

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

PRINTED: 01/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004
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F 000	INITIAL COMMENTS An abbreviated survey was conducted 01/09/13 through 01/11/13 to investigate KY19620. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000	F000 The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Corrections prepared and executed solely because it is required by Federal and State law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F157 1. Resident # 1 was discharged from the facility 1-8-2013. This was a closed record review. 2. All reports of incident and 24 hour communication report sheets for the past 30 days have been reviewed to ensure the Physician and Family of the resident were notified of any incidents with or without injury and any change in condition for the resident. This was completed by 2/4/2013 by Director of Nursing and Administrator.	

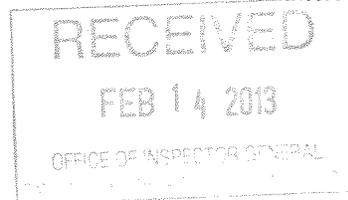
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 2/14/2013

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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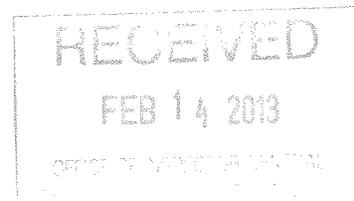
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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to notify the attending Physician of health changes for one (1) of five (5) sampled residents. Resident #1 developed a mild fever of 100.1 and experienced an oxygen saturation of 89%.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the Notification of Changes Policy, dated 07/01/08, revealed the facility would immediately consult the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status; deterioration of health, mental, or psychosocial status in either life-threatening conditions or clinical complications. A need to alter treatment significantly; to commence a new form of treatment. <p>Review of the facility's Lipincot Manual used as a reference to the nursing staff, revealed a normal oxygen saturation level for pulse oximeter was 95% to 100% for all adults.</p> <p>Review of Resident #1's record, revealed the facility admitted the resident on 12/29/12 with diagnoses of Urinary Trach Infection, Aortic Atresia/stenosis, Dehydration, Dementia with out behaviors, Difficulty Walking, Muscle Weakness/general and Pulmonary Hypertension. Review of the Oxygen Flow Records, dated 01/07/13 on the 7 PM-7 AM shift, revealed Licensed Practical Nurse (LPN) #5 documented</p>	F 157	<ol style="list-style-type: none"> Licensed nurses were re-educated on the facility policy for notification of change, including identification of changes in patient condition that require physician notification or additional evaluation, including low or high blood pressure, elevated temp, decreased O2 saturations, lack of urinary output, lack of bowel movements, changes in level of consciousness, weight loss or gain, decreased oral intake of food or fluids, initiation and completion of the incident reporting process and investigation system, completion of the 24 hour report, and nursing documentation guidelines. This included notification to families and physicians when an incident occurs or a change in condition occurs. This education was presented by Director of Staff Development on 2/4/2013. Nurses completed a post test after the education to 		



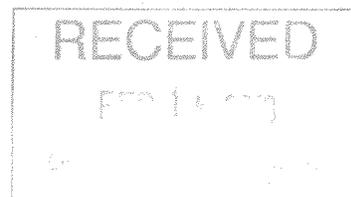
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F 157	<p>Continued From page 2</p> <p>Resident #1 had an oxygen saturation of 89%. Review of the Neurological Assessment, dated 01/07/13, revealed Resident #1 had a temperature of 100 on four (4) occasions and 100.1 on one (1) occasion through the night of 01/07/13 starting at 10:30 PM through 01/08/13 ending at 7:00 AM.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 01/09/13 at 3:34 PM, revealed she informed LPN #5 of Resident #1's oxygen saturations of 89% and temperature of 100.1.</p> <p>Interview with CNA #3, on 01/10/13 1:36 PM, revealed Resident #1's oxygen saturations were low and temperatures were near the 100's. CNA #3 stated she was not able to write Resident #1's sats down because there was not a spot on the neuro sheet to write the oxygen saturations down. CNA #3 stated Resident #1's oxygenation saturations was 87 to 88 and when LPN #5 was informed of this information, LPN #5 stated she was not worried about the saturation unless it was a lot lower. CNA #3 stated she was told to report an oxygenation saturation that was lower than 92%.</p> <p>Interview with LPN #5, on 01/10/13 at 2:10 PM, revealed Resident #1 oxygenation saturation had gotten as low as 88%. LPN #5 stated the CNA's did not report to her that Resident #1's temperature was in the 100's. LPN #5; however, stated she did review the Neuro checks worksheet and if the oxygenation saturation did not get below 88%, she would not be required to call the physician. Further interview, on 01/10/13 at 5:43 PM, revealed a temperature of 101 constituted as a fever. LPN #5 stated she would</p>	F 157	<p>evaluate understanding. This education will be repeated monthly for 3 months then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator. D O N to monitor nurses report sheets, and C.N.A. vital sheets daily and weekend sheets will be reviewed on Monday to identify any abnormal findings that would indicate the need for physician notification or additional evaluation and then will review documentation to ensure appropriate action was taken. If issues are noted, additional education will be provided to individual staff and finding will be used to develop additional education for nursing staff. The facility is utilizing the INTERACT SBAR as a tool to assist in notification of physicians regarding resident condition.</p>	



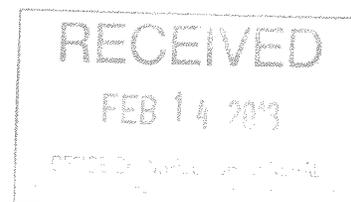
4. The DON or Nurse Supervisor will audit all incidents reported, using the incident reporting procedure and the 24 hour communication tool, to ensure notification was made to the physician and family and was documented in the clinical record weekly for the next 3 months. DON or Nurse Supervisor will audit 25% of the incident reports and all 24 hour reports monthly thereafter to ensure continued compliance. DON will report finding related to review of nurses report sheet, and C.N.A. vital sheets to QA sub-committee monthly and will continue review of same for a minimum of 3 months, then will review report sheets and C.N.A. vital sheets weekly for 3 months, then monthly. DON to review all SBARs completed weekly to evaluate nurses skills in regards to assessment and appropriate notification to physicians. Findings will be reported to the facility QA sub-committee monthly. Facility sub-committee will report to the facility QA committee quarterly for at least one year. QA Committee to evaluate all findings to determine need for additional education, audits, reviews, and/or policy revisions to ensure continued compliance.
5. Date of completion 2/5/2013



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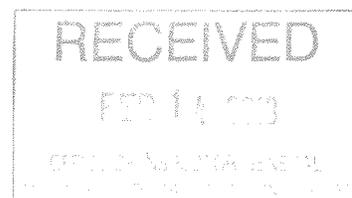
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F 157	Continued From page 3 not call the Doctor or give Tylenol for a temperature of 100.1 Interview with the Director of Nursing (DON), on 01/10/13 at 2:40 PM, revealed she would consider 100.1 to be a fever. The DON stated If a resident had an oxygenation saturation of 88, she would check the residents chart first to make sure the resident did not have chronic obstructive pulmonary syndrome, put the resident on two (2) liters of oxygen and then she would call the Doctor. Interview with the Medical Doctor (MD), on 01/10/13 at 1:46 PM, revealed he stated the nurse should have called him if the oxygen saturation was running 89% and the resident was running a fever. The resident may have needed to be sent to the hospital for further observation.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to meet standards of practice as it related to oxygen saturations and processing a Tylenol order in a timely manner for one (1) of five (5) sampled residents. Resident #1 displayed oxygen saturation of 89% and a Tylenol order was not processed timely.	F 281	F 281 1. Resident #1 was discharged from the facility 1-8-13. This was a closed record review. 2. As part of the Falls Management Meeting, the Interdisciplinary Team (Director of Nursing, MDS Coordinator, Director of Staff Development, Social Services Director, Administrator and Therapy Manager) reviewed documentation of all	



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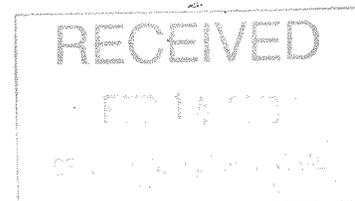
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F 281	<p>Continued From page 4 The findings include:</p> <p>Review of the facility's Lipincot Manual used as a reference to the nursing staff, revealed a normal oxygen saturation level for pulse oximeter was 95% to 100% for all adults.</p> <p>Review of Resident #1's Oxygen Flow Records for the month of 01/2013 revealed, on 01/07/13 on the 7PM to 7AM shift, Resident #1 had an oxygen level of 89%.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, 01/10/13 at 5:19 PM, revealed she would call the doctor if a resident's oxygen saturation was 88 to 89%. LPN #7 stated she would say that shortness of air was defined as having breathing difficulty outside of the normal breathing pattern. LPN #7 stated an oxygen saturation of 90% meant the resident was having difficulty breathing.</p> <p>Interview with LPN #8, on 01/10/13 at 5:35 PM, revealed an oxygen saturation of 88 to 89% would be a sign of shortness of air. LPN #8 stated she would call the Doctor if there was no order for oxygen.</p> <p>Interview with LPN #5, on 01/10/13 at 2:10 PM, revealed Resident #1's oxygen saturation had gotten as low as 88%. LPN #5 stated if the oxygen saturation did not get below 88%, the nurse would not be required to call the physician. Further interview, on 01/10/13 at 5:43 PM, revealed LPN #5 would not call the Doctor for an oxygen saturation of 89%.</p> <p>Interview with the facilities Consulting Respiratory Therapist, on 01/11/13 at 11:15 AM, revealed if a</p>	F 281	<p>neurochecks completed for past 30 days to ensure all checks were documented per policy. Director of Nursing reviewed all Physician orders for past 30 days, compared them to the MAR to ensure all orders were processed accurately.</p> <p>3. Education was provided by Director of Staff Development to licensed nursing staff (LPNs and RNs). Education included the facility policy on clinical record documentation. A posttest was given. They were reviewed by Director of Staff Development or Director of Nursing to determine understanding. This was completed on 2/4/2013. All newly hired licensed staff will be educated during orientation by the Director of Staff Development. Nursing Staff re-educated on the procedure for</p>		



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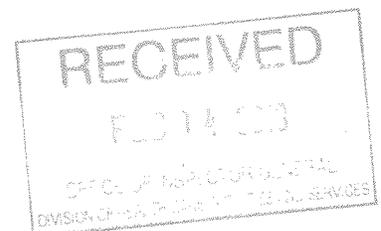
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F 281	<p>Continued From page 5</p> <p>residents oxygen saturation was 88 or 89%, she would first investigate what the family and doctors wishes were. The Consulting Respiratory Therapist expected the nurse to at least call the doctor for any oxygen saturation below 90%.</p> <p>Interview with the Director of Nursing (DON), on 01/10/13 at 2:40 PM, revealed if a resident had an oxygen saturation of 88%, she would check the resident's chart first to make sure the resident did not have Chronic Obstructive Pulmonary Syndrome, then place the resident on two (2) lters of oxygen and then, she would call the Doctor.</p> <p>2. The facility did not provide a policy in regards to the process of sending orders to the pharmacy.</p> <p>Review of Resident #1's nursing notes, on 01/07/13 at 9:00 PM, revealed Registered Nurse (RN) #1 documented at 4:00 PM that Resident #1 had a temperature of 100.4 degrees. RN #1 received an order for Tylenol 650 mg. On 01/07/13 at 5:00 PM, revealed an order for Tylenol 650 mg every four (4) hours for fever.</p> <p>Review of the Pharmacy fax containing the order for Tylenol, revealed it was faxed on 01/08/13 at 1:41 AM. No documentation could be provided by the pharmacy to show the Tylenol was replaced in the EDK box.</p> <p>Interview with RN #1, on 01/09/13 at 11:22 AM, revealed she was busy the night of the Tylenol order. There were four (4) other patients she was observing for temperatures that evening. RN #1 stated she knew she gave the medication, but she did not remember if she took the order off.</p>	F 281	<p>processing MD orders for medications, obtaining medications from the pharmacy and completion of the MAR. This was completed by Director of Staff Development on 2/4/2013.</p> <p>4. DON will review documentation of all resident assessments (identified by reviewing the reports of incidents, and the 24 hour report) weekly for 4 weeks, then a minimum of 5 per week for 4 weeks then 10 per month for 6 months. Results of these reviews will be used to determine need for re-education.</p> <p>Director of Nursing will check all MD orders daily for 5 days then weekly for 4 weeks to ensure all medication orders are processed accurately.</p>		



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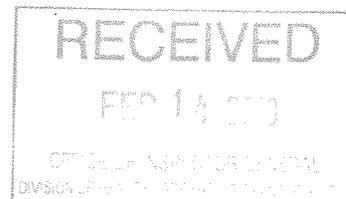
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F 281	Continued From page 6 RN#1 stated she normally wrote the order, faxed the top portion of the carbon paper to the pharmacy, and then signed that it was faxed. This process normally occurred as soon as the order was written. Interview with LPN #5, on 01/10/13 at 2:10 PM, revealed she did remember taking off orders in the early morning. LPN #5 stated there were so many orders, that she needed the assistance from LPN #4. Interview with the DON, on 01/10/13 at 2:40 PM, revealed when taking orders off, she would expect the nursing staff to receive the order, pull the copy, fax to the pharmacy and put it into the order pile for filling. This should occur as soon as possible, so the order would not be forgotten. The Tylenol order should not have been faxed 8 hours later.	F 281	Corporate Consultant will review audits of clinical documentation monthly for 3 months to ensure the incident is documented sufficiently in the clinical record and meets policy guidelines. All reviews, audits, observations will be reported to the facility QA sub-committee monthly and then will be reported to the facility QA Committee no less than quarterly for one year. 5. Date of completion 2/5/2013		
F 514 SS=D	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.	F 514			



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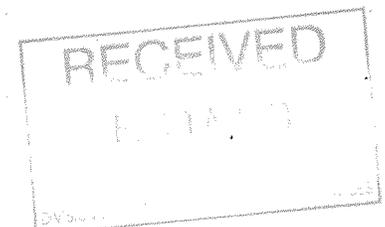
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F 514	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview, record review and review of the facility's policy, it was determined the facility failed to keep an accurate record as it related to nursing staff documentation of the administration of medication and not documenting Neuro checks as outlined per the facility's policy for one (1) of five (5) sampled residents. Resident #1.</p> <p>The findings include:</p> <p>1. Review of the Clinical Record Documentation Guidelines Policy, effective 02/20/12, revealed it was the policy of the facility to maintain a clinical record on each resident that was complete, accurately documented, accessible and organized. A complete clinical record contains an accurate and functional representation of the experience of the resident in the facility. It contains information to show that the facility knew the status of the resident, has a plan of care and provides evidence of the effects of the care provided. Documentation should provide a picture of the residents progress, including response to treatment, change in condition and changes in treatment. The record must contain sufficient information to identify individual assessments, plan of care, services provided and progress notes.</p> <p>Review of Resident #1's nursing notes, revealed on 01/07/13 at 9:00 PM, Registered Nurse (RN) #1 documented Resident #1 had a temperature at 4:00 PM of 100.4, relieved by 650 mg Tylenol dose ordered per Doctor. No adverse reaction was noted related to the new medication. Resident #1's orders revealed on 01/07/13 at 5</p>	F 514	<p>F514</p> <p>1. Resident #1 was discharged from the facility 1-8-2013. This was a closed record review.</p> <p>2. All reports of any incident and the 24 hour communication report sheets for the past 30 days have been reviewed to ensure the Physician and family of the resident were notified of any incidents with or without injury and any change in condition for the resident. This was completed on 2/4/2012 by Director of Nursing and Administrator.</p> <p>DON and Administrator reviewed clinical documentation related to each reported incident and any noted change in condition as noted on the 24 hour report to ensure appropriate assessment of the resident was completed. This was completed on 2/4/2013.</p>		



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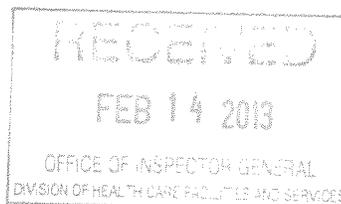
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F 514	<p>Continued From page 8</p> <p>PM a telephone order was written to administer Tylenol 650 mg for fever every four (4) hours. Not to exceed 4 grams daily. The Medication Administration Record (MAR) revealed no order for Tylenol 650 mg was transcribed onto the MAR. The Emergency Drug Kit (EDK) box, revealed no evidence anyone pulled Tylenol and filled out the carbon copy for a record of the withdrawal.</p> <p>Interview with RN #1, on 01/09/13 at 11:22 AM, revealed RN #1 walked to the EDK box to give Resident #1 a Tylenol. RN #1 stated she remembered she did not have an order and had to get permission to give the Tylenol. RN #1 stated she remembered four (4) other residents being sick that night and was very busy. RN #1 stated she did not miss giving the Tylenol to Resident #1 and she remembered faxing the pulled copy to pharmacy late that evening, but she was not sure if she faxed the order.</p> <p>Record review of Resident #1's faxed Tylenol order, revealed the order was faxed on 01/08/13 at 1:41 AM,</p> <p>Further interview with RN #1 stated she normally writes the order, faxes the top portion of the carbon copy to the pharmacy and signs that the order was faxed. RN #1 further stated she could not say if the record held an accurate account of what happened on 01/07/13 if there was no evidence to prove the Tylenol was given.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 01/10/13 at 5:19 PM, revealed when the nurse obtains an order the nurse can sometimes get the medication from the EDK box. Once the</p>	F 514	<p>As part of the Falls Management Meeting, the Interdisciplinary Team (DON MDS Coordinator, Director of Staff Development, Administrator, Director of Social Services, and Therapy Manager) reviewed documentation of all neurochecks completed for past 30 days to ensure all checks were documented per policy.</p> <p>Director of Nursing reviewed all Physician orders for past 30 days, compared them to the MAR to ensure all orders were processed accurately.</p> <p>3. Education was provided by Director of Staff Development to licensed nursing staff (LPNs and RNs). Education included</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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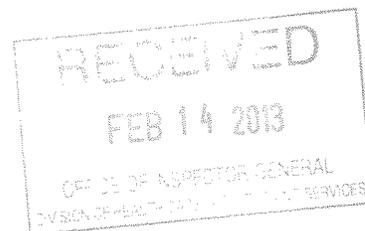
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2013
NAME OF PROVIDER OR SUPPLIER COLONIAL HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004	
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F 514	<p>Continued From page 9</p> <p>medication was pulled from the EDK box, a form is completed to identify the medication taken from the box and is then faxed to the pharmacy.</p> <p>2. Review of the Neurological Assessment policy, updated 01/19/10, revealed to complete the Neurological Assessment sheet according to the following guidelines for the first 24 hour period: every fifteen (15) minutes for the first hour, then every thirty (30) minutes for the next hour, then every two (2) hours for the next twenty-two (22) hours. Please note Medical Doctor must be notified immediately if there is anything different from the residents normal status.</p> <p>Review of Resident #1 Neurological Assessment form, dated 01/07/13, revealed between the hours of three (3) AM and seven (7) AM, no neurological assessment was completed.</p> <p>Review of Resident #1's Neurological Assessment at 3:00 AM, revealed a Blood Pressure of 136/66, temperature of 99.6, pulse of 86 and respirations of 20 was documented. At 7:00 AM, revealed a blood pressure of 110/62, temperature of 100.1, pulse of 116 and respirations of 24. Resident #1 was sent out to the Emergency Room for evaluation on 01/08/13 at 7:30 AM.</p> <p>Interview with LPN #5, on 01/10/13 at 6:29 PM, revealed she did not notice there was no Neurological check completed at 5 AM. She had it written down on her piece of paper, long enough to do her assessment, because she was passing medication. LPN #5 stated she failed to transcribe the assessment over onto the neurological assessment form.</p>	F 514	<p>the facility policy on clinical record documentation. A posttest was given. They were reviewed by Director of Staff Development or Director of Nursing to determine understanding. This was completed on 2/4/2013. All newly hired licensed staff will be educated during orientation by the Director of Staff Development.</p> <p>Licensed nurses were re-educated on the facility policy for notification of change, initiation and completion of the incident reporting process and investigation system, completion of the 24 hour report, and nursing documentation guidelines. This included notification to families and physicians when an incident occurs or a change in condition occurs. This education was presented by Director of Staff Development on 2/4/2013. Nurses</p>	



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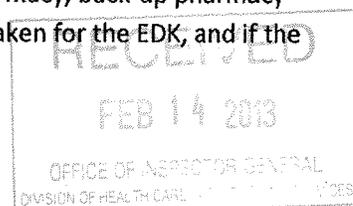
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F 514	Continued From page 10 Interview with the Director of Nursing (DON), on 01/10/13 at 2:40 PM, revealed she would expect the nursing staff, when taking orders off to complete the ordering process in a timely manner and to document for accuracy when completing assessments.	F 514	completed a posttest after the education to evaluate understanding. Tests were reviewed by the Director of Staff Development. This education will be repeated monthly for 3 months then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator. Nursing Staff re-educated on the procedure for processing MD orders for medications, obtaining medications from the pharmacy and completion of the MAR. Included in the education was the EDK process. This was completed by Director of Staff Development . The facility EDK box was reviewed as to content and the policy related to accessing the EDK box was reviewed. A copy of the procedure "Emergency Pharmacy Service and Emergency Kits" was placed in the Reference Book on each unit .		



4. The Director of Nursing and Administrator will audit all incidents reported, using the incident reporting procedure and the 24 hour communication tool, to ensure notification was made to the physician and family and was documented in the clinical record, and that a clinical assessment of the resident is completed and documented, weekly for the next 3 months. DON or Nurse Supervisor will audit 25% of the incident reports monthly thereafter to ensure continued compliance.

Director of Nursing will review documentation of all resident assessments (identified by reviewing the reports of incidents, and the 24 hour report) weekly for 4 weeks, then a minimum of 5 per week for 4 weeks then 10 per month for 6 months. Results of these reviews will be used to determine need for re-education.

Director of Nursing will check all MD orders daily for 5 days then weekly for 4 weeks to ensure all medication orders are processed accurately, if it was a stat order for a new medication facility will determine if medication was delivered from pharmacy, back-up pharmacy or taken for the EDK, and if the



EDK is used that all appropriate documentation was completed.

Corporate Consultant will review audits of clinical documentation, and review of all reported incidents monthly for 3 months. Then she will continue audits/reviews of 25% of the incident reports monthly for 3 months to ensure the incident is documented sufficiently in the clinical record and meets policy guidelines.

All reviews, audits, observations will be reported to the facility QA sub-committee monthly and then will be reported to the facility QA Committee no less than quarterly for one year.

5. Date of completion 2/5/2013