

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

PRINTED: 09/02/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186340	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  C 08/18/2014
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141
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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 000	INITIAL COMMENTS  An Abbreviated Survey Investigating KY #22068 was conducted on 08/12/14 through 08/18/14 to determine the facility's compliance with Federal requirements. KY #22068 was unsubstantiated with unrelated deficiencies cited.	F 000	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 conclusion set forth in this Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.	
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 observation, interview, record review, review of the facility's policy/procedure, and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to have an effective system to ensure medication was administered according to the professional standards of quality for one (1) resident, in the selected sample of three (3) residents (Resident #1). The facility failed to have an effective system in place to ensure medications were supervised by the licensed staff.  The findings include:  Review of the facility's policy and procedure titled "Medication Administration - General Guidelines", revised 12/18/12 revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Additional guidelines for self-administration of medications revealed residents who desire to self-administer	F 281	F281  1. ARNP was notified by the nurse on 08/13/2014. Order to leave meds at bedside for resident to take with meal was discontinued on 08/13/2014 as well. Memo was placed in front of Resident #1's MAR, Medication Administration Record, on 08/13/14 alerting nurses of change in resident's plan of care. Resident's care plan was updated and resident and family were made aware of changes and voiced their understanding and agreement.  2. A 100% audit was completed by the Director of Nursing on 08/14/2014 for orders to leave meds at bedside. No other residents had that order.  3. Inservice was provided to all licensed staff and CMT(Certified Medication Techs) on Medication Administration Guidelines to include but not limited to standards of practice for drug administration on 09/03/2014 by the Assistant Director of Nursing.  4. Med Care Pharmacy will complete medication pass observation report monthly times 6 months for licensed staff and CMT(Certified Medication Techs). The findings of these observation reports will be reported to the Director of Nursing who will review and forward the results to the QA committee.  5. Date of Completion: 09/03/2014	9/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Chris Page</i>	TITLE  ADMINISTRATOR	(X6) DATE  9-11-14
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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>medications are permitted to do so if the facility's interdisciplinary team has determined the practice would be safe for the resident and other residents of the facility. Additionally, a review of the facility's standards of practice for drug administration, titled "Enteral Administration", revealed the staff should stay with the resident until he/she had swallowed the medications not leaving them unattended.</p> <p>Review of the KBN Advisory Opinion, AQS #14, last revised 10/2010, revealed Registered Nurses (RN) and Licensed Practical Nurses (LPN) are required to administer medications and treatments prescribed by the physician, physician assistant, dentist and advanced practice registered nurse. Components of medication administration are preparing and giving medication in the prescribed dosage, route, and frequency and monitor for its affect.</p> <p>Record review revealed the facility admitted Resident #1 on 11/29/12 with diagnoses which included Alzheimer's, Hyperlipidemia, Diabetes Mellitus Type II, Anxiety, Osteoarthritis, Depression, Hypertension, Osteoporosis, Chronic Kidney Disease, Anemia, and Cardiomegaly. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/09/14, revealed the facility assessed Resident #1 as cognitively intact, with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Resident #1 had sustained a head injury related to two (2) recent falls.</p> <p>Review of a physician's order, dated 01/22/14, revealed "may leave PO medications at the bedside with the resident to take with meals".</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>Review of a Physician's Progress Notes, dated July 2014, revealed Resident #1 had a recent decline in his/her Alzheimer's. Additionally, a review of the Emergency Room (ER) record, dated 08/18/14, and again on 07/19/14, revealed "CT head without contrast as soon as possible due to head injury".</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 08/06/14, revealed "may leave by mouth (PO) medications at the bedside to take with meals".</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated 08/01/14 through 08/31/14, revealed medications ordered to be given at 8:00 AM included Aspirin 81 milligrams (mg), take two (2) tablets; Coreg 3.125 mg, take one (1) tablet; Celexa 10 mg, take one-half (1/2) tablet; Ferrous Sulfate 325 mg, take one (1) tablet; Namenda XR 21 mg, take one (1) capsule; Septra DS 800/160 mg, take one (1) tablet; Torsemide 10 mg, take one (1) tablet; Vitamin D3 2000 Units, take one (1) capsule; and Macrobid 100 mg, take one (1) tablet. Additionally, at 9:00 AM, medications included Tylenol 500 mg, take one (1) tablet.</p> <p>On 08/13/14 at 8:36 AM and 9:01 AM, Resident #1 was observed to have nine and one-half pills laying on his/her over-the-bed table, unattended by the licensed staff as well as the Certified Medication Technician (CMT). At 9:54 AM, 10:55 AM, and 11:22 AM, Resident #1 was observed to have eleven and one-half pills laying on his/her over-the-bed table, unattended by the licensed staff or the CMT, and with no supervision by the nurse to be administered.</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>On 08/13/14 at 12:07 PM, an interview and review of the resident's MAR with CMT #1, revealed she had taken both 8:00 AM and 9:00 AM doses of medications into the resident's room and left them unattended. She voiced a concern about wandering residents picking the medication up and/or taking the medication; however, observations revealed the medication remained on the resident's bedside table throughout the morning.</p> <p>On 08/14/14 at 12:42 PM, an interview with the Director of Nursing (DON), revealed medications should not be left unattended at any time. She stated the facility conducts an assessment of the resident to determine if they are capable of self-administering their own medications; however, she does not have a process to document an assessment to identify safety of self-administering medications.</p> <p>On 08/15/14 at 1:12 PM, an interview with the resident's Physician revealed this was not a safe practice related to other residents potentially getting the medication. He expressed the extreme importance that this resident received his/her medications as ordered to prevent worsening of his/her condition. He stated the resident has experienced conditions, that without proper medication administration, he/she could expire. He stated this resident had recently had a decline in his/her Alzheimer's Disease and felt he/she required supervision to take their medications. Additionally, he voiced concerns that the resident's recent falls could be a contributing factor to him/her not being able to self-administer his/her own medications. He revealed he had not co-signed any orders for PO medications to be left at the bedside.</p>	F 281			

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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, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide adequate supervision of medications to prevent accidents for one (1) resident, in the selected sample of three (3) residents (Resident #1). The facility failed to have an effective system in place to ensure medications were supervised by the licensed staff. On 08/13/14 at 8:36 AM and 9:01 AM, there were nine and one-half (9 1/2) pills laying on the resident's over-the-bed table. Continued observation at 9:54 AM, 10:55 AM, and 11:22 AM, revealed there were eleven and one-half (11 1/2) pills laying on his/her over-the-bed table, unattended by staff.</p> <p>The findings include:  Review of the facility's policy and procedure titled "Medication Administration - General Guidelines", revised 12/18/12 revealed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Additional guidelines for self-administration of medications revealed residents who desire to self-administer</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> <li>1. ARNP was notified by the nurse on 08/13/2014. Order to leave meds at bedside for resident to take with meal was discontinued on 08/13/2014 as well. Memo was placed in front of Resident #1's MAR, Medication Administration Record, on 08/13/14 alerting nurses of change in resident's plan of care. Resident's care plan was updated and resident and family were made aware of changes and voiced their understanding and agreement.</li> <li>2. A 100% audit was completed by the Director of Nursing on 08/14/2014 for orders to leave meds at bedside. No other residents had that order.</li> <li>3. Inservice was provided to all licensed staff and CMT(Certified Medication Techs) on Medication Administration Guidelines to include but not limited to standards of practice for drug administration on 09/03/2014 by the Assistant Director of Nursing.</li> <li>4. Med Care Pharmacy will complete medication pass observation report monthly times 6 months for licensed staff and CMT(Certified Medication Techs). The findings of these observation reports will be reported to the Director of Nursing who will review and forward the results to the QA committee.</li> <li>5. Date of Completion: 09/03/2014</li> </ol>	9/3/14	

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F 323	<p>Continued From page 5</p> <p>medications are permitted to do so if the facility's interdisciplinary team has determined the practice would be safe for the resident and other residents of the facility. Additionally, a review of the facility's standards of practice for drug administration, titled "Enteral Administration", revealed the staff should stay with the resident until he/she had swallowed the medications not leaving them unattended.</p> <p>Record review revealed the facility admitted Resident #1 on 11/29/12 with diagnoses which included Alzheimer's, Hyperlipidemia, Diabetes Mellitus Type II, Anxiety, Osteoarthritis, Depression, Hypertension, Osteoporosis, Chronic Kidney Disease, Anemia, and Cardiomegaly. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/09/14, revealed the facility assessed Resident #1 as cognitively intact, with a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. Resident #1 had sustained a head injury related to two (2) recent falls.</p> <p>Review of a physician's order, dated 01/22/14, revealed "may leave PO medications at the bedside with the resident to take with meals".</p> <p>Review of a Physician's Progress Notes, dated July 2014, revealed Resident #1 had a recent decline in his/her Alzheimer's. Additionally, a review of the Emergency Room (ER) record, dated 06/18/14, and again on 07/19/14, revealed "CT head without contrast as soon as possible due to head injury".</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 08/06/14, revealed "may leave by mouth (PO) medications at the bedside to take</p>	F 323			

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F 323	<p>Continued From page 6 with meals".</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated 08/01/14 through 08/31/14, revealed medications ordered to be given at 8:00 AM included Aspirin 81 milligrams (mg), take two (2) tablets; Coreg 3.125 mg, take one (1) tablet; Celexa 10 mg, take one-half (1/2) tablet; Ferrous Sulfate 325 mg, take one (1) tablet; Namenda XR 21 mg, take one (1) capsule; Septra DS 800/160 mg, take one (1) tablet; Torsemide 10 mg, take one (1) tablet; Vitamin D3 2000 Units, take one (1) capsule; and Macrobid 100 mg, take one (1) tablet. Additionally, at 9:00 AM, medications included Tylenol 500 mg, take one (1) tablet.</p> <p>On 08/13/14 at 8:35 AM and 9:01 AM, Resident #1 was observed to have nine and one-half pills laying on his/her over-the-bed table, unattended by the licensed staff as well as the Certified Medication Technician (CMT). At 9:54 AM, 10:55 AM, and 11:22 AM, Resident #1 was observed to have eleven and one-half pills laying on his/her over-the-bed table, unattended by the licensed staff or the CMT, and with no supervision by the nurse to be administered.</p> <p>On 08/13/14 at 8:36 AM, an interview with Resident #1 revealed he/she would take his/her medications in awhile. The resident stated he/she liked to take them a few at a time with his/her meals.</p> <p>On 08/13/14 at 12:07 PM, an interview and review of the resident's MAR with CMT #1, revealed she had taken both 8:00 AM and 9:00 AM doses of medications into the resident's room and left them unattended. She stated there was</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>an order from the physician to leave the medications at the bedside, and the medications had been there since approximately 8:30 AM. She voiced a concern about wandering residents picking the medication up and/or taking the medication; however, observations revealed the medication remained on the resident's bedside table throughout the morning.</p> <p>On 08/13/14 at 11:22 AM, an observation and interview with the Director of Nursing (DON) revealed there were eleven and one half (11 1/2) medications laying on the resident's over the bed table. She revealed concerns related to the medications being unsupervised to include other residents wandering into the room and taking the medications, and voiced concern about Resident #1 not taking his/her medications in a timely manner. Further interview with the DON, on 08/14/14 at 12:42 PM, revealed medications should not be left unattended at any time. She stated the facility conducts an assessment of the resident to determine if they are capable of self-administering their own medications; however, she does not have a process to document an assessment to identify safety of self-administering medications.</p> <p>On 08/15/14 at 1:12 PM, an interview with the resident's Physician revealed this was not a safe practice related to other residents potentially getting the medication. He expressed the extreme importance that this resident received his/her medications as ordered to prevent worsening of his/her condition. He stated the resident has experienced conditions, that without proper medication administration, he/she could expire. He stated this resident had recently had a decline in his/her Alzheimer's Disease and felt</p>	F 323			

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F 323	Continued From page 8 he/she required supervision to take their medications. Additionally, he voiced concerns that the resident's recent falls could be a contributing factor to him/her not being able to self-administer his/her own medications. He revealed he had not co-signed any orders for PO medications to be left at the bedside.	F 323			