return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.	F 520			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1968.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1968, and upgraded in 1998 with 20 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1968.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Propane.</p> <p>A Standard Life Safety Code Survey was conducted on 05/29/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen C. Evans TITLE: Administrator (X6) DATE: 7/13/2014

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 80 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 CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42256	
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K 000	Continued From page 1	K 000	<u>K 062</u> NFPA 101 LIFE SAFETY CODE STANDARD	
K 062 SS=F	<p>Deficiencies were cited with the highest Scope and Severity deficiency identified at the "F" level. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on review of the sprinkler system record, and interview it was determined the facility failed to maintain the sprinkler system in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <p>Sprinkler record review, on 05/29/14 at 10:28 AM with the Maintenance Supervisor, revealed the facility failed to provide documented evidence that the sprinkler system had an internal investigation since July of 2008.</p> <p>Interview, on 05/29/14 at 10:29 AM with the Maintenance Supervisor, revealed he was unaware the internal pipe inspection was overdue since the sprinkler company was marking "N/A" (non-applicable) on the report.</p>	K 062	<p><u>The corrective action accomplished to correct the alleged deficient practice:</u></p> <p>On 6/13/2014, a representative from Armor Fire Protection completed the facility internal pipe inspection in accordance with NFPA standards.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 6/13/2014, a representative from Armor Fire Protection completed a review of facility sprinkler maintenance record keeping ensuring other records were maintained in accordance with NFPA standards.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 5/22/2014, Administrator re-educated Maintenance Director regarding the NFPA standard for sprinkler maintenance record keeping and periodic testing.</p> <p>Beginning 6/4/2014, Armor Fire Protection will exit with Administrator and to report all mandatory testing in need of scheduling in accordance with NFPA standards.</p> <p>On 6/6/2014, Administrator ended the current sprinkler maintenance agreement</p>	

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMROKE, KY 42268	
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K 062	Continued From page 2 The census of forty-one (41) was verified by the Administrator on 05/29/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/29/14. Actual NFPA Standard: Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5	K 062	and contracted with Armor Fire Protection on 6/4/2014 to ensure NFPA standards are followed. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u> Administrator will review sprinkler reports no less than quarterly. Any negative outcome reported will additionally be reviewed with the Quality Assurance Committee quarterly for at least three (3) quarters or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Manager and Social Services Director with the Medical Director attending at least quarterly. <u>Completion Date:</u>	7/11/2014

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186338	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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K 062	Continued From page 3 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, fillers, orifices Inspection 5 years 9-4.1.2	K 062		

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K 062	Continued From page 4 Check Valves Interior Inspection 5 years 9-4.2.1 Preactlon/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3	K 062		

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K 082	Continued From page 5 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.8 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 082		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and	K 143	<u>K 143</u> NFPA 101 LIFE SAFETY CODE STANDARD <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 6/18/2014, Maintenance Director ordered a 1 hour rated fire door in accordance with NFPA standards. On 7/7/2014, liquid oxygen was removed from the facility until the one (1) hour fire rated door is installed. As of 7/7/2014 no	

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K 143	<p>Continued From page 6</p> <p>(c) In an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of the Plan of Correction, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per National Fire Protection Association (NFPA) requirements. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/29/14 at 8:00 AM with the Maintenance Supervisor, revealed the oxygen trans-filling room had a fire rated door installed but it was rated for 0.75 hour. Observation revealed the door frame was steel, but there was no fire rating tag installed on the door frame.</p> <p>Interview, on 05/29/14 at 9:01 AM with the Maintenance Supervisor, revealed he was unaware the trans-filling room was required to have an hour rated door.</p> <p>The census of forty-one (41) was verified by the</p>	K 143	<p>liquid oxygen is stored or used at the facility eliminating the requirement for a fire door for trans-filling or storage of liquid oxygen until said fire door is installed.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 5/22/2014, Maintenance Director completed an audit of facility doors required to be rated for fire resistance according to NFPA standards. No concerns were identified.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 5/22/2014, Administrator re-educated Maintenance Director regarding NFPA standards for standards for doors requiring specific fire rating.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p> <p>The Maintenance Director will conduct an audit of all fire doors monthly for three (3) months to ensure all doors have the appropriate fire rating in accordance with NFPA requirements. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality</p>	

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K 143	Continued From page 7 Administrator on 05/29/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/29/14. Actual NFPA Standard: Reference: NFPA 99 (1999 Edition). 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143	Assurance Committee will convene to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Manager and Social Services Director with the Medical Director attending at least quarterly. <u>Completion Date:</u>	7/11/2014
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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K 144 SS=F	<p>Continued From page 8</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <p>Generator documentation review, on 05/29/14 at 11:07 AM with the Maintenance Supervisor, revealed the generator did not have documented evidence on the amount of load the facility was pulling from the generator on a monthly basis. Further review determined the facility did not have an annual load bank test performed on the generator during the last year.</p> <p>Interview, on 05/29/14 at 11:08 AM with the Maintenance Supervisor, revealed the facility had the annual load bank test in the contract from the</p>	K 144	<p><u>K 144</u> NFPA 101 LIFE SAFETY CODE STANDARD</p> <p><u>The corrective action accomplished to correct the alleged deficient practice:</u></p> <p>On 5/23/2014, Maintenance Director scheduled the generator for a one hour load bearing test to ensure NFPA standards are followed.</p> <p>On 6/9/2014, Vanguard completed the generator one hour load bearing test in accordance with NFPA standards.</p> <p><u>Other residents had the potential to be affected.</u></p> <p>On 5/23/2014, Maintenance Director reviewed documentation logs and validated all generator testing had been completed as documented.</p> <p><u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u></p> <p>On 5/22/2014, Administrator re-educated Maintenance Director on the NFPA standards and requirements for emergency generator testing.</p> <p><u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u></p>	

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K 144	<p>Continued From page 9 generator contractor but was unaware the testing was not completed as required.</p> <p>The census of forty-one (41) was verified by the Administrator on 05/29/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/29/14.</p> <p>Actual NFPA Standard: Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and</p>	K 144	<p>The Maintenance Director will complete an audit of all generator reports monthly for three (3) months to ensure all testing is completed per NFPA standards. The results of these reports will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Manager and Social Services Director with the Medical Director attending at least quarterly.</p> <p><u>Completion Date:</u></p>	7/11/2014

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K 144	Continued From page 10 exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of forty-one (41) on the day of the survey. The findings include: Observation, on 05/29/14 at 9:14 AM with the Maintenance Supervisor, revealed a mini-nebulizer plugged into a power strip located in resident room #38. Interview, on 05/29/14 at 9:15 AM with the Maintenance Supervisor, revealed he was unaware of the mini-nebulizer plugged into the power strip as the facility does audits to check for electrical issues.	K 147	<u>K 147</u> NFPA 101 LIFE SAFETY CODE STANDARD <u>The corrective action accomplished to correct the alleged deficient practice:</u> On 5/22/2014, Maintenance Director plugged the refrigerator directly in the wall that was located in the Social Service/Admissions Office in accordance with NFPA standards. On 5/23/2014, Maintenance Director plugged medical equipment directly in the wall for the resident rooms #38, 34, and 20 in accordance with NFPA standards. On 5/23/2014, Maintenance Director corrected the multi-plug strip loose from the bracket in rooms #18 and 23 in accordance with NFPA standards. <u>Other residents had the potential to be affected.</u> On 5/22/2014, Maintenance Director completed an audit of the facility to validate all other medical equipment and refrigerators were plugged directly into a wall outlet. Any deficient areas identified were immediately corrected.	

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K 147	Continued From page 11 Observation, on 05/29/14 at 10:00 AM with the Maintenance Supervisor, revealed a mini-nebulizer, resident bed, oxygen concentrator, and an air mattress plugged into a multi-plug adaptor located in resident room #34. Interview, on 05/29/14 at 10:01 AM with the Maintenance Supervisor, revealed he was unaware of the items plugged into the multi-plug adapter as the facility does audits to check for electrical issues. Observation, on 05/29/14 at 10:10 AM with the Maintenance Supervisor, revealed a multi-plug strip was knocked loose from the bracket in room #18. Interview, on 05/29/14 at 10:11 AM with the Maintenance Supervisor, revealed he was unaware the strip had been knocked loose in the room. Observation, on 05/29/14 at 10:33 AM with the Maintenance Supervisor, revealed a resident bed plugged into a power strip located in resident room #20. Interview, on 05/29/14 at 10:34 AM with the Maintenance Supervisor, revealed he was unaware of the bed plugged into the power strip as the facility does audits to check for electrical issues. Observation, on 05/29/14 at 10:50 AM with the Maintenance Supervisor, revealed a multi-plug strip was knocked loose from the bracket in room #23.	K 147	<u>The measures or systemic changes were made to ensure that the alleged deficient practice will not recur:</u> On 5/22/2014, Administrator re-educated Maintenance Director regarding the NFPA requirement to plug medical equipment, including refrigerators, directly into a wall outlet. <u>How the facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained:</u> Beginning the week of 5/26/2014, Maintenance Director will complete an audit once (1) weekly for twelve (12) weeks to validate that medical equipment, including refrigerators, are plugged directly into a wall outlet in accordance with NFPA requirements. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Dietary Manager and Social Services Director with the Medical Director attending at least quarterly. <u>Completion Date:</u>	7/11/2014

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K 147	<p>Continued From page 12</p> <p>Interview, on 05/29/14 at 10:51 AM with the Maintenance Supervisor, revealed he was unaware the strip had been knocked loose in the room.</p> <p>Observation, on 05/29/14 at 11:00 AM with the Maintenance Supervisor, revealed a refrigerator plugged into a power strip located in the Social Services office.</p> <p>Interview, on 05/29/14 at 11:01 AM with the Maintenance Supervisor, revealed he was unaware of the refrigerator plugged into the power strip as the facility does audits to check for electrical issues.</p> <p>The census of forty-one (41) was verified by the Administrator on 05/29/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/29/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 edition)3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure</p>	K 147		

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K 147	Continued From page 13 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 384-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147			

