

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

PRINTED: 09/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(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 000	<p>INITIAL COMMENTS</p> <p>Amended CMS 2567 issued to the facility on 9/26/12. Changes made to Initial Comments, F281, F312, F425, F431, F493, F502, F505, F520 Changes made regarding scope and severity of F371, F493 Deleted F332</p> <p>An abbreviated survey (KY #18900, #18959, #18984) was conducted 08/20/12 through 09/07/12 during this time two different Immediate Jeopardy (IJ) situations had been identified. The annual recertification survey was initiated and conducted in conjunction with the abbreviated surveys on 09/04/12 through 09/07/12.</p> <p>1. IJ was determined to exist on 07/25/12 and is ongoing regarding Residents #8, #7, and #5 at F157, F309, F425, F490, F493, F520 (KY #18959, KY #18984). The facility failed to provide pharmaceutical services that ensured the availability and timely administration of drugs and biologicals to meet the needs of each resident. The facility failed to ensure the contracted pharmacy could ensure all necessary medications ordered to meet the residents' needs could be procured timely whether for routine or emergency medications. Furthermore, the facility failed to ensure the contracted pharmacy had contracted with a local pharmacy to ensure timely procurement of medications for it's residents. The facility failed to ensure staff was knowledgeable of the pharmacy and facility policies and procedures for the procurement of medications to ensure timely receipt and administration of medications. The facility failed to ensure the emergency drug kit maintained</p>	F 000	<p>Lake Way Nursing & Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Way's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further, Lake Way reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jim Kennedy

ADMINISTRATOR

11-9-2012

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 000	<p>Continued From page 1</p> <p>pharmaceuticals to meet the needs of residents while having the knowledge of identified difficulties in getting timely receipt of medications from the contract pharmacy. Furthermore, the facility failed to take necessary action to address identified issues with the contracted pharmacy's inability to provide medication timely to the facility. The facility failed to ensure pain medication was available and administered timely to for two residents #8 and #7.</p> <p>Resident #8 was admitted to an acute care hospital with a diagnosis to include Hyponatremia (low sodium). Resident #5 returned to the facility on 07/25/12 with physician orders for Samsca (hyponatremia); however, the facility failed to ensure the resident received the medication for seven days after re-admission. An interview with the hospital physician revealed the hyponatremia would get worse without the Samsca and could be life threatening.</p> <p>The facility admitted Resident #7 on 07/25/12 after having back surgery. Due to the facility's failure to ensure timely receipt of medications, per their pharmacy contract, Resident #7 experienced severe intense pain per the facility's assessment, having no pain medication for 14 hours after admission. Additionally, the facility failed to ensure staff conducted a thorough assessments of residents to identify a change in condition. The facility failed to ensure timely physician notification of change in condition to include providing an accurate assessment of the resident's condition to the physician to address the resident's change in condition.</p> <p>Director of Nursing (DON), on 08/31/12, revealed</p>	F 000			

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F 000	<p>Continued From page 2</p> <p>there was no policy (or standard of practice) utilized in the facility related to assessment of a resident. On 08/18/12 at 6:30 AM, the facility found Resident #5 on the floor sustaining a fall from the bed. While the facility assessed the resident while on the floor identifying no injuries, upon transfer assistance to the bed, Resident #5 complained of neck pain. The facility did not re-assess, initiate standards of practice to stabilize the resident due to potential neck injury, and did not notify the physician of the condition change. The staff continued to dress and transfer the resident to the wheelchair and transported the resident to the dining room for breakfast. The resident continued to express increased complaints of pain to multiple staff including the facility Registered Nurse (RN). The facility failed to re-assess the resident due to increased pain. The facility did not notify the physician for approximately two hours, the facility did not detail an accurate description of the resident condition stating the resident had no injury with a little pain. The physician ordered pain medication; however, the medication was not available. The back-up pharmacy was not open. The facility's emergency drug kit contained no pain medications. The facility made no further attempts to pain medication was given to the resident timely. Additionally, the resident's family requested the facility send the resident to the emergency room. The physician indicated he was agreeable for the family to take resident #5 by family car; however, did not order an ambulance at the time. Resident #5's family arrived at the facility to find the resident with continued neck pain. The resident was transferred by family to the emergency room at approximately 9:30 AM, three hours after the fall. Resident #5 did not receive any pain</p>	F 000		
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F 000	<p>Continued From page 3</p> <p>medication prior to the transfer. The resident was admitted to the hospital with an acute C2 spine fracture. The physician stated the facility's assessment was not expressed as a serious situation.</p> <p>2. Then continued non-compliance at the IJ level was identified on 08/04/12 and is ongoing related to Resident #2 at F280, F323, F490, and F493 (KY #18900). The facility failed to assess residents to determine the safe use of devices (air mattress and side rails) prior to utilization. The facility failed to ensure staff was trained and knowledgeable regarding low air loss/alternating mattresses and to ensure appropriate setting for each residents assessed needs. The facility failed to identify causal factors of a fall which prevented the facility from taking the necessary action to ensure the safe use of assistive devices. On 07/26/12, the facility initiated the use of a low air loss/alternating pressure mattress with bilateral half side rails for Resident #2 related to pressure sores. The facility failed to assess for the safe use of these assistive devices. Resident #2 sustained two falls from the low air loss/alternating air mattress, with the second fall resulting in a side rail entrapment. The facility failed to identify or determine the causal factor of the fall or complete an assessment to determine whether the continued use of the low air loss/alternating mattress with bilateral half side rails was safe for use by Resident #2. The facility failed to revise the care plan to include a new intervention to prevent recurrence of the falls and entrapment after the fall on 08/04/12. While the mattress was discontinued on 08/06/12, the facility placed the resident back on the low air loss/alternating mattress with bilateral half side</p>	F 000			

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F 000	<p>Continued From page 4</p> <p>rails again on 08/21/12 at which time the facility failed to assess the resident for the safe use of the assistive devices until 08/22/12, the day after the devices were utilized for Resident #2. The facility failed to include the history of entrapment as a risk for the resident. The facility failed to revise the care plan to ensure safety interventions were included related to the resident's continued use of the air loss/alternating mattress with bilateral half side rails. The facility failed to ensure the resident's mattress was inflated adequately to his/her weight and failed to ensure the correct spacing between the mattress and side rail were provided to prevent entrapment. The facility failed to ensure all staff was trained and knowledgeable of how to operate the low air loss/alternating mattress specific to the resident's needs and failed to ensure their knowledge of risks associated with these devices. The facility had identified two other residents (#3 and #4) utilizing a low air loss/alternating mattress with bilateral half side rails for which the facility failed to assess for the safe use of these devices and failed to ensure the inflation of the air mattress was adequate for each resident.</p> <p>Based on the above findings, it was determined that Immediate Jeopardy was initially determined to exist as of 07/25/12 based on residents #8 and #7 and is considered ongoing.</p> <p>An abbreviated survey (KY #18900, #18959, #18984) was conducted 08/20/12 through 09/07/12 during this time two different Immediate Jeopardy (IJ) situations had been identified. The annual recertification survey was initiated and conducted in conjunction with the abbreviated surveys on 09/04/12 through 09/07/12.</p>	F 000			

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F 000	Continued From page 5 KY#18900, #18959, #18964 were substantiated with deficiencies cited. Immediate Jeopardy was identified on 08/23/12 and determined to exist on 07/25/12 and continued non-compliance at an IJ level was determined to exist on 08/04/12 with Substandard Quality of Care Identified at 42 CFR 483.25 Quality of Care F309, F312 and F323. Deficiencies were cited with the highest S/S at a "L."	F 000			
F 157 SS=J	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.	F 157	F157 Resident #5 was discharged from the facility on 8/18/12. Prior to discharge, Resident #5 experienced a fall on August 18, 2012 at 0630. The resident's skin and range of motion was assessed by the licensed nurse. The assessment found the resident to have no injury. The resident did say his "neck hurt a little" as he touched the back left side, according to documentation in the medical record. At 0825 the resident began to complain of increased neck pain. Three attempts were made by the licensed nurse to contact the responsible parties listed in the medical record with no answer. At 0830 the licensed nurse notified the resident's attending MD of the resident's increased complaints of neck pain and orders were received for Tramadol 50mg BID PRN for pain. The nurse asked the MD to		

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F 157	Continued From page 6 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure timely physician notification for two residents (#5, #9) in the selected sample of eighteen residents. The facility failed to immediately consult with the physician after an accident involving a resident which resulted in injury and had the potential for requiring physician intervention for one resident (#5), Resident #5 sustained a fall from the bed, on 08/18/12 at 6:30 AM. Registered Nurse (RN) #2 assessed Resident #5 after the fall. The resident was holding the back of his/her neck and complained of "a little bit" of neck pain. After the transfer to bed, the nurse failed to notify the physician immediately after the fall with a complaint of neck pain. Multiple staff which included State Registered Nurse Aide (SRNA) #1, Nurse Aide (NA) #1, and RN #2, stated the resident continued to complain of neck pain as evidenced by statements of "my neck hurts" every time the staff passed by the resident. The facility failed to re-assess the resident's condition. The facility notified the physician at 8:30 AM, two hours after the fall, detailing the resident had no injury with a little pain, failing to give the physician an accurate picture of the resident's condition, which prevented the physician from being able to order timely and effective treatment. These failures prevented Resident #5 from receiving	F 157	call the prescription in to the backup pharmacy. At 0835 the licensed nurse reached a responsible party. The nurse informed the responsible party of the resident's fall as well as the new orders received. This responsible party requested the resident be sent to the ER for evaluation. At 0837 the licensed nurse notified the physician of the responsible party's request and the physician gave the order to send Resident #5 to the hospital for evaluation. The licensed nurse contacted the nurse practitioner at 0845 and requested pain medication. At 0930 family members arrived to take the resident to the ER for evaluation. Resident #5 was discharged from the facility on 8/18/12. Registered Nurse #2 is no longer employed by the facility. All current in-house residents who had fallen within the last 30 days were re-assessed. The Facility Consultant completed the re-assessments 9/5/12 through 9/7/12. The re-assessments included 1) a review of the investigation into the fall 2) a review of the assessment	

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F 157	<p>Continued From page 7</p> <p>timely treatment experiencing increased pain for more than three hours without treatment, and the family having to transport the resident to the emergency room. The resident was admitted to the hospital with an acute fracture of the neck. Additionally, the facility failed to ensure timely physician notification of a lab result, indicating an antibiotic ordered for Resident #9, was ineffective. This failure resulted in a delay of the physician's response to order an effective treatment for Resident #9. The facility assessed Resident #9 as continuing to have signs and symptoms of fluctuations of blood pressure and temperature for the period of 05/25/12 through 05/29/12 without effective antibiotic treatment.</p> <p>The facility's failure to ensure the physician was immediately consulted after an accident involving Resident #5 that resulted in injury has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/31/12 and determined to exist on 08/18/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined to be on-going. (Refer to F309).</p> <p>Findings include:</p> <p>A review of the "Notification of Physician for a Change in Resident's Condition" policy, dated 04/07, revealed the facility would notify the physician when a significant change in a resident's condition occurred with documentation.</p> <p>1. A record review revealed the facility admitted Resident #5 on 08/03/12 with diagnoses to include History of Transient Ischemic Attack,</p>	F 157	<p>and documentation completed at the time of the event. 3) re-assessment of the residents to ensure they were not experiencing any change in condition, experiencing any new pain or experiencing pain that is unrelieved at this time. 4) Identification of three residents who had an event/change which required MD/RP notification. The three residents' medical doctors and responsible parties were notified and appropriate action taken.</p> <p>All Licensed Nurses were in-serviced by the Staff Facilitator beginning on 9/5/12 and completed on 9/20/12 related to their responsibility to notify Physicians of accidents, changes in condition to include continued complaints of unrelieved pain to ensure that Residents are receiving the proper follow up based on their individual needs.</p> <p>Additional in-servicing with all licensed staff was initiated on 9/21/12 and completed on 9/29/12 by the Facility Consultant related to assessing pain, to include after a fall or if there is a change in condition.</p>		

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F 157	<p>Continued From page 8</p> <p>Vascular Dementia, Muscle Weakness, Lack of Coordination, Dysphagia, and Dysarthria. A review of the initial Minimum Data Set (MDS), dated 08/10/12, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance of two staff with bed mobility, transfer, and ambulation. A review of the pain management assessment, dated 08/10/12, revealed the resident did not have any current reports of pain and no pain medication ordered. A review of the Fall Risk assessment, dated 08/17/12, revealed a fall score of twelve (12), which indicated he/she was at risk for falls.</p> <p>A review of the incident report, dated 08/18/12 at 6:30 AM, revealed Resident #5 sustained an unwitnessed fall and was assessed with "no injury"; however, the resident complained of neck pain after being transferred from the floor to the bed. According to the report, the resident touched the back left side of his/her neck and stated "it hurt a little bit."</p> <p>An interview with SRNA #1, on 08/24/12 at 12:20 PM, revealed she found Resident #5 in his/her room on the floor. The resident was found on his/her right side beside the bed, one foot straight out while the other was curled up underneath him/her. The resident's neck was turned to the side and he/she was looking at her when she entered the room. She indicated the resident's position was "weird." She immediately informed RN #2 of the fall. RN #2 then assessed the resident. SRNA #1 and SRNA #2 then transferred the resident to the bed and he/she immediately complained of neck pain, pointing to the back of the neck. RN #2 asked the resident if he/she could move his/her neck, and the resident was</p>	F 157	<p>The packet titled "Checklist for Conducting an Assessment after an Event" was implemented on 9/5/12. This Checklist includes a neurological observation sheet, a pain tool, assessment tool, and witness statement. Copies of the Checklist will be kept at the nurse stations in a binder titled "Assessment & Observation of a Nursing Home Resident". The staff facilitator and/or DON will be responsible for keeping copies of the Checklist packets available daily for staff to use when a resident has a change in condition, incident, or accident.</p> <p>Education on when and how to use the "Checklist for Conducting an Assessment After an Event" was provided on 9/5/12 and again on 9/10/12 by the Facility Consultant. Training participants included the MDS RN, MDS LPN, QI nurse, RN staff facilitator, LPN admissions coordinator, ADON, DON, and administrator. The training provided instruction that the Checklists be used as guides to assist the licensed staff when assessing the resident</p>	

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F 157	<p>Continued From page 9</p> <p>able to follow instructions. SRNA #1 dressed the resident and transferred him/her to the wheelchair for breakfast, with assistance from SRNA #2. The resident continued to complain of neck pain during the provision of care and up until the time he/she was transferred to the emergency room.</p> <p>An interview with SRNA #2, on 08/24/12 at 1:00 PM, revealed she assisted SRNA #1 in transferring the resident to bed. The resident indicated the back of his/her neck hurt "a little bit" at that time. She assisted SRNA #1 in dressing the resident and getting him/her up for breakfast. While providing care, the resident complained of neck pain "once or twice."</p> <p>An interview with NA #1, on 08/24/12 at 12:05 PM, revealed she saw the resident up in the lobby with continued complaints of neck pain. She revealed the resident's neck was "stiff" and he/she constantly repeated "my neck hurts." She made RN #2 aware of the complaints, but was unaware of what action RN #2 had taken.</p> <p>A review of the Progress Notes, dated 08/18/12 at 8:30 AM, revealed the physician was not notified of the fall until two hours later.</p> <p>An interview with RN #2, on 08/24/12 at 1:05 PM, revealed the resident complained of "a little bit" of pain after being transferred from the floor to the bed. The resident's pain worsened throughout the morning; however, she was unable to describe the pain as she did not reassess the resident. She stated that the resident would repeat "my neck hurts" every time she passed him/her in the lobby area. She admitted the resident's physician was not notified</p>	F 157	<p>after a change in condition, incidents or accidents, including falls. Competency using the Checklist, for the administrative nurses and administrator, was determined through discussion, question and answer period, at the end of the training.</p> <p>The second educational training on when and how to use the "Checklist for Conducting an Assessment After an Event" was provided on 9/5/12 and again on 9/10/12 by the staff facilitator, ADON, and QI nurse. Licensed nurses received the Checklist training prior to their next scheduled shift. Competency was determined by the instructors through discussion, question and answer period at the end of the trainings.</p> <p>Education on the Checklist and tools will be provided for newly hired licensed staff during the orientation process by the staff facilitator. Competency will be determined by the staff facilitator through return demonstrations during the orientation process.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 157	<p>Continued From page 10</p> <p>until 8:30 AM, as she had other tasks to complete. She informed the physician about the resident's fall with a complaint of neck pain.</p> <p>An interview with Family #1 and Family #2, on 08/30/12 at 9:00 AM and 9:20 AM, respectively, revealed Family #1 received a call from RN #2 approximately two hours after the resident sustained the fall. He was informed the resident had "no injury" but complained of neck pain. He requested the facility send the resident to the emergency room, but RN #2 stated (at a later time) that the resident could go by family car as the physician refused to send the resident by ambulance. Family #1 and Family #2 indicated they arrived at the facility to take the resident to the emergency room at approximately 9:30 AM. Family #1 stated the resident was complaining of neck pain and "holding" his/her neck when they arrived. Family #2 verified the resident was "almost out of the wheelchair trying to hold his/her neck up." The resident continuously repeated "my neck hurts." Family #1 verified the resident "never" complained of pain prior to this incident. He stated that even if the resident was in pain, he/she usually would not complain.</p> <p>A review of the progress notes, dated 08/16/12 at 9:30 AM, revealed the resident was transferred by family car to the emergency room. Further interview with RN #2 revealed if the family was still concerned about the resident, they could transfer him/her to the emergency room per family car. RN #2 stated she did not ask to send the resident per ambulance at that time.</p> <p>An interview with the Primary Physician, on 08/30/12 at 10:20 AM, revealed he was informed</p>	F 157	<p>The facility QI nurse was in-serviced on 9/7/12 by the Facility Consultant related to the review of how to complete the Fall/Incident Assessment QI to include: 1) review of the "Checklist for Conducting an Assessment After an Event" for completion, 2) validate MD/RP notification date/time, 3) review of daily progress note for entry of event, 4) assessment, and actions, review of documentation for pain assessment, 5) pain management action taken, and 6) evaluation of resident's response to pain intervention. Specifically, identifying if pain medication was provided if indicated, and checking the time frame between complaint of pain and the time pain medication given. The Facility QI nurse was deemed competent to review and complete incident investigations based on over-sight by the Facility Consultant and review of completed incident reports and investigations. (The facility QI Nurse has been removed from this position. The facility is accepting applications for the QI nurse position. The task of reviewing Fall/Incident Assessment QIs is currently reassigned to the</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 157	<p>Continued From page 11</p> <p>the resident had rolled out of bed and "appeared fine." He did not recall hearing about the neck pain initially. He expected the staff to transmit to him what they had assessed related to an injury after a fall.</p> <p>A review of the Discharge Summary from the hospital, dated 08/20/12, revealed the resident sustained an acute fracture of C2 (neck fracture) in the lateral mass and facet area with a mild subluxation of C2 on C3. Further interview with RN #2 revealed she should have notified the physician immediately; however, she did not realize the seriousness of the situation. Further interview with the physician revealed the information expressed to him was not sufficiently given as a serious situation.</p> <p>An interview with the Director of Nursing (DON), on 08/31/12 at 1:15 PM, revealed the physician should be notified immediately (within a few minutes after the assessment) of a possible neck injury after a fall. She expected the nurse to leave the resident in the bed as neck pain was indicative of a neck injury and should be treated as such.</p> <p>Resident #5 sustained a fall from the bed, on 08/18/12 at 6:30 AM. RN #2 assessed Resident #5 after the fall as having neck pain after transfer to the bed. The facility notified the physician at 8:30 AM, two hours after the fall, detailing the resident had no injury with a little pain, failing to give the physician an accurate picture of the resident's condition which prevented the physician from being able to order timely and effective treatment. These failures prevented Resident #5 from receiving timely treatment</p>	F 157	<p>DON, ADON and Facility Consultant.)</p> <p>The DON, ADON, QI nurse, MDS nurses, staff facilitator, and Facility Consultant will review daily the resident progress notes to ensure resident changes in condition, incidents, and accidents are documented and identify any unreported resident changes in condition, incidents, and accidents which will then be reported to the administrator and DON. The DON will be responsible for ensuring completion of corrective actions.</p> <p>The DON, QI nurse or Facility Consultant will conduct incident review for each occurrence, identify problems, and determine corrective action necessary. The DON will be responsible for validating completion of corrective action. The review will be documented on an Incident Assessment QI (Exhibit T157-1). The Incident Assessment QI will be completed by the DON, QI nurse or the Facility Consultant 1 x weekly for a minimum of 8 weeks then 1 x monthly for a minimum of 2 months.</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 841 SOUTH BENTON, KY 42026		
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F 157	<p>Continued From page 12</p> <p>experiencing increasing pain for more than three hours without treatment, family having to transport the resident to the emergency room. The resident was admitted to the hospital with an acute fracture of the neck.</p> <p>2. Review of the facility's policy, MONITORING SYSTEMS, dated 01/2011, revealed reporting results was not addressed in the policy.</p> <p>Review of the facility's policy, DIAGNOSTIC SERVICES, dated 07/2007, included the following: "Labs, x-ray and other diagnostic reports are signed, dated and made part of the resident's chart. Appropriate forms are filled out and sent with the resident. when reports are received, they are filed in the resident's medical record. The attending physician is notified regarding the findings".</p> <p>A record review revealed the facility admitted Resident #9 on 03/01/10 with diagnoses to include Anemia, Dementia with Delusional Features, Paralysis Agitans, Diabetes Mellitus and Chronic Pain Syndrome.</p> <p>A review of the annual MDS assessment, dated 09/03/12, revealed the facility assessed Resident #9 as cognitively impaired, non-ambulatory, incontinent of bowel and bladder and required extensive assistance with activities of daily living.</p> <p>A review of a Progress Note, dated 05/13/12 at 3:52 PM, revealed "Faxed MD (Medical Doctor) about rales noted in lungs and coughing up thick yellow sputum this afternoon." A Progress Note, dated, 05/14/12 at 9:37 PM, revealed an order for a chest x-ray due to coughing with thick yellow</p>	F 157	<p>The results of the QI tools will be reviewed in a weekly QI Committee meeting consisting of the Administrator, DON, ADON, QI Nurse, Social Worker & any other Interdisciplinary Team members as appointed by the Administrator. The results of the reports will be compiled by the QI Committee. The QI Committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective action is completed and date the completion is due.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 157	<p>Continued From page 13</p> <p>sputum and rales noted in the lungs. Ordering a sputum culture to be obtained to be started on Augmentin (antibiotic) 500 milligrams (mg) by mouth every eight hours for ten days.</p> <p>A review of the Sputum Culture results, with a collection date of 05/17/12, revealed the culture and sensitivity results indicated Escherichia coli and Pseudomonas aeruginosa. The organisms were listed as resistant to Augmentin, indicating a need for discontinuing the existing treatment of Augmentin and changing the resident's antibiotic therapy to one in which would be effective and would be susceptible.</p> <p>A review of the faxed lab report, dated 05/25/12, revealed the laboratory reported the results to the facility. The faxed laboratory report revealed RN #3 faxed the results to the medical doctor's office on 05/25/12 at 2:43 PM. The "Call Placed" section was blank. The "Orders Received" section indicated a date of 05/29/12 and was initiated by RN #3. The faxed document had a date of 05/29/12 at 1:52 PM. New orders were written on the faxed document for "Ceftriaxone one gram by intramuscular injection every twenty-four hours for five doses and mix with Lidocaine," and "Cipro 500 mg by mouth twice a day for ten days," and was signed by RN #3. A physician's order, dated 05/29/12 and signed by the physician, revealed "Ceftriaxone one gram by intramuscular injection every twenty-four hours for five doses and mix with Lidocaine," and "Cipro 500 mg by mouth twice a day for ten days." The order was signed by RN #3.</p> <p>Review of a Progress Note, dated 05/25/12 at 2:03 PM revealed "BLOOD PRESSURE</p>	F 157	<p>scheduled meeting. The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p> <p>The Physician for Resident #9 was notified on 5/29/12 by the licensed nurse as reflected by clinical documentation related to sputum culture lab results. Orders were received and implemented. Antibiotic therapy was changed to a more effective antibiotic based on C&S results. The antibiotic therapy was completed as ordered.</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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F 157	<p>Continued From page 14</p> <p>WARNING Value 116/80, +10% change from baseline value". A Progress Note, dated 05/27/12 at 2:16 PM revealed "BLOOD PRESSURE WARNING Value 118/56, -10% change from baseline. A Progress Note, dated 05/29/12 at 8:44 PM revealed TEMPERATURE WARNING Value 92.0 degrees.</p> <p>An interview with RN #3, on 09/06/12 at 2:20 PM, revealed she did not recall anything about the laboratory result, dated 05/25/12, which was faxed to the facility for Resident #9. RN #3 stated if a physician was not in the office she would call the results to the physician. Additionally, she stated, "If I called the physician I would have documented it and would have likely gotten orders if the Culture and Sensitivity result showed the current antibiotic was ineffective."</p> <p>An interview with the Assistant Director of Nursing (ADON), on 09/07/12 at 10:30 AM, revealed nurses were instructed upon hire to call the physician directly if the physician's office was closed. The Medical Director was to be notified if the resident's physician was not available. She stated she did not know if a call was made, but it should have been noted in the nurse's notes if the physician was called.</p> <p>An interview with the DON, on 09/05/12 at 10:15 AM, revealed the laboratory was always closed on the weekend and 05/25/12 was the start of a long holiday weekend. The DON revealed she would have called the physician and she gave no explanation why RN #3 did not notify the physician by phone. Additionally, the DON stated she saw laboratory results not being acknowledged timely as a problem and a</p>	F 157	<p>A 100% lab audit for all ordered labs, to include for Resident #9, from 9/6/12 through 9/25/12 to include cultures was completed on 9/25/12 by a facility consultant on current residents to ensure that appropriate labs had been drawn per MD order, results received and timely MD notification of lab results had occurred. Any concerns were addressed by the DON as appropriate. An additional lab audit was completed by the Consultant Pharmacist on 9/24/12 during the regularly scheduled review. Any concerns identified were addressed as of 9/28/12.</p> <p>All facility residents, to include Resident #9, continue to have a nurse's timely recognition of the residents' changes in condition and the physicians are notified as appropriate. This includes physician notification of accidents, changes in condition to include continued complaints of unrelieved pain and lab results as warranted allowing the physician to order timely and effective treatment as based on the assessment and condition of the</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
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F 157	Continued From page 15 potential for Resident #9 to decline. An interview with Resident #9's physician, on 09/06/12 at 2:45 PM, revealed she did not recall getting a phone call about Resident #9's culture and sensitivity results. She would have expected to be notified timely if the antibiotic the resident was on was ineffective and would have given an order for a new antibiotic which the organisms identified were susceptible. Additionally, the physician stated she had been out of the office, and on 05/29/12, she had returned to the office and reviewed the faxed laboratory results and made the change in orders at that time.	F 157	resident as evident by clinical documentation. (Continued on blank paper)	11/20/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 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 implement written policies and procedures that prohibit neglect of residents for one resident (#1) in the selected sample of eighteen residents. The facility received an allegation of neglect, on 08/13/12; however, failed to report the allegation to the appropriate state agency. Findings include:	F 226	<u>F 226</u> A detailed investigation was completed and it was determined that the resident concern occurred while resident was not in the facility. Therefore it was not reported to the state agencies. There have been no Allegations reported related to Resident #1 since the Resident Concern received on 8/13/12. Resident #1 expired in facility on 10/23/12. All interviewable residents were interviewed on 9/23/12 by the Social Worker with no allegations of abuse. All residents who are not interviewable were reviewed by the Facility Consultant for grimacing,	

F157 Continued

All licensed nurses were in-serviced, beginning on 9/26/12, related to their responsibility to notify physicians of lab results and ensuring residents are receiving the proper follow up. Training was completed and verified for all nurses on 9/29/12. Competency was determined by the use of Scenario Testing and Skills Checklist for Assessments (Exhibit T157-2a, 2b, 2c and T157-3).

All newly hired licensed nurses, during the orientation process, will be in-serviced by the staff facilitator regarding physician notification requirements related to these areas. Competency will be determined by the staff facilitator through the use of Scenario Testing and Skills Checklist for Assessments. (Exhibit T157-2a, 2b, 2c and T157-3).

The Administrative Assistant assigned oversight of lab orders was re-educated on 9/8/12 by the Facility Consultant regarding the facility's process for utilization of the Daily Lab Audit form (Exhibit 157-4). Completion of the Daily Lab Audit form includes: resident name/lab ordered, room number, date lab received, date MD notified, date MD replied, date lab requested/results on chart, any requests made/new orders and if information is entered into the resident's progress notes.

The administrative assistant's completion of the Daily Lab Audit form includes ensuring that lab results are reported timely to the MD for appropriate follow up as indicated. If lab results are not reported timely to the MD, the administrative assistant informs the resident's assigned nurse and notifies the DON.

Competency of the administrative assistant to complete the Daily Lab Audit form (Exhibit 157-4) was determined by the Facility Consultant and DON. Competency was based on the oversight observations of the Facility Consultant and DON who also validated Daily Lab Audit forms completed by the administrative assistant.

The Administrative Assistant will complete a Daily Lab Audit Form (Exhibit T157-4) 5 times weekly with tracking of labs drawn, results received and appropriate follow up to include MD notification. DON, QI nurse or Facility Consultant will review the Daily Lab Audit form daily to ensure timely MD notification for lab results.

Any lab results received after hours or on weekends will be addressed by the nurse assigned to the specific resident. The nurse will document any actions taken on the lab results sheet and in nursing progress notes.

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 226	Continued From page 16 A review of the Abuse, Neglect, or Misappropriation of Resident Property Policy, dated 02/2009, revealed the Administrator would ensure the Division of Licensure and Regulation would be notified immediately of all complaints of abuse, neglect, including injuries of unknown origin, or misappropriation of resident property. A review of a Resident Concern sheet, dated 08/13/12, revealed a family member was concerned about Resident #1 as he/she had been transferred to the hospital. The resident had pressure sores, reportedly upon admission to the hospital. The concern stated that the family member did not want the resident treated that way. An interview with the Director of Nursing (DON), on 08/22/12 at 5:00 PM, revealed she discussed the resident's condition with the family member on 08/13/12. She indicated the family member was upset and thought the resident had acquired the pressure sores from the facility. An investigation was conducted and it was determined the pressure sores were actually acquired at the hospital. The concern was not reported to the state as the DON did not feel it was an allegation of neglect. An interview with the Administrator, on 09/06/12 at 8:40 AM, revealed she did not report the allegation to the state as no abuse or neglect had taken place. She verified all allegations were supposed to be reported to the state agency.	F 226	flinching, and bruising on 9/23/12 with no abnormal findings. All allegations of abuse, neglect, and misappropriation of property will be reported immediately, 24 hours/day, 7 days/week, 365 days a year. All allegations will be reported to the administrator and DON. The facility has reported all alleged violations and all substantiated incidents to the state agency and to all other agencies as required. The facility has taken all necessary corrective actions depending on the results of the investigations. (Continued on blank paper)	11/20/12	
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 The most recent Care Plan Revision for Resident #2 occurred on 9/25/12		

F226 Continued

An audit was completed on 10/02/12 by the Facility Consultant of all Resident concern forms in the last 30 days to include for Resident # 1 ensuring that any allegations of abuse, neglect or misappropriation have been reported to the appropriate state agencies. Any concerns were addressed at the time of the audit as indicated. An Audit of Resident Concerns Form (Exhibit T226-1) was used. The Audit of Resident Concerns form lists the number of concerns, the category of concerns (alleged abuse, misappropriation of property, missing personal item, nursing, dietary, or other), number of resident concern forms, number of concerns not completed, number of concerns reported to OIG.

100% of staff re-education on abuse, neglect or misappropriation of resident property and reporting of such was initiated on 9/23/12 and completed on 11/2/12.

All newly hired staff received this training during the orientation process.

Ongoing competency will be verified by the DON and Staff Facilitator through quizzing of staff concerning abuse, neglect, and misappropriation of property (Exhibit T226-2).

The Administrator, DON, and Social Worker were re-educated on the facility's policy for reporting allegations of abuse, neglect or misappropriation of resident's property which includes reporting the allegation to the appropriate state agencies as indicated on 10/1/12 by the Facility Consultant.

Competency was verified by oversight from the Facility Consultant as evidenced by reporting all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and all necessary corrective actions, depending on investigation results.

All Resident concern forms will be reviewed by the Administrator, DON and Social Worker to determine that the forms contain no allegations of abuse, neglect, or misappropriation of resident property requiring investigation/reporting and ensure all resident concerns related to allegations of abuse, neglect or misappropriation of resident property have been reported to the appropriate state agencies as needed. Reporting will be reflected in the recorded resolution, if applicable.

An Audit of Resident Concerns Form (Exhibit T-226-1) will be completed by the QI nurse of Facility Consultant on a monthly basis ensuring that any allegations of abuse, neglect or misappropriation have been reported to the appropriate state agencies. Any concerns were addressed at the time of the audit as indicated.

Allegations of abuse, neglect or misappropriation of resident property will be reviewed in a weekly QI Committee meeting consisting of the Administrator, DON, ADON, QI Nurse, Social Worker & any other Interdisciplinary Team members as appointed by the Administrator where the results of these reports will be compiled and assessed for trends by the QI Committee & actions taken based on these assessments.

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 17</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Resident Care Plan policy, it was determined the facility failed to ensure the comprehensive care plan was revised by a team of qualified persons for three residents (#2, #3, and #4) in the selected sample of eighteen residents. Resident #2 was placed on a low air loss/alternating pressure mattress with bilateral half side rails on 07/26/12. He sustained a fall from the mattress on 08/04/12, pinning his/her left arm in the side rail. The facility assessment of the resident included a bruise to the left wrist and</p>	F 280	<p>and reflects a thorough assessment. Based on this assessment, the care plan was revised to reflect detailed needs of this resident to include the current use of a specialty mattress. A Roho mattress was provided for the resident on 9/25/12. The changes were made after a resident assessment, evaluation of the resident and evaluation of the device. Resident #2 expired in the facility on 10/14/12.</p> <p>Resident #3 and Resident #4 were assessed and due to healed wounds and safety risk, both specialty mattresses were removed on 8/23/12. Care plans for Resident #3 and Resident #4 were updated on 8/25/12 by the MDS Nurse to reflect current interventions for problems listed based on their individual assessment and needs. There are currently no low air loss / alternating pressure mattresses in use in the facility.</p> <p>A review of current residents and resident care plans were conducted on 8/29/12 by the DON, ADON, QI Nurse and MDS Nurse. The care plans were reviewed to ensure each</p>		

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F 280	<p>Continued From page 18</p> <p>upper arm with a skin tear to the left lower arm. The facility placed the resident back in the bed; however, the facility did not revise the care plan to identify the side rail entrapment or the potential risk for entrapment after the fall. The mattress was discontinued on 08/06/12; however, the facility initiated the use of the the low air loss/alternating mattress with bilateral half side rails on 08/21/12. Again, the care plan was not revised to indicate the previous entrapment or the potential risk of entrapment while utilizing the assistive devices. Resident #3 and #4 were also identified as having a low air loss/alternating mattress with bilateral half side rails. The comprehensive care plan for these residents did not identify potential risks while utilizing the assistive devices. As a result, facility staff was unaware of the risks associated with these devices to ensure appropriate supervision and monitoring was afforded these residents based on their assessed needs.</p> <p>The facility's failure to ensure each resident's comprehensive care plan was revised to ensure staff awareness of resident care needs that must be met has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/23/12 and determined to exist on 08/04/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined on-going. (Refer to F323)</p> <p>The findings include:</p> <p>A review of the Resident Care Plan policy, revised 09/19/11, revealed the facility would provide an</p>	F 280	<p>resident care plan reflected the resident's current needs to include addressing any specialty mattresses or side rails in use.</p> <p>A second resident care plan audit was completed by the MDS nurses on 10/25/12 to ensuring the care plans reflect a thorough assessment and based on this assessment the care plan was revised to reflect the detailed needs of the resident.</p> <p>The Facility Consultant completed an in-service with the MDS team on 10/2/12 to include the Dietary manager, Activity Director, Social Workers and MDS Nurses regarding the care plan teams' responsibility that resident care plans reflect the needs and conditions of the residents based on their most recent assessment and changes. Competency was and will continue to be verified by the DON. The DON will continue comprehensive care plan reviews to ensure the care plans accurately reflect the needs and conditions of the residents based on their most recent assessment and changes.</p>		

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F 280	<p>Continued From page 19</p> <p>interdisciplinary written care plan based on the assessment of the resident needs. Any new problem or need of the resident which was identified between his/her scheduled care plan review would be addressed on the care plan.</p> <p>1. A record review revealed Resident #2 was admitted to the facility on 11/28/11 with diagnoses to include Paralysis Agitans, Senile Dementia, Lack of Coordination, and Convulsions. A review of the quarterly Minimum Data Set (MDS), dated 07/23/12, revealed the facility identified the resident as severely cognitively impaired and required total assistance with bed mobility and transfers. A review of the Low Air Loss initial sheet, dated July 2012, revealed the facility began utilizing a low air loss/alternating mattress on 07/26/12. A review of the Risk for Falls care plan, initiated 11/29/11, revealed poor safety awareness/unaware of safety needs, unsteady gait, and history of falls. A review of the Risk for Skin Breakdown care plan, initiated 08/10/12, revealed a low air loss mattress (as of 08/21/12); however, there were no guidelines of appropriate settings of the mattress specific to the resident's needs.</p> <p>A fall investigation, on 08/04/12, revealed the resident was found sitting on the mat beside the right side of the bed. His/her arm was "pinned" in the rail of the bed. Bruising was noted to the resident's left leg and wrist, with a skin tear to the left arm.</p> <p>An interview with Licensed Practical Nurse (LPN) #6, on 08/26/12 at 9:00 PM, revealed she was the nurse working at the time of the fall, on 08/04/12. She revealed the resident's arm was twisted into</p>	F 280	<p>A weekly audit of care plans for residents with events/incident within a 7 day look back will be completed by the DON to ensure that needed care plan changes and current interventions are reflected in each resident's care plan using the Care Plan Change Audit Tool (Exhibit T280-1). This review will be comprehensive to include changes needed as a result of side rail and specialty mattress use as applicable. The results of the audit and any subsequent follow up to any concerns identified will be documented on the Care Plan Change Audit Tool (Exhibit T280-1) and will make corrections at the time identified by the DON or the MDS Nurse. The QI Tool will be completed weekly for minimum of 8 weeks then monthly for a minimum of 2 months.</p> <p>The results of the QI tools will be reviewed in a weekly QI Committee meeting consisting of the Administrator, DON, ADON, QI Nurse, Social Worker & any other Interdisciplinary Team members as appointed by the Administrator where the results of these reports will</p>	

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F 280	<p>Continued From page 20</p> <p>the side rail, and the resident was holding the rail tightly. She revealed after the fall, the resident was put back into the bed on the low air loss/alternating mattress with bilateral half side rails. She indicated the DON was notified of the fall, but did not instruct her to take the resident off the mattress. She could not remember if she updated the resident's care plan to include the risk of entrapment.</p> <p>There was no documentation of a care plan revision to include the potential risk of entrapment or interventions implemented to reduce the risk while continuing to utilize the mattress and side rails after the fall on 08/04/12. A review of the Physician's Orders revealed the low air loss/alternating mattress was discontinued on 08/08/12; however, the Low Air Loss initial sheet, dated August 2012, indicated the resident was placed back on the mattress 08/21/12. A review of the Risk for Falls care plan, dated 08/21/12, revealed half side rails bilaterally to define parameters in the bed. A review of the Risk for Skin Breakdown care plan, dated 08/21/12, revealed a low air loss mattress to the bed. Neither care plan addressed potential risks (including entrapment) for the use of the low air loss/alternating air mattress with bilateral half side rails.</p> <p>An observation of Resident #2's bed, on 08/23/12 at 9:00 AM, revealed the gap between the side rail and the bed frame measured one inch on both sides of the bed. When lying on the bed, the side of the mattress deflated slightly when close to the edge.</p> <p>An interview with the QI Nurse, on 08/23/12 at</p>	F 280	<p>be compiled and assessed for trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give</p>		

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F 280	<p>Continued From page 21</p> <p>11:55 AM, revealed she completed the resident's side rail and low air loss/alternating mattress assessment on 08/22/12; however, she did not update the resident's care plan to include potential safety risks of the assistive devices. Additionally, she did not ensure education of staff related to monitoring Resident #2 with these assistive devices and the potential risk of entrapment.</p> <p>An interview with the MDS coordinator, on 08/23/12 at 12:50 PM, revealed she was not aware of Resident #2's history of side rail entrapment, had she been aware she would have updated the care plan to include the risk.</p> <p>An interview with Registered Nurse (RN) #1, on 08/23/12 at 7:50 AM, revealed she was not aware of any resident's being entrapped by a side rail. She revealed Administrative Staff had never discussed the possible risks associated with side rails and the low air loss/alternating mattress. An interview with State Registered Nurse Aide (SRNA) #3, #6, and Nurse Aide (NA) #1 on 08/23/12 at 9:40 AM, 10:10 AM, and 08/24/12 at 12:05 PM, revealed they were not aware of the risks of using side rails with the low air loss/alternating mattress.</p> <p>An interview with the DON, on 08/23/12 at 1:55 PM, revealed she was aware of the resident's side rail entrapment after a fall on 08/04/12, and she made the decision to put Resident #2 back on the low air loss/alternating mattress with bilateral half side rails on 08/21/12. She asked staff to monitor the resident closely while on the low air loss/alternating air mattress with side rails, but should have updated the care plan to ensure</p>	F 280	<p>necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	11/20/12	

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 841 SOUTH BENTON, KY 42025		
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F 280	<p>Continued From page 22</p> <p>staff were aware of the risks related to using the assistive devices.</p> <p>2. A record review revealed Resident #3 was admitted to the facility on 06/06/11 with diagnoses of Dementia, History of Falls, Behavioral Disturbances, Psychosis, Insomnia, and Alzheimer's Disease. A review of the quarterly Minimum Data Set (MDS), dated 07/17/12, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance of two staff for bed mobility and transfers. A review of the Skin Breakdown and Potential for Falls care plan, dated 05/01/12, revealed a low air loss mattress with padded side rail covers to half side rails; however, the care plans did not address the potential risks (including entrapment) while utilizing the assistive devices. No changes were made to Resident #3's care plan to ensure potential risks were identified while using these devices with new interventions to ensure the resident's safety.</p> <p>3. A record review revealed Resident #4 was admitted to the facility on 01/27/12 with diagnoses to include Malaise, Fatigue, and Hypotension. A review of the quarterly MDS, dated 07/12/12, revealed the facility assessed the resident as cognitively intact and required limited assistance with bed mobility and transfers. A review of the Skin Breakdown and Risk for Falls care plan, dated 05/02/12, indicated a low air loss mattress for the resident, but did not address side rails for the resident. Review of the care plans revealed after the entrapment of Resident #2, there were no changes to Resident #4's care plan to ensure potential risks were identified while using these assistive devices with new interventions to ensure</p>	F 280			

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F 280	Continued From page 23 the resident's safety.	F 280			
F 281 SS=D	<p>An interview with Resident #4, on 08/23/12 at 10:25 AM, revealed if not positioned correctly, it was easy to roll off the low air loss/alternating mattress. The resident revealed he/she had learned how to position in the bed to avoid injury.</p> <p>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 and record review, it was determined the facility failed to ensure services provided by the facility meet professional standards of quality. The facility failed to ensure medications were administered per the physician's order for two (2) residents (#16, #8) in the selected sample of eighteen (18). The facility failed to administer two (2) scheduled doses of a blood thinner to Resident #16. The facility failed to perform accuchecks timely, per the physician's order for Resident #8 to assess blood sugar level for the determination of safe administration of insulin.</p> <p>Findings include: A record review revealed resident # 16 was admitted to the facility on 08/23/12 with diagnoses to include Left Hip Fracture with Open Reduction Internal Fixation, Difficulty walking and Muscle Weakness.</p>	F 281	<p><u>F 281</u> The Lovenox for Resident #16 continued to be administered by the charge nurse per physician's order on 9/6, 9/7, 9/9, 9/10, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, and 9/23/12. Resident # 16 Lovenox was discontinued per physician's order on 9/23/12. Resident #8 continues to receive Accu-checks per scheduled time on the MAR to allow assessment of the Resident's blood sugar level for the determination of safe administration of insulin thereby meeting professional standards of practice.</p> <p>A 100% audit was conducted of all current in house residents' MARs, to include Resident #16, on 9/29/12 by the Facility Consultant to ensure that medications were being administered and documented per physician's order on the MAR. Any concerns</p>		

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F 281	<p>Continued From page 24</p> <p>A record review of the admission order, dated 08/23/12, revealed a physician order for Lovenox (a low molecular weight heparin) 30 mg subcutaneous at hour of sleep (HS) for thirty (30) days for Resident # 16. This order is documented to end 09/23/12.</p> <p>A record review of the Medication Administration Record (MAR) for 09/01/12 - 09/30/12, revealed no documentation was entered for Lovenox being given on 09/02/12 and 09/05/12 for Resident # 16. Doses are scheduled for eight (8) PM daily.</p> <p>An interview with KMA # 1, on 09/07/12 at 12:50 PM, revealed after review of the MAR for Resident # 16, that he/she was unable to say whether the resident received the Lovenox on 09/02/12 or 09/05/12 as neither day is initialed as given by staff.</p> <p>An interview with LPN # 10, on 09/07/12 at 1:00 PM, revealed that after record review of the MAR for Resident # 16, he/she was unable to determine whether the resident had received the ordered Lovenox doses on 09/02/12 or 09/05/12. Areas for documentation were blank on review of the MAR.</p> <p>A telephone interview with LPN # 2, on 09/07/12 at 1:44 PM, revealed that he/she left the shift early on 09/05/12 and that he/she did not administer the Lovenox for Resident # 16.</p> <p>A telephone interview with LPN # 5, on 09/07/12 at 2:03 PM, revealed that he/she was in charge on 09/05/12 and would not have been the staff administering Resident # 16's medications on that</p>	F 281	<p>were addressed at the time of the audit as indicated.</p> <p>Medication Pass Audits (Exhibit T281-1a & 1b) to include audits on Accu-checks for Resident # 8 were completed on 9/29/12 for all Licensed Nurses and KMAs by the Facility Consultant, DON, ADON, QI Nurse, and/or Staff Facilitator.</p> <p>Licensed nurses and KMAs were re-educated beginning on 9/1/12 by the Facility Consultant regarding medication administration including correctly documenting medications when administered on the MAR and performing Accu-checks timely.</p> <p>Competency of training of Licensed Nurses and KMAs is verified by the completion of Med Pass Audits to ensure non-significant med error rate of less than 5%.</p> <p>Licensed nurses and KMAs were in-serviced beginning on 9/1/12 regarding reviewing the MARs at change of shift daily to ensure that documentation has been completed on the MARs with documenting completion of this task by signing</p>	

F281 Continued

The DON, QI Coordinator, ADON, or Staff Facilitator will use the MAR Documentation Review QI Tool (Exhibit T281-3) 3 x weekly for 4 weeks then weekly x 4 weeks, then monthly for a minimum of 2 months to ensure the completion of the Medication Administration Record (MAR).

Documentation Review form (Exhibit T281-2) is being completed at the change of each shift by the Licensed staff/KMAs that documentation of medications given has occurred. Any concerns identified will be corrected at the time of the audit.

Ongoing competency will be monitored by the use of a Medication Pass Audit Form (Exhibit T281-1a&1b) 8 times monthly to include timely Accu-checks. The medication pass audits will be completed by the Pharmacy Consultant, Staff Facilitator, DON, ADON, and/or Facility Consultant to ensure license nurses and KMAs are properly administering medications as ordered and correctly documenting medication administration, to include accu-checks. Re-training will occur as needed during the Medication Pass observation and/or a deficient practice was identified.

The results of the MAR Documentation Review QI Tools (Exhibit T281-3) and the Med Pass audit QI tools will be reviewed with the Administrator & DON in the weekly QI Committee meeting.

The compiled information will be reviewed by the Vice President of Operations & the Vice-President of Clinical Services for additional oversight to ensure areas are corrected monthly. Trends & the accompanying action will be reviewed in the Executive QI Committee with the Medical Director monthly for further retraining or other intervention implementation as necessary.

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

The Governing Body (Vice President of Operations & the Vice-President of Clinical Services and/or the Regional Vice President) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
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F 281	Continued From page 25 shift. An interview with LPN # 12, on 09/07/12 at 3:10 PM, revealed that he/she did not recall giving Resident # 16 Lovenox on 09/02/12. He/she reported that she did give the resident other medications on that shift. An interview with LPN # 13, on 09/07/12 at 3:17 PM, revealed that the current medication supply of Lovenox for Resident # 16 was sixteen (16), 30 mg unit doses. The pharmacy date noted on the plastic bag was 08/27/12. An interview with the DON, on 09/07/12 at 6:50 PM, revealed that he/she was made aware of the lack of staff documentation for Lovenox does for Resident # 16 on 09/02/12 and 09/05/12. 2. Review of the Resident #8's physician's orders, dated 08/01/12 through 08/31/12 revealed accuchecks were to be provided at 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM and Humalog insulin 4 Units was to be administered at 8:00 AM, 12:00 PM and 5:00 PM. An observation, on 08/30/12 at 1:30 PM, revealed LPN #11 was performing an accucheck on Resident #8. The resident's blood sugar was 239 and 4 Units of Humalog insulin was administered. An interview with LPN #11 on 08/30/12 at 1:40 PM revealed she just did not get to the accucheck and insulin in time and they had told her to do it as she passed the afternoon meds.	F 281	the MAR Documentation Review form (Exhibit T281-2). All newly hired license Nurses and KMAs will receive the education regarding medication administration, performing Accu-checks timely and regarding reviewing the MARs at change of shift during the orientation process by the Staff Facilitator. Training was completed for all nurses 10/12/12 (Continued on blank paper)	11/20/12
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	<u>F309</u> Resident #5 was discharged from facility on 8/18/12. Prior to discharge, at time of the fall, the resident was assessed and MD/RP was notified by the RN#2. RN#2 is no longer employed by the facility.	

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F 309	<p>Continued From page 26</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure each resident received the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well being for three residents (#5, #7, #11), in the selected sample of eighteen residents. The facility failed to ensure staff conducted a thorough assessment of a resident after experiencing a change in condition related to pain after a fall. Additionally, the facility failed to ensure timely notification and failed to provide an accurate assessment of the resident's condition to the physician to address the resident's continued and increased complaints of pain. On 08/18/12 at 6:30 AM, the facility found Resident #5 on the floor sustaining a fall from the bed. While the facility assessed the resident while on the floor identifying no injuries, upon transfer assistance to the bed, Resident #5 complained of neck pain. The facility did not re-assess, initiate standards of practice to stabilize the resident due to potential neck injury, and did not notify the physician of the condition change. The staff continued to dress and transfer the resident to the wheelchair and transported the resident to the dining room for breakfast. The</p>	F 309	<p>Resident #5 received a physical assessment, assistance with ADLs, and transfer to Acute Care Hospital.</p> <p>Resident #7 was discharged from the facility on 9/8/12 with home health services. Upon the 7/25/12 admission, the pain assessment indicated Resident #7 rated her pain as mild. The resident had a Percocet and Tylenol ordered for pain. Another pain assessment was completed on 8/3/12. Tylenol was administered for pain. The resident's first dose of Percocet was administered the next day.</p> <p>Resident #11 is receiving care and services needed to maintain highest well being to include receiving medications as ordered and monitoring of blood pressure values.</p> <p>All facility residents to include Resident #11 continue to have timely recognition of changes in condition and Physician notification as needed by facility nurses. This includes assessing for changes and assessing conditions that require monitoring and or reporting and assessing for continued and / or increased</p>		

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F 309	Continued From page 27 resident continued to express increased complaints of pain to multiple staff including the facility Registered Nurse (RN). The facility failed to re-assess the resident due to increased pain. The facility did not notify the physician for approximately two hours, the facility did not detail an accurate description of the resident condition stating the resident had no injury with a little pain. The physician ordered pain medication; however, the medication was not available. The back-up pharmacy was not open. The facility's emergency drug kit contained no pain medications. The facility made no further attempts to pain medication was given to the resident timely. Additionally, the resident's family requested the facility send the resident to the emergency room. The physician indicated he was agreeable for the family to take the resident by family car; however, did not order an ambulance at the time. The resident's family arrived at the facility to find the resident with continued neck pain. The resident was transferred by family to the emergency room at approximately 9:30 AM, three hours after the fall. Resident #5 did not receive any pain medication prior to the transfer. The resident was admitted to the hospital with an acute C2 spine fracture. The physician stated the facility's assessment was not expressed as a serious situation. Additionally, the facility failed to ensure pain medication was available and administered timely to a new admission. The facility admitted Resident #7 on 07/25/12 after having back surgery. Due to the facility's failure to ensure timely receipt of medications, per their pharmacy contract, Resident #7 experienced severe intense pain per the facility's assessment, having no pain medication for 14 hours after admission. Resident #7 stated "I cried, it was terrible." Furthermore,	F 309	complaints of pain to include after a fall. On 9/20/12 all current residents were assessed for pain using the Facility Pain Assessment form by the MDS nurses. Five residents required MD notification for possibility of obtaining an order for routine pain medications. A Checklist packet for conducting an assessment after an event was implemented on 9/5/12 and will be kept available at the nurse stations in the "Assessment & Observation of a Nursing Home Resident" binder. The Staff Facilitator, and/or DON will be responsible for keeping these Checklists available daily for staff use. This Checklist packet includes a neurological observation sheet, a pain tool, fall assessment tool, and witness statement. On 9/5/12 and again on 9/10/12, the Facility Consultant educated the administrative nurses including the MDS nurses, QI nurse, staff facilitator, DON, administrator, ADON, and admission's coordinator on the Checklists. Competency		

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F 309	<p>Continued From page 28</p> <p>the facility staff failed to monitor Resident #11's blood pressure when the resident's blood pressure medications were unavailable for 6 days.</p> <p>The facility's failure to ensure each resident received necessary care and services related to conducting a thorough assessment of a resident after complaining of neck pain and ensuring timely receipt of pain medication for a resident experiencing intense pain for fourteen hours has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/31/12 and determined to exist and determined to exist on 07/25/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined on-going. (Refer to F157, F425).</p> <p>Findings include:</p> <p>Interview with the Director of Nursing (DON), on 08/31/12 at 1:15 PM, revealed there was no policy (or standard of practice) utilized in the facility related to assessment of a resident.</p> <p>1. A record review revealed the facility admitted Resident #5 on 08/03/12 with diagnoses to include History of Transient Ischemic Attack, Vascular Dementia, Muscle Weakness, Lack of Coordination, Dysphagia, and Dysarthria. A review of the initial Minimum Data Set (MDS), dated 08/10/12, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance of two staff with bed mobility, transfer, and ambulation. A review of the Fall Risk assessment, dated 08/17/12,</p>	F 309	<p>using the Checklist was determined by the Facility Consultant through discussion, question and answer period, at the end of the training.</p> <p>The Checklist packets will be used as guides to assist the licensed staff with assessing the resident after a change in condition, or incident to include falls. Education of these checklists for the licensed staff was initiated on 9/5/12 and again on 9/10/12 by the Staff Facilitator, ADON, and QI Nurse. Licensed Nurses received this education prior to their next scheduled shift. Competency was determined by the instructors through discussion, question and answer period at the end of the trainings.</p> <p>Education on these assessment Checklist packets will be provided for newly hired licensed staff during the orientation process by the staff facilitator. The staff facilitator will determine competency through discussion, questions and answer period at the end of the training.</p> <p>The Administrator, DON, ADON, Staff Facilitator, QI Nurse,</p>		

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F 309	<p>Continued From page 29</p> <p>revealed a fall score of (12) which indicated he/she was at risk for falls. A review of the Pain Management Assessment, dated 08/10/12, revealed the resident had no current complaints of pain with no pain medication. A review of the Physician's Orders, dated 08/03/12 through 08/31/12, revealed no evidence of pain medications.</p> <p>A review of the incident report, dated 08/18/12 at 6:30 AM, and an interview with State Registered Nurse Aide (SRNA) #1, on 08/24/12 at 12:20 PM, revealed she initially heard a "cry for help" while providing care for another resident. She indicated at 6:30 AM, she found Resident #5 in his/her room on the floor. The resident was found on his/her right side beside the bed, one foot straight out while the other curled up under him/her. The resident's neck was turned to the side and he/she was looking at her when she entered the room. She indicated the resident's position was "weird." She immediately informed RN #2 of the fall.</p> <p>An interview with RN #2, on 08/24/12 at 1:05 PM, revealed she immediately assessed the resident. She indicated the resident was on his/her back when she entered the room. SRNA #1 and SRNA #2 assisted the resident up out of the floor to the bed. Afterwards, the resident complained of neck pain. She stated the resident was able to move his/her neck in all directions. She allowed staff to get the resident up for breakfast.</p> <p>Interviews with SRNA #1 and SRNA #2, on 08/24/12 at 12:20 PM and 1:00 PM, respectively, revealed they transferred the resident to the bed when he/she immediately complained of neck pain, pointing to the back of the neck. The</p>	F 309	<p>Admissions Coordinator, and MDS Nurses were educated on 9/3/12 and on 9/10/12 by the Facility Consultant on conducting acute symptom assessments and intervening appropriately based on the event and seriousness of the resident's presentation. This education covered:</p> <ul style="list-style-type: none"> • Recognizing the typical presentation of a nursing home resident • Discussing the vulnerability of the nursing home resident related to the typical presentation • Recognizing the relationship between the prompt assessment of acute changes and/or illness • Discussion of interventions to be taken when a change in a resident's condition occurs <p>Handouts were given to re-enforce this education. Along with this education these staff members were also educated on guidelines for assessing on multiple conditions, including falls using a resource taken from the American Medical Director's Association entitled "Protocols for Physician Notification –</p>		

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F 309	<p>Continued From page 30</p> <p>SRNAs revealed they dressed the resident and transferred him/her to the wheelchair for breakfast. SRNA #1 stated the resident continued to complain of neck pain while she was providing care. SRNA #2 stated while providing care, the resident complained of neck pain "once or twice." SRNA #1 revealed Resident #5 ate breakfast in the dining room, but continuously complained of neck pain.</p> <p>An interview with Nurse Aide (NA) #1, on 08/24/12 at 12:05 PM, revealed she saw the resident up in the lobby with continued complaints of neck pain. She revealed the resident's neck was "stiff" and he/she constantly repeated "my neck hurts." She made RN #2 aware of the complaints, but was unaware of what action RN #2 had taken.</p> <p>An interview with RN #2, on 08/24/12 at 1:05 PM, revealed the resident was up in the lobby area and ate breakfast in the dining room. The resident's pain worsened throughout the morning; however, she was unable to describe the pain as she did not reassess the resident. She stated that the resident would repeat "my neck hurts" every time she passed him/her in the lobby area. She admitted the resident's physician was not notified until 8:30 AM as she had other tasks to complete. She stated she should have notified the physician immediately; however, she did not realize the seriousness of the situation. Tramadol was ordered for pain, but it was not available in the facility. She instructed the physician to call the prescription into the pharmacy by 12:00 PM or it would not arrive at the facility prior to closing. She admitted no further attempts were made to ensure pain medication was received timely. She</p>	F 309	<p>– Assessing and Collecting Data on Nursing Facility Patients.” This education was initiated on 9/3/12 by the ADON, QI Nurse, and Staff Facilitator with Consultant oversight, for all licensed nurses. This education also included reminders that the computer is time sensitive and that it would be helpful to write down times on a notepad so that when actual documentation occurs, the correct times, such as when the event took place, when the physician was called, etc, can be included accurately in the progress note. Re-education is being conducted as needed.</p> <p>Education was initiated on 9/21/12 for all licensed nursing staff by the Facility Consultant on conducting an assessment for pain following an event such as a fall or change in condition using a pain scale for residents who are able to self report where 0 is identified as no pain up to 10 meaning unbearable pain. This education also includes recognition of indicators of pain for residents who are unable to self report using facial expressions and or increased behaviors such as crying, groaning,</p>		

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F 309	<p>Continued From page 31</p> <p>was not aware if pain medication was available in the emergency drug kit and verified she did not check the kit. She stated she could have called the physician for a non-narcotic pain medication, but she did not have time.</p> <p>An interview with the physician, on 08/30/12 at 10:20 AM, revealed he was informed the resident had rolled out of bed and "appeared fine." The physician revealed he did not order ambulance services for the resident because he expected staff to transmit to him what they had assessed related to injury after a fall. He revealed the information expressed to him was not sufficiently given as a serious situation.</p> <p>A review of the Progress Notes, dated 08/18/12 at 8:30 AM, revealed the physician was notified of the fall (two hours later). The note revealed the physician ordered pain medication, but no other orders at that time. A review of the Physician's Orders, dated 08/18/12 at 8:40 AM, revealed an order for Tramadol 50 milligrams (mg) twice daily as needed for pain. A review of the Medication Administration Record (MAR), dated 08/03-31/12, revealed the Tramadol was not administered to the resident. A review of the medication list from the Emergency Drug Kit, dated 07/03/07, revealed no pain medications (narcotic or non-narcotic) were available, if needed.</p> <p>An interview with Family #1 and Family #2, on 08/30/12 at 9:00 AM and 9:20 AM, respectively, revealed they arrived at the facility to take the resident to the emergency room at approximately 9:30 AM. Family #1 stated the resident was complaining of neck pain and "holding" his/her neck when they arrived. Family #2 verified the</p>	F 309	<p>or grimacing. This education was completed 9/29/12.</p> <p>The resource binder titled "Assessment & Observation of a Nursing Home Resident" was created by the Facility Consultant on 9/3/12 and reviewed by the new Facility Consultant on 9/11/12. This assessment resource guide is a tool at each nurse's station that includes guidelines taken from a resource published by the American Medical Directors Association entitled "Protocols for Physician Notification - Assessing and Collecting Data on Nursing Facility Patients", copies of the new fall assessment packets, copies of handouts that were used in education and in-servicing of licensed nurses, Kentucky Medication Aides (KMA)s, and SRNAs on identifying changes in condition and acute symptom assessment, the facilities procedure for ordering medication, in addition to the new list of narcotic pain medications available in the facilities Emergency Drug Kit.</p> <p>The Facility Consultant educated the Administrator, DON, ADON, Staff</p>	

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F 309	<p>Continued From page 32</p> <p>resident was "almost out of the wheelchair trying to hold his/her neck up." The resident continuously repeated "my neck hurts." Interview with RN #2, on 08/24/12 at 1:05 PM, revealed the family had requested to transfer the resident to the emergency room.</p> <p>Further interview with RN #2 revealed the family transferred the resident to the emergency room per family car at approximately 9:30 AM, three hours after the fall. She stated the facility had not administered any pain medications to Resident #5 prior to the transfer.</p> <p>A review of the "Packing List", dated 08/18/12, revealed the Tramadol was filled at 10:50 AM (over two hours after the order was received). A review of the Discharge Summary, dated 08/20/12, revealed the resident sustained an acute fracture of C2 (neck fracture) in the lateral mass and facet area with a mild subluxation of C2 on C3. Interview with RN #2 revealed she did not realize the seriousness of the situation.</p> <p>An interview with the DON, on 08/31/12 at 1:15 PM, revealed the physician should be notified immediately (within a few minutes after the assessment) of a possible neck injury after a fall. She expected the nurse to leave the resident in the bed as neck pain was indicative of a neck injury and should be treated as such. The DON provided a standard of practice for an acute illness assessment; however, it had not been utilized in the facility. She also stated that three hours was not acceptable to wait for pain medication. It typically takes at least an hour and a half to receive medications from the back-up pharmacy. She revealed RN #2 should have</p>	F 309	<p>Facilitator, QI Nurse, Admissions Coordinator, and MDS Nurses on use of this "Assessment & Observation of a Nursing Home Resident" binder in the education that took place on 9/3/12 and 9/10/12. All Licensed Nurses were also educated by the ADON, QI Nurse and Staff Facilitator on using this "Assessment & Observation of a Nursing Home Resident" binder as an assessment resource guide for completing a thorough detailed assessment of the resident experiencing a change in condition or after a fall as well as the other reference tools available during the education that took place on 9/3/12. All licensed nurses received this education prior to their next scheduled shift.</p> <p>Education on using this "Assessment & Observation of a Nursing Home Resident" binder including the tools in it and on the guidelines for assessments including the assessment data to have available when notifying the physician about any resident experiencing a fall or any change in condition will be provided for all newly hired nurses</p>		

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F 309	<p>Continued From page 33</p> <p>called the physician for a non-narcotic pain medication, such as Tylenol, and it could have been "borrowed" from another resident. She was aware the emergency drug kit had no pain medication available; however, she was unsure of the reason.</p> <p>2. A record review revealed the facility admitted Resident #7 on 07/25/12 with diagnoses to include After care following surgery, Closed Fracture Lumbar Vertebra, Displacement Intervertebral Disc, Lumbago, Muscle Weakness, Thoracic/Lumbosacral Neuritis, Chronic Pain Syndrome and Diabetes Mellitus.</p> <p>Review of an admission assessment, dated 07/25/12 at 11:52 PM, revealed the resident had back pain, lower extremity pain that was due to recent back surgery. Pain was worse during the day and the night and interfered with Resident #7's activities of daily living.</p> <p>Review of the admission MDS assessment, dated 08/01/12, revealed the facility had assessed the resident with no cognitive impairment, and required extensive assistance with activities of daily living. The pain frequency was assessed as frequent pain that had made it hard to sleep at night and had limited day to day activities and was determined to be severe in intensity.</p> <p>Observation and interview, on 08/30/12 at 5:15 PM, revealed Resident #7 was seated on the side of his/her bed and stated he/she was admitted to the facility after having back surgery. He/she stated he/she could hardly stand at the time and had pain in his/her back and legs. The resident stated "I cried", "It was terrible".</p>	F 309	<p>and other staff as indicated, during the orientation process by the Staff Facilitator.</p> <p>On 8/31/12, SRNAs and KMAs were educated by the ADON and QI Nurse on contributing factors to resident changes, illness, and any observation in a resident's condition that is not normal may indicate onset of an acute illness or decline in the resident, and that all changes, even minor ones, should be taken seriously and reported to the Nurse. A handout was given titled "Observations of and Reporting Changes in Resident's Condition". This education was completed prior to their next scheduled shift. Competency was determined by the instructors through discussion, question and answer period, at the end of the training.</p> <p>This education including handouts will be provided for all newly hired SRNAs and KMAs during the orientation process by the Staff Facilitator. The staff facilitator will determine competency through discussion, questions and answer period during orientation.</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(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 309	<p>Continued From page 34</p> <p>Review of Resident #7's record revealed the resident arrived at the facility on 07/25/12 at 9:00 PM. Admitting orders from the hospital included a prescription from the hospital, dated 07/25/12 and signed by the hospital physician, for Percocet 10/325 milligrams (mg) every four to six hours as needed for pain. Additional medications were: Gabapentin 300 mg twice a day (for chronic pain), Levothyroxine (for hypothyroidism) 50 micrograms (mcg) one a day, Ranitidine HCL (for gastritis) 150 mg two times a day, Calcium with Vitamin D (for calcium deficiency) 600/400 mg every day, Metformin HCL (antidiabetic) 1,000 mg twice a day, Flexeril (muscle relaxant) 10 mg three times a day, Glipizide (antidiabetic) 10 mg twice a day, Lisinopril (antihypertensive) 10 mg once a day, Atenolol (antihypertensive) 100 mg once a day, Famotidine (gastritis) 10 mg twice a day, Prozac (antidepressant) 20 mg once a day and Mevacor (antilipemic) 20 mg every day.</p> <p>Review of the admission Medication Administration Record (MAR), dated 07/25/12 through 07/31/12, revealed Percocet 10/325 mg was not administered to Resident #7 until the next day, 07/26/12 at 10:30 AM. Additionally, many of the routine medications were not administered on 07/26/12 including Flexeril HCL 10 mg due at 8:00 AM.</p> <p>All of the initials for these medications were circled indicating they were not given. The back of the MAR revealed documentation of "07/26/12, 8:00 AM, 12:00 PM, All medications, No medications from pharmacy".</p> <p>There was no evidence an intern care plan for</p>	F 309	<p>Progress notes for all residents are being read daily by the Administrative Nurses including the DON, ADON, QI Nurse, SDC, MDS Nurses, and Facility Consultant as assigned by the DON These nurses were educated by the Facility Consultant on 9/6/12 in using a resident daily census to identify that the expectations are that any resident experiencing an acute episode, such as a fall; or other change in condition, has had an adequate assessment conducted to include follow up with the resident's RP and MD as well as that any new orders, including pain medication have been implemented, and that this is reflected in the nurse's note documentation. Any identified concerns will be addressed immediately by the Administrative Nurse, up to and including reassessment of the resident and notification of the MD as appropriate. Competency of the nurses is determined by the administrative nurses with 1:1 re-training as necessary. The DON is meeting with any nurse that has ongoing concerns.</p>		

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F 309	<p>Continued From page 35</p> <p>pain was implemented on 07/25/12. Review of the resident's care plan for pain, dated 07/26/12, the day the medications were received, revealed interventions to include: Acknowledge presence of pain and discomfort. Listen to resident's concerns. Administer pain medication as per MD orders and note the effectiveness. Encourage resident and/or family to request pain medication before pain becomes severe. Monitor for sign/symptoms of non-verbal pain such as changes in breathing, grunting, moans, yelling out mood/behavior changes; sad expression, crying, clenched teeth, grimacing, tenseness, rigidity of body/limbs.</p> <p>An interview with Resident #7's roommate, on 08/30/12 at 5:15 PM, revealed he/she recalled the night Resident #7 was admitted. The roommate said "Resident #7 cried off and on all night that night because he/she was hurting and that was uncalled for". Resident #8 stated he/she has had to wait for medications in the past as well.</p> <p>On 09/05/12 at 1:30 PM, an interview with Licensed Practical Nurse (LPN) #5, revealed she worked the 10:00 PM to 6:00 AM shift starting on 07/25/12 and did the admission assessment on Resident #7. She revealed the resident had arrived at the facility on the 2:00 PM to 10:00 PM shift and had recent back surgery. She revealed staff had said in report that they had not received the resident's medications and they would be delivered in the morning. LPN #5 stated she had faxed the pharmacy. LPN #5 also stated she did not contact the DON or anyone about Resident #7's medications. She stated there had been a pharmacy issue lately and it was frustrating, "You call, you fax, you call, you fax." Additionally, LPN</p>	F 309	<p>Review of in-house residents experiencing falls within the past 30 days was completed on 9/7/12 by the Facility Consultant. Residents were reviewed for change in condition, experiencing any new pain or experiencing continued complaints of unrelieved pain to determine that the appropriate follow up action had been completed as warranted based on the condition of the Resident. Concerns were addressed at time of discovery with follow up as directed by the Physician under the direction of the Facility Consultant.</p> <p>Education was initiated on 9/3/12 by the ADON, QI Nurse and the Staff Facilitator with oversight by the Facility Consultant for All Licensed Nurses related to Acute Symptom Assessment and Intervening appropriately based on the seriousness of the condition of the Resident. In-servicing was initiated on 9/21/12 with all licensed Nurses related to Pain Assessment and required follow up. The education included follow up with the Physician for additional orders as needed in order to appropriately</p>		

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F 309	<p>Continued From page 36</p> <p>#5 stated it was her job to administer medications to residents and it "Did NOT make me feel great, I want to see them get what they need". She said the problem was obtaining medications after hours.</p> <p>An interview with LPN #9, on 08/31/12 at 9:00 AM, revealed she remembered Resident #7 was in a lot of pain the morning of 07/26/12 and she had reported to whoever was in charge. The Administrator, the DON and another person had gone to talk with the resident the morning of 07/26/12 and then someone went to the local pharmacy to obtain the medications.</p> <p>Resident #7 had arrived for admission at the facility late on 07/26/12 according to an interview with the DON conducted on 08/31/12 at 9:00 AM. On 07/26/12 when the DON arrived at the facility around 8:00 AM to 8:30 AM, staff reported Resident #7 was hurting. The DON stated she told Resident #7 she would get the medication as soon as possible and thought the Administrator had gone to the pharmacy for the medication. Nurses were to fax the out of state pharmacy and that pharmacy was to fax the local pharmacy.</p> <p>An interview with Resident #7's facility physician, on 09/07/12 at 9:30 AM, revealed she would expect the facility to notify her if a resident did not have pain or any other medication available. The physician did not recall if anyone from the facility had called about Resident #7 not getting his/her medications. Resident #7 stated in an interview on 08/30/12 at 5:15 that "I had to wait fourteen hours for pain medication, I cried, it was terrible".</p> <p>3. A review of the facility's vital sign policy and</p>	F 309	<p>address the condition of the Resident to include the ensuring the administration of pain medication as warranted. Nurses were in-serviced on 9/13/12 through 9/18/12 related to procedure for ordering and obtaining medications. Additional in-servicing with All Licensed staff was initiated on 9/21/12 by the Facility Consultant related to assessing pain to include after a fall or as a change in condition. All newly hired license nurses will receive the education during the orientation process by the Staff Facilitator.</p> <p>Training was completed and verified for all scheduled nurses by 10/29/12 for these areas. Competency was determined by the use of Scenario Testing and Skills Checklist for Assessments (Exhibit T309-1a, 1b,1c & 2).</p> <p>The review and follow up to any concerns identified are being documented on a QI Tool for Monitoring Acute Changes/ Incidents (Exhibit T309-3). The QI Tool will be completed 3 x weekly for minimum of 4 weeks then weekly</p>		

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F 309	<p>Continued From page 37</p> <p>procedure, dated 04/2007, revealed vital signs should be taken per policy and/or as needed. The purpose will be a diagnostic aid to determine any change in a resident's condition.</p> <p>A record review revealed the facility admitted Resident #11 on 06/15/10 with diagnosis of Hypertension. A review of the quarterly MDS assessment, dated 07/04/12, revealed the facility assessed Resident #11's cognition as cognitively impaired and had a diagnosis of Hypertension. A review of the Comprehensive Care Plan for Hypertension: At risk for complications, dated 04/18/12, revealed interventions to administer medication and monitor blood pressure, as ordered by physician.</p> <p>A review of the physician's orders, dated 08/01/12 through 08/31/12, revealed the facility should administer Resident #11 Tenormin (anti-hypertensive) 25 milligrams (mg.) twice a day and Zestril/Prinivil (anti-hypertensive) 20 mg. twice a day. In addition, there was an order to obtain weekly blood pressures on Mondays.</p> <p>A review of the August 2012 Medication Administration Record (MAR) revealed there were initials with a circle around them in the boxes next to the Tenomin 25 mg. and Zestril/Prinivil 20 mg. on 08/08/12 at 7:00 AM, on 08/09/12 at 7:00 AM, on 08/10/12 at 7:00 AM and 7:00 PM, on 08/11/12 at 7:00 AM and 7:00 PM, on 08/12/12 at 7:00 AM and 7:00 PM. on 08/13/12 at 7:00 AM and 7:00 PM and on 08/14/12 at 7:00 AM and 7:00 PM. In addition, the box for Monday (08/13/12) next to obtain weekly blood pressures on Mondays was blank. A review of Resident #11's vital sign summary,</p>	F 309	<p>x 4 weeks then monthly for a minimum of 2 months.</p> <p>The results of these QI tools will be reviewed in a weekly QI Committee meeting consisting of the Administrator, DON, ADON, QI Nurse, Social Worker & any other Interdisciplinary Team members as appointed by the Administrator where the results of these reports will be compiled and assessed for trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p>		

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F 309	<p>Continued From page 38</p> <p>dated 08/08/12-08/14/12, revealed there were no blood pressures taken during this time.</p> <p>Interview with LPN #7, on 09/07/12 at 1:45 PM, revealed she placed her initials with a circle around them in the boxes at 7:00 AM next to the Tenomin and Zestril/Prinivil orders because the medications were not available. She revealed she and another nurse faxed and called the pharmacy several times before the medications were finally delivered to the building. She stated the blood pressure should have been monitored during that time so staff would have been aware if the resident's blood pressure increased. She stated the resident had another blood pressure medication ordered that could have been given if the resident's blood pressure had increased. She couldn't explain why the blood pressure was not monitored or why the blood pressure was not taken on 08/13/12, as ordered.</p> <p>Interviews with LPN #1 and LPN #8, on 09/07/12 at 5:10 PM, revealed Resident #11's blood pressure should have been monitored daily while the resident was not receiving blood pressure medications. They were unable to provide an explanation as to why Resident #11's blood pressure was not monitored.</p> <p>Interview with LPN #12, on 09/07/12 at 2:35 PM, revealed she was not sure if it was her initials circled at 7:00 PM next to the Tenomin and Zestril/Prinivil. She stated the reason it would have been circled was because the medication was not available. When asked why there were two days the medication was initiated as given she stated that some of the nurses will borrow the medication from other residents even though</p>	F 309	<p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	11/20/12	

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F 309	Continued From page 39 we're not supposed to.	F 309			
F 312 SS=F	<p>Interview with the DON, on 09/07/12 at 5:25 PM, revealed she would have expected the staff to call the pharmacy and make them aware they were out of the medication. She stated the staff should have monitored the resident's blood pressure daily during the time the medication was not available to ensure the resident's blood pressure did not increase.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and procedure, it was determined the facility failed to ensure 12 residents (#1, #3, #6, #7, #9, #11, #12, #15, #22, #23, #24 and #25), in the selected sample of 18, who were unable to carry out the necessary activities of daily living, received the necessary services to maintain good grooming and personal hygiene. The facility failed to ensure Residents (#1, #3, #6, #7, #9, #11, #12, #15, #22, #23, #24 and #25) received full baths two times a week per the facility's policy and procedure, and shower schedule. A resident group interview revealed the facility was often too short of staff to ensure residents received their showers as scheduled. Staff interviews revealed there was not enough</p>	F 312	<p><u>F 312</u> Resident #6 was discharged on 9/18/12 to acute care facility. Resident #7 was discharged to home on 9/8/12. Resident #15 was discharged to home on 10/2/12. No intervention for these residents was provided due to their discharged status.</p> <p>Residents #1, #3, #9, #11, #12, #22, #23, #24, and #25 have received full baths or showers per their preference as of 9/18/12 by the SRNA and will continue to receive full baths two times per week per the facility's policy, shower schedule or per each resident's individual preference as appropriate.</p> <p>All other residents will receive necessary services to maintain good nutrition, grooming, and personal care, and oral hygiene.</p>		

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F 312	<p>Continued From page 40 staff to complete the showers. Resident #7 stated he/she felt pretty "icky" sometimes.</p> <p>These facility's failures related to failing to provide necessary care and services to maintain good grooming and personal care resulted in the determination of Substandard Quality of Care at 42 CFR 483.25.</p> <p>Findings include:</p> <p>Review of the facility's Bathing policy and procedure, dated 04/2007, revealed "Bathing of residents will be done according to the facility's schedule. Residents will be given two (2) full baths per week (according to health status) and a partial or complete bath on other days, depending on the status of the resident. This will not be documented because it is a part of daily care."</p> <p>The legend for documenting bath type revealed the following: "F" for full bed bath "P" for partial bed bath "S" for shower "T" for tub "W" for whirlpool "N" for none "NR" for response not required.</p> <p>If none, give reason: "1" for resident refused "2" for not scheduled "3" resident out of facility "NR" response not required</p> <p>Resident's bath type was entered into the kiosk daily for each resident by the Certified Nurse Aide</p>	F 312	<p>The facility shower schedule was reviewed on 9/13/12 by the DON. Changes are made ongoing, to the shower schedule to ensure residents are receiving showers / baths two times per week, per the facility's policy, per the shower schedule and/or per each resident's individual preference as appropriate</p> <p>Licensed Nurses, KMAs and SRNAs were re-educated beginning on 10/03/12 by the Facility Consultant related to providing showers/baths per the facility's policy and per the facility shower schedule or per each resident's individual preference. All newly hired SRNA and licensed nurses will be educated during the orientation process by the Staff Facilitator. Competency will be verified by the completion of the Resident Care Audit Tool (Exhibit T312-1), Shower/Bath Audit Tool (Exhibit T312-2), observation of well groomed residents, and resident interviews.</p> <p>Licensed Nurses, KMAs and SRNAs were re-educated beginning on 11/3/12 by the staff facilitator, DON and Facility Consultant related to</p>	

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F 312	<p>Continued From page 41</p> <p>(CNA) who was responsible for that resident. Review of the "SHOWER LIST" revealed showers were divided up by day, and shifts of 6:00 AM to 2:00 PM shift and 2:00 PM to 10:00 PM shift, as well as by room number.</p> <p>1. Resident #7 was admitted to the facility on 07/25/12 with diagnoses to include After care following surgery, Closed fracture Lumbar Vertebra, Displacement Intervertebral Disc, Lumbago, Muscle Weakness, Thoracic/Lumbosacral Neuritis and Chronic Pain Syndrome.</p> <p>Review of the admission MDS assessment, dated 08/01/12, revealed the facility had assessed the resident with no cognitive impairment; however, the resident required assistance with bathing. Review of the shower list revealed the facility scheduled Resident #7 for Mondays on the 6:00 AM to 2:00 PM shift and Thursdays on the 2:00 PM to 10:00 PM shift. Review of the Bath Type log for Resident #7 for August 2012 revealed no shower was provided on 08/20/12 or on 08/23/12. Additionally, scheduled showers on 08/13/12 and 08/27/12 were not provided as well.</p> <p>An interview with Resident #7, on 08/30/12 at 5:15 PM and on 09/06/12, revealed he/she did not get showers when scheduled some of the time. The resident stated she had just been provided shower assistance the night before (08/29/12) and the shower should have been provided on 08/27/12. The resident said the staff was too busy, there was not enough staff and the facility could not keep staff. Interview on 09/06/12 at 2:15 PM revealed he/she wanted showers more frequently due to working hard in physical</p>	F 312	<p>grooming. Competency will be determined through the use of the Resident Care Audit Tool (Exhibit T312-1), observation of well groomed residents, and resident interviews.</p> <p>The DON, ADON, QI nurse, MDS nurses, Staff facilitator, and Facility Consultant will complete resident care audits. Resident care audits will include ADLs such as good grooming, personal and oral hygiene. Documentation of the audits will occur on the Resident Care Audit Tool (Exhibit T312-1) and Shower/Bath Audit Tool (Exhibit T312-2).</p> <p>The Resident Care Audit Tool will document the care provided and whether or not care was provided correctly and any corrective action taken, as appropriate. The Resident Care Audit Tool will be completed 3 times per week for 4 weeks, then weekly for 4 weeks, then monthly for a minimum of 2 months to ensure residents are receiving ADL services to include grooming, personal and oral hygiene.</p>	

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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F 312	<p>Continued From page 42</p> <p>therapy but there was just not enough staff. The staff say they will try to get to it but don't. Resident #7 stated he/she felt pretty "lcky" sometimes.</p> <p>2. Resident #9 was admitted to the facility on 03/01/10 with diagnoses to include Dementia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/13/12, revealed the facility had assessed the resident as requiring physical help with bathing. The facility scheduled Resident #9 to have a shower two times a week, on Tuesdays and Fridays, per the shower list.</p> <p>Review of the BATH TYPE log for Resident #9 revealed during the month of August 2012, Resident #9 received only two full baths. 08/16/12 and 08/31/12 was marked for Full bed bath. All other dates in the month of August 2012 revealed the resident received only a partial bed bath ("P"), or none (N) for the remainder of the month.</p> <p>An observation on 09/04/12 (Tuesday) at 3:00 PM revealed Resident #9 was seated in a wheel chair in his/her room and the resident's hair appeared oily and in need of washing. An interview with the resident was attempted; however, due to the resident's cognitive impairment no reliable information was provided. Interview with the resident's spouse at the time of the observation revealed staff provided shampooing and bathing but some times there was a problem with the facility being short of staff for one reason or another. The resident was on the shower list for a shower on Tuesday 6:00 AM to 2:00 PM shift.</p> <p>An interview with CNA #2 on 09/07/12 at 4:20 PM</p>	F 312	<p>The Shower/Bath Audit Tool will be used to directly observe the scheduled shower/bath is being performed on scheduled shower days or per each resident's individualized preference. The Shower/Bath Audit Tool will be used 3 times per week for 4 weeks, then weekly for 4 weeks, then monthly for a minimum of 2 months to ensure residents are receiving showers as scheduled or per each resident's individual preference utilizing the Shower/Bath Audit Tool (Exhibit T312-2)</p> <p>The results of the Resident Care Audit Tool and Shower/Bath Audit Tool will be reviewed with the Administrator & DON in a weekly QI Committee meeting to ensure that assistance with ADLs, such as good grooming, personal and oral hygiene, and showers/baths are being provided per each resident's assessed needs and individual preference. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.</p> <p>The compiled information will be reviewed monthly by the Vice</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
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F 312	<p>Continued From page 43</p> <p>revealed she had stayed over from day shift to assist in getting scheduled day shift showers completed. CNA #2 stated she frequently stayed over on the 2:00 PM to 10:00 PM shift to assist in getting scheduled showers and bathing completed from the 6:00 AM to 2:00 PM shift.</p> <p>On 08/30/12 at 10:35 AM an interview with LPN #4 revealed she had never given a resident a shower but had provided a partial bed bath at the time of a treatment maybe two times. LPN #4 stated she knew showers were not done sometimes and she would try to figure out how to get them done. She said there were call ins from the CNAs and the facility was trying to staff them. She stated "I have residents tell me showers are not done and I have had family members complain, but the CNAs do not usually tell me showers are not done, sadly, I find out by just looking at the resident".</p> <p>3. A record review revealed Resident #11 was admitted to the facility on 09/10/09 with diagnoses to include Altered Mental Status, Chronic Kidney Disease and Chronic Airway Obstruction. A review of the quarterly MDS assessment, dated 07/04/12, revealed the facility assessed Resident #11's cognition as moderately impaired and the resident was totally independent on one staff for bathing.</p> <p>A review of the Comprehensive Care Plan for Bathing last updated, 06/20/12, revealed one person should provide some physical assistance with bathing and should encourage the resident to participate in self care, as ability permitted.</p> <p>A review of the Bath Type Log for Resident #11</p>	F 312	<p>President of Operations & the Vice-President of Clinical Services for additional over sight to ensure areas are corrected. Trends & the accompanying action will be reviewed monthly in the Executive QI Committee with the Medical Director monthly for further retraining or for other such interventions to be implemented as necessary.</p>	11/20/12

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F 312	<p>Continued From page 44</p> <p>revealed from 07/30/12 through 09/05/12, Resident #11 received one shower on 08/31/12. All other dates during this time revealed documentation that the resident received either a partial bed bath ("P"), or was not scheduled (N2).</p> <p>4. A record review revealed Resident #15 was admitted to the facility on 07/05/12 with diagnoses to include Senile Dementia and Malaise and Fatigue. A review of the admission MDS assessment, dated 07/12/12, revealed the facility assessed Resident #15's cognition as moderately impaired and he/she required physical help of one staff with part of the bath.</p> <p>Interview with Resident #15, on 09/04/12 at 11:45 AM, revealed staff fail to provide him/her a shower at times. The resident stated staff are very busy and there are times staff do not have time to give showers. He/she stated two staff came to the resident yesterday and told him/her they would come later to give shower. They never showed up. The resident stated she waited until 8:30 PM and decided to go to bed.</p> <p>A review of the Bath Type Log for Resident #15 revealed the resident's last shower was given on 08/23/12 (Thursday). There were no full baths or showers documented from 08/24/12 through 09/05/12. All other dates during this time revealed documentation that the resident received either a partial bed bath ("P"), or was not scheduled (N2).</p> <p>5. A record review revealed Resident #6 was admitted to the facility on 02/22/11 with diagnoses to include Abnormal Posture, Pyogenic Arthritis, Osteoarthritis, Senile Dementia, Altered Mental</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 841 SOUTH BENTON, KY 42026		
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F 312	<p>Continued From page 45</p> <p>Status, and Depressive Disorder. A review of the annual MDS, dated 06/11/12, revealed the facility identified the resident as moderately cognitively impaired and required total assistance of two staff for bathing and extensive assistance with hygiene. A review of the Type of Bath log, dated 07/31/12 through 09/05/12, revealed the facility provided Resident #6 with only one full bath between 08/19/12 and 08/25/12; however, had been scheduled to receive 2 showers.</p> <p>6. A review of the Type of Bath log for Resident #22, dated 08/01/12 through 09/07/12, revealed the facility documented only provided one full bath/shower between 08/05/12-08/11/12 and 08/26/12-09/01/12. Additionally, the resident did not receive any type of bath on 08/28/12. A group interview including Resident #22, on 09/05/12 at 11:00 AM, revealed Resident #22 would like to have two bed baths a week, at least. He/She was afraid to get a shower as most staff were inexperienced.</p> <p>7. A review of the Type of Bath log for Resident #23, dated 08/01/12 through 09/07/12, revealed only one full bath/shower between 08/05/12 and 08/11/12. Additionally, the resident did not receive any type of bath on 08/21/12. A group interview including Resident #23, on 09/05/12 at 11:00 AM, revealed staff would tell him/her they would be back to provide a shower; however, would not come back.</p> <p>8. A review of the Type of Bath log for Resident #24, dated 08/01/12 through 09/07/12, revealed the facility documented providing only one full bath/shower between 08/12/12-08/18/12 and 08/26/12-09/01/12. Additionally, the resident did</p>	F 312			

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F 312	<p>Continued From page 46</p> <p>not receive any type of bath on 08/01/12, 08/02/12, 08/06/12, 08/10/12, 08/15/12, 09/03/12 and 09/06/12. A group interview including Resident #24, on 09/05/12 at 11:00 AM, revealed he/she was "lucky" to get a shower once a week; however, he/she was supposed to get two weekly. The resident indicated he/she would take a "spit bath" on the other days. Resident #24 also revealed if staff come in at 6:00 AM and offer him/her a bath, the resident says "yes" as they may not be back later.</p> <p>9. A review of the Type of Bath log for Resident #25, dated 08/01/12 through 09/07/12, revealed the facility documented providing only one full bath/shower between 08/05/12-08/11/12 and 08/19/12-08/25/12. Additionally, the resident did not receive any type of bath on 08/01/12, 08/07/12, 08/08/12, 08/10/12, 08/11/12, 08/12/12, 08/17/12, 08/21/12, 08/22/12, 08/23/12, 08/26/12, 08/31/12, and 09/04/12. A group interview including Resident #25, on 09/05/12 at 11:00 AM, revealed staff would tell him/her they would be back to provide a shower; however, would not come back.</p> <p>10. Resident #3 was admitted to the facility on 06/06/11 with diagnoses to include; Unspecified Hemorrhage of Gastric/Intestinal Tract, Alzheimer's Disease, Dementia Without Behaviors, Generalized Anxiety, Generalized Pain, Depressive Disorder and Unspecified Psychosis.</p> <p>Review of the shower list revealed the facility scheduled Resident #3 to have showers twice weekly on Monday and Friday. Review of the BATH TYPE log for Resident #3 revealed that during the month of August, the facility</p>	F 312			

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F 312	<p>Continued From page 47</p> <p>documented providing the resident two showers on 08/03/12 and 08/31/12. The facility documented providing four full bed baths during the month on 08/06/12, 08/13/12, 08/27/12 and 08/28/12. All other dates for the month of August revealed that the facility provided the resident a partial bed bath ("P") or none ("N") for the remainder of the month.</p> <p>11. Resident # 12 was admitted to the facility on 01/01/08 with diagnoses to include; Cerebrovascular Accident, Senile Dementia, Vascular Dementia, Chronic Kidney Disease, Atrial Fibrillation, Unspecified Venous Insufficiency, and Osteoarthritis.</p> <p>Review of the BATH TYPE log for Resident #3 revealed during the week of 06/22/12 he/she received one shower on 06/24/12 and during the week of 06/29/12, he/she didn't receive any showers or full baths. The week of 07/06/12, he/she received one full bath only, 07/10/12, no showers were given. The week of 07/13/12, he/she received one shower only, 07/14/12, no full baths. The week of 07/20/12, 08/03/12 and 08/09/12, resident did not receive any showers or full baths. The rest of the times were either marked none, ("N") or partial ("P"). The resident was on the shower schedule for Tuesdays and Saturdays.</p> <p>An interview with CNA #4, on 09/07/12 at 9:30AM, revealed that the facility has periods where there are not enough staff. Several students are in the CNA classes but then they quit after they become certified. Sometimes the "office people" come out and help the staff give showers. If the showers do not get done, the task is passed</p>	F 312			

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F 312	<p>Continued From page 48</p> <p>on to the oncoming shift. If residents want to more that two showers a week, it is hard to complete if the facility is short staffed. CNA #4 revealed that a full bed bath includes the whole body, while a partial bed bath just includes the face, under the breasts, under the arms and the peri area.</p> <p>12. A record review revealed that Resident # 1 was admitted to the facility on 12/08/08 with diagnoses to include Cerebrovascular Disease, Alzheimer's Disease, Dementia and Muscle Weakness.</p> <p>A record review of the Type of Bath record for Resident # 1, revealed the facility provided the resident a shower/full bath on 09/04/12.</p> <p>An interview conducted, on 09/03/12 at 9:30 AM, with CNA #16 revealed she has worked many times with the staffing short. She stated she has had a hard time completing showers and had stayed over yesterday (08/02/12) to provide showers.</p> <p>An interview with Licensed Practical Nurse (LPN) #5, on 09/05/12 at 1:30 PM, revealed she did not normally provide showers on the 10:00 PM to 6:00 AM shift unless a resident was going out of the facility for an appointment. LPN #5 stated she had heard residents complain of not getting showers and she had written it down and told the day shift nurses. She gave no other specific information related to showers not being completed.</p> <p>An interview with the Director of Nursing (DON),</p>	F 312			

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F 312	Continued From page 49 on 08/31/12 at 9:30 AM, revealed the facility had some staffing issues and some residents might not get a shower on the day it was scheduled. The facility would try to get the showers on another day and would pass the information on to the next shift in an attempt to get the showers completed. The DON stated she had provided showers for some residents in the past and that some nurses help but that some did not. The DON stated "We have hired everything that walks in the door, and they quit due to the money". She also said people were not dedicated.	F 312			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one resident (#2) in the sample selection of eighteen residents. The facility failed to ensure physician notification policies were followed related to a Resident's worsening	F 314	<u>F 314</u> Based on chart review it was determined that resident #2 had underlying risk factors to include decreased po intake, had decreased level of function, total assist for transfers, contractures of lower extremities, low albumin level, Paralysis, Dementia, Combative behaviors, was incontinent of bowel/bladder and had a history of pressure ulcers which left the resident with impaired circulation to the tissue. The combination of these factors contributed to the clinically unavoidable decline in the resident's skin condition. Resident # 2 wound was reviewed by the ARNP on 8/22/12. New orders were received and followed on 8/22/12. Resident #2 continued to receive treatment per physician's		

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F 314	<p>Continued From page 50</p> <p>pressure sore. The facility failed to ensure staff was knowledgeable of how to use the low air loss/alternating mattress and to ensure settings were maintained specific to a resident's assessed need. Resident #2 acquired a pressure sore to the left trochanter (hip) identified 08/16/12. The facility assessed the pressure sore again on 08/20/12 and 08/22/12. Observations and staff interviews identified that the facility was not maintaining the settings of the low air loss/alternating mattress as required for Resident #2. Changes in the wound were identified in color and stage with an increase in the resident's pain; however, the facility failed to notify the physician for a treatment change to promote healing.</p> <p>Findings include:</p> <p>A review of the Notification of Physician for Change in Resident's Condition policy, dated 04/2007, revealed staff was to notify the physician when a significant change in a resident's condition occurred with documentation.</p> <p>A record review revealed the facility admitted Resident #2 on 11/28/11 with diagnoses to include Paralysis Agitans, Transient Cerebral Ischemia, Senile Dementia, and History of a Traumatic Fracture. The Norton Scale for Predicting Pressure Ulcers, dated 11/29/11, revealed the facility assessed the resident at high risk for pressure sores. A review of the initial Minimum Data Set (MDS), dated 12/04/11, revealed the facility assessed the resident as having no pressure sores upon admission. A review of the quarterly MDS, dated 07/23/12, revealed the facility identified the resident as severely cognitively impaired and required total</p>	F 314	<p>order ensuring that the resident was receiving the treatment necessary. Resident #2 expired on 10/14/12 in the facility. The low air loss mattress for Resident #2 was removed on 8/23/12 by the QI Nurse and the resident was placed on a Dynamic Elite mattress due to falls on 9/5/12.</p> <p>A Roho mattress was provided for the Resident on 9/25/12 as assessed and determined appropriate. All remaining low air loss / alternating mattresses were removed on 8/23/12.</p> <p>A 100% audit of currently wounded Residents was completed to include Resident # 2 from 9/9/12-9/13/12 by the Wound Consultant to visually inspect current wounds to ensure necessary treatment was in place to promote healing, prevent infection, and prevent new sores from developing and that the MD had been notified of any areas that appeared worsening or new wounded areas with new orders implemented as given by the Physician.</p> <p>A review of wounded Residents was completed on 9/29/12 by the Wound Consultant to ensure the appropriate treatment and interventions, to</p>	

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F 314	<p>Continued From page 51</p> <p>assistance of two staff with bed mobility, hygiene, and bathing. A review of the Skin Breakdown care plan, initiated 08/10/12, revealed the resident was at risk for pressure sores related to a history of skin breakdown, incontinence, and total care for all activities of daily living.</p> <p>A review of the Wound/Ulcer Flow Sheet, dated 08/16/12, revealed the facility identified a pressure sore (suspected deep tissue injury) to the resident's left trochanter (hip) measuring 2 centimeters (cm) in length by 4.5 cm width. Further review of the flow sheet indicated the definition of a suspected deep tissue injury as: "purple or maroon localized area or discoloration intact skin or blood-filled blister due to damage of underlying soft tissue that was painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue." There was no signs or symptoms of infection and no pain. The facility notified the physician of the suspected deep tissue injury with a new order for treatment. A review of the Physician Orders, dated 08/16/12, revealed staff was to cleanse the left hip with a cleanser and apply a foam dressing. Change the dressing daily and as needed.</p> <p>A review of the Wound/Ulcer Flow Sheet, dated 08/20/12, revealed the facility assessed the left hip pressure sore as a Stage II measuring 3 cm in length by 4 cm width, depth superficial. The definition of a Stage II pressure area was as follows: "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister." The facility assessed the area as having no signs or symptoms of infection, red in color with</p>	F 314	<p>include mattresses, were in use to aide with prevention and treatment of pressure wounds as needed. Any concerns identified were addressed at the time of discovery.</p> <p>All other facility residents have had skin checks completed. Any concerns identified were addressed at the time of discovery.</p> <p>Nurses, KMAs, and SRNAs received training on Pressure Ulcer Prevention by 10/24/12- 10/31/12. Competency will be determined through skills checklists completed by the staff facilitator by 11/17/12. Re-training will be provided as necessary by the staff facilitator.</p> <p>The treatment nurse was in-serviced by the Facility Consultant regarding Wound Care and implementation of interventions including prompt notification of the MD in the event a wound is not responding to the currently ordered treatment. This in-servicing was completed on 9/29/12. Competency was verified by use of the Wound/Skin Skills Check List on 10/29/12.</p>		

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F 314	<p>Continued From page 52</p> <p>blanchable redness around the wound, with no odor or drainage. The wound had no necrosis (dead tissue) and pain was noted with turning the resident. There was no documented evidence the physician was made aware of the wound changes.</p> <p>A review of the Progress Notes, dated 08/20/12 at 7:27 PM, revealed the Director of Nursing (DON) discussed benefits of a low air loss/alternating mattress with the resident's family. A review of the Skin Breakdown care plan, initiated 08/10/12, revealed a low air loss mattress was initiated 08/21/12. A review of the Manufacturer's Guidelines, undated, revealed if the user set the comfort level less than the patient's actual weight, it may have the risk of bottoming out and developing a pressure ulcer. If set greater than the patient's weight, the patient may feel the mattress was too hard and not comfortable. There are four therapy modes (auto firm, alternate, static, and seat inflation). Please consult with your physician for a suitable setting.</p> <p>A review of the Low Air Loss initial sheet, dated August 2012, revealed the pressure setting for Resident #2 was (110). Observations, on 08/22/12 at 10:20 AM and 11:20 AM, revealed the comfort setting at (350), therapy setting "auto firm." Interviews with LPN #1, #2, #3, and RN #1 on 08/22/12 at 6:20 PM, 6:25 PM, and 08/23/12 at 7:20 AM and 7:50 AM, respectively, revealed they had received no training over the operation of the low air loss/alternating air mattresses. An interview with LPN #4, on 08/23/12 at 7:00 AM, revealed she checked the mattress settings during the day shift, as she was the treatment nurse most days. She always set the mattresses</p>	F 314	<p>The treatment nurse will continue to assess all wounded residents weekly to ensure that interventions and treatment plans in place are those necessary for promotion of wound healing, prevention of infection and for prevention of the development of additional wounds. Included in this review will be the consideration the mattress type in use. There will be RN oversight who will visually review all wounded residents with the treatment nurse weekly.</p> <p>The DON, ADON, QI nurse or Facility Consultant will monitor the wound care and skin assessment form (Exhibit T314-1) (which reveals the location/type of ulcer, stage of ulcer, healing status, dietary interventions, pain management, MD/RP notification, Weekly documentation, pressure relief devices and recommended changes) weekly at the wound QI Committee meeting to ensure all newly identified wounds or worsening wounds have the necessary treatment to promote healing, prevent infection and prevent new sores from developing with MD notification. The wound care and skin assessment</p>	

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F 314	<p>Continued From page 53</p> <p>to "alternate," so the resident's weight would be shifted while on the mattress. Interviews with the DON, on 08/22/12 at 4:20 PM and 08/23/12 at 1:55 PM, revealed the comfort setting was set by the resident's weight. She preferred staff to keep the therapy setting on "auto firm"; however, she was unable to verify how this was determined. She was unable to provide documentation of staff education related to the operation of the low air loss/alternating mattress.</p> <p>An observation of wound care, on 08/22/12 at 11:10 AM, revealed an open area to the resident's left hip covered completely with a brown substance. The area around the wound was dark red in color. The resident appeared in pain during the treatment, wincing and moaning when the wound was touched. Licensed Practical Nurse (LPN) #4 performed the wound care and described the wound as an unstageable pressure sore measuring 2 cm in length by 4 cm width. The sore was covered with brown slough and the area was dark red around the perimeter of the wound. She indicated the resident received a "pain pill" prior to the anticipated wound treatment. The definition of an unstageable pressure sore, according to the Wound/Ulcer Flow Sheet, revealed the following: "Full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.</p> <p>An interview with LPN #4, on 08/22/12 at 2:00 PM, revealed she assessed the resident as having a suspected deep tissue injury to the left hip on 08/16/12. When assessed on 08/20/12, the wound bed was visible; therefore, it was</p>	F 314	<p>form (Exhibit T314-1) will be completed weekly x 8 weeks then monthly ongoing.</p> <p>The results of these Wound care and skin assessment forms will be reviewed with the Administrator & DON in a weekly QI Committee meeting. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p>		

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F 314	Continued From page 54 considered a Stage II. During today's assessment (08/22/12), it had obviously changed as it was now unstageable. She stated it was typical to keep a treatment in place for two weeks before notifying the physician of the wound decline. She did not notify the physician of the wound changes on 08/20/12 or 08/22/12. An interview with the DON, on 08/22/12 at 5:00 PM, revealed she would expect the nurse to notify the physician when a pressure sore showed signs of decline, as soon as it was noticed. An interview with the Advanced Practitioner Registered Nurse (APRN), on 08/22/12 at 3:15 PM and 3:25 PM, revealed she was not aware of a decline in Resident #2's pressure sore. She visualized the wound (after interview with surveyor at 3:15 PM). She indicated a treatment change was necessary and she would have expected staff to notify her of the changes in the resident's wound. However, review of the Allegation of Compliance submitted by the facility on 08/25/12 revealed the facility discontinued the use of the low air loss/alternating mattress utilized to prevent worsening of the resident's wounds on 08/23/12 and a winged pressure redistribution foam mattress was added for safety and pressure reduction despite identification that Resident #2's wound had worsened on 08/22/12.	F 314	The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.	11/20/12
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	<u>F323</u> Resident #2 expired in the facility on 10/14/12. Resident #2 was reassessed by the QI nurse on 8/23/12 for use of low air loss mattress. The low air loss mattress was discontinued at that	

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F 323	Continued From page 55 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Manufacturer's Guidelines for the low air loss/alternating mattress, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible for three residents (#2, #3, #4) in the selected sample of eighteen residents. The facility failed to assess residents to determine the safe use of devices (air mattress and side rails) prior to utilization. The facility failed to ensure staff was trained and knowledgeable regarding low air loss/alternating mattresses and to ensure appropriate setting for each residents assessed needs. The facility failed to identify causal factors of a fall which prevented the facility from taking the necessary action to ensure the safe use of assistive devices. On 07/26/12, the facility initiated the use of a low air loss/alternating pressure mattress with bilateral half side rails for Resident #2 related to pressure sores. The facility failed to assess for the safe use of these assistive devices. Resident #2 sustained a fall from the low air loss/alternating mattress on 08/02/12 with no injury. The facility placed the resident back in the bed; however, the facility failed to identify or determine the causal factor of the fall or complete an assessment to determine whether the continued use of the low air loss/alternating mattress with bilateral half side	F 323	time and resident was placed on a Dynamic Elite mattress due to falls on 9/5/12. A Roho mattress was provided for Resident #2 on 9/25/12 after the safe use of the device was evaluated. Residents #3 & #4 were on low air loss mattresses and were re-assessed for specialty mattress needs on 8/23/12 by the QI Nurse. Due to healed wounds and safety risk, both specialty mattresses were removed on 8/23/12 and standard pressure relieving mattresses were assessed to be appropriate on 8/23/12 by the QI Nurse and reviewed by the Administrator, DON and ADON. All in-house residents experiencing falls within the past 30 days were reviewed to include evaluation of interventions and devices implemented to include mattresses or side rails. This review was completed on 9/07/12 by the Facility Consultant. The facility will provide an environment that remains as free of hazards as possible and each resident receives assisted devices to prevent	

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F 323	Continued From page 56 rails was safe for Resident #2. On 08/04/12, the resident fell out of bed pinning his/her left arm in the side rail. The facility assessed the resident as sustaining bruising to the left wrist and upper arm with a skin tear to the left lower arm. The facility placed the resident back in bed; however, failed to identify or determine the causal factor of the fall or complete an assessment to determine whether the continued use of the low air loss/alternating mattress with bilateral half side rails was safe for use by Resident #2. The facility failed to revise the care plan to include a new intervention to prevent recurrence of the falls and entrapment after the fall on 08/04/12. While the mattress was discontinued on 08/06/12, the facility placed the resident back on the low air loss/alternating mattress with bilateral half side rails again on 08/21/12 at which time the facility failed to assess the resident for the safe use of the assistive devices until 08/22/12, the day after the devices were utilized for Resident #2. The facility failed to include the history of entrapment as a risk for the resident. The facility failed to revise the care plan to ensure safety interventions were included related to the resident's continued use of the air loss/alternating mattress with bilateral half side rails. The facility failed to ensure the resident's mattress was inflated adequately to his/her weight and failed to ensure the correct spacing between the mattress and side rail were provided to prevent entrapment. The facility failed to ensure all staff was trained and knowledgeable of how to operate the low air loss/alternating mattress specific to the resident's needs and failed to ensure their knowledge of risks associated with these devices. The facility had identified two other residents (#3 and #4) utilizing a low air loss/alternating mattress with bilateral	F 323	accidents. Residents requiring use of restraints have been reviewed for appropriate use and reduction with the implementation of specialty chairs (i.e. Evolution) through the use of the Restraint/Enabler QI process. Residents have been assessed through the RAI process for the use of: transfer assistance, Wandering behaviors and the need to be placed on the Wandering Program, Mobility assistance and the use of assistive devices, falls risk and the need for falls interventions, Side rail usage, DISCUS assessment for the use of Psychotropic Medications and Smoking assessment as appropriate. Currently the facility has no residents who smoke. Education related to making careful observations of the resident's environment to determine if any hazards are present which may result in an injury was initiated for all staff on 10/25/12 and will continue through 11/1/12. Competency will be verified by the use of an Environmental Safety Awareness Quiz. Additional review of all		

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F 323	<p>Continued From page 57</p> <p>half side rails for which the facility failed to assess for the safe use of these devices and failed to ensure the inflation of the air mattress was adequate for each resident. Interview with Resident #4 revealed if not positioned correctly on the mattress, he/she would slide off easily.</p> <p>The facility's failure to ensure each resident was free of accident hazards has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/23/12 and determined to exist on 08/04/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined on-going. (Refer to F280)</p> <p>The findings include:</p> <p>A review of the Manufacturer's Guidelines, undated, revealed it was recommended to use the mattress system with a bed frame and adequate side rails to prevent falling. The guidelines also revealed if the user set the comfort level less than the patient's actual weight, it may have the risk of bottoming out and developing a pressure ulcer. If set greater than the patient's weight, the patient may feel the mattress was too hard and not comfortable. There are four therapy modes (auto firm, alternate, static, and seat inflation). Please consult in your physician for a suitable setting.</p> <p>1. A record review revealed the facility admitted Resident #2 on 11/28/11 with diagnoses to include Paralysis Agitans, Senile Dementia, Lack of Coordination, and Convulsions. A review of the quarterly Minimum Data Set (MDS), dated</p>	F 323	<p>residents' interventions /devices in use was completed on 9/19/12 by the Facility Consultant. These reviews included ensuring that the devices in use continued to provide a safe environment for the resident based on their current condition and need. These reviews also include review of Resident Care Guides and Care Plans. Any concerns noted were addressed at time of discovery.</p> <p>Nurses were in-serviced beginning on 9/3/12 related to incident occurrence and required follow up. The in-servicing included the responsibility of the nurse to conduct a thorough assessment of the resident for change in condition after a fall and consideration of devices in use to include devices. The in-service included conducting an acute symptom assessment and intervening appropriately. Checklists are provided for the staff as a resource tool if needed. All newly hired license nurses will receive the education during the orientation process by the Staff Facilitator. Competency was determined by the use of Scenario Testing and Skills</p>		

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F 323	<p>Continued From page 58</p> <p>07/23/12, revealed the facility assessed the resident as severely cognitively impaired requiring total assistance with bed mobility and transfers. A review of the Low Air Loss initial sheet for Resident #2, dated July 2012, revealed a low air loss/alternating mattress was utilized on 07/26/12. There was no documented evidence the facility completed an assessment to ensure the low air loss mattress was safe to utilize the device. An interview with the Quality Improvement (QI) Nurse, on 08/23/12 at 11:55 PM, revealed she was unaware it was her responsibility to assess resident's for the use of the low air loss/alternating mattress. An assessment was not completed prior to utilization of the low air loss/alternating mattress on 07/26/12.</p> <p>A review of a fall investigation, on 08/02/12, revealed the resident sustained an unobserved fall from the bed at approximately 1:40 PM. There resident was found with his/her feet over the edge of the bed. No injury occurred as a result of the fall. Mats were placed to each side of the bed after the fall as an intervention and staff put the resident back in the bed. A Quality Improvement Fall Review was conducted on 08/03/12, indicating the resident had rolled over the side of the bed and was caught by the bedding. There was no mention of the low air loss/alternating air mattress in the review. There was no documented evidence the facility re-assessed Resident #2 for the continued use of the mattress to ensure it was safe after the fall on 08/02/12.</p> <p>A review of a fall investigation, on 08/04/12, revealed staff found Resident #2 sitting on the mat beside the right side of the bed. His/her left arm was "pinned" in the rail of the bed. Bruising</p>	F 323	<p>Checklist for Assessments (Exhibit T323-1a, 1b, 1c and T323-2).</p> <p>The Facility QI Nurse was in-serviced on 9/7/12 by the Facility Consultant related to the Review of how to complete the Fall/Incident Assessment QI to include: review of residents with falls, MD/RP notification date/time, Daily Progress Note review to ensure completed by the assigned staff member or designee, assessments for Incidents were completed per Facility Assessment Packet, pain medication provided if indicated, and checking the time frame from complaint of pain and the time pain medication given.</p> <p>The Facility QI Nurse was deemed competent to review and complete incident investigations based on over-sight by the Facility Consultant and review of completed incident reports and investigations.</p> <p>Training was completed and verified for all nurses by 11/1/12 for these areas. Competency was determined by the DON, administrative nurses</p>		

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F 323	<p>Continued From page 59</p> <p>was noted to the resident's left leg and wrist, with a skin tear to the left arm. An interview with Licensed Practical Nurse (LPN) #6, on 08/26/12 at 9:00 PM, revealed she was the nurse working at the time of the fall, on 08/04/12. She revealed the resident's arm was twisted into the side rail, and the resident was holding the rail tightly. She revealed after the fall, the resident was put back into the bed on the low air loss/alternating mattress with bilateral half side rails. She indicated the DON was notified of the fall, but did not instruct her to take the resident off the mattress. A bed alarm was put in place at that time to prevent further falls; however, there was no documented evidence the facility completed an assessment to ensure the safe use of the low air loss/alternating mattress with bilateral half side rails after the fall on 08/04/12. The Risk for Falls care plan, initiated 11/29/11, was not updated to address the resident's risk for entrapment while utilizing the assistive devices.</p> <p>A review of the Physician's Orders, dated 08/06/12, revealed the low air loss/alternating mattress was discontinued as the resident's pressure sore was healed; however, a review of the Nursing Notes, dated 08/20/12 at 7:27 PM, revealed the Director of Nursing (DON) had spoken with the resident's family about the possibility of utilizing the low air loss/alternating air mattress again due to skin issues. The note indicated the risks and benefits were discussed and the family understood the increased risk of the resident rolling out of the bed. The note did not indicate the risk for entrapment while using the mattress with bilateral half side rails. A review of the Low Air Loss Initial sheet for Resident #2, dated August 2012, revealed the facility utilized</p>	F 323	<p>and Facility Consultant through the ongoing QI review process.</p> <p>The Facility QI Nurse has been removed from this position with these job duties currently reassigned. Facility is accepting applications for this position.</p> <p>The DON, QI Nurse or Facility Consultant will continue to conduct Incident reviews to include evaluation of interventions and devices initiated to ensure that the resident's environment remains free of accident hazards as much as possible and to determine that the device is safe for use. Follow up to any concerns will occur at the time identified. This review will be documented on an Incident Assessment QI Tool (Exhibit T323-3). The QI Tool will be completed 3 x weekly for minimum of 4 weeks then weekly x 4 weeks then monthly for a minimum of 2 months.</p> <p>The Incident Assessment QI Tool will be reviewed in a weekly QI committee meeting with the Administrator and DON. The compiled results of these audits will</p>		

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F 323	<p>Continued From page 60</p> <p>the mattress on 08/21/12; however, there was no documented evidence the facility conducted an assessment for Resident #2's safe use of the low air loss mattress with side rails until 08/22/12. A review of the Side Rail Assessment, dated 08/22/12 at 3:17 PM, revealed the facility recommended Resident #2's use of the bilateral half side rails. Risks for the side rails included the increased potential for injuries such as skin tears and bruising; however, the assessment did not indicate the potential for side rail entrapment or the resident's previous history of entrapment on 08/04/12. A review of the Specialty Mattress Screening Tool, dated 08/22/12, revealed the risks of utilizing the low air loss/alternating air mattress included falls, skin tears, and bruising; however, the facility's assessment did not address Resident #2's prior side rail entrapment or the risk for another entrapment. A review of the Risk for Falls care plan, dated 08/21/12, revealed the facility implemented half side rails bilaterally to define parameters in the bed for Resident #2. A review of the Risk for Skin Breakdown care plan, dated 08/21/12, revealed the facility implemented a low air loss mattress to the bed. There was no documented evidence either care plan addressed potential risks (including entrapment) for the resident's use of the low air loss/alternating air mattress with bilateral half side rails or further additional interventions implemented to prevent recurrence. Additionally, the care plans did not address guidelines to ensure staff was utilizing appropriate settings of the mattress specific for the resident.</p> <p>An interview with the QI Nurse, on 08/23/12 at 11:55 AM, revealed she did not complete the assessment for the side rails and mattress until</p>	F 323	<p>be assessed for any trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(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 323	<p>Continued From page 61</p> <p>08/22/12 because she was not aware of the utilization of the assistive devices until the next day. She was aware of the resident's previous side rail entrapment and the risk for another entrapment; however, she did not indicate the information on the assessment. She did not update the resident's care plan to include potential safety risks of the assistive devices. Additionally, she did not ensure education of staff related to monitoring Resident #2 with these assistive devices and the potential risk of entrapment.</p> <p>An observation of Resident #2's bed, on 08/23/12 at 9:00 AM, revealed the gap between the side rail and the bed frame measured one inch on both sides of the bed. When lying on the bed, the side of the mattress deflated slightly when close to the edge. An interview with Resident #4, on 08/23/12 at 10:25 AM, revealed if he/she was "too close" to the edge of the mattress it was "as slick as a whistle" and you would fall off if not careful. The resident revealed he/she had learned how to position in the bed to avoid injury.</p> <p>A review of the Low Air Loss initial sheet, dated August 2012, revealed the pressure setting for Resident #2 was (110). Observations, on 08/22/12 at 10:20 AM and 11:20 AM, revealed the comfort setting at (350), therapy setting "auto firm."</p> <p>An interview with the DON, on 08/23/12 at 1:55 PM, revealed she was aware of the resident's side rail entrapment after a fall on 08/04/12, and she made the decision to put Resident #2 back on the low air loss/alternating mattress with bilateral half side rails on 08/21/12. She did not</p>	F 323	<p>necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	11/20/12	

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F 323	<p>Continued From page 62</p> <p>complete an assessment or ask the QI Nurse to document an assessment for the assistive devices until 08/22/12. Assessments were not "typically" completed to include risks versus benefits for residents on specialty mattresses. She indicated there was not a policy to do such assessments. She would have expected the QI Nurse to indicate a risk of side rail entrapment on the assessments. She asked staff to monitor the resident closely while on the low air loss/alternating air mattress with side rails, but should have updated the care plan to ensure staff was aware of the risks related to using the assistive devices.</p> <p>An interview with Registered Nurse (RN) #1, on 08/23/12 at 7:50 AM, revealed she was not aware of any residents being entrapped by a side rail. She revealed Administrative Staff had never discussed the possible risks associated with side rails and the low air loss/alternating mattress. An interview with State Registered Nurse Aide (SRNA) #3, #6, and Nurse Aide (NA) #1 on 08/23/12 at 9:40 AM, 10:10 AM, and 08/24/12 at 12:05 PM, revealed they were not aware of the risks of using side rails with the low air loss/alternating mattress.</p> <p>2. A record review revealed the facility admitted Resident #3 on 06/06/11 with diagnoses of Dementia, History of Falls, Behavioral Disturbances, Psychosis, Insomnia, and Alzheimer's Disease. A review of the quarterly Minimum Data Set (MDS), dated 07/17/12, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance of two staff for bed mobility and transfers. An interview with the DON, on</p>	F 323			

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F 323	<p>Continued From page 63</p> <p>08/23/12 at 9:55 AM, revealed through record review the resident had been placed on a low air loss/alternating mattress with side rails since 06/14/11; however, the facility had not assessed the resident for the safe use of the low air loss mattress. A review of the Low Air Loss initial sheet for Resident #3, dated August 2012, revealed the pressure setting for Resident #3 was (200). Observations, on 08/21/12 at 9:45 AM, 10:35 AM, 1:55 PM, and 08/22/12 at 10:15 AM, revealed the comfort setting at (350), therapy setting at "seat inflation" or "alternate." A review of the Risk for Skin Breakdown care plan, initiated 05/01/12, revealed the facility utilized a low air loss mattress for the resident; however, there were no guidelines to ensure staff was utilizing the appropriate settings.</p> <p>3. A record review revealed the facility admitted Resident #4 on 01/27/12 with diagnoses to include Malaise, Fatigue, and Hypotension. A review of the quarterly MDS, dated 07/12/12, revealed the facility assessed the resident as cognitively intact and required limited assistance with bed mobility and transfers. An interview with the DON, on 08/23/12 at 9:55 AM, revealed through record review the resident had been placed on a low air loss/alternating mattress with side rails on 02/02/12; however, the facility had not assessed the resident for the safe use of the low air loss mattress. A review of the Low Air Loss initial sheet, dated August 2012, revealed the pressure setting for Resident #4 was (200). Observations, on 08/23/12 at 7:00 AM, revealed the comfort setting at (140), therapy setting "alternate." A review of the Risk for Skin Breakdown care plan, initiated 05/02/12, revealed the facility utilized a low air loss mattress for the</p>	F 323			

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F 323	Continued From page 64 resident; however, there were no guidelines to ensure staff was utilizing the appropriate settings. Interviews with LPN #1, #2, #3, and RN #1 on 08/22/12 at 6:20 PM, 6:25 PM, and 08/23/12 at 7:20 AM and 7:50 AM, respectively, revealed they had received no training over the operation of the low air loss/alternating air mattresses. LPN #1 and RN #1 verified they were not aware of the Low Air Loss initial sheet to check the mattress every shift. An interview with LPN #4, on 08/23/12 at 7:00 AM, revealed she checked the mattress settings during the day shift, as she was the treatment nurse most days. The comfort setting of the bed depended on how much the resident weighed. The Low Air Loss initial sheet indicated the comfort setting for the resident, and was supposed to be checked each shift and documented as correct. She always set the mattresses to "alternate," so the resident's weight would be shifted while on the mattress. Interviews with the DON, on 08/22/12 at 4:20 PM and 08/23/12 at 1:55 PM, revealed the treatment nurse or the licensed nurse was supposed to check the low air loss/alternating mattress every shift to ensure it was inflated, there was good positioning of the resident, and the settings were correct. She revealed the comfort setting was set by the resident's weight. She preferred staff to keep the therapy setting on "auto firm"; however, she was unable to verify how this was determined. She was unable to provide documentation of staff education related to the operation of the low air loss/alternating mattress.	F 323			
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353			

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F 353 SS=F	<p>Continued From page 65 PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure sufficient nursing staff to ensure residents received related services to attain or maintain the highest practiceable well-being as determined by resident assessments and individual plans of care for eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25) in the selected sample of 18. The facility failed to ensure Residents received full baths two times a week per the facility's policy and procedure and shower</p>	F 353	<p>F 353 Resident #6 was discharged on 9/18/12 to acute care facility. Resident #7 received showers/baths prior to discharge to home on 9/8/12. It was determined based on resident interviews and staff observation that residents #1, #3, #6, #7, #9, #11, #12, #22, #23, #24, and #25 were not receiving baths.</p> <p>Staffing patterns were reviewed by the Facility Administrator and the DON on 9/28/12. Changes were made to assure that nursing staff are available on a daily basis to meet residents' needs to include residents #1, #3, #6, #7, #9, #11, #12, #22, #23, #24, and #25 for the delivery of nursing services in a manner & in an environment which promotes each resident's physical, mental, & psychosocial well being to enhance their quality of life.</p> <p>The Administrator, DON and Scheduler were in-serviced by the Facility Consultant on 10/2/12 regarding ensuring staffing patterns remain appropriate based on care needs of our residents. Competency was determined by the Facility</p>		

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F 353	<p>Continued From page 66</p> <p>schedule. A resident group interview revealed the facility was often too short of staff to ensure residents received their showers as scheduled. Staff interviews revealed there was not enough staff to complete the showers. Resident #7 stated he/she felt pretty "icky" sometimes.</p> <p>Findings include:</p> <p>An interview with the Director of Nursing (DON), on 09/07/12 at 4:00 PM, revealed there was no policy related to staffing.</p> <p>1. (Refer to F312) Record review of eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25) revealed the facility had assessed these residents as requiring assistance with bathing and had scheduled, per the facility's shower list, the residents to receive two showers weekly. The facility's documentation revealed these resident's were not consistently provided showers per the shower schedule and care plan.</p> <p>An observation on 09/04/12 (Tuesday) at 3:00 PM revealed Resident #9, who the facility assesses as cognitively impaired per the MDS assessment dated 08/13/12, was seated in a wheel chair in his/her room and the resident's hair appeared oily and in need of washing. Interview with the resident's family at the time of the observation revealed staff provided shampooing and bathing but some times there was a problem with the facility being short of staff for one reason or another.</p> <p>An interview with Resident #7 on 08/30/12 at 5:15 PM and on 09/06/12 revealed he/she did not get showers when scheduled some of the time. The</p>	F 353	<p>Consultant through feedback, question and answer at the end of the training.</p> <p>The facility daily staffing sheet has been updated on 9/28/12 by the Facility Administrator. Pay incentives have been offered by the Administrator as of 9/6/12 to employees that work open shifts in order to provide additional coverage in the event an employee calls in. Ads were posted in local newspapers and on line to entice recruitment & recruitment bonuses were initiated by the Facility Administrator as of 8/25/12.</p> <p>Daily Staffing is being reviewed prior to the beginning of the day by the Administrator, DON & or Scheduling Coordinator utilizing the Daily Staffing Sheet to ensure that nursing staff are available on a daily basis to meet each resident's needs to include in a manner & in an environment which promotes each resident's physical, mental, & psychosocial well being to enhance their quality of life.</p>		

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F 353	<p>Continued From page 67</p> <p>resident stated she had just been provided shower assistance the night before (08/29/12) and the shower should have been provided on 08/27/12. The resident said the staff were too busy, there was not enough staff and the facility could not keep staff. Interview, on 09/06/12 at 2:15 PM, revealed he/she wanted showers more frequently due to working hard in physical therapy but there was just not enough staff. The staff say they will try to get to it but don't. Resident #7 stated he/she felt pretty "icky" sometimes. The facility had assessed Resident #7 with no cognitive impairment. Record review revealed the facility had not provided showers per the schedule on 08/13/12, 08/20/12, 08/23/12, and 08/27/12.</p> <p>A group interview (including Resident #22, #23, #24, and #25), on 09/05/12 at 11:00 AM, revealed Resident #22 would like to have two bed baths a week, at least; however, it was not always completed. The resident verified he/she had to wait 30-45 minutes for staff to answer the call light. The resident indicated he/she had to wait on the bedpan for lengthy periods of time, until he/she was sore (happened 2-3 times per week). Resident #23 indicated she had to wait "nearly" an hour for staff to answer the call light. The resident indicated he/she had incontinent episodes while waiting, stating "it made me feel bad." Resident #24 stated he/she was "lucky" to get a shower once a week; however, he/she was supposed to get two weekly. The resident indicated he/she would take a "spit bath" on the other days. Resident #24 also revealed if staff come in at 6:00 AM and offer him/her a bath, the resident says "yes" as they may not be back later. Resident #23 and #25 revealed staff would tell</p>	F 353	<p>A compiled review of the Daily Staffing Sheets will be reviewed by the Administrator & DON in a weekly QI Committee meeting. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are</p>		

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F 353	<p>Continued From page 68</p> <p>them they would be back to give the residents a shower or bath; however, the staff do not always come back. Resident #25 verified he/she had to wait for staff to answer the call light, approximately 45 minutes, stating "if I needed anything quickly, I would have just died." It was the consensus of the group interview that staffing was an issue at the facility.</p> <p>An interview with SRNA #4 on 09/07/12 at 9:30AM revealed that the facility has periods where there are not enough staff. Several students are in the SRNA classes but then they quit after they become certified. Sometimes the "office people" come out and help the staff give showers. If the showers do not get done, the task is passed on to the oncoming shift. If residents want more than two showers a week, it is hard to complete if the facility is short staffed.</p> <p>An interview with SRNA #2, on 09/07/12 at 4:20 PM, revealed she had stayed over from day shift to assist in getting scheduled day shift showers completed. SRNA #2 stated she frequently stayed over on the 2:00 PM to 10:00 PM shift to assist in getting scheduled showers and bathing completed from the 6:00 AM to 2:00 PM shift.</p> <p>An interview conducted, on 09/03/12 at 9:00 AM, with Kentucky Medication Aid (KMA) #1 revealed there had been issues with staffing and that the staff were doing the best they could. She stated staff just do not stay and thought it was due to the pay. KMA #1 said "They can make more at McDonalds, they come here get certified and then they get a better offer elsewhere".</p> <p>An interview conducted, on 09/03/12 at 9:35 AM</p>	F 353	<p>corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	1/20/12	

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F 353	<p>Continued From page 69</p> <p>with SRNA #16, revealed she has worked many times with the staffing short. She stated she has had a hard time completing showers and had stayed over yesterday (09/02/12) to provide showers.</p> <p>An interview with SRNA #12, on 08/30/12 at 3:50 PM, revealed she was assigned with one other staff member today, 08/30/12 (2-10 shift), taking care of 38 residents. There were six showers scheduled on her shift. She revealed showers were almost impossible when there were just two staff for the unit. She indicated she could not provide incontinent care and reposition residents every two hours. She stated "we try, but it was just too many residents". She further stated weekends were "even worse".</p> <p>An interview with SRNA #13, on 08/30/12 at 3:55 PM, revealed she was responsible for eighteen (18) residents today, 08/30/12 (2-10 shift), with an orientee. She indicated it was most difficult to get showers done on her shift as she had eight (8) scheduled.</p> <p>An interview with SRNA #11, on 08/30/12 at 4:05 PM, revealed she worked 2-10 shift. She indicated there was no time in the shift to ensure incontinent care and repositioning every two hours due to staffing.</p> <p>An interview with SRNA #1, on 08/31/12 at 7:50 AM, revealed she worked 6-2 shift. She revealed if staffing was low, it was impossible to ensure showers were given. She stated it was not unusual for call lights to go off for long periods of time.</p>	F 353		

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F 353	<p>Continued From page 70</p> <p>An interview with Licensed Practical Nurse (LPN) #5, on 09/05/12 at 1:30 PM, revealed she did not normally provide showers on the 10:00 PM to 8:00 AM shift unless a resident was going out of the facility for an appointment. LPN #5 stated she had heard residents complain of not getting showers and she had written it down and told the day shift nurses. She gave no other specific information related to showers not being completed.</p> <p>On 08/30/12 at 10:35 AM, an interview with LPN #4 revealed she had never given a resident a shower but had provided a partial bed bath at the time of a treatment maybe two times. LPN #4 stated she knew showers were not done sometimes and she would try to figure out how to get them done. She said there were call ins from the SRNA's and the facility was trying to staff them. She stated "I have residents tell me showers are not done and I have had family members complain, but the SRNA's do not usually tell me showers are not done, sadly I find out by just looking at the resident".</p> <p>An interview with State Registered Nurse Aide (SRNA) #15 and Medical Records, on 09/07/12 at 2:25 PM, revealed SRNA #15 was responsible for staffing, but previously had been taken care of by Medical Records. SRNA #15 revealed day shift and second shift indicated they were not able to complete all tasks required by the end of the shift. She indicated a copy of the staffing sheet was given to Administration daily, so they were aware of the staffing situation. Medical Records indicated there were no incentives for staff to stay at the facility.</p>	F 353		

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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 353	Continued From page 71	F 353		
F 371 SS=F	<p>An interview with the Director of Nursing (DON), on 08/31/12 at 9:30 AM, revealed the facility had some staffing issues and some residents might not get a shower on the day it was scheduled. The facility would try to get the showers on another day and would pass the information on to the next shift in an attempt to get the showers completed. The DON stated she had provided showers for some residents in the past and that some nurses help but that some did not. The DON stated, "we have hired everything that walks in the door, and they quit due to the money". She also said people were not dedicated. The facility was unable to provide documented evidence of how they had addressed the staffing issue to ensure residents received baths per their care plan and shower schedules.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, food temperature log and interview it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions.</p>	F 371	<p><u>F 371</u> Food temps will be checked daily by the dietary cook with oversight by the dietary manager. The buttermilk was discarded on 8/30/12 by the dietary manager. The container of pudding was discarded on 9/05/12 by the dietary manager.</p> <p>Food and chemical contamination concerns to include the chain on the information board above the steam table, the personal items on the tray with resident food items, the ceiling vent over the dry storage area, the walk in refrigerator/ freezer door and hinges have been corrected.</p>	

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F 371	<p>Continued From page 72</p> <p>The facility failed to ensure policies and procedures were implemented related to food temperature and sanitation. The facility failed to ensure foods available for residents consumption were served at safe temperatures and failed to ensure their food temperature log was completed per their policy. Additionally, the facility failed to ensure staff used appropriate hand washing procedures in the kitchen and the kitchen was maintained sanitary.</p> <p>Findings include:</p> <p>Review of the facility policy titled, HOUSEKEEPING AND SANITATION, MAINTENANCE OF SANITARY CONDITIONS, dated 09/2006, revealed the following: "It is the responsibility of the Food Service Manager to ensure that sanitary conditions are maintained in the storage, preparation and serving areas, as well as in the distribution of food, dish washing, pot and pan washing, etc. Cleaning schedules are posted by the manager for routine cleaning."</p> <p>Review of the facility policy titled, FOOD TEMPERATURE and dated 09/2006, revealed the following: "Temperature checklists and thermometers will be available in the kitchen. The Food Service Manager and/or Cooks are responsible for taking food temperatures prior to service of all meals and record on the Steam Table Food Temperature form (BN-404)." This policy also stated "Hot foods will be maintained at 140 degrees or above in the kitchen (or on the steam table) prior to service and cold foods will be maintained at 41 degrees or lower".</p> <p>Observation of the supper meal preparation, on</p>	F 371	<p>Biological contamination was addressed by correcting the solution in the sanitizer bucket on 9/5/12 by the dietary manager.</p> <p>A comprehensive dietary inspection was conducted 11/2/12 by the dietary consultant to identify other areas of concern with corrective action taken as appropriate. Identified areas of concern were reported to the administrator and Facility Consultant. The dietary manager is responsible for correcting the identified areas of concern.</p> <p>Any future areas of concern will be taken to the facility QI Committee for review and plan development and action as appropriate.</p> <p>The dietary manager and the dietary staff were re-trained by the dietary consultant on 10/27/12 through 11/2/12 regarding sanitary conditions, prevention of food contamination, food storage, safe food preparation, food distribution. Also included in the training was the importance taking food temperatures. Temperatures of served foods served are checked at the beginning of each</p>		

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F 371	<p>Continued From page 73</p> <p>08/30/12 at 6:05 PM, revealed a prepared glass of buttermilk, sitting on a serving cart was at the temperature of 54 degrees Farenheit when checked by the Dietary Manager.</p> <p>A container of pudding ready to be served was observed at 61.5 degrees Farenheit on 09/05/12 at 12:40 PM.</p> <p>Steam Table Food Temperature logs were observed with no temperatures recorded in multiple sections. Week of 08/06/12 through 08/12/12 revealed no recorded temperatures of food for 08/06/12, 08/07/12, 08/09/12, 08/11/12 and 08/12/12 for the breakfast and lunch meals. The log for 08/13/12 through 08/19/12 revealed no temperatures for 08/16/12 and 08/17/12 for the breakfast or lunch meals. The week of 08/20-26/12 had no recorded food temperatures for the 08/25/12 and 08/26/12 lunch meal. The week of 08/27/12 through 09/02/12 revealed no recorded temperatures for 09/01-02/12 dinner meals.</p> <p>Observations during the breakfast tray line on 09/05/12 at 7:30 AM revealed:</p> <p>Kitchen staff #1 to leave the tray line, retrieved a food item from the walk in refrigerator in the kitchen area which contaminated her hands. The kitchen staff #1 washed her hands at the handwashing sink and then lifted the lid to the trash can to toss the drying towel and then returned to the tray line and served food.</p> <p>An observation of an information board hanging</p>	F 371	<p>meal service with temperature adjustments made as indicated. Staff were also educated related to proper handling of trash can lids, hand washing, not storing personal items on trays with resident food items, hand washing procedures in the kitchen and cleaning schedule.</p> <p>Competency of the dietary manager was determined through the successful completion of the Competency Test on 11/2/12 administered by the dietary consultant. Competency of the dietary manager and the dietary staff was determined by the completion of the Dietary Audit Tool (T371-1), Infection Control/Hand washing audits (T371-2) and quizzing. Competency was determined by the dietary consultant after completion of the audits, quizzing, and return demonstrations.</p> <p>Newly hired dietary staff will be in-serviced by the dietary manager, during the orientation process, regarding storing, preparing, and distributing and serving food under sanitary conditions to include temperatures of all foods served are</p>		

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F 371	<p>Continued From page 74</p> <p>directly over the food steam table was hung with chains that were covered in thick accumulation of dust and hair.</p> <p>A pack of cigarettes, a cell phone and personal keys were observed on a tray that had resident food items on it.</p> <p>A black substance was observed around the ceiling vent over the dry storage.</p> <p>A build up of a black grime was observed on the walk in refrigerator/freezer door and hinges.</p> <p>A sanitizer bucket was checked by the Dietary Manager and determined it contained zero sanitizer.</p> <p>Interviews with the Dietary Manager on 08/30/12 at 6:10 PM and on 09/05/12 at 7:40 AM revealed cold items as milk and pudding should remain at 40 degrees Farenheit or below. She stated staff should not handle the trash can lid with their hands there was a foot pedal opener so the lid did not have to be touched. The Dietary Manager confirmed hair was adhered to the chain holding the menu information board over the steam table as well as a build up of dust and it should not be there. Personal items like cigarettes, cell phones and keys should never be placed on trays with resident food items. She stated dirt and grime build up should not be on any surface in the kitchen and she had no explanation why there was no sanitizer in the sanitizer buckler.</p> <p>The Dietary Manager also stated some of the kitchen staff was new and she was unaware the staff had not been recording food temperatures</p>	F 371	<p>checked at a minimum of twice during each meal service & that temperature adjustments are made as needed, proper handling of trash can lids, not storing personal items on trays with resident food items, hand washing procedures in the kitchen and cleaning schedule. Competency will be determined by the dietary manager through observation and audit process.</p> <p>A Kitchen Monitoring QI tool (Exhibit T371-1) (which looks at food temperatures and temperature logs, the cleaning schedule and the cleanliness of the dietary department/kitchen, to ensure that personal items are stored away from food and food prep areas) will be completed by the dietary manager, administrator or Facility Consultant to ensure that foods are served to residents at the appropriate temperatures, to ensure that the temperature log is being completed a minimum twice per meal service, to ensure that the cleaning schedule is being followed as posted, and to ensure that personal items are not on trays with resident food item weekly x 4 weeks then monthly 4 months.</p>		

F371 Continued

The dietary manager, administrator or Facility Consultant will complete hand washing audits to ensure dietary staff uses appropriate hand washing procedures in the kitchen. Hand washing audits will be performed 3 times a week then weekly x 4 weeks then monthly for a minimum of 2 months.

The results of the Kitchen Monitoring QI audit tool and the hand washing audits will be reviewed in a weekly QI Committee meeting with the administrator & DON. The compiled results of these audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed.

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F 371	Continued From page 75 for days at a time and should have.	F 371	(Continued on blank paper)	11/20/12
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 §483.75(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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, pharmacy contract review, and facility policy and procedure review, it was determined the facility failed to provide pharmaceutical services that ensured the availability and timely administration of drugs and biologicals to meet the needs of each resident for seven (7) residents (#3, #4, #5, #6, #7, #8 and #11) in the selected sample of eighteen (18). The facility failed to ensure the contracted pharmacy could ensure all necessary	F 425 <u>F425</u>	Resident #5 was discharged from facility on 8/18/12. Medications were ordered and received for Tramadol, but resident had already left the facility. Resident #6 was discharged on 9/18/12 to acute care facility and Tylenol Arthritic was ordered and received. Resident #7 was discharged to home on 9/8/12 and medications were received prior to discharge. On 9/ 10/12 the Pharmacy Consultant audited the medication carts and medication rooms to identify medications were available for use. No areas of concern were identified. On 9/5/12 the Facility Consultant educated the administrative nurses including the DON, ADON, Q1 Nurse, Staff Facilitator, Administrator, MDS Nurses, and Admission's Coordinator on the facility's policy for obtaining	

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F 425	<p>Continued From page 76</p> <p>medications ordered to meet the residents' needs could be procured timely whether for routine or emergency medications. Furthermore, the facility failed to ensure the contracted pharmacy had contracted with a local pharmacy to ensure timely procurement of medications for it's residents. The facility failed to ensure staff was knowledgeable of the pharmacy and facility policies and procedures for the procurement of medications to ensure timely receipt and administration of medications. The facility failed to ensure the emergency drug kit maintained pharmaceuticals to meet the needs of residents while having the knowledge of identified difficulties in getting timely receipt of medications from the contract pharmacy. Furthermore, the facility failed to take necessary action to address identified issues with the contracted pharmacy's inability to provide medication timely to the facility.</p> <p>Resident #8 was admitted to an acute care hospital with a diagnosis to include Hyponatremia (low sodium). The resident returned to the facility on 07/25/12 with orders for Samsca (hyponatremia); however, the facility failed to ensure the resident received the medication for seven days after re-admission. An interview with the hospital physician revealed the hyponatremia would get worse without the Samsca and could be life threatening.</p> <p>Resident #7 was admitted to the facility from an acute care hospital after back surgery on 07/25/12. The physician ordered Percocet (narcotic pain medication); however, it was unavailable at the facility and the resident did not receive the medication for fourteen hours. The Resident complained of pain stating "I cried" and</p>	F 425	<p>medications from the pharmacy (Neil Medical) and backup pharmacies (1: J&R Pharmacy, 2: CVS Pharmacy, Benton, KY or 3: Walgreens Pharmacy, Murray, KY). The facility's routine pharmacy (Neil Medical Pharmacy) has an On-Call Pharmacist available at all times. If a new medication is ordered, the nurse will first fax the order to both the facility's regular pharmacy (Neil Medical) and the Back-up Pharmacy (J&R Pharmacy) to ensure that both pharmacies receive the orders and that the facility receives the medication in a timely manner.</p> <p>For after hours, weekends, and holidays the nurse will contact the facility's On-Call Pharmacist (Neil Medical) who will in turn contact the Back-up Pharmacy (J&R On-Call Pharmacist) with the orders, and the prescription will be filled by the Back-up pharmacy (J&R Pharmacy). In the event that J&R Pharmacy is closed or does not have the medication in stock, the nurse will contact the Neil Medical On-call Pharmacist and have the medication called into the second Back up Pharmacy (CVS Pharmacy, Benton,</p>	

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F 425	<p>Continued From page 77 "It was terrible."</p> <p>Resident #5 sustained a fall with neck pain. Tramadol (narcotic pain medication) was ordered; however it was not available at the facility. There was no evidence the facility took action to procure pain medication for the resident to administer as soon as possible. The resident transferred to the hospital three hours later without receiving any pain medication. Resident #5 was diagnosed with a neck fracture.</p> <p>The facility failure to provide pharmaceutical services that ensured the availability and timely administration of drugs and biologicals to meet the needs of each resident has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/31/12 and determined to exist and determined to exist on 07/25/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The immediate Jeopardy was determined on-going. (Refer to F157, F309).</p> <p>Findings include:</p> <p>A review of the Pharmacy Contract, effective 11/01/91, revealed the contract did not indicate a specified local back up pharmacy.</p> <p>Review of the facility policy titled PHARMACEUTICAL SERVICES, dated 04/2007, included the following: "The facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Pharmaceutical services are</p>	F 425	<p>KY). In the event that J&R Pharmacy or CVS does not have the medication, the nurse will contact the Neil Medical On-call Pharmacist and have the medication call into the third Back up Pharmacy (Walgreens Pharmacy, Murray, KY). These pharmacy numbers are posted at the nurse's station. On 9/13/12-9/18/12 education was conducted by the Staff Facilitator and/or Facility Consultant on the facility's procedure for ordering medication. This education will be provided for all newly hired nurses during the orientation process by the Staff Facilitator.</p> <p>On 9/12/12 the facility added a 24 hour/7 day secondary back up pharmacy (Walgreens Pharmacy, Murray, KY). In the event the primary pharmacy (Neil Medical) or the secondary pharmacy (J&R Pharmacy, Benton, KY) does not have a medication or cannot supply the medication due to extenuating circumstances, then and, the facility will utilize this pharmacy and a courier service to obtain needed medications.</p> <p>An additional contract was obtained for a third back up pharmacy (CVS</p>		

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F 425	<p>Continued From page 78</p> <p>provided in accordance with accepted professional principals and appropriate federal, state, and local laws.</p> <p>A review of the Procurement of Emergency and After-Hours Medications policy, undated, revealed the nurse should call the "on-call" pharmacist, if after hours, weekends, or holidays and communicate to him/her the medication order in its entirety. The "on-call" pharmacist shall then make whatever arrangements necessary with a predetermined local pharmacy (back-up pharmacy), or if the back-up pharmacy could not supply, with any other local retail pharmacy or hospital pharmacy, for procurement of the needed medications such that administration may begin the time frames dictated by policy, if at all possible. The nurse or any other facility personnel should not contact the back-up pharmacy or any other alternate source of medications without first contacting the "on-call" pharmacist.</p> <p>A review of the Starting of New Medication Orders policy, revised 04/19/11, revealed administration of any medication order specified by the prescriber as "emergency" or "stat" shall be started within one hour of said order. If unavailable in the facility's Emergency Medication Kit, such medications shall be obtained from the back-up pharmacy. Administration of routine or scheduled medication orders for treatment of pain shall be started no later than 12 noon of the following day unless the order was designated by the physician as stat or urgent. Routine medication orders, if ordered prior to 5:00 PM and 4:00 PM on weekends, should be started with the next regularly scheduled dose following the next regular pharmacy delivery.</p>	F 425	<p>Pharmacy, Benton, KY) on 10/22/12 to provide an additional pharmacy resource to provide pharmacy back up services.</p> <p>In the event a resident experiences a new onset of pain or experiences pain that is not relieved by the currently ordered pain medication the licensed nurse will contact the MD. A list of available medications the facility has in the Emergency Drug Kit is available in the "Assessment & Observation of a Nursing Home Resident" binder at the nurses' station.</p> <p>If a new pain medication is ordered by the physician that the facility does not have on hand in the evening or early morning hours, the nurse is to call the facility's On-Call Pharmacist (Neil Medical). The On-Call Pharmacist will communicate with the physician to obtain a verbal prescription. If the medication is a narcotic that is available in the facility's Emergency Drug Kit, the On-Call Pharmacist will contact the nurse at the facility and instruct her/him to remove the narcotic from the Emergency Narcotic Drug Kit to</p>	

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F 425	<p>Continued From page 79</p> <p>An interview with the Pharmacist (local/back-up pharmacy), on 08/30/12 at 3:00 PM, revealed there was no written contract requiring them to provide medications on a 24 hour basis.</p> <p>An interview with the Pharmacist (contract pharmacy), on 08/31/12 at 8:25 AM, revealed after hours the facility should be contacting the pharmacist on call, not the back-up pharmacy directly. It was the contract pharmacy's responsibility to coordinate getting medications to the facility (per the back-up pharmacy). He stated the facility would have to obtain an "emergent" or "stat" medication order if needed within one hour; however, the area was "limited" on availability of 24 hour pharmacies. He revealed the facility should ask the physician for a medication available (in the emergency drug kit). He was aware of no pain medications in the emergency drug kit; however, it was the facility's responsibility to determine which medications were needed in the kit.</p> <p>1. Resident #8 was admitted to the facility on 06/19/12 with diagnoses to include Late Stage Chronic Obstructive Pulmonary Disease, Chronic Pain, O 2 Dependence and Chronic Pain. Review of the admission MDS assessment, dated 07/30/12, revealed the facility had assessed Resident #8 with no cognitive impairment and requiring limited assistance with activities of daily living.</p> <p>Resident #8 was transferred to an acute care hospital on 07/21/12 with acute respiratory failure and hyponatremia. Medications administered during the hospital stay included Samsca 15 mg</p>	F 425	<p>administer to the resident. In the event the medication is not available in the facility's Emergency Narcotic Drug Kit, the On-Call Pharmacist (Neil Medical) will contact the Back-up pharmacy (J&R Pharmacy) to deliver the drug. In the event that J&R Pharmacy is closed or does not have the medication in stock, the nurse will contact the Neil Medical On-call Pharmacist and have the medication called into the second Back up Pharmacy (CVS Pharmacy, Benton, KY). In the event J&R or CVS does not have the medication, the nurse will contact the Neil Medical On-call Pharmacist and have the medication call into the third Back up Pharmacy (Walgreens Pharmacy, Murray, KY).</p> <p>In the event that starting the new order within these time frames is not possible due to extenuating circumstances, the physician will be notified by the licensed nurse immediately for further orders and documentation of such circumstances will be made in the nurse's notes of the resident's medical record.</p>	

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
(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 80</p> <p>every day. Hospital laboratory tests revealed Resident #8's serum sodium was 128 mEq (normal 132-146) on admission and 134 mEq on 07/25/12. The hospital physician gave readmission orders to include Samsca 15 mg every day for the treatment of hyponatremia (low sodium) and for Basic metabolic profile laboratory test to be drawn in three days with results to the resident's nursing facility physician. Resident #8 returned to the nursing facility on 07/25/12.</p> <p>Review of Resident #8's MAR, dated 07/01/12 through 07/31/12, revealed initials that were circled (meaning not given) for the dates of 07/26/12, 07/27/12, 07/28/12. While the facility obtained the lab results of the Basic metabolic profile laboratory test obtained on 07/28/12 which revealed serum sodium was 137 (normal 132-146), the facility continued to not have this physician ordered medication available to be administered. Continued review of Resident #8's July 2012 MAR revealed circled initials (meaning medications not given) for the dates of 07/29/12, 07/30/12, 07/31/12. Review of a fax sent to Resident #8's physician on 07/31/12 revealed the following documentation: "Samsca for Resident #8 will not be available for a few days from pharmacy but they can get it. Do you want to order anything else in the meantime?". There was no documented response to the fax.</p> <p>Review of the August 2012 MAR revealed circled initials continued on 08/01/12 for Samsca 15 mg indicating the medication was not given. The MARs revealed the Samsca 15 mg to treat hyponatremia was not given for seven (7) days.</p> <p>An interview with Resident #8, on 08/30/12 at</p>	F 425	<p>Acetaminophen, Ibuprofen, and Naproxen Sodium were approved for addition to the Emergency Drug Kit by the Administrator, DON, Pharmacy Consultant and Medical Director on 9/5/12. Education for the Licensed Nurse's regarding these additions to the EDK box was initiated on 9/7/12 by the ADON. All Nurses received this in-service prior to their next scheduled shift. Arrangements were also made for the addition of Ativan po/injection, Lortab 7.5/500mg, Ultram, and Percocet to the Emergency Drug Kit by the Administrator, Pharmacy Consultant, DON and Medical Director on 9/12/12. These medications arrived to the facility on 9/17/12 and were placed in the Emergency Drug Box. A list of these medications has been placed in the "Assessment & Observation of a Nursing Home Resident" binder for reference by the licensed staff. Education for the Licensed Nurse's regarding these additions to the Emergency Drug Kit was initiated on 9/12/12 by the ADON and the Facility Consultant. All Nurses received this education prior to their next scheduled shift.</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 425	<p>Continued From page 81</p> <p>6:15 PM, revealed he/she was aware that a medication was not available for a few days but did not know which medication it was.</p> <p>An interview was conducted with Pharmacist #3, from the primary pharmacy on 09/05/12 at 4:22 PM, which revealed the readmission orders had been received on 07/25/12 at 6:36 PM. The local pharmacy was contacted the next day. He stated there was a contract with the local pharmacy and the local pharmacy was responsible to supply the initial medications and then the primary pharmacy would send the balance; however, review of the pharmacy contract and interview with the local pharmacy revealed there was no written contract. Further interview with Pharmacist #3 stated the Samsca 15 mg for Resident #8 was dispensed on 07/31/12. He did not know why the initial medication was not sent from the local pharmacy.</p> <p>An interview conducted with Pharmacist #2 from the local back up pharmacy on 09/05/12 at 4:05 PM revealed there was no record of Samsca being ordered for Resident #8. The pharmacist also was unfamiliar with the medication and looked for information about the drug. She stated the information revealed it was used as an electrolyte and renal agent to treat clinically significant Hyponatremia. The information also indicated the medication should be initiated and reinitiated in a hospital setting so sodium levels could be monitored.</p> <p>An interview conducted with Resident #8's facility physician, on 09/07/12 at 9:00 AM, revealed he would have expected the facility to let him know Resident #8 was not receiving the prescribed Samsca and the facility should have provided that</p>	F 425	<p>This education will be provided for all newly hired nurses during the orientation process by the Staff Facilitator.</p> <p>All other medications will continue to be re-ordered per the facility's procedure for ordering medications. On 9/11/12, re-education was initiated with licensed staff and KMAs by the Facility Consultant and ADON on ordering medication refills from the facility's pharmacy using the "Automatic Reorder Sheet" and following up on the "Urgent Early Refill Request" forms to ensure medications are reordered correctly and timely. The "Automatic Reorder Sheets" will be kept on the front of the MAR and medications will be high-lighted by the licensed nurse or KMA when received in the medication order. In the event the medications were not received, the pharmacy (Neil Medical) will be contacted as soon as the medication check in process is completed by the licensed nurse or KMA and arrangements made to obtain them from the Back-up Pharmacy (J&R Pharmacy, Walgreens Pharmacy, Murray, KY</p>		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
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F 425	<p>Continued From page 82</p> <p>medication. The facility normally faxed or called about laboratory results of medication issues that could affect a resident's wellbeing, and then said "faxing is NOT good", "I have never scolded a nurse for calling". The physician also said "They should loosen the purse strings and go to the local pharmacy". The physician stated Samsca was a drug he had not previously used and stated side effects could be lethargy, mental confusion, coma and seizures.</p> <p>An interview with Resident #8's hospital physician, on 09/07/12 at 9:15 AM, revealed he would expect the facility to provide the prescribed medication to Resident #8 and he was not aware it was not available and Resident #8 did not receive it for seven (7) days. The physician stated if the resident did not receive the Samsca his/her low sodium could get worse and could be life threatening. Resident #8 had Syndrome of Inappropriate Antidiuretic Hormone (SIADH) requiring treatment with the medication Samsca, once treatment is successful then the drug can be discontinued.</p> <p>An interview with the Director of Nursing (DON), Administrator and Assistant Director of Nursing (ADON) on 09/07/12 at 7:35 PM, revealed medication orders were to be sent to the primary pharmacy and that pharmacy was to relay it to the back up pharmacy and the back up pharmacy was to send a five day supply of the medications. The local pharmacy had been saying they were not receiving the orders from the primary pharmacy. Both pharmacies were being faxed orders at one time because they said they were not receiving the orders. Nurses were to call the DON or the primary pharmacy when medication</p>	F 425	<p>or CVS Pharmacy, Benton, KY as appropriate) if needed and the DON and Administrator will be notified for further action as necessary. This re-education continued until all licensed staff and KMAs had received this education. Education on obtaining medications and re-ordering medications from the facility pharmacy will be provided for all newly hired nurses and KMAs during the orientation process by the Staff Facilitator.</p> <p>The DON, ADON, Staff Facilitator, QI Nurse and Admissions Coordinator were educated by the Facility Consultant on 9/12/12 on how to complete a Medication Pass Audit using the facility Med Pass Audit tool.</p> <p>On 9/12/12, competencies of licensed staff and KMAs began to include procurement of medications not available during medication pass using the Medication Pass Audit Form (Exhibit T425-1a & 1b) by the Administrative Nursing Staff, Facility Consultants, and Pharmacy Consultants. These audits were completed on all licensed nurses and</p>		

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F 425	<p>Continued From page 83</p> <p>orders were not filled adequately. The DON stated she had "Started a log today" to monitor.</p> <p>The facility could provide no evidence they followed their policies and procedures to ensure timely procurement of medications to assure appropriate and adequate administration of physician ordered medications to treat Resident #8's Syndrome of Inappropriate Antidiuretic Hormone (SIADH). As per the interviews with the hospital physician, the facility's failure to ensure the resident was administered the medication Samsca to address his/her low sodium could have caused the condition to worsen and could be life threatening.</p> <p>2. (Refer to F309) Resident #7 was admitted to the facility on 07/25/12 with diagnoses to include after care following surgery, Closed Fracture Lumbar Vertebra, Displacement Intervertebral Disc, Lumbago, Muscle Weakness, Thoracic/Lumbosacral Neuritis, Chronic Pain Syndrome and Diabetes Mellitus. Review of the admission assessment, dated 07/25/12 at 11:52 PM, revealed the facility had assessed the resident as having low back pain, lower extremity pain due to recent back surgery. The pain history listed pain was worse during the day and the night and that the pain interfered with the resident's daily activities. Review of the admission MDS assessment, dated 08/01/12, revealed the facility had assessed the resident with no cognitive impairment, and required extensive assistance with activities of daily living.</p> <p>Review of Resident #7's record revealed the resident arrived at the facility on 07/25/12 at 9:00 PM. Admitting orders from the hospital included</p>	F 425	<p>KMAs by 9/23/12. Any not completed by this date were completed on or before their next scheduled shift. The results of these audits will be reviewed with the employee with retraining or education completed as appropriate. In the event the employee does not pass the Med Pass Audit with an error rate of less than 5% after a second attempt, the employee will receive 1:1 med pass observation by a RN Facility Consultant until competency is achieved. Medication carts, Medication rooms and medication refrigerators will continue to be audited by the DON, ADON, QI Nurse, Staff Facilitator, or Facility Consultant using a QI tool four times weekly for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly for two months. At the end of the monthly for two months time frame, this will be re-evaluated by the QI team consisting of the Administrator, DON, SDC, QI Nurse, and Facility Consultant for evaluation of frequency of monitoring. If the medications are not available, the nurse will contact the facility pharmacy (Neil Medical) and order</p>	

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2807 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
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F 425	<p>Continued From page 84</p> <p>a prescription from the hospital, dated 07/25/12 and signed by the hospital physician, for Percocet 10/325 milligrams (mg) every four to six hours as needed for pain. Additional medications were: Gabapentin 300 mg twice a day (for chronic pain), Levothyroxine (for hypothyroidism) 50 micrograms (mcg) one a day, Ranitidine HCL (for gastritis) 150 mg two times a day, Calcium with Vitamin D (for calcium deficiency) 600/400 mg every day, Metformin HCL (antidiabetic) 1,000 mg twice a day, Flexeril (muscle relaxant) 10 mg three times a day, Glipizide (antidiabetic) 10 mg twice a day, Lisinopril (antihypertensive) 10 mg once a day, Atenolol (antihypertensive) 100 mg once a day, Famotidine (gastritis) 10 mg twice a day, Prozac (antidepressant) 20 mg once a day and Mevacor (antilipemic) 20 mg every day.</p> <p>Review of the admission Medication Administration Record (MAR), dated 07/25/12 through 07/31/12 revealed Percocet 10/325 mg was not administered to Resident #7 until the next day, 07/26/12 at 10:30 AM. Additionally, many of the routine medications were not administered on 07/26/12 including: Calcium with Vitamin D 600/400 mg due at 1:00 PM, Metformin HCL 1,000 mg due at 7:00 AM, Flexeril HCL 10 mg due at 8:00 AM and 12:00 PM, Glipizide 10 mg due at 7:00 AM, Lisinopril 10 mg due at 12:00 PM, Atenolol 100 mg due at 8:00 AM, Januvia 100 mg due at 4:00 PM, Famotidine 10 mg due at 7:00 AM, Prozac 20 mg due at 4:00 PM, Gabapentin 300 mg due at 7:00 AM, Levothyroxine 50 mcg due at 7:00 AM and Ranitidine HCL 150 mg due at 7:00 AM. All of initials for these medications were circled indicating not given. The back of the MAR revealed documentation of "07/26/12, 8:00 AM,</p>	F 425	<p>the medications from the Back-up Pharmacy (J&R Pharmacy, Benton, KY to deliver the drugs. In the event that J&R Pharmacy is closed or does not have the medication in stock, the nurse will contact the Neil Medical On-call Pharmacist and have the medication called into the second Back up Pharmacy (CVS Pharmacy, Benton, KY). In the event J&R or CVS does not have the medication, the nurse will contact the Neil Medical On-call Pharmacist and have the medication called into the third Back up Pharmacy (Walgreens Pharmacy, Murray, KY) as indicated.</p> <p>When medications are received by two KMAs or Charge nurse on each delivery day (Tuesday-Saturday) from the pharmacy (Neil Medical), the medications and medication packing sheet will be compared to the "Automatic Reorder Sheet" to verify that all medications were received. The DON and/or Administrator will be made aware, in the event the medications were not received with each scheduled delivery. The backup pharmacy (CVS Pharmacy, Benton, KY,</p>	

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F 425	<p>Continued From page 85</p> <p>12:00 PM, All meds, No medications from pharmacy".</p> <p>Observation and interview with Resident #7, on 08/30/12 at 5:15 PM, revealed when first admitted on 07/25/12 the facility had did not provide him/her any pain medications for "fourteen hours". The resident stated "i cried", "It was terrible" as she had been admitted to the facility after having back surgery and could hardly stand the pain in his/her back and legs. An interview with Resident #8, Resident #7's roommate on 08/30/12 at 5:15 PM revealed "Resident #7 cried off and on all night that night because he/she was hurting and that was uncalled for," on the day he/she was admitted. Resident #8 stated he/she has had to wait for medications in the past as well.</p> <p>An interview conducted, on 09/05/12 at 1:30 PM, with Licensed Practical Nurse (LPN) #5 revealed she worked the 10:00 PM to 6:00 AM shift starting on 05/25/12 and did the admission assessment on Resident #7. She revealed the resident had arrived at the facility on the 2:00 PM to 10:00 PM shift and had recent back surgery. She revealed staff had said in report that they had not received the resident's medications and they would be delivered in the morning. LPN #5 stated she had faxed the pharmacy. LPN #5 also stated she did not contact the DON or anyone about Resident #7's medications. She stated there had been a pharmacy issue lately and it was frustrating, "You call, you fax, you call, you fax." Additionally, LPN #5 stated it was her job to administer medications to residents and it "Did not make me feel great, I want to see them get what they need". She said the problem was</p>	F 425	<p>Walgreens Pharmacy, Murray, KY or J&R Pharmacy, Benton, KY as appropriate) will be contacted as soon as the medication check-in process is completed by the licensed nurse or KMA to obtain the medications.</p> <p>The frequency of consultant Pharmacist visits has been increased to twice monthly effective 9/12/12. These visits will occur within the first week and third week of each month. The results from these visits will be forwarded to the DON, Administrator, Facility Consultant, Vice President of Clinical Services and Vice President of Operations for further follow up as indicated.</p> <p>Audits will be conducted by the Pharmacy Consultant during these visits to identify that all residents have medications available and that the medications are being documented appropriately. Med Pass audits will also continue to be conducted on an ongoing basis monthly and as needed by the Pharmacy Consultant, Administrative Nurses and Facility Consultants to ensure continued</p>		

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F 425	<p>Continued From page 86</p> <p>obtaining medications after hours.</p> <p>An interview with LPN #9, on 08/31/12 at 9:00 AM, revealed she remembered Resident #7 was in a lot of pain the morning of 07/26/12 and she had reported to whoever was in charge and they told someone (not sure who). She said the Administrator, the DON and another person had gone in to talk with the resident the morning of 07/26/12 and then someone went to the local pharmacy.</p> <p>An interview with the DON, on 08/31/12 at 9:30 AM, revealed Resident #7 had arrived at the facility late on admission. On 07/26/12 when the DON arrived around 8:00 AM to 8:30 AM staff reported Resident #7 was hurting. The DON stated she told Resident #7 she would get the medication as soon as possible and thought the Administrator had gone to the pharmacy for the medication. Nurses were to fax the out of state pharmacy and that pharmacy was to fax the local pharmacy.</p> <p>An interview with Resident #7's facility physician, on 09/07/12 at 9:30 AM, revealed she would expect the facility to notify her if a resident did not have pain or any other medication available. The physician did not recall if anyone from the facility had called about Resident #7 not getting his/her medications. The physician additionally stated the facility used to keep certain medications at the facility but now generally have someone on call from the pharmacy.</p> <p>3. (refer to F309) A record review revealed the facility admitted Resident #5 on 08/03/12 with diagnoses to include History of Transient</p>	F 425	<p>competency of licensed staff and KMAs who are passing medications.</p> <p>Pharmacy Services are being provided to ensure that drugs and biologicals are available in order to meet the needs of facility residents. Facility Residents, to include Resident #3, #4, #8 and #11, are receiving medications as ordered as evident through review of Medication Administration Records (MAR and MAR to med cart audits by the Administrative Nurses to include the DON, ADON, QI Nurse or Facility Consultant.</p> <p>Medication Administration Record reviews is being completed by the Administrative Nurses to include the DON, ADON, QI Nurse, MDS Nurses and the Facility Consultant. Facility Nurses and KMA's were in-serviced by the Staff Facilitator and the Facility Consultant beginning on 9/13/12 related to the policies and procedures for obtaining medications ordered for administration to Residents as ordered by the Residents Physician. This in-servicing included education related to the use of the Emergency Drug</p>	

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F 425	<p>Continued From page 87</p> <p>Ischemic Attack, Vascular Dementia, Muscle Weakness, Lack of Coordination, Dysphagia, and Dysarthria. A review of the initial Minimum Data Set (MDS), dated 08/10/12, revealed the facility assessed the resident as severely cognitively impaired and required extensive assistance of two staff with bed mobility, transfer, and ambulation. A review of the Pain Management Assessment, dated 08/10/12, revealed the resident had no current complaints of pain with no pain medication. A review of the Physician's Orders, dated 08/03/12 through 08/31/12, revealed no evidence of pain medications.</p> <p>A review of the incident report, dated 08/18/12 at 6:30 AM, revealed Resident #5 sustained a fall from the bed with "a little bit" of neck pain. An interview with RN #2, on 08/24/12 at 1:05 PM, revealed she validated the incident and stated the resident's pain worsened throughout the morning. She notified the physician at 8:30 AM and Tramadol was ordered for pain; however, it was not available in the facility. She was not aware if pain medication was available in the emergency drug kit stating she did not check the kit. She instructed the physician to call the prescription into the local pharmacy by 12:00 PM or it would not arrive at the facility prior to closing as it was Saturday and the back-up pharmacy was only open from 9:00 AM-1:00 PM. She admitted no further attempts were made to ensure pain medication was received and administered timely to address the resident's pain. She stated she could have called the physician for a non-narcotic pain medication, but she did not have time.</p> <p>An interview with the physician, on 08/30/12 at 10:20 AM, revealed nursing staff typically have</p>	F 425	<p>Kit and obtaining medications from the facility's back up Pharmacy in the event the medications were not available or received in a time frame to allow timely administration to the Resident when ordered by the Physician.</p> <p>All newly hired KMA's and Nurses will receive the education during the orientation process by the Staff Facilitator. Training has been completed and verified for all nurses by 10/12/12 for this area.</p> <p>Licensed Nurses and KMAs will review each resident's MAR at the change of shift daily to ensure that all medications are being administered as ordered & that documentation has been completed on the MARs with documenting completion of this task by signing the MAR Documentation Review QI tool (Exhibit T425-2). The DON, QI Coordinator, ADON, or Staff Facilitator will review the MAR documentation review QI tool 3 x weekly for 4 weeks then weekly x 4 weeks, then monthly x 2 months to ensure completion. Any issues</p>		

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F 425	<p>Continued From page 88</p> <p>him call narcotics into the back-up pharmacy as they require a "hard script." He was unable to verify an exact time he called the Tramadol to the back-up pharmacy.</p> <p>A review of the Physician's Orders, dated 08/18/12 at 8:40 AM, revealed an order for Tramadol 50 milligrams (mg) twice daily as needed for pain. A review of the Medication Administration Record (MAR), dated 08/03-31/12, revealed the Tramadol was not administered to the resident. A review of the medication list from the Emergency Drug Kit, dated 07/03/07, revealed no pain medications (narcotic or non-narcotic) were available, if needed.</p> <p>Further interview with RN #2 revealed the family transferred the resident to the emergency room per family car et approximately 9:30 AM, three hours after the fall. She stated the facility had not administered any pain medications to Resident #5 prior to the transfer.</p> <p>A review of the "Packing List", dated 08/18/12, revealed the Tramadol was filled by the local, uncontracted, backup pharmacy at 10:50 AM (over two hours after the order was received). An interview with the Pharmacist (back-up pharmacy), on 08/30/12 at 3:00 PM, revealed the pharmacy hours on Saturday were 9:00 AM to 1:00 PM. The facility would have to get the prescription to their pharmacy by 12:00 PM in order to get the medication that day. She verified if an order was received prior to 9:00 AM, they would have to wait until the pharmacy opened to get it filled.</p> <p>An interview with the DON, on 08/31/12 at 1:15</p>	F 425	<p>identified will be corrected at the time of the audit.</p> <p>The results of the MAR documentation review QI tools (Exhibit T425-3) and the Med Pass audit QI tools will be reviewed with the Administrator & DON in the weekly QI Committee meeting. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.</p> <p>The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p>		

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F 425	<p>Continued From page 89</p> <p>PM, revealed it typically takes at least an hour and a half to receive medications from the back-up pharmacy. She revealed RN #2 should have called the physician for a non-narcotic pain medication, such as Tylenol, and it could have been "borrowed" from another resident. She was aware the emergency drug kit had no pain medication available; however, she was unsure of the reason. An interview with the Administrator, on 08/31/12 at 9:35 AM, revealed the contents of the Emergency Drug Kit were already in place when she became Administrator in 2011. She was not sure how often it was reviewed for changes.</p> <p>Continued interview with the DON, on 08/31/12, revealed it was not acceptable for a resident to wait three hours for pain medication. There was no evidence that the facility nurse followed the facility's policies and procedures for obtaining medication after hours as evidenced by RN #2's interview revealing she instructed the physician to contact the local pharmacy instead of notifying the contract pharmacy. Furthermore, there was no evidence that the facility nurse attempted to obtain an emergent or stat order for the pain medication to ensure timely receipt and resident administration of the medication in order to relieve the resident's pain. A review of the Discharge Summary, dated 08/20/12, revealed the resident sustained an acute fracture of C2 (neck fracture) in the lateral mass and facet area with a mild subluxation of C2 on C3. Interview with RN #2 revealed she did not realize the seriousness of the situation.</p> <p>4. A record review revealed Resident #11 was admitted to the facility on 06/15/10 with a</p>	F 425	<p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	11/20/12	

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F 425	<p>Continued From page 90</p> <p>diagnosis of Hypertension. A review of the physician's orders, dated 08/01/12-08/31/12, revealed the facility should have administered Tenormin (anti-hypertensive) 25 milligrams (mg.) twice a day and Zestril/Prinivil (anti-hypertensive) 20 mg. twice a day to Resident #11.</p> <p>A review of the August 2012 Medication Administration Record (MAR) revealed the boxes next to the Tenormin 25 mg. and Zestril/Prinivil 20 mg. at 7:00 AM had initials with a circle around them for 08/08/12, 08/09/12, 08/10/12, 08/13/12 and 08/14/12. For 7:00 PM, there were initials with a circle on 08/10/12, 08/11/12, 08/12/12 and 08/13/12.</p> <p>Interviews with LPN #7, on 09/07/12 at 1:45 PM, revealed she placed her initials with a circle around them in the boxes at 7:00 AM next to the Tenormin and Zestril/Prinivil orders because the medications were not available. She revealed her and another nurse faxed and called the pharmacy several times before the medications were finally delivered to the building.</p> <p>Interview with LPN #12, on 09/07/12 at 2:35 PM, revealed she was not sure if it was her initials circled at 7:00 PM next to the Tenormin and Zestril/Prinivil. She stated the reason it would have been circled was because the medication was not available. She further revealed that some nurses will borrow the medication from other residents even though we're not supposed to and that is probably why there were two days the medication was initialed as administered.</p> <p>Interview with the DON, on 09/07/12 at 5:25 PM, revealed she would have expected the staff to</p>	F 425		

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F 425	<p>Continued From page 91</p> <p>call the pharmacy and make them aware they were out of the medication. She stated the failure to administer the blood pressure medication could have caused the resident's blood pressure to increase.</p> <p>5. Resident #4 was admitted to the facility on 01/27/12 with diagnoses to include; Malaise and Fatigue, Chronic Kidney disease, Congestive Heart Failure, Dysphagia, Constipation, Hypertension and Hypotension.</p> <p>A review of the Physician's Order dated 09/01/12 revealed that Resident #4 was ordered Tylenol Arthritis 650mg, by mouth daily at 7:00AM and 12:00PM, Equanil 200mg, by mouth three times daily, and Flomax 0.4mg, by mouth at bedtime. The Physician's Order also revealed that the facility was to ask the pharmacy to make sure that Resident #4's medications are received in a timely manner and make sure the resident is never out of medication.</p> <p>A review of Medication Administration Record (MAR) revealed Resident #4 did not receive his/her Tylenol Arthritis on 08/18/12 and 08/19/12, Equanil on 07/26/12, 07/27/12 and 07/29/12 and his/her Flomax on 07/31/12, due to the medication not being available.</p> <p>An interview with the Physician on 09/07/12 at 9:00AM revealed that he had written an order for Resident #4 to receive his/her medications in a timely manner</p> <p>An interview with Resident #4, on 09/06/12 at 10:30AM, revealed that he/she had missed doses of Tylenol Arthritis and Flomax for up to 4-5 days</p>	F 425			

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F 425	<p>Continued From page 92</p> <p>due to it not being available in the facility. The resident stated that he/she had been out of Equanil for 3 days at a time and that he/she had to wait 4 days to get Vick's Vapor Rub from the pharmacy.</p> <p>6. Resident #3 was admitted to the facility on 06/06/11 with diagnoses to include; Unspecified Hemorrhage of Gastric/Intestinal Tract, Alzheimer's Disease, Dementia Without Behaviors, Generalized Anxiety, Generalized Pain, Depressive Disorder and Unspecified Psychosis. A review of the Physician's Orders, dated 09/01-30/12, revealed an order for Risperdal (anti-psychotic) 0.5 mg daily, Proscar 5 mg (treats benign prostatic hyperplasia) every morning, and Ativan (anti-anxiety) 1 mg at night. A review of the Medication Administration Record (MAR) revealed the facility had documented that the following medications were not available to administer to Resident #3: Risperdal on 07/31/12, Proscar on 06/06/12, and Ativan on 08/14/12, 08/15/12 and 08/16/12.</p> <p>7. A record review revealed the facility admitted Resident #6 on 02/22/11 with diagnoses to include Abnormal Posture, Pyogenci Arthritis, and Osteoarthritis. A review of the annual MDS, dated 06/11/12, revealed the facility assessed the resident as moderately impaired and having pain during the assessment period. A review of the Pain care plan, created on 03/02/11, revealed to administer pain medication as per physician orders and note the effectiveness. The Physician Orders, dated 08/01-31/12, revealed an order for Tylenol Extra Strength (pain medication) 500 mg three times daily. The MAR, dated 08/01-31/12, revealed the Tylenol 500 mg was unavailable at</p>	F 425			

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F 425	<p>Continued From page 93</p> <p>the facility on 08/08/12, 08/09/12, and 08/10/12; therefore, the facility staff did not administer the medication to the resident.</p> <p>An interview with LPN #7, on 09/07/12 at 1:45 PM, revealed the resident was out of the medication. She indicated the process for receiving medications included to fax and call the pharmacy. Sometimes, the medication would be delivered the next day; however, it could take a few days.</p> <p>An interview with the Director of Nursing (DON) and Administrator, on 09/07/12 at 7:35 PM, revealed they were aware of the concern related to the timely receipt of medications. The Administrator revealed she could not prove where the system failure was, but medications were not being delivered timely. No plan of action was provided.</p> <p>An interview with the Facility Consultant, on 09/07/12 at 8:30 PM, revealed it varied how often she was at the facility, but tried to come at least once a month. It was not always possible to do that as she had four facilities to oversee. She was aware of a "couple" of incidents related to timely medications; however, she was unaware of a concern receiving pain medications. She would expect the facility staff to notify her of pharmacy issues.</p> <p>An interview with the Regional Vice President, on 09/07/12 at 8:40 PM, revealed he was at the facility at least monthly, sometimes bi-weekly. He was not aware of any pharmacy related issues prior to 08/20/12. He would expect the facility staff to notify him of these issues.</p>	F 425			

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F 431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 431	<p><u>F 431</u></p> <p>All medications refrigerators, to include the East and West Unit medication rooms, were checked on 9/10/12 by the Pharmacy Consultant for open medications and expired medications, to include Influenza Vaccine and Pneumococcal Vaccine, to identify medications available for use. Any medication items found expired were discarded and replaced as needed ensuring medications were available.</p> <p>Nurses were in-serviced beginning on 10/3/12 by the Staff Facilitator related to the dating and time limits of use for opened Medications to include vaccines. In-servicing included the need to replace items discarded in order to ensure medications were available as needed for resident use. New nurses will receive training on opening and dating of medications per policy during the orientation process by the Staff Facilitator prior to administering medications to facility residents. Training will be completed and verified for All Nurses by 10/12/12 for this area.</p>	

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F 431	<p>Continued From page 95</p> <p>Based on observation and interview, it was determined the facility failed to ensure the proper storage of medications in the refrigerator related to expired medications available for use.</p> <p>Findings include:</p> <p>An interview with the Director of Nursing (DON), on 09/07/12 at 6:40 PM, revealed there was no written policy related to the removal of expired medications from the medication refrigerators; however, medication nurses are responsible to complete this task.</p> <p>An observation of the refrigerator in the medication room on the East and West Units, on 09/05/12 at 10:30 AM and 09/05/12 at 12:35 PM, respectively, revealed the following:</p> <ol style="list-style-type: none"> 1. One vial of Influenza Vaccine opened, with an expiration date of 06/12 (East). 2. One vial of Pneumococcal Vaccine opened, with an expiration date of 03/10/12 (West). <p>An interview with Licensed Practical Nurse (LPN) #7, on 09/07/12 at 1:20 PM, revealed she usually passed medications in the facility; however, it was the charge nurse that checked the refrigerator for expired medications.</p> <p>An interview with LPN #9, on 09/07/12 at 1:30 PM, revealed she was usually a medication nurse for dayshift. She verified she did not check the refrigerator for expired medications and was responsible for the task.</p> <p>An interview with the Staff Development Coordinator (SDC), on 09/07/12 at 1:25 PM, revealed she was acting as the charge nurse for</p>	F 431	<p>All medications carts and medication rooms will be checked as applicable during the medication pass by the hall nurse for the dating of opened medications.</p> <p>Administrative Nurses to include the DON, ADON, QI Nurse, Staff Facilitator and the Facility Consultant will conduct checks of the medications carts and medications rooms utilizing a QI Tool For Checking Medications Carts, Rooms and Refrigerators (Exhibit T431-1&2) to be completed 3 times weekly for 4 weeks then weekly for 4 weeks, monthly for a minimum of 2 months. Any items opened and not dated or expired will be discarded and replaced as needed by the Administrative Nurse. Medication carts will also continue to be checked by the Pharmacy Consultant during facility visits currently scheduled bi-monthly for aiding with ensuring that medications are available for administration as ordered by the resident's Physician.</p>	

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F 431	Continued From page 96 dayshift (East), on 09/07/12. She indicated it was the medication nurse's responsibility to check the refrigerator for expired medications. An interview with LPN #10, on 09/07/12 at 1:10 PM, revealed she was the usual charge nurse for dayshift (West). She usually checked the refrigerator for expired medications every two to three weeks; however, there was no specific related policy. An interview with the DON, on 09/07/12 at 6:40 PM, revealed the staff passing medications should ensure expired medications were removed from the refrigerators, on a weekly basis.	F 431	The QI Tool for Checking Medications Carts, Rooms and Refrigerators (Exhibit T431-I&2) will be reviewed with the Administrator & DON in the weekly QI Committee meeting. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments. (Continued on blank paper)	11/20/12
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 observation, interview, record review, and review of the Administrator's Job Description, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator failed to ensure assessments of residents were completed to determine the safe use of devices (air mattress and side rails) prior	F 490	<u>F490</u> The governing body has appointed a new Administrator, on 9/11/12, licensed in the state of Kentucky, to oversee & ensure that the facility's resources are utilized effectively & efficiently to ensure the delivery of the required care & services for the residents. Identified areas of systemic failure are Notification of change, the reporting of abuse, neglect and misappropriation of resident property, the revision of care plans, the giving of medications timely, ensuring medications are available, monitoring for change in condition,	

F431 Continued

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

needed for resident use. New nurses will receive training on opening and dating of medications per policy during the orientation process by the Staff Facilitator prior to administering medications to facility residents. Training will be completed and verified for All Nurses by 10/12/12 for this area.

All medications carts and medication rooms will be checked as applicable during the medication pass by the hall nurse for the dating of opened medications.

Administrative Nurses to include the DON, ADON, QI Nurse, Staff Facilitator and the Facility Consultant will conduct checks of the medications carts and medications rooms utilizing a QI Tool For Checking Medications Carts, Rooms and Refrigerators (Exhibit T431-1&2) to be completed 3 times weekly for 4 weeks then weekly for 4 weeks, monthly for a minimum of 2 months. Any items opened and not dated or expired will be discarded and replaced as needed by the Administrative Nurse. Medication carts will also continue to be checked by the Pharmacy Consultant during facility visits currently scheduled bi-monthly for aiding with ensuring that medications are available for administration as ordered by the resident's Physician.

The QI Tool for Checking Medications Carts, Rooms and Refrigerators (Exhibit T431-1&2) will be reviewed with the Administrator & DON in the weekly QI Committee meeting. The compiled results of the audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.

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F 490	Continued From page 97 to utilization. The Administrator failed to ensure thorough assessment of residents were completed after experiencing a change in condition and failed to ensure timely physician notification for appropriate treatment. The Administrator failed to assure the contracted pharmacy could ensure all necessary medications ordered to meet the residents' needs could be procured timely whether for routine or emergency medications. Resident #2 sustained multiple falls from the low air loss/alternating mattress, on 08/04/12, the resident fell out of bed pinning his/her left arm in the side rail resulting in injury. The facility continued the use of the low air loss/alternating mattress and side rails without completing an accurate assessment to ensure the devices were safe for the resident's continued use. On 08/18/12 at 6:30 AM, the facility identified Resident #5 fell from the bed, was aware of the resident's initial complaint of neck pain upon transfer and continued increasing complaints of pain for approximately two hours before the facility took action to notify the physician of the incident, the resident's pain and significant change after the fall. The resident was transferred by family to the emergency room and received no pain medication prior to the transfer. The resident was admitted to the hospital with an acute C2 spine fracture. The facility admitted Resident #7 on 07/25/12 after having back surgery. Due to the facility's failure to ensure timely receipt of medications, per their pharmacy contract, Resident #7 experienced severe intense pain per the facility's assessment, having no pain medication for 14 hours after admission. Resident #7 stated "I cried, it was terrible." Additionally, the facility failed to ensure adequate staffing to meet the shower needs of (11) residents (#1, #3, #6,	F 490	implementation of pain medications timely, ensuring showers and treatment provided to prevent pressure ulcers, timely notification of lab results, ensure a med pass error rate of <5% and dietary sanitation, safe food temps and hand washing. Any other areas identified as systemic failure through the QI review process will have a plan implemented for review, auditing and monitoring. Oversight of the new Administrator will be conducted by the Vice President of Operations/Governing Body through emails, phone conversations and/or teleconferences at least twice weekly. On-site visits will occur monthly by the Vice President of Operations/Governing Body to monitor for compliance of the identified deficiencies. A new Facility Consultant was appointed on 9/11/12 to work in conjunction with the DON to re-establish effective systems to achieve and maintain compliance. This registered nurse consultant will maintain a presence in the building, and be assisted by other Facility		

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
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F 490	<p>Continued From page 98 #7, #9, #11, #12, #22, #23, #24 and #25) in the selected sample of 18.</p> <p>This failure to administer the facility effectively and efficiently to maintain each residents highest practicable physical, mental, and psychosocial well-being has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 08/23/12 and determined to exist on 08/04/12. A second Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 08/31/12 and determined to exist on 07/25/12. The Immediate Jeopardy was determined on-going. (Refer to F157, 280, 309, 323, 425, 490, 520).</p> <p>Findings include:</p> <p>A review of the Administrator's Job Description, dated 11/21/06, revealed the primary purpose of the position was to direct the overall operation of the facility's activities in accordance with federal, state, and local standards, guidelines, and regulations, and as directed by the Vice President of Operations to assure that the highest degree of quality resident care was maintained at all times.</p> <p>(Refer to F309) The facility failed to ensure staff conducted a thorough assessment of a resident after experiencing a change in condition related to pain after a fall. Additionally, the facility failed to ensure timely notification and failed to provide an accurate assessment of the resident's condition to the physician to address the resident's</p>	F 490	<p>Consultants as needed, to evaluate the effectiveness and progression of the rebuilding of systems through the QI process and implementing policy and procedures to assist in developing licensed and unlicensed nursing staff competencies until compliance is maintained.</p> <p>Oversight of the new Facility Consultant will be conducted by the Vice President of Clinical Services/Governing Body through emails, phone conversations and/or teleconferences at least twice weekly. On-site visits will occur monthly by the Vice President of Clinical Services to monitor for compliance of the identified deficiencies.</p> <p>The Administrator and DON will continue to conduct twice weekly meetings with the Medical Director and the Facility Consultant and/or Vice President of Clinical Services to apprise them of the progress in achieving compliance and request input and direction as necessary. This will occur until compliance is maintained. Documentation of this meeting will be placed on a</p>	

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F 490	<p>Continued From page 99</p> <p>continued and increased complaints of pain. On 08/18/12 at 6:30 AM, the facility identified Resident #5 fell from the bed, was aware of the resident's initial complaint of neck pain upon transfer and continued increasing complaints of pain for approximately two hours before the facility took action to notify the physician of the incident, the resident's pain and significant change after the fall. The resident was transferred by family to the emergency room, by family and received no pain medication prior to the transfer. The resident was admitted to the hospital with an acute C2 spine fracture. The physician stated the facility's assessment was not expressed as a serious situation. The facility admitted Resident #7 on 07/25/12 after having back surgery. Due to the facility's failure to ensure timely receipt of medications, per their pharmacy contract, Resident #7 experienced severe intense pain per the facility's assessment, having no pain medication for 14 hours after admission. Resident #7 stated "I cried, it was terrible."</p> <p>An interview with the DON, on 08/31/12 at 1:15 PM, revealed the physician should be notified immediately (within a few minutes after the assessment) of a possible neck injury after a fall. She expected the nurse to leave the resident in the bed as neck pain was indicative of a neck injury and should be treated as such. She also stated that three hours was not acceptable to wait for pain medication. She revealed RN #2 should have called the physician for a non-narcotic pain medication, such as Tylenol, and it could have been "borrowed" from another resident. She was aware the emergency drug kit had no pain medication available; however, she was unsure of the reason. On 08/31/12 at 9:35 AM, the</p>	F 490	<p>"Meeting with Medical Director Form" (Exhibit T490-1).</p> <p>The Medical Director has been apprised of the findings during this survey process through telephone and personal conferences with the DON and Administrator. The Medical Director is aware of the facility's plan of corrective action. The Medical Director will continue to attend the Executive QI Committee meetings monthly with the Administrator, DON, ADON, QI Nurse, Facility Consultant and any other persons deemed by the Administrator to continue to oversee and assist the facility in maintaining compliance.</p> <p>A review and re-education of the Policies and Procedures for Tags F157, F280, F309, F323, F425, F490, F493 and F520 was completed by the Facility Consultant on 9/24/12 to ensure the governing body (Vice President of Clinical Services, and Vice President of Operations) implements policies regarding the management and operation of the facility that could potentially cause</p>	

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F 490	Continued From page 100 Administrator stated the contents of the Emergency Drug Kit were already in place and she was not sure how often it was reviewed for changes. (Refer to F323) The facility failed to assess residents to determine the safe use of devices (air mattress and side rails) prior to utilization. The facility failed to ensure staff was trained and knowledgeable regarding low air loss/alternating mattresses and to ensure appropriate setting for each residents assessed needs. The facility failed to identify causal factors of a fall which prevented the facility from taking the necessary action to ensure the safe use of assistive devices. Resident #2 sustained two falls from the low air loss/alternating mattress on 08/02/12 with no injury and on 08/04/12 where the resident's left arm was pinned in the side rail sustaining bruising to the left wrist and upper arm with a skin tear to the left lower arm. The facility placed the resident back in bed; however, failed to identify or determine the causal factor of the fall or complete an assessment to determine whether the continued use of the low air loss/alternating mattress with bilateral half side rails was safe for use by Resident #2. While the mattress was discontinued on 08/06/12, the facility placed the resident back on the low air loss/alternating mattress with bilateral half side rails again on 08/21/12 at which time the facility failed to assess the resident for the safe use of the assistive devices until 08/22/12, the day after the devices were utilized for Resident #2. The facility failed to include the history of entrapment as a risk for the resident. Interview with Resident #4, another resident utilizing the air mattress, revealed if not	F 490	serious injury, harm, impairment, or death to a resident. The Facility Consultant met with the Quality Assurance Committee consisting of Administrator, DON, VP of Clinical Services, VP of Operations/Governing Body and the Medical Director on 9/21/12 to reeducate these individuals regarding developing and implementing appropriate plans of action to correct identified quality deficiencies including pharmacy services. The Vice President of Clinical Services/Governing Body and the Vice President of Operations/Governing Body will ensure this is occurring thru monthly review of Executive QI Committee Meeting minutes on an ongoing basis.	11/20/12	

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F 490	<p>Continued From page 101</p> <p>positioned correctly on the mattress, he/she would slide off easily.</p> <p>On 08/23/12 at 1:55 PM, the DON revealed staff was not trained on the operation (including the appropriate settings) of the low air loss/alternating mattresses. She was unable to give specific instructions of how to operate the mattress, or verify how she determined the settings based on an assessment of each residents needs.</p> <p>During a group interview including the Administrator, on 08/23/12 at 9:55 AM, administrative staff revealed it the facility had no policy regarding assessing residents for the safe use of specialty mattresses.</p> <p>(Refer to F425) The facility failed to ensure the contracted pharmacy could ensure all necessary medications ordered to meet the residents' needs could be procured timely whether for routine or emergency medications. Furthermore, the facility failed to ensure the contracted pharmacy had contracted with a local pharmacy to ensure timely procurement of medications for it's residents. The facility failed to ensure staff was knowledgeable of the pharmacy and facility policies and procedures for the procurement of medications to ensure timely receipt and administration of medications. The facility failed to ensure the emergency drug kit maintained pharmaceuticals to meet the needs of residents while having the knowledge of identified difficulties in getting timely receipt of medications from the contract pharmacy. Furthermore, the facility failed to take necessary action to address</p>	F 490			

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F 490	<p>Continued From page 102</p> <p>identified issues with the contracted pharmacy's inability to provide medication timely to the facility. Resident #8 admitted to an acute care hospital with a diagnosis to include Hyponatremia (low sodium). The resident returned to the facility on 07/25/12 with orders for Samsca (hyponatremia); however, the facility failed to ensure the resident received the medication for seven days after re-admission. An interview with the hospital physician revealed the hyponatremia would get worse without the Samsca and could be life threatening. Resident #7 admitted to the facility from an acute care hospital after back surgery on 07/25/12. The physician ordered Percocet (narcotic pain medication); however, it was unavailable at the facility and the resident did not receive the medication for fourteen hours. The Resident complained of pain stating "I cried" and "it was terrible."</p> <p>An interview with the Administrator, on 09/07/12 at 7:35 PM, revealed she knew medications were not being delivered timely; however, could not provide a plan of action the facility had taken to correct the problem. She stated she could not prove the cause of the system failure.</p> <p>(Refer to F353) The facility failed to ensure sufficient nursing staff to ensure residents received showers as scheduled and per the residents' care plan for eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25) in the selected sample of 18.</p> <p>An interview with the Administrator, on 09/07/12 at 7:35 PM, revealed she was aware of staffing issues in the facility; however, was not able to</p>	F 490			

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F 493	Continued From page 107 received baths per their care plan and shower schedules. An interview with the Administrator, on 09/07/12 at 7:35 PM, revealed she was aware of staffing issues in the facility; however, was not able to provide a corrective plan that she had implemented to address staffing concerns. She stated she had informed her supervisor (governing body); however, had no documented evidence and could not remember the specific date she informed the govern body of the staffing issues the facility was having. The Facility Consultant, on 09/07/12 at 8:30 PM, revealed it varied how often she was at the facility, but tried to come at least once a month. It was not always possible to do that as she had four facilities to oversee. She was aware of a "couple" of incidents related to timely medications; however, she was unaware of a concern receiving pain medications. She would expect the facility staff to notify her of pharmacy issues. An interview with the Regional Vice President, on 09/07/12 at 8:40 PM, revealed he was at the facility at least monthly, sometimes bi-weekly. While the Governing Body visited the facility on a routine basis, there was no documented evidence these professionals identified, through their reviews and audits, these quality problems nor evidence of action taken to correct the systems failures.	F 493		
F 502 SS=D	483.75(j)(1) ADMINISTRATION	F 502		

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F 490	Continued From page 103 provide a corrective plan that she had implemented to address staffing concerns.	F 490			
F 493 SS=L	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the governing body implemented policies regarding the management and operation of the facility. The governing body failed to provide adequate oversight to ensure the management and operation of the facility was appropriate to assure all residents' needs were being met through thorough nursing assessment, timely physician notification of a resident's condition change, pharmaceutical procurement and timely medication administration. Immediate Jeopardy was identified at 42 CFR 483.10 Residents Rights F157; 42 CFR 483.20 Resident Assessment F280; 42 CFR 483.25 Quality of Care F309, F323; 42 CFR 483.60 Pharmacy Services F425; and 42 CFR 483.75 Administration F490, and F520. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F309, F312 and F323. On 07/25/12, the facility admitted	F 493	F493 Identified areas of systemic failure are notification of change, the reporting of abuse, neglect and misappropriation of resident property, the revision of care plans, the giving of medications timely, ensuring medications are available, monitoring for change in condition, implementation of pain medications timely, ensuring showers and treatment provided to prevent pressure ulcers, timely notification of lab results, ensure a med pass error rate of <5% and dietary sanitation, safe food temps and hand washing. Any other areas identified as systemic failure through the QI review process will have a plan implemented for review, auditing and monitoring. The governing body is actively and aggressively overseeing the management and operation of the facility to assure all residents' needs are being met through thorough nursing assessment, timely physician notification of resident condition		

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F 493	Continued From page 104 Resident #7, after having back surgery and assessed for intense pain; however, failed to ensure timely receipt and administration of medications to Resident #7 who experienced severe intense pain, having no pain medication for 14 hours after admission. Resident #7 stated "I cried, it was terrible." On 08/18/12, the facility failed to address the needs of Resident #5's complaints of pain after a fall through assessment, timely notification of the physician, procurement and administration of pain medication. Resident #5 was diagnosed with a C2 spinal neck fracture. On 08/04/12, the facility failed to ensure Resident #2 was thoroughly assessed for the continued use and later re-initiation (on 08/21/12) of the low air loss/alternating mattress and side rails after experiencing a fall from the bed with entrapment of the resident's left arm causing injury. The facility failed to ensure staff was knowledgeable of the appropriate use/inflation of the low air loss/alternating mattress and the risks/benefits associated with its use per each resident's assessed needs. Substandard Quality of Care was identified at F312 for the facility's failure to ensure appropriate grooming and hygiene was afforded to the residents of the facility. Additionally, the failures of F312 resulted in the identification of the facility's failure to ensure adequate staffing was provided to meet the needs of the residents as detailed in F353. While the Governing Body visited the facility on a routine basis, there was no documented evidence these professionals identified, through their reviews and audits, these quality problems nor evidence of action taken to correct the systems failures.	F 493	change, pharmaceutical procurement, and timely medication administration, including ensuring corrective measures are implemented and completed for Tags F157, F280, F309, F323, F425, F490, F493 and F520 based on areas of concern identified through the QI review process. The governing body has appointed a new Administrator, on 9/11/12, licensed in the state of Kentucky, to oversee & ensure that the facility's resources are utilized effectively & efficiently to ensure the delivery of the required care & services for the residents. The governing body has renewed responsibility for oversight while being on the premises to oversee & ensure that the facility's resources are utilized effectively & efficiently to ensure the delivery of the required care & services for the residents. This oversight will include ensuring that facility residents are receiving assessments related to use of devices, assessing and addressing changes in the resident's condition.	

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F 493	<p>Continued From page 105</p> <p>The facility's failure to ensure the governing body implemented policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 08/23/12 and determined to exist on 08/04/12. A second Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 08/31/12 and determined to exist on 07/25/12. The Immediate Jeopardy was determined on-going. (Refer to F157, 280, 309, 323, 425, 490, 520).</p> <p>The Findings Include:</p> <p>(Refer to F425) While review of the pharmacy contract revealed the facility did in fact have a contract since 1991 with a pharmacy there was no evidence of a contract with a local pharmacy to address emergent or stat orders as the contract pharmacy is located out of state. An interview with the Administrator, on 09/07/12 at 7:35 PM, revealed she made corporate staff (governing body) aware of the pharmacy issues prior to the survey; however, she did not have any documentation or knowledge of a date it was discussed.</p> <p>An interview with the Facility Consultant (governing body), on 09/07/12 at 8:30 PM, revealed she was aware of "a couple" incidents involving medications unavailable at the facility.</p> <p>An interview with the Regional Vice President, on 09/07/12 at 8:40 PM, revealed he was not aware of any issues related to the pharmacy, but would</p>	F 493	<p>Notification of Physicians for appropriate treatments as warranted based on their condition and changes, ensuring contracted pharmacy services were available for procurement of their medications and that medications are being administered as ordered.</p> <p>Oversight of the new Administrator will be conducted by the Vice President of Operations through emails, phone conversations and/or teleconferences at least twice weekly. On-site visits will occur monthly by the Vice President of Operations to monitor for compliance of the identified deficiencies.</p> <p>A new Facility Consultant was appointed on 9/11/12 to work in conjunction with the DON to re-establish effective systems to achieve and maintain compliance. This Registered Nurse Consultant will maintain a presence in the building, and be assisted by other Facility Consultants as needed, to evaluate the effectiveness and progression of the rebuilding of systems through the QI process and implementing policy</p>		

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F 493	Continued From page 106 expect the Administrator to relay the information. (Refer to F157, 280, 309, 323) Policy review and interview with the Director of Nursing (DON), on 08/31/12 at 1:15 PM, revealed there was no policy (or standard of practice) utilized in the facility related to assessment of a resident. The DON provided a standard of practice for an acute illness assessment; however, revealed it had not been implemented for use in the facility. The facility was unable to provide evidence that they had identified problems with nursing assessments of residents through their investigations and review of the incidents regarding Resident #2's falls and entrapment on 08/04/12 and Resident #5's complaints of pain after a fall resulting in a diagnosed C2 spinal neck fracture nor could they provide evidence that they had initiated corrective action to prevent recurrence. (Refer to F312, F353) The facility failed to ensure sufficient nursing staff to ensure residents received showers as scheduled and per the residents' care plan for eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25) in the selected sample of 18. Director of Nursing (DON) interview, on 08/31/12 at 9:30 AM, revealed the facility had some staffing issues and some residents might not get a shower on the day it was scheduled. The DON stated, "we have hired everything that walks in the door, and they quit due to the money". She also said people were not dedicated. The facility was unable to provide documented evidence of how they had addressed the staffing issue to ensure residents	F 493	and procedures to assist in developing licensed and unlicensed nursing staff competencies until compliance is maintained. Oversight of the new Facility Consultant will be conducted by the Vice President of Clinical Services through emails, phone conversations and/or teleconferences at least twice weekly. On-site visits will occur monthly by the Vice President of Clinical Services to monitor for compliance of the identified deficiencies. The Administrator and DON will continue to conduct twice weekly meetings with the Medical Director and the Facility Consultant and/or Vice President of Clinical Services to apprise them of the progress in achieving compliance and request input and direction as necessary. This will occur until compliance is maintained. Documentation of this meeting will be placed on a "Meeting with Medical Director Form". (Exhibit T493-1) (Continued on blank paper)	11/20/12	

F493 Continued

The Medical Director has been apprised of the findings during this survey process through telephone and personal conferences with the DON and Administrator. The Medical Director is aware of the facility's plan of correction action.

The Medical Director will continue to attend the Executive QI Committee meetings monthly with the Administrator, DON, ADON, QI Nurse, Facility Consultant and any other persons deemed by the Administrator to continue to oversee and assist the facility in maintaining compliance.

A review and re-education of the Policies and Procedures for Tags F157, F280, F309, F323, F425, F490, F493 and F520 was completed by the Facility Consultant on 9/24/12 to ensure the governing body (Vice President of Clinical Services, and Vice President of Operations) implements policies regarding the management and operation of the facility that could potentially cause serious injury, harm, impairment, or death to a resident. The Facility Consultant met with the Quality Assurance Committee consisting of Administrator, DON, VP of Clinical Services, VP of Operations and the Medical Director on 9/21/12 to reeducate these individuals regarding developing and implementing appropriate plans of action to correct identified quality deficiencies including pharmacy services.

The Vice President of Clinical Services and the Vice President of Operations will ensure this is occurring thru monthly review of Executive QI Committee Meeting minutes on an ongoing basis.

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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025	
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F 502	<p>Continued From page 108</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedure, it was determined the facility failed to ensure two (2) residents (#2 and #12) in the selected sample of 18, received laboratory services in a timely manner.</p> <p>Findings include:</p> <p>Review of a facility's policy titled MONITORING SYSTEMS, dated 01/2011, revealed "The facility should maintain a Laboratory Log which will contain written or verbal laboratory physician orders as well as regularly scheduled facility or pharmacy standing laboratory orders. A staff member should be assigned to maintain this log on a daily basis. The assigned staff member should review and enter into the Log physician laboratory orders daily. The staff member should also maintain a schedule for obtaining standing laboratory orders in the Log. The staff member should also schedule standing order laboratory with either facility staff or outside phlebotomists. The assigned staff member should also review laboratory values on a daily basis and should enter into the Log the date of receipt of the laboratory value. Any laboratory value which is not received within three days after being obtained should be investigated to ensure that the specimen was indeed drawn or obtained. The</p>	F 502	<p><u>F502</u></p> <p>Resident #2 had a thyroid stimulating hormone level, lipid profile, and a Phenytoin level drawn on 9/26/12 per MD orders. These results were reported to the MD on 9/27/12 by the licensed nurse. Resident #12 had a PT/INR drawn on 9/6/12. The results were reported to the MD on 9/7/12 by licensed nurse.</p> <p>A 100% lab audit for all ordered labs from 9/6/12 through 9/25/12 was completed on 9/27/12 by the Facility Consultant on current residents to ensure that appropriate labs had been drawn per MD order, results received and timely MD notification of lab results. Any concerns were addressed by the DON as appropriate.</p> <p>The Administrative Assistant was re-educated on 9/8/12 by the Facility Consultant regarding the facility's process for utilization of the Daily Lab Audit form (Exhibit T502-1) to ensure ordered labs are obtained in a timely manner as ordered, results received timely and that the results</p>	

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F 502	<p>Continued From page 109</p> <p>staff member should then contact the laboratory as needed to obtain copies of ordered laboratory values which have not been received." Reporting results was not addressed in the policy.</p> <p>Review of the facility policy titled DIAGNOSTIC SERVICES, dated 04/2007, included documentation of "Labs, x-ray, and other diagnostic reports are signed, dated, and made part of the resident's chart. Appropriate forms are filled out and sent with the resident. "When reports are received, they are filed in the resident's medical record. The attending physician is notified regarding the findings".</p> <p>1. Resident #2 was admitted to the facility on 11/28/11 with diagnoses to include; Paralysis Agitans, Dysphagia, Depressive Disorder, Convulsions, Senile Dementia, Cardiovascular Disease, Hypertension, and Transient Cerebral Ischemia.</p> <p>Review of the Physician's Order dated 09/01/12-09/30/12 revealed that the facility was to perform a Thyroid stimulating Hormone and a Lipid profile every six months and a Phenytoin level performed every three months for Resident #2</p> <p>Review of the Medical Record revealed that the facility had obtained a Thyroid Stimulating Hormone and Lipid Profile on 12/01/11, however, there was no documented evidence of any further profiles performed since 12/01/11. Review of the record also revealed that the Phenytoin level was obtained on 02/13/12, 07/05/12, 07/17/12 and 07/25/12, but there was no documented evidence that it was performed in May, when it was due.</p>	F 502	<p>are reported timely to the MD for appropriate follow up as indicated.</p> <p>Competency of the administrative assistant to complete the Daily Lab Audit form was determined by the Facility Consultant and DON. Competency was based on the oversight observations of the Facility Consultant and DON who also validated Daily Lab Audit forms completed by the administrative assistant.</p> <p>All licensed nurses were in-serviced 9/26/12 through 10/12/12 related to their responsibility to notify physicians of lab results and ensuring residents are receiving the proper follow up. Competency was determined by the DON and Facility Consultant through observation and the Daily Lab Audit review process.</p> <p>All newly hired licensed nurses will be in-serviced regarding ensuring ordered labs are obtained in a timely manner as ordered, results received timely and that the results are reported timely to the MD for appropriate follow up as indicated during the orientation process by the</p>	

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F 502	Continued From page 110 An interview with the Director of Nursing (DON) on 09/07/12 at 4:00PM revealed that the labs should be drawn as the physician orders them. When the lab is ordered, a request is filled out and placed in the laboratory file. When Laboratory Services come, they take the requisitions sheets and draw the labs that have been requested. 2. Resident #12 was admitted to the facility on 01/01/08 with diagnoses to include; Hemiplegia, Cerebrovascular Accident, Senile Dementia, Vascular Dementia, Chronic Kidney Disease, Atrial Fibulation, Hypertension, Venous Insufficiency and Osteoarthritis. Review of the Physician's Order dated 08/28/12 revealed that the facility was to perform a Prothrombin Time/International Normalized Ratio (PT/INR) on 09/04/12 that was not drawn till 09/06/12. Review of the Medical Record revealed that there were no results for the PT/INR and no evidence that one was drawn on 09/04/12. Review of the Lab Slip revealed that the lab was drawn on 09/06/12 at 3:55PM. Interview with the Director of Nursing on 09/07/12 at 4:00PM revealed that when laboratory (lab) orders are written, a laboratory requisition is filled out, with the date the lab is to be drawn and placed in the laboratory box on the wall. When laboratory comes in to draw labs, they check the box and draw the labs for that day. She was unable to explain why these labs were not timely.	F 502	Staff Facilitator. The Staff Facilitator will determine competency through observation of performance while nurses are orientating on the floor. The Administrative Assistant will complete a Daily Lab Audit Form 5 times weekly with tracking of labs drawn, results received and appropriate follow up to include MD notification. DON, QI nurse or Facility Consultant will review the Daily Lab Audit form daily to ensure timely MD notification for lab results. Any lab results received after hours or on weekends will be addressed by the nurse assigned to the specific resident. The nurse will document any actions taken on the lab results sheet and in nursing progress notes. (Continued on blank paper)	11/20/12
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	F 505	<u>F 505</u> The Physician for resident #9 was notified of the sputum culture results	

F502 Continued

The Lab Audit QI Tool (exhibit T502-2) will be used to review the Daily Lab Audit form. The Lab Audit QI Tool reviews the number of labs ordered, the number of labs received, timeliness of MD notification, if MD replied, if there is a new order, and corrective action need. The Lab Audit QI Tool will be used by the QI nurse, DON, or Facility Consultant weekly for minimum of 8 weeks then monthly for a minimum of 2 months. Results of the Lab Audit QI Tool will identify corrective actions needed. The DON will be responsible for validating completion of corrective action.

The results of these Daily Lab Audit forms and Lab Audit QI Tool will be reviewed in a weekly QI committee meeting with the Administrator and DON. The compiled results of these audits will be assessed for any trends by the QI Committee & actions taken based on these assessments.

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.

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F 505	<p>Continued From page 111</p> <p>The facility must promptly notify the attending physician of the findings.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the attending physician was notified timely of laboratory results that indicated a need to significantly alter the treatment for one resident (#9), in the selected sample of 18 residents. Resident #9 was noted to have coughing with thick yellow sputum and rales in the lungs on 05/13/12. A sputum specimen was obtained, the resident was started on an antibiotic and culture results were reported to the facility on 05/25/12 indicating that the antibiotic was ineffective. The physician was not notified of the culture results or the need to alter treatment until 05/29/12, four days later.</p> <p>Findings include:</p> <p>Review of a facility's policy titled MONITORING SYSTEMS, dated 01/2011, revealed the staff process for reporting results was not addressed in the policy.</p> <p>Review of the facility policy titled DIAGNOSTIC SERVICES, dated 04/2007, included documentation of "Labs, x-ray, and other diagnostic reports are signed, dated, and made part of the resident's chart. Appropriate forms are filled out and sent with the resident. "When reports are received, they are filed in the resident's medical record. The attending physician is notified regarding the findings".</p>	F 505	<p>on 5/29/12. New antibiotic treatment was implemented as ordered.</p> <p>A 100% lab audit for all ordered labs, to include for Resident #9, from 9/6/12 through 9/25/12 to include cultures was completed on 9/25/12 by a facility consultant on current residents to ensure that appropriate labs had been drawn per MD order, results received and timely MD notification of lab results had occurred. Any concerns were addressed by the DON as appropriate. An additional lab audit was completed by the Consultant Pharmacist on 9/24/12 during the regularly scheduled review. Any concerns identified were addressed as of 9/28/12.</p> <p>The Administrative Assistant was re-educated on 9/8/12 by the Facility Consultant regarding the facility's process for utilization of the Daily Lab Audit form (Exhibit T505-1) to ensure ordered labs are obtained in a timely manner as ordered, results received timely and that the results are reported timely to the resident's physician for appropriate follow up as indicated.</p>		

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F 505	<p>Continued From page 112</p> <p>An interview with the Assistant Director of Nursing (ADON) conducted on 09/07/12 at 10:30 AM revealed nurses were instructed upon hire to call the physician directly if the physician's office was closed. The Medical Director was to be notified if the resident's physician was not available.</p> <p>A record review revealed the facility admitted Resident #9 on 03/01/10 with diagnoses to include Anemia, Dementia with Delusional Features, Paralysis Agitans, Diabetes Mellitus, and Chronic Pain Syndrome.</p> <p>A review of the annual Minimum Data Set (MDS) Assessment, dated 09/03/12, revealed the facility assessed Resident #9 as cognitively impaired, non-ambulatory, incontinent of bowel and bladder, and required extensive assistance with activities of daily living.</p> <p>A review of Resident #9's record revealed on 05/13/12 at 3:52 PM the facility faxed the Medical Doctor about the resident having audible rales in the lungs and coughing up thick yellow sputum. On 05/14/12 at 9:37 PM the physician ordered a chest x-ray and a sputum culture to be obtained and then the resident was to start on Augmentin 500 milligrams (mg) every eight hours for ten days.</p> <p>Results of the sputum culture was received by the facility on 05/25/12 according to the faxed laboratory report. A review of the Sputum Culture results, with a collection date of 05/17/12, revealed the culture and sensitivity results indicated Escherichia coli and Pseudomonas aeruginosa. The organisms were listed as</p>	F 505	<p>Competency of the administrative assistant to complete the Daily Lab Audit form was determined by the Facility Consultant and DON. Competency was based on the oversight observations of the Facility Consultant and DON who also validated Daily Lab Audit forms completed by the administrative assistant.</p> <p>All Licensed Nurses were in-serviced 9/26/12 through 10/12/12 related to their responsibility to notify physicians of lab results and ensuring residents are receiving the proper follow up. Competency was determined by the DON and Facility Consultant through observation and the Daily Lab Audit review process.</p> <p>All newly hired licensed nurses will be in-serviced regarding ensuring ordered labs are obtained in a timely manner as ordered, results received timely and that the results are reported timely to the MD for appropriate follow up as indicated during the orientation process by the Staff Facilitator. The Staff Facilitator will determine competency through observation of</p>	

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F 505	<p>Continued From page 113</p> <p>resistant to Augmentin, indicating a need for discontinuing the existing treatment of Augmentin and changing the resident's antibiotic therapy to one in which the organisms were susceptible and effective.</p> <p>Review of the laboratory report revealed the facility had received the results of the culture and sensitivity on 05/25/12. RN #3 had faxed the results to the medical doctor's office on 05/25/12 at 2:43 PM. However, there was no indication the RN had attempted to call the medical doctor as the "Call Placed" section of the form was blank. The "Orders Received" section indicated a date of 05/29/12 and was initialed by RN #3. The faxed document had a date of 05/29/12 at 1:52 PM indicating new orders from the physician. The orders were: "1. Ceftriaxone one gram by intramuscular injection every twenty four hours for five doses and mix with Lidocaine. 2. Cipro 500 mg by mouth twice a day for ten days". The faxed order was signed by RN #3 as received.</p> <p>An interview conducted on 09/06/12 at 2:20 PM with RN #3 revealed she did not recall anything about the laboratory result for Resident #9. RN #3 stated if a physician was not in the office she would call the results to the physician. She additionally stated "If I called the physician I would have documented it and would have likely gotten orders if the Culture and Sensitivity result showed the current antibiotic was ineffective".</p> <p>An interview with Resident #9's physician was conducted on 09/06/12 at 2:45 PM. The physician revealed she would have expected to be notified if the antibiotic the resident was on was ineffective and would have given an order for</p>	F 505	<p>performance while nurses are orientating on the floor.</p> <p>The Administrative Assistant will complete a Daily Lab Audit Form 5 times weekly with tracking of labs drawn, results received and appropriate follow up to include MD notification. DON, QI nurse or Facility Consultant will review the Daily Lab Audit form daily to ensure timely MD notification for lab results.</p> <p>Any lab results received after hours or on weekends will be addressed by the nurse assigned to the specific resident. The nurse will document any actions taken on the lab results sheet and in nursing progress notes.</p> <p>The Lab Audit QI Tool (exhibit T505-2) will be used to review the Daily Lab Audit form. The Lab Audit QI Tool reviews the number of labs ordered, the number of labs received, timeliness of MD notification, if MD replied, if there is a new order, and corrective action need. The Lab Audit QI Tool will be used by the QI nurse, DON, or Facility Consultant weekly for</p>	

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F 505	Continued From page 114 a new antibiotic. The physician had been out of the office and on 05/29/12 had returned to the office and reviewed the faxed laboratory results and made the change in orders for Resident. Continued interview with the ADON revealed she didn't know if a call was made but it should have been noted in the nurse's notes if the physician was called. The ADON stated she could not answer why there was a delay in notifying the physician. An interview with the Director of Nursing (DON) on 09/05/12 at 10:15 AM revealed the Laboratory was always closed on the weekend and 05/25/12 was the start of a long holiday weekend. The DON revealed she would have called the physician and gave no explanation why RN #3 did not notify the physician by phone and revealed RN #3 should have. Additionally, the DON stated she saw laboratory results not being acknowledged timely as a problem and a potential for Resident #9 to have gotten worse. An interview on 09/07/12 at 7:35 PM with the DON, Assistant Director of Nursing (ADON) and Administrator revealed they had not identified a problem with the system for obtaining and reporting laboratory test results.	F 505	minimum of 8 weeks then monthly for a minimum of 2 months. Results of the Lab Audit QI Tool will identify corrective actions needed. The DON will be responsible for validating completion of corrective action. The results of these Daily Lab Audit forms and Lab Audit QI Tool will be reviewed in a weekly QI committee meeting with the Administrator and DON. The compiled results of these audits will be assessed for any trends by the QI Committee & actions taken based on these assessments. (Continued on blank paper)	11/20/12
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 nursing services; a physician designated by the facility; and at least 3 other members of the	F 520	<u>F520</u> The facility QI Committee will identify other areas of quality concern through the QI review process, for example: review of charts, rounds tools, review of Point Click Care (Electronic Medical Record) audit reports,	

F505 Continued

The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.

The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.

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F 520	<p>Continued From page 115 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 Improvement Program policy/procedure, it was determined the Quality Assessment and Assurance (QAA) committee failed to develop and implement appropriate plans of action to correct identified quality deficiencies related to pharmacy services. The facility failed to ensure medications were available from the contract pharmacy for eight residents (#3, #4, #5, #6, #7, #8, #9 and #11) in the selected sample of 18 residents. On 07/25/12, the facility readmitted Resident #8 after an acute care hospital stay with a diagnosis to include Hyponatremia (low sodium). The facility failed to ensure the resident received physician</p>	F 520	<p>staff/resident/family interviews, resident council minutes, resident concern logs, pharmacy reports, weight meetings, wound meeting, RD consults, and Psych services recommendations.</p> <p>The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns.</p> <p>A Facility QI Committee Meeting held on 10/17/12. The Medical Director, Administrator, DON and QI Nurse will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate.</p> <p>Corrective action has been taken for the identified concerns related to Pharmacy Services F425 and Staffing F353 as reflected in the plan of correction</p> <p>The Facility Administrator, Medical Director, DON and QI Nurse were</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025		
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F 520	Continued From page 116 ordered medication Samsca (treatment for hyponatremia) for seven days after re-admission due to failures with the pharmaceutical procurement. The hospital physician stated the hyponatremia would get worse without the Samsca and could be life threatening. On 7/25/12, the facility admitted Resident #7 from an acute care hospital after back surgery. The physician ordered Percocet (narcotic pain medication); however, it was unavailable at the facility and the resident did not receive the medication for fourteen hours. Staff interviews revealed there was no pain medication in the facility's emergency drug kit. The Resident complained of pain stating "I cried" and "it was terrible." On 08/18/12, Resident #5 sustained a fall with neck pain. Tramadol (narcotic pain medication) was ordered; however it was not available at the facility. There was no evidence the facility took action to procure pain medication for the resident to administer as soon as possible. The resident transferred to the hospital three hours later without receiving any pain medication. Resident #5 was diagnosed with a C2 spinal neck fracture. Additionally, record review of Resident #3, #4, #6, #9, and #11, revealed different medications were unavailable for multiple days. Interview with members of the QAA committee revealed they had identified an issue with the pharmacy; however, a plan of action to correct the problem was not provided. Furthermore, Substandard Quality of Care (SQC) was identified at F312 with a related deficiency at F353 identifying the facility failed to ensure sufficient nursing staff to ensure residents received showers as scheduled and per the residents' care plan for eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25)	F 520	in-serviced by the Facility Consultant on 9/21/12 related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. The Committee will continue to meet at a minimum of Quarterly with oversight by the Vice President of Operations, Vice President of Clinical Services and the Facility Consultant, The QI Committee meeting agenda and minutes with resulting plans of corrections and audit results will be reviewed as a component of this oversight after each QI Committee meeting. The Executive QI Committee with the Medical Director will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator		

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F 520	<p>Continued From page 117</p> <p>in the selected sample of 18. Administrative staff interviews revealed the facility had identified staff issues and had discussed issues in QAA; however, failed to have documented evidence of how they had addressed the staffing issue to ensure residents received baths per their care plan and shower schedules through their Quality Assurance process.</p> <p>The QAA committee's failure to develop and implement appropriate plans of action to correct identified quality deficiencies related to pharmacy services has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and SQC was identified at 42 CFR 483.25 Quality of Care on 08/23/12 and determined to exist on 08/04/12. A second Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 08/31/12 and determined to exist on 07/25/12. The Immediate Jeopardy was determined on-going. (Refer to F157, 280, 309, 323, 425, 490, 520). Additionally, SQC was identified at F312 due to the facilities failure to ensure residents received appropriate care and services to meet their grooming and hygiene needs based on the facility's failure to ensure adequate staffing was provided (Refer to F312, F353)</p> <p>The Findings Include:</p> <p>A review of the Quality Improvement Program policy, dated 01/11, revealed the pharmacy review committee met quarterly to ensure concerns noted during the pharmacist's visits</p>	F 520	<p>will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or his designee will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>The Governing Body (Vice President of Operations & the Vice-President of Clinical Services) will provide additional oversight to ensure deficient areas of practice are corrected. The Governing Body will review monthly the compiled information from the QI Committee and the Executive QI Committee. The Governing Body will give necessary direction to the facility to ensure deficient areas of practice are corrected and solutions sustained. The administrator will be responsible for ensuring directives from the Governing Body are completed and the Governing Body is kept informed of both deficient practices identified and solutions sustained.</p>	11/20/12

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F 520	<p>Continued From page 118</p> <p>were discussed and a plan of action was formulated to alleviate those concerns.</p> <p>Interviews with Licensed Practical Nurse (LPN) #7, on 09/07/12 at 1:45 PM, revealed medications were not available. She revealed she had to fax and call the pharmacy several times before the medications were finally delivered to the building, and it could take a few days.</p> <p>An interview conducted, on 09/05/12 at 1:30 PM, with LPN #5 revealed there had been a pharmacy issue lately and it was frustrating, "You call, you fax, you call, you fax." Additionally, LPN #5 stated it was her job to administer medications to residents and it "Did not make me feel great, I want to see them get what they need". She said the problem was obtaining medications after hours.</p> <p>An interview with a facility Physician, on 09/07/12 at 9:00 AM, revealed that he has had to write "to receive medications in a timely manner" on the physician order.</p> <p>An interview with the Director of Nursing (DON), on 08/31/12 at 1:15 PM, revealed it typically takes at least an hour and a half to receive medications from the back-up pharmacy. She was aware the emergency drug kit had no pain medication available; however, she was unsure of the reason. An interview with the Administrator, on 08/31/12 at 9:35 AM, revealed the contents of the Emergency Drug Kit were already in place when she became Administrator in 2011. She was not sure how often it was reviewed for changes.</p>	F 520			

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F 520	Continued From page 119 An interview with members of the QAA committee, including the Administrator, DON, the Assistant Director of Nursing (ADON), and the Admissions Coordinator, on 09/07/12 at 7:35 PM, revealed they had discussed pharmacy issues in the QAA meetings (as well as the daily meetings). The group indicated pharmacy had been contacted numerous times about the pharmacy process. The Admissions Coordinator indicated she implemented a system with new admissions. A resident would not be admitted if not in the facility between 2-3 PM, in order to get medications timely for the resident. She was unable to provide documentation of this new system. The Administrator revealed she could not prove where the system failure was, but medications were not being delivered timely. An interview with the Medical Director, on 09/07/12 at 5:50 PM, revealed he was not notified until today (09/07/12) of the issue related to timely receipt of medications from the pharmacy. (Refer to F312, F353) The facility failed to ensure sufficient nursing staff to ensure residents received showers as scheduled and per the residents' care plan for eleven (11) residents (#1, #3, #6, #7, #9, #11, #12, #22, #23, #24 and #25) in the selected sample of 18. Director of Nursing (DON) interview, on 08/31/12 at 9:30 AM, revealed the facility had some staffing issues and some residents might not get a shower on the day it was scheduled. The DON stated, "we have hired everything that walks in the door, and they quit due to the money".	F 520		

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F 520	<p>Continued From page 120</p> <p>An interview with the Administrator, on 09/07/12 at 7:35 PM, revealed she was aware of staffing issues in the facility; however, was not able to provide a corrective plan that she had implemented to address staffing concerns. She stated she had informed her supervisor (governing body) and it had been discussed in the QA meetings; however, she could not provide a specific date staffing was discussed in QA nor action taken.</p> <p>The facility was unable to provide documented evidence that they had followed their Quality Improvement Program policy by taking corrective action, initiated by the Quality Assurance/Quality Improvement program/committee, to correct the system failure related to pharmacy services and adequate staffing to ensure care and services were provided to residents to meet their individual needs.</p>	F 520			