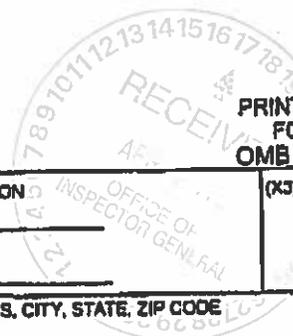


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/09/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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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
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<p>F 000 INITIAL COMMENTS</p> <p>An Abbreviated Survey Investigating Complaints #KY22923, #KY22894 and #KY22920 was conducted on 03/04/15 through 03/09/15. #KY22923 was substantiated with related deficiencies, #KY22920 was unsubstantiated with unrelated deficiencies and #KY22894 was unsubstantiated with no deficiencies. The highest Scope and Severity was a "D"</p> <p>F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14, it was determined the facility failed to follow professional standards of practice and facility policy related to medication administration for one (1) of nine (9) sampled residents (Resident # 1).</p> <p>Registered Nurse (RN)#1 administered Norco (narcotic pain medication) 5-325 milligrams (mg) to Resident #1 on 03/04/15 at 8:00 PM without a physician's order to administer the medication at that time and failed to document the accurate time the medication was administered, the reason for the administration of the medication and the results.</p> <p>The findings include: Review of the Kentucky Board of Nursing AOS</p>	<p>F 000 <i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.</i></p> <p>F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>F 281</p> <ol style="list-style-type: none"> 1. Resident #1 no longer resides in the facility. On 3/9/2015 RN #1 received disciplinary action and verbal counseling by the DON concerning how to follow physician orders and properly administer medication. RN #1 was removed from the floor to be retrained. She completed her revised skills competency education and check off list on 3/24/2015. The Physician was made aware on 3/6/2015 by the DON. 2. An audit of medication documentation was completed on 3/25/2015 by the DON and her designee to determine if any other residents had been affected. 3. Re-education was completed by the Staff Development Coordinator (SDC) on 4/1/2015 with licensed nurses to "Follow and Work within the Scope of their Practice", "Accurate Medication Administration", "Proper Documentation of Med Pass", and "Follow-Up Documentation on the Effectiveness of Medication." The Competency check list was revised 3/10/2015 and initiated for newly hired licensed nurses to ensure they know how to administer medications appropriately and document.
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Kindsey</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-17-2015</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>#14, last revised October 2014, revealed licensed staff should prepare and administer medication in the prescribed dosage, route, and frequency as ordered and document on the MAR immediately after giving a medication.</p> <p>Review of the facility's policy titled, "Medication Administration", dated January 2014, revealed unless otherwise specified by the prescriber, routine medications should be administered according to the established medication administration schedule for the nursing care center. If a dose of regularly scheduled medication was withheld, refused or given at other than the scheduled time, the space provided on the front of the Medication Administration Record (MAR) for that medication administration should be initialed and circled. Medications should be administered in accordance with written orders of the prescriber. When a medication was given as an as needed (PRN) dose, documentation should include complaints or symptoms for which the medication was given, results achieved from giving the dose and the time results were noted.</p> <p>Record review revealed the facility readmitted Resident #1 on 01/27/15 with diagnoses which included Chronic Respiratory Failure, Chronic Pain, Chronic Kidney Disease, Arthritis, Diabetes, and Deep Vein Thrombosis of Lower Extremities.</p> <p>Review of the March 2015 Physician's Orders revealed to administer Norco 5-325 mg three times a day (TID).</p> <p>Review of March 2015 Medication Administration Record (MAR) revealed Norco 5-325 mg was to be administered at 8:00 AM, 2:00 PM, and 10:00</p>	F 281	<p>4. QAPI forms titled "Review of Medication Pass" and "Pain Management-Chronic Care Residents" will be conducted by the DON, ADONs, SDC and designee weekly for four weeks then monthly for two months with results presented in QAPI for tracking and trending and further recommendations. The Audits were to ensure the licensed nurses and CMTs were giving medication consistent with the physician order, the medications were given within at least 60 minutes before or after scheduled time and documented as such, medications were given by a qualified individual, the reason and the results of the pain medication are being documented on pain flow sheets, the care plan includes non-pharmacological as well as pharmacological interventions. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director, NHA, DON, ADONs, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p> <p>5. Completion Date 4/2/2015</p>	4/2/15	

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F 281	<p>Continued From page 2</p> <p>PM daily. Further review revealed the Norco was initiated as administered on 03/04/15 at 10:00 PM; however, review of the Controlled Drug Record revealed the Norco was signed out by Registered Nurse (RN) #1 at 6:00 PM on 03/04/15.</p> <p>Review of the Nursing Notes, dated 03/04/15, and further review of the March 2015 MAR, revealed there was no documentation of Norco being administered at 6:00 PM, or documentation of why the Norco was administered at an earlier time and the results. In addition, review of the Physician's Orders revealed there was no order to administer the medication at an earlier time. Further review of the Nursing Notes, revealed Resident #1 was found expired on 03/04/15 at 9:50 PM when RN #1 went into the resident's room to do an accucheck (check blood sugar).</p> <p>Interview with RN #1, on 03/08/15 at 5:33 PM, revealed she did not know how to change the time (override computer set times) to be able to document the time she actually gave the pain medication. RN #1 stated it was an omission on her part not to have called the physician and she knew it was not in her scope of practice to administer medication without an order but did so anyway. RN #1 revealed she did not go back into the room to reassess the resident's pain after administering the Norco at 6:00 PM. RN #1 stated she had only worked at this facility for about one (1) month.</p> <p>Interview with the Director of Nursing (DON), on 03/9/15 at 8:40 AM, revealed she would have expected RN #1 to know how to chart the correct time of medication in the computer, to call the physician if the medication needed to be</p>	F 281			

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F 281	Continued From page 3	F 281			
F 282 SS=D	<p>administered at an earlier time than ordered and to chart what was done in the Nurse's Notes.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to provide care in accordance with the written plan of care for one (1) of nine (9) sampled residents (Resident #1).</p> <p>Resident #1 was care planned for Pain with interventions to administer medication as ordered and to monitor for the effectiveness and any side effects of the medication. However, on 03/04/15 at 6:00 PM, Registered Nurse (RN) #1 administered Norco (narcotic pain medication) 5-325 milligrams (mg) without a physician's order to administer at that time and failed to monitor for the effectiveness of the medication per the resident's care plan.</p> <p>The findings include: Review of the facility policy titled, "Comprehensive Care Plans", dated October 2010, revealed each resident's comprehensive care plan was designed to identify the professional services that are responsible for each element of care, and reflect currently</p>	F 282	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <ol style="list-style-type: none"> Resident #1 no longer resides in the facility. On 3/9/2015 RN #1 received disciplinary action and verbal counseling by the DON concerning how to follow physician orders, properly administer medication, and following the plan of care. RN #1 was removed from the floor to be retrained. She completed her revised skills competency education and check off list on 3/24/2015. An audit of residents on PRN pain medication was conducted by DON/Designee to determine if residents have been re-assessed for effectiveness of PRN pain medication and if med given as ordered. This audit was completed on 3/25/2015. Re-education was conducted and completed by the SDC/Designee on 4/1/2015 to licensed nurses on "Following the Plan of Care for Administering Meds as Ordered". 		

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F 282	<p>Continued From page 4</p> <p>recognized standards of practice for problem areas and conditions. The resident's Physician is integral to the Interdisciplinary Process of the Care Plan.</p> <p>Record review revealed the facility readmitted Resident #1 on 01/27/15 with diagnoses which included Deep Vein Thrombosis (DVT), Chronic Pain, Chronic Kidney Disease (CKD), Arthritis, Chronic Respiratory Failure, and Pressure Ulcer.</p> <p>Review of Resident #1's Comprehensive Care Plan for pain, dated 02/04/15, revealed interventions to administer medication as ordered and monitor for effectiveness and for possible side effects from medication.</p> <p>Review of the March 2015 Physician's Orders revealed to administer Norco 5-325 mg. per gastrostomy tube (GT) three (3) times a day (TID).</p> <p>Review of the March 2015 Medication Administration Record (MAR) revealed Norco(pain medication) was given at 10:00 PM; however, review of the Controlled Drug Record revealed the Norco was signed out by Registered Nurse (RN) #1 at 8:00 PM on 03/04/15.</p> <p>Further review of the March 2015 MAR and Nursing Notes for 03/04/14, revealed there was no documented evidence the nurse monitored for the effectiveness of the medication.</p> <p>Interview with RN #1, on 03/08/15 at 5:33 PM, revealed she administered the Norco to Resident #1 at 8:00 PM for pain because the resident was groaning. RN #1 stated she did not call the resident's physician to obtain an order to</p>	F 282	<p>4. QAPI forms titled "Review of Medication Pass" and "Pain Management-Chronic Care Residents" will be conducted by the DON, ADONs, SDC and designee weekly for four weeks then monthly for two months with results presented in QAPI for tracking and trending and further recommendations. The Audits were to ensure the licensed nurses and CMTs were giving medication consistent with the physician order, the medications were given within at least 60 minutes before or after scheduled time and documented as such, medications were given by a qualified individual, the reason and the results of the pain medication are being documented on pain flow sheets, the care plan includes non-pharmacological as well as pharmacological interventions. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director, NHA, DON, ADONs, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p> <p>5. Completion Date 4/2/2015</p>	4/2/15	

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F 282	<p>Continued From page 5</p> <p>administer the Norco early (ordered for 10:00 PM) because she was behind and did not know how to "override" the computer to set the time she actually administered the medication, so she documented she administered it at 10:00 PM. RN #1 stated she did not go back in the resident's room to reassess the resident's pain level after administering the Norco.</p> <p>Interview, on 03/08/15 at 9:02 AM with Licensed Practical Nurse (LPN) #4, revealed if a resident was assessed as having pain, the nurse should check the MAR to see when the last medication was administered for pain and if it had been long enough, then administer the pain medication. LPN #4 stated the nurse should then go back thirty (30) minutes later to reassess the resident's pain level. LPN #4 revealed the nurse should chart in the Nurse's Notes and on MAR in the computer the time the medication was administered and the results. LPN #4 stated a nurse has to have a physician's order to administer a routine medication at an earlier time and the nurse should follow the care plan for pain.</p> <p>Interview with RN #2, on 03/07/15 at 10:30 AM, revealed if a resident was medicated for pain, the nurse should reassess the resident's pain level after about forty five (45) minutes and document this on the MAR. RN #2 stated the nurse should also document in the nurse's notes before and after pain medication was administered. RN #2 revealed the nurse should follow the resident's care plan for pain.</p> <p>Interview with the Director of Nursing, on 03/09/15 at 8:40 AM, revealed she expected the nurses to follow the care plan.</p>	F 282		
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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the environment remained as free of accident hazards as was possible for residents.</p> <p>Observation on 03/04/15 at 4:20 PM, revealed a construction team was remodeling an area in the front lobby of the building when an "arc fire flashed out of a wall receptacle". The fire was immediately extinguished with a fire extinguisher and then 911 was called; however, staff failed to pull the fire alarm prior to obtaining the extinguisher per the facility's policy preventing staff, residents and visitors from knowing about the fire. This resulted in the fire doors not being activated which placed residents at risk should the fire spread throughout the lobby before the fire department could respond to the 911 call.</p> <p>Review of the facility's Census and Condition Form, dated 04/04/15, revealed of the facility's 129 residents eighteen (18) were bedfast, sixty-nine (69) were in a chair all or most of the time, and two (2) were physically restrained.</p>	F 323	<p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <ol style="list-style-type: none"> The fire department came to the facility on 3/4/2015 and gave the all clear for the flash fire that occurred a few minutes prior. Staff and construction workers received education on the fire policy. This education was completed on 4/1/2015. There were no residents in or near the lobby at the time of the incident. The fire was cleared by the fire department at 4:45pm on 3/4/2015. Safety Meetings are held monthly to discuss any previous incidents or potential accidents or hazards. The results of this meeting are presented to the QAPI committee. The Safety Committee members include the SDC (Staff Development Coordinator), Maintenance Director, HR (Human Resources Director), ESD (Environmental Services Director), DM (Dietary Manager), ADONs and Unit Mangers. Education was completed by the Construction Crew Leader to the construction workers on the Fire Policy including RACE and PASS on 3/6/2015. Education was given by the SDC/Designee on the Fire Policy including RACE and PASS to all staff. This education was completed on 4/1/2015. 	
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F 323	<p>Continued From page 7</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Life Safety Code NFPA 101, Section 3104.2", Plant Operations Policy and Procedure Manual, Disaster Preparedness/ Fire Plan, dated January 2005, revealed, the person discovering the fire should yell "code red" and give the location of the fire three (3) times. 1. Remove any residents from the danger area and close the doors and windows. 2. Page out the code adopted by the facility : "Code Red" three times. 3. If the alarm has not been activated, the person discovering the fire must pull the nearest fire alarm and return with the portable fire extinguisher. 4. Any person in the immediate area of the fire must investigate the area and report findings back to the person in charge. 5. All staff members will report to the fire alarm panel for evacuation instructions from the person in charge.</p> <p>Review of the facility's plan titled R.A.C.E. - Rescue or Remove-Alarm-Contain-Extinguish or Evacuate.</p> <p>Observation on 03/03/15 at 4:20 PM, revealed several employees were running in the front lobby. Further observation revealed a fine mist was visible in the front lobby and two (2) construction workers were on the floor of the lobby with a piece of the wall board in their hands. Interview with the Maintenance Supervisor and Administrator at that time, revealed there had been a small arc type fire in the front lobby. Surveyors could hear no audible fire alarms or overhead page sounding in the facility or the front lobby, and the front exterior door of the facility was observed to be propped open. Further</p>	F 323	<p>4. QAPI forms titled "Fire Safety" and "Life Safety-Fire Inspection" will be conducted by the SDC/maintenance Director/Designee monthly for three months with results presented in QAPI for tracking and trending and further recommendations. The audits were to ensure that fire drills are conducted and recorded once a month, new staff orientation includes fire/evacuation procedures, and during a drill the staff in the immediate area, have appropriate response to the "fire scene". QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director, NHA, DON, ADONs, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask the Maintenance Director or others to participate if the need arises.</p> <p>5. Completion Date 4/2/2015</p>	4/2/15	

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F 323	<p>Continued From page 8</p> <p>observation on 03/04/15 at 4:30 PM revealed the fire department arrived at the facility to make sure the fire was extinguished and there was no damage to the wall or electrical circuit. Review of the Fire Department Report, dated 03/04/15, revealed the all clear was given at 4:45 PM by the fire department.</p> <p>Phone interview with Construction Worker #1, on 03/05/15 at 3:50 PM, revealed she was putting the iuan (wall board) on the wall and had to cut a hole in the material. She stated when she unscrewed the two (2) screws from the electrical receptacle and pulled out the plug, it must have hit the utility box and caused a spark. She revealed it arced and a flame shot out, and their first reaction was to say fire and then someone got the fire extinguisher. She stated someone from the facility sprayed it with the fire extinguisher, but the fire was already out. She revealed that she was aware of the fire policy for the facility but doesn't know why she didn't pull the fire alarm. She revealed there were other employees of the facility present and they were the ones that got the fire extinguisher. She stated three (3) of the crew members had language barriers and would not be able to interview over the phone.</p> <p>Interview with the Maintenance Supervisor, on 03/03/15 at 4:25 PM, revealed the construction worker sprayed the wall board with a spray adhesive, then she proceeded to pull the plug receptacle through the hole in the board, causing a spark that ignited an "arc flame" to run up a piece of wall board. The Maintenance Supervisor stated the fire was immediately extinguished by the construction worker, and someone then called 911. The Maintenance Supervisor further</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/08/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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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
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F 323	<p>Continued From page 9</p> <p>revealed staff did not pull the fire alarm; and the smoke detector in the area of the fire did not alarm due to the mist going out the propped open front door. The Maintenance Supervisor stated someone sprayed the area with a fire extinguisher and that was what caused the cloudy mist in the area.</p> <p>Interview with the Administrator, on 03/04/15 at 4:25 PM, revealed the construction crew had been using a spray adhesive to apply wall board to the lower portion of the wall in the front lobby and it caused an arc fire. She revealed staff sprayed the area with a fire extinguisher and alerted the fire department by calling 911.</p> <p>Further interview with the Administrator by phone, on 03/05/15 at 10:28 AM, revealed at the time of the fire she was working in her office (located in the front lobby area) with two (2) other staff members when she heard one of the construction workers yell fire. She stated she immediately ran out of her office into the lobby area and saw a construction worker with a piece of wall board with a small flame running up the board. She revealed she immediately ran to get the fire extinguisher, and by the time she got back with it the fire was out. She stated they sprayed the fire extinguisher just to make sure the fire was out. She stated there was no smoke visible from the fire and the fire detector did not go off and she told the Maintenance Supervisor to call the fire department. She further revealed the fire alarm did not go off and there was no smoke with the flame. She stated it was an instant flame and the mist in the lobby was from the fire extinguisher, so they opened the front door. She revealed there were no residents in the lobby at the time of the fire.</p>	F 323		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 323	<p>Continued From page 10</p> <p>Interview with Assistant Project Manager for the facility, on 03/07/15 at 8:40 AM, revealed the contracted construction crew was expected to obey all facility rules and policy and procedures while they were in the facility. He stated the facility had a safety meeting on the morning of 03/04/15 to remind everyone to follow the safety rules but the fire safety plan was not discussed. He revealed he gave the construction crew a packet of papers to read and sign with the fire rescue plan in it, and they could have asked questions if needed, but he did not go over the plan with them.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/09/15 at 11:00 AM, revealed she was familiar with the facility's fire plan, and thought it was important to know for when there was a drill or a real fire. She stated when the fire alarm goes off, staff should go to the fire panel and the panel will indicate the location of the fire to ensure the safety of all the residents. She revealed if the alarm was not pulled no one would know how to react to the situation and know what plan to put in place.</p> <p>Interview with LPN #2, on 3/09/15 at 11:15 AM, revealed she was not aware of the fire in the facility until after the fact, and stated, "I was in a resident's room" at the time of the fire. She revealed she was familiar with the facility's fire plan and felt it was important to pull the fire alarm even if the fire was extinguished, because there was a possibility the fire could ignite again. She stated she thought it was important to make sure everyone in the facility was aware of what was going on to ensure everyone's safety.</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>Interview with Registered Nurse (RN) #1, on 03/09/15 at 11:10 AM, revealed she thought it was important to pull the alarm when you see a fire or suspect a fire in the facility. She stated when the alarm goes off, the fire doors close enabling you to keep the residents in a safe area. She revealed if the alarm was not pulled the fire doors would not automatically close and the entire facility would not be aware of the fire.</p> <p>Interview with Staff Development Coordinator, on 03/07/15 at 11:00 AM, revealed if staff saw a visible fire, she expected them to follow the RACE plan. She stated all staff were trained on the facility's fire plan including the RACE plan on 08/13/14 and 08/14/14, and were given copies of the fire plan to attach to their name badges. She revealed it was a part of all new employees training during the orientation process.</p> <p>Interview with Quality Assurance Nurse, on 03/07/15 at 9:50 AM, revealed she was in the lobby at the time of the fire, and saw that the fire was already extinguished when she returned with the fire extinguisher. She stated she sprayed the area with the fire extinguisher and then opened the front door. She revealed she was aware of the facility's policy related to RACE (Rescue, Alarm, Confine, Extinguish) and pulling the alarm would have meant she needed help, and would have scared the residents.</p> <p>Interview with Director of Nursing (DON), on 03/07/15 at 9:45 AM, revealed she was aware of the facility's fire policy (RACE), and she was in the front lobby at the time of the fire. She stated it was a rapid fire and the construction worker had it contained. She revealed they yelled fire then extinguished it out before we could get the fire</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 323	Continued From page 12 extinguisher. She stated there was no reason to pull the fire alarm because the fire was so quick and was extinguished so fast.	F 323			
F 514 SS=D	Interview with the Medical Director, on 03/08/15 at 1:50 PM, revealed he was not aware there was a fire at the facility. He stated if there was a fire in the facility he expected the staff to follow the fire protocol. He revealed if the facility had a policy in place, it was important to follow it. He stated pulling the fire alarm would have notified all the people in the facility of the fire. 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 facility policy review it was determined the facility failed to ensure a clinical record was complete and accurate for one (1) of nine(9) sampled residents	F 514	F 514 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 1. Resident #1 no longer resides in the facility. On 3/9/2015 RN #1 received disciplinary action and verbal counseling by the DON concerning how to document pain levels prior to and after the administration of pain medication and documenting the accurate time of medication administration. RN #1 was removed from the floor to be retrained. She received additional training on the EZMar system. She completed her revised skills competency education and check off list on 3/24/2015. 2. An audit of medication documentation was completed on 3/25/2015 by the DON and her designee to determine if any other residents had been affected.		

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F 514	<p>Continued From page 13</p> <p>(Resident #1). Registered Nurse (RN) #1 failed to document Resident #1's pain level prior to and after the administration of pain medication and failed to document the accurate time the medication was administered.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medication Administration", dated January 2014, revealed if a dose of regularly scheduled medication was withheld, refused or given at other than the scheduled time, the space provided on the front of the Medication Administration Record (MAR) for that medication administration should be initialed and circled. When a medication was given as an as needed (PRN) dose, documentation should include complaints or symptoms for which the medication was given, results achieved from giving the dose and the time results were noted.</p> <p>Record review revealed the facility readmitted Resident #1 on 01/27/15 with diagnoses which included Chronic Pain, Arthritis, Chronic Kidney Disease, Deep Vein Thrombosis of Lower Extremities, and Respiratory Failure.</p> <p>Review of the March 2015 MAR revealed staff should administer Norco 5-325 mg, three times a day at 6:00 AM, 2:00 PM and 10:00 PM. Further review of the MAR revealed the Norco was administered on 03/04/15 at 10:00 PM; however, review of the Controlled Drug Record (Narcotic Record) revealed Norco 5-325 mg was signed out at 6:00 PM by RN #1.</p> <p>Review of Nurse's Notes for 03/04/15 and further review of the MAR revealed there was no</p>	F 514	<p>3. Re-education was completed by the Staff Development Coordinator (SDC) on 4/1/2015 with licensed nurses on "Accurate Medication Administration", "Proper Documentation of Med Pass", "Follow-Up Documentation on the Effectiveness of Medication" and "Pain Flow Sheets." The Competency check list was revised 3/10/2015 and initiated for newly hired licensed nurses to ensure they know how to administer medications appropriately, document, and have the capabilities to maneuver through the EZMar system.</p> <p>4. QAPI forms titled "Review of Medication Pass" and "Pain Management-Chronic Care Residents" will be conducted by the DON, ADONs, SDC and designee weekly for four weeks then monthly for two months with results presented in QAPI for tracking and trending and further recommendations. The Audits were to ensure the licensed nurses and CMTs were giving medication consistent with the physician order, the medications were given within at least 60 minutes before or after scheduled time and documented as such, medications were given by a qualified individual, the reason and the results of the pain medication are being documented on pain flow sheets, the care plan includes non-pharmacological as well as pharmacological interventions. QAPI meetings will be held weekly till issue is resolved. QAPI members consist of the Medical Director, NHA, DON, ADONs, Unit Manager, RT (Resp. Therapist), RD (Reg. Dietician), SDC (Staff Development Coordinator), MDS Coordinators., Admission Coordinator, Chaplin, SSD (Social Service Directors), HR (Human Resources Director), Q of L Dir. (Quality of Life Director). The NHA or DON may ask CNAs or others to participate if the need arises.</p>		

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F 514	<p>Continued From page 14</p> <p>documented evidence the Norco was administered at 6:00 PM and no documented evidence of Resident #1's pain level prior to and after the administration of the pain medication.</p> <p>Interview with RN #1, on 03/08/15 at 5:33 PM revealed she administered Norco to Resident #1 at 6:00 PM because the resident was groaning in pain but documented the medication was administered at 10:00 PM on the MAR. RN #1 stated she knew she was supposed to chart at the time the medication was administered but she did not know how to do so on the computer. RN #1 revealed she did not feel she had to chart about the pain medication in the nurse's notes, as she had charted it on the MAR in the computer. RN #1 stated she did not go back into the room to reassess the resident's pain after administering the Norco at 6:00 PM.</p> <p>Interview, on 03/07/15 at 10:55 AM with Licensed Practical Nurse (LPN) #3, and on 03/08/15 at 9:02 AM with LPN #4, revealed the nurse should document the resident pain level before and after the pain medication was administered on the MAR and in the nurse's notes.</p> <p>Interview with RN #2, on 03/07/15 at 10:30 AM, revealed if a resident was medicated for pain, the nurse would document the results of the medication on the MAR.</p> <p>Interview, on 03/09/15 at 8:40 AM with the Director of Nursing (DON), revealed she expected RN#1 to document the time the pain medication was administered and the results of the pain medication on the MAR and in the nurse's notes.</p>	F 514	5. Completion Date 4/2/2015	4/2/15	