

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

PRINTED: 03/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2011
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 000	INITIAL COMMENTS	F 000		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</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 one (1) of twenty-two (22) sampled residents, Resident #17's needs were accommodated related to the call light and water pitcher being within reach. Observation revealed the call light was clipped to the resident's pillow, out of the resident's reach, and the type of call light provided was inappropriate as the resident was unable to activate the lights. Further, interview revealed the facility failed to ensure call lights were answered timely.</p>	F 246	<p>483.15 (e)(1)</p> <p>F246 Reasonable accommodation of needs/preferences</p> <p>Corrective Action for Residents Affected:</p> <p>(1.) Resident #17 was immediately assessed and a touch call light was provided and water pitcher/cup put within reach. Resident able to demonstrate use without any difficulty.</p> <p>(2.) An interview for Resident #8 and #16 completed by Social Services by 2-10-11 regarding their concern of timeliness of answering of call lights, to ensure their needs have been met. No further concerns noted however will follow-up weekly for four weeks.</p> <p>Identification of Residents with potential to be affected:</p> <p>(1.) Residents assessed by ADDNS/MDS nurses to determine physical ability to operate the call light that they currently have, completed 2-18-11. Assessment completed, to include a return demonstration from the resident of their present call light. Concerns addressed, adjustments completed based on findings of assessment, care plans updated accordingly. Family/responsible party/POA/resident notified of any changes.</p>	2-28-11

RECEIVED
MAR 7 - 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nikki Schrey, NHA</i>	TITLE Administrator	(X6) DATE 3-07-11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	<p>Continued From page 1</p> <p>The findings include:</p> <p>1. Record review revealed Resident #17 was admitted to the facility on 12/05/08. Diagnoses include Transcerebral Ischemia, Diabetes Mellitus, Depression, and Multiple Joint Contractures.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/18/10 revealed the facility assessed the resident as having moderately impaired cognition, functional limitations in range of motion with a partial loss in the upper extremities. Review revealed the facility assessed the resident as being able to communicate needs and understands instructions.</p> <p>Observation on 01/20/11 at 9:00 AM revealed Resident #17 in the bed with the head of the bed elevated. Observation revealed the resident's left hand and wrist were contracted and the right hand and wrist were slightly contracted. Observation further revealed an over the bed table with an empty cup on it. The water pitcher was on the bedside table which was out of the resident's reach. Further observation revealed the push button call light was clipped to the right side of the pillow.</p> <p>Interview with Resident #17 on 01/20/11 at 9:05 AM revealed the resident voiced being thirsty. When prompted to call for the nurse, the resident reached for the call light, which was clipped to the pillow, and could not reach it. The nurse then came in and handed the resident the call light. Observation revealed the resident could not push the button on the call light due to the contractures of the right hand.</p>	F 246	<p>(2.) Residents interviewed by SSD/ADONS/DON on 2-15-11 to determine any issues with call lights being answered timely. No further concerns identified. Per resident council monthly agenda, call lights being answered timely is routinely discussed. Concerns noted and further follow-up by SSD/DON/Admin conducted with the resident and interdisciplinary team.</p> <p>Measures or system changes to prevent reoccurrence:</p> <p>(1.) Residents will be assessed on admission and with significant change to determine appropriate call light to use. MDS to review charts upon admission and with a significant change to ensure call light assessment completed.</p> <p>(2.) Weekly call light audits to be conducted by SSD/Admin/DON for four weeks, with findings reported weekly to Admin/DON to ensure appropriate follow-up.</p> <p>(3.) Social Service Director to complete 5 resident interviews weekly for four weeks to determine timeliness of answering of call lights. Interviews to be turned into the Admin/DON weekly.</p> <p>(4.) Staff was in-serviced by Administrator and education completed by 2-4-11, regarding timely answering of call lights and ensuring call light and water pitcher are within reach of the resident.</p>	

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 246	<p>Continued From page 2</p> <p>Interview with the Assistant Director of Nursing (ADON) on 01/20/11 at 9:30 AM revealed she had never known Resident #17 to use the call light and stated the resident was not able to push the button therefore the facility would switch the call light to a touch type, rather than the push button type. Interview further revealed the water pitcher should have been placed on the over the bed table, within the resident's reach.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #5 on 01/20/11 at 2:00 PM revealed Resident #17 would not be able to reach the call light clipped to the pillow. Further interview revealed Resident #17 could now call for assistance with the new touch type call light.</p> <p>2. In a group interview conducted with unsampled residents it was revealed, call lights sometimes rang for as long as an hour before they were answered. Unsampled residents further stated the issue of call lights not being answered in a timely manner had been brought up in Resident Council meetings and was supposed to have been addressed by staff, but was not.</p> <p>A review of the Resident Council meetings for the months of October 2010 and November 2010 revealed residents had expressed concerns regarding call lights not being answered in a reasonable time.</p> <p>An interview conducted with Resident #8 on 01/19/11 at 9:30 AM revealed he/she had waited for two (2) hours one night before the call light was answered. The aide assigned to Resident #8 on the specified night could not be reached for comment.</p>	F 246	<p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendations and further follow-up as indicated.</p>		

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F 246	<p>Continued From page 3</p> <p>Six (6) State Registered Nursing Aides (SRNAs) were interviewed during the survey to determine their training on responding to call lights. All SRNAs interviewed revealed all SRNAs and nurses were to respond to call lights as soon as possible, whether they were assigned to the resident requiring assistance or not. Two (2) of the SRNAs stated they were unable to hear call lights when they were assisting a resident in his/her room. One (1) SRNA stated it sometimes took up to thirty (30) minutes to answer call lights during busy times.</p> <p>3. Interview on 01/21/11 at 10:40 AM with the Assistant Director of Nursing on the North Hall revealed any staff member was to answer call bells/lights. She stated there was a complaint from a family member on her unit about a month ago and she provided an inservice to the staff. However, stated there was no auditing or timing of call bells to her knowledge.</p> <p>Interview on 01/21/11 at 10:50 AM with the Director of Nursing (DON) revealed she had done recent inservices related to call bells being answered timely and had a recent grievance which she had addressed related to call bells. She further stated she did not remember if audits were done.</p> <p>Review of a Grievance Complaint Form dated 12/21/10 from the family of Resident #16 revealed the daughter complained of the resident having to wait forty-five (45) minutes on call light responses day or night "for just about any request". Further review of the Grievance Complaint Form revealed a section labeled: follow up, which stated the DON was to perform call light audits.</p>	F 246		

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F 246	Continued From page 4 Review of the Inservice Sheets revealed staff were inserviced related to call lights on 1-1/23/10, 12/21/10, 12/24/10, and 01/08/11. Review of the call bell audits revealed audits were completed on 12/22/10, 12/23/10, 12/29/10, and 01/12/11. Review of the facility Call Light System Policy, revealed "each resident is provided with a functional call light system within his/her reach. When the resident is in his/her room, be sure call light is always within easy reach of the resident whether the resident is in or out of bed, or able to utilize, answer the call light as quickly as possible, turn off the call light in the resident's room, help the resident whenever possible. If you cannot give the resident the item or service asked for, do the following: explain to the resident that you will ask someone else, get assistance from the charge nurse, return to the resident quickly with a reply".	F 246		
F 281 SS=D	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure services provided met professional standards of quality. The facility failed to ensure Physician Orders were followed for the administration of Ibuprofen for pain and Prednisone for Rheumatoid Arthritis for one (1) of twenty-one (21) sampled residents (Resident #7). The findings include:	F 281	483.20(k)(3)(i) Services provided meet professional standards F281 Corrective Action for Residents Affected: (1.) Resident #7's orders were clarified on 12-04-10 and medications were initiated as ordered. Identification of Residents with potential to be affected: (1.) Physician orders for current residents were reviewed by DON/ADONS/SDC/wound care nurse by 1-31-11 to ensure residents are receiving medications as ordered. No concerns identified based upon the completed audit.	2-28-11

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F 281	<p>Continued From page 5</p> <p>Review of Resident #7's clinical record revealed diagnoses which included Senile Dementia, and Rheumatoid Arthritis with Joint Contractures of the Hands.</p> <p>Review of the Nurse's Notes dated 12/01/10 at 4:30 PM revealed orders were received for Ibuprofen six hundred (600) milligrams (anti-inflammatory medication used for mild to moderate pain and fever) by mouth every eight (8) hours and prednisone ten (10) milligrams (corticosteroid used for a variety of diseases including rheumatic disorders) by mouth every day.</p> <p>Continued review of the Nurse's Notes dated 12/04/10 at 3:00 PM revealed the orders from 12/01/10 were lost and pharmacy requested a rewritten order. "Rewrote 12/01/10" new orders, faxed to pharmacy".</p> <p>Review of the Physician's Orders dated 12/01/10 revealed an order for Ibuprofen 600 mgs by mouth every 8 hours related to pain and Prednisone 10 mgs by mouth every day related to Rheumatoid Arthritis.</p> <p>Further review of the Physician's Orders dated 12/01/10 revealed the Order had been re-written for Ibuprofen 600 mgs every eight hours related to pain and Prednisone 10 mgs by mouth daily related Rheumatoid Arthritis with a refaxed date of 12/04/10</p> <p>Review of the Medication Administration Record (MAR) revealed Ibuprofen 600 mg every 8 hours been transcribed to be administered at 6:00 AM, 2:00 PM, and 10:00 PM with an arrow for the first</p>	F 281	<p>Measures or system changes to prevent recurrence:</p> <p>(1.) Resident charts will be checked daily by Evening Supervisor/Licensed staff/ADONs for any new orders to ensure orders are transcribed on the MAR/TAR and administered accordingly. The findings will be reported to the DON weekly to ensure appropriate completion and follow-up.</p> <p>(2.) Licensed staff will be in-serviced by Pharmacy/SDC on proper policy and procedure of medication administration, ordering and receiving of medications, and contents/use of the Emergency Drug Box by 2-28-11 and upon hire.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendations and further follow-up as indicated.</p>	

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F 281	<p>Continued From page 6</p> <p>dose to be administered on 12/02/10 at 10:00 PM. There were no initials on the MAR on 12/02/10 at 10:00 PM to denote the medication, and the doses for 12/03/10 at 8:00 AM and 2:00 PM were initialed and circled. There was no documented evidence the medication was administered until 12/03/10 at 10:00 PM. Further review revealed there was no explanation as to why the medication was not administered on the Nurse's Medication Notes on the back of the MAR, except for a notation on 12/02/10 (no time noted) which stated pharmacy was notified related to the Ibuprofen not received yet.</p> <p>Further review of the MAR revealed Prednisone ten (10) milligrams every day was transcribed to be given at 9:00 AM. There was no documented evidence the medication was administered until 12/04/10 at 9:00 AM. Further review revealed there was no explanation as to why the medication was not administered on the Nurse's Medication Notes on the back of the MAR, except for a notation on 12/02/10 (no time noted) which stated pharmacy was notified related to the Prednisone not received yet.</p> <p>Interview on 01/19/10 at 10:00 AM with the Unit Manager/Assistant Director of Nursing (ADON) assigned to the resident, revealed the Ibuprofen had been ordered on 12/01/10 and was not administered according to the MAR until 12/03/10 (two days later), and the prednisone which was ordered on 12/01/10 was not administered according to the MAR until 12/04/10 (three days later). Continued interview revealed the nurse who received the order from the physician was to fax the order to pharmacy and if the order was received before 5:00 PM, it would be delivered the same evening. She further stated there was a</p>	F 281		

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F 281	<p>Continued From page 7</p> <p>back up pharmacy which could be called if needed. Observation of the Emergency Box in the medication room on the unit with the ADON revealed both medications were available, and the ADON indicated the nurses should have obtained the medications from the Emergency Box. She further stated she was not sure the nurses were aware of the Emergency Box.</p> <p>Interview on 01/19/10 at 11:00 AM with Licensed Practical Nurse (LPN) #3 revealed she had received the order for the Ibuprofen and Prednisone from the Physician on 12/01/10 and had transcribed the order to the MAR. According to the LPN, the medication was ordered due to the resident having an episode of an increased heart rate and sweating which Hosploe determined was a pain issue. Continued interview revealed she had faxed the order to pharmacy on 12/01/10 and re-faxed the order on 12/04/10 after realizing the medication had not been received from pharmacy. Continued interview revealed she did not think the medications were available in the emergency box.</p> <p>Interview with LPN #4 on 01/20/11 at 5:00 PM revealed she had initialed and circled the Ibuprofen on 12/03/10 at 6:00 AM to denote the medication was not administered. She further stated she had documented on the back of the MAR on 12/02/10 to indicate pharmacy was notified the Ibuprofen and Prednisone were unavailable. Continued interview revealed when the initials were circled, this would indicate the medication was not administered. She further stated, the medications were unavailable in the emergency box.</p> <p>Interview on 01/20/11 at 2:30 PM with the Director</p>	F 281		

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F 281	Continued From page 8 of Nursing (DON) revealed medications were to be administered the same day they were ordered. She stated the Physician's Orders was to be faxed to pharmacy by the nurse who received the order and pharmacy would deliver medications daily between 9:00 PM and 10:30 PM. Continued interview revealed the facility also had a back up pharmacy for stat medications and for medications needed sooner, and the facility also had an Emergency Box which contained medications. She stated the nurses should have checked the Emergency Box to find out if the medications were available, and should have contacted pharmacy to inform them the medication had not been delivered. She also stated the nurses were to document a reason why the medication was not administered as ordered when circling their initials on the MAR. Interview on 01/20/11 at 4:00 PM with the pharmacist revealed the pharmacy had no record of receiving a Physician's Order on 12/01/10 for Ibuprofen and Prednisone and did not receive the order until 12/04/10. He further stated the pharmacy did not receive an Emergency Box slip denoting Ibuprofen was obtained; however, did receive an Emergency Box slip on 12/04/10 denoting one dose of Prednisone 10 milligrams was obtained.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282	483.20(k)(3)(i) Services by qualified person/per care plan F282 Corrective Action for Residents Affected: (1.) Resident #7s orders were clarified on 12-04-10 and medications were initiated as ordered. (2.) Resident #17 assessed by DON on 1-20-11 and touch-type call light was placed within reach and care plan updated.	2-28-11

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STREET ADDRESS, CITY, STATE, ZIP CODE

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LEXINGTON, KY 40517

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F 282	<p>Continued From page 9</p> <p>by: Based on observation, interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for two (2) of twenty-one (21) sampled residents (Resident #7 and #17). Resident #7 had a Plan of Care which stated the resident was at risk for pain and the interventions included administering medication as ordered. Physicians Orders were received on 12/01/10 for Ibuprofen for pain and Prednisone for Rheumatoid Arthritis; however, there was no documented evidence the resident received the Ibuprofen until 12/03/10 (two days later) and the Prednisone until 12/04/10 (three days later). Resident #17 had a Plan of Care which stated to keep the call light within reach, however observation revealed the call light was not within reach.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #7's medical record revealed diagnoses which included Senile Dementia, Aphagia, and Rheumatoid Arthritis of Juvenile Onset with Joint Contractures of the Hands. <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/11/10 revealed the facility assessed the resident as having severe impairment in cognitive skills, as requiring total assistance with all Activities of Daily Living (ADLs), and as having contractures of the hands and arms.</p> <p>Review of the Plan of Care dated 09/03/10 revealed the resident was at risk for pain and was unable to voice pain related to Aphasia. The</p>	F 282	<p>Identification of Residents with potential to be affected:</p> <ol style="list-style-type: none"> ADONs reviewed pain assessments for current residents on 1-24-11 to ensure pain medication administered as per resident care plans. Room rounds were completed by Admin/DON/ADONs on 1-20-11 to ensure residents call lights were within reach, per their care plan. Residents assessed by ADONs/MDS nurses to determine physical ability to operate the call light that they currently have, completed 2-18-11. Assessment completed, to include a return demonstration from the resident of their present call light. Concerns addressed, adjustments completed based on findings of assessment, care plans updated accordingly. Family/responsible party/POA/resident notified of any changes. MDS reviewed current resident care plans to ensure appropriate interventions in place. Updated care plans to reflect the call light assessment outcomes. 	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2011
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NAME OF PROVIDER OR SUPPLIER

BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3576 PIMLICO PARKWAY
LEXINGTON, KY 40517

(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 282	<p>Continued From page 10</p> <p>interventions stated the resident would demonstrate relief or reduction in pain intensity within one hour after receiving intervention. The interventions included administering medications as ordered. A new intervention was added to the Care Plan on 12/01/10 for Ibuprofen scheduled as ordered, and Prednisone scheduled as ordered.</p> <p>Review of the Physician's Orders revealed an order dated 12/01/10 for Ibuprofen six hundred milligrams (600 mg's) (anti-inflammatory medication used for mild to moderate pain and fever) by mouth every eight (8) hours and prednisone ten (10) milligrams (corticosteroid used for a variety of diseases including rheumatic disorders) by mouth every day related to Rheumatoid Arthritis.</p> <p>Continued review of the Physician's Orders revealed an order dated 12/01/10 with a refaxed date of 12/04/10 for Ibuprofen 600 mg's every eight hours related to pain and Prednisone 10 mg's by mouth daily related Rheumatoid Arthritis.</p> <p>Review of the Medication Administration Record (MAR) revealed there was no documented evidence the Ibuprofen was administered until 12/03/10 at 10:00 PM (two days later).</p> <p>Further review of the MAR revealed there was no documented evidence the Prednisone was administered until 12/04/10 at 9:00 AM (three days later). Interview on 01/19/10 at 10:00 AM with the Unit Manager/Assistant Director of Nursing (ADON) assigned to the resident, revealed the Ibuprofen had been ordered on 12/01/10 and was not administered according to the MAR until 12/03/10 (two days later), and the prednisone which was ordered on 12/01/10 was</p>	F 282	<p>Measures or systems changes to prevent reoccurrence:</p> <p>(1.) ADONs/Weekend Supervisor will conduct a daily audit to ensure residents are receiving pain medication as per their care plan. Findings of the audits will be reported to the DON weekly to ensure appropriate follow-up.</p> <p>(2.) Room rounds will be completed daily by SSD/Chaplain/SDC/Wound Nurse/Weekend Supervisor to ensure call lights within reach. Findings of the audits will be reported to the Admin/DON weekly.</p> <p>(3.) Residents will be assessed by licensed nursing staff/MDS upon admission, with significant change, and with quarterly assessment, to include return demonstration of use of call light.</p> <p>(4.) Nursing staff will be in-serviced by 2-28-11 by SOC/DON/MDS related to call lights being within reach, following care plans, call light assessment, etc.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendations and further follow-up as indicated Findings of the above stated audits</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 282	<p>Continued From page 11</p> <p>not administered according to the MAR until 12/04/10 (three days later). Observation of the Emergency Box in the medication room on the unit with the ADON revealed both medications were available. The ADON stated the nurses should have called the back up pharmacy if the medication was unavailable and should have checked the Emergency Box for the medication. Continued interview revealed the Ibuprofen and Prednisone were ordered for pain and should have been administered as ordered.</p> <p>Interview on 01/19/10 at 11:00 AM with Licensed Practical Nurse (LPN) #3 revealed she had received the order from the Physician and transcribed the order to the MAR on 12/01/10 and refaxed the order to pharmacy on 12/04/10. She stated the order was written due to the resident having an episode of an increased heart rate and sweating which Hospice determined was a pain issue. Continued interview revealed she did not think the medications were available in the Emergency Box.</p> <p>Interview on 01/20/11 at 2:30 PM with the Director of Nursing (DON) revealed medications should be administered the same day they were ordered. She stated the Physician's Orders was to be faxed to pharmacy and pharmacy delivered medications daily between 9:00 PM and 10:30 PM. Continued interview revealed the facility also had a back up pharmacy for stat medications and for medications needed sooner. She stated the nurses also should have checked the Emergency Box to find out if the medications were available.</p> <p>2. Record review revealed Resident #17 was admitted with diagnoses which included Transcerebral Ischemia, Diabetes Mellitus,</p>	F 282		

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F 282	<p>Continued From page 12 Depression, and Multiple Joint Contractures.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/18/10 revealed the facility assessed the resident as having moderately impaired cognition, functional limitations in range of motion with a partial loss in the upper extremities. The facility also assessed the resident as being able to communicate needs and understands instructions.</p> <p>Observation on 01/20/11 at 9:00 AM revealed Resident #17 to be in the bed with the head of the bed elevated. The resident's left hand and wrist were observed to be contracted and the right hand and wrist were slightly contracted. Further observation revealed the push button call light was clipped to the right side of the resident's pillow. When prompted to call for the nurse, the resident was observed to reach for the call light, that was clipped to the pillow, and could not reach it.</p> <p>Review of the Plan of Care dated 05/11/10 and revised on 12/30/10 revealed an intervention to provide call light within reach.</p> <p>Interview with the DON on 1/20/11 at 3:00 PM revealed the call light should be within reach for Resident #17.</p> <p>Review of the facility "Care Plan Policy" revealed "the resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care".</p>	F 282		

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F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents were free of significant medication errors for one (1) of twenty-one (21) sampled residents (Resident #7). Physicians Orders were received for Ibuprofen for pain and Prednisone for Rheumatoid Arthritis on 12/01/10; however, there was no documented evidence the resident received the Ibuprofen until 12/03/10 (two days later) and the Prednisone until 12/04/10 (three days later).</p> <p>The findings include:</p> <p>Review of Resident #7's clinical record revealed diagnoses which included Senile Dementia, and Rheumatoid Arthritis with Joint Contractures of the Hands. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/11/10 revealed the facility assessed the resident as having severe impairment in cognitive skills, and requiring total assistance with all Activities of Daily Living (ADLs). The facility assessed the resident as having contractures of the hands and arms.</p> <p>Review of the Nurse's Notes dated 12/01/10 at 4:30 PM revealed new orders were received for Ibuprofen six hundred milligrams (anti-inflammatory medication used for mild to moderate pain and fever) by mouth every eight</p>	F 333	<p>483.25(m)(2) Residents free of significant med errors</p> <p>F333</p> <p>Corrective Action for Residents Affected:</p> <p>(1.) Resident #7's orders were clarified on 12-04-10 and medications were initiated as ordered.</p> <p>Identification of Residents with potential to be affected:</p> <p>(1.) Physician orders for current residents were reviewed by DON/ADONS/SDC/wound care nurse by 1-31-11 to ensure residents are receiving medications as ordered. No additional residents identified.</p> <p>Measures or system changes to prevent reoccurrence:</p> <p>(1.) Resident charts will be checked daily by Evening Supervisor/Licensed staff/ADONS for any new orders to ensure orders are transcribed on the MAR/TAR and administered accordingly. The findings will be reported to the DON weekly to ensure appropriate completion and follow-up.</p> <p>(2.) Licensed staff will be in-serviced by Pharmacy/SDC on proper policy and procedure of medication administration, ordering and receiving of medications, and contents/use of the Emergency Drug Box by 2-28-11 and upon hire.</p>	2-28-11

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F 333	<p>Continued From page 14</p> <p>(8) hours and Prednisone ten (10) milligrams (corticosteroid used for a variety of diseases including rheumatic disorders) by mouth every day.</p> <p>Further review of the Nurse's Notes dated 12/04/10 at 3:00 PM revealed the new orders form 12/01/10 were lost and pharmacy requested a rewritten order. "Rewrote 12/01/10" new orders and faxed to pharmacy.</p> <p>Review of the Physician's Orders revealed an order dated 12/01/10 for Ibuprofen 600 mgs by mouth every 8 hours related to pain and Prednisone 10 mgs by mouth every day related to Rheumatoid Arthritis.</p> <p>Further review of the Physician's Orders revealed an order dated 12/01/10 with a refaxed date of 12/04/10 for the above ordered Ibuprofen and Prednisone.</p> <p>Review of the MAR revealed Ibuprofen 600 mg every 8 hours had been transcribed to be administered at 6:00 AM, 2:00 PM, and 10:00 PM. Further review revealed the medication had an arrow for the first dose to be administered on 12/02/10 at 10:00 PM. There were no initials to denote the medication was given on 12/02/10 and the 12/03/10 doses for 6:00 AM and 2:00 PM were initialed and circled. There was no explanation as to why the medication was not administered on the Nurse's Medication Notes on the back of the MAR, except for a notation on 12/02/10 (no time noted) which stated pharmacy was notified related to the Ibuprofen not received yet.</p> <p>Further review of the MAR revealed Prednisone</p>	F 333	<p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendations and further follow-up as indicated.</p>	

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F 333	<p>Continued From page 15</p> <p>ten (10) milligrams every day was transcribed to be given at 9:00 AM. According to the MAR, the first dose initialed as administered was for 12/04/10 at 9:00 AM. There was no explanation as to why the medication was not administered on the Nurse's Medication Notes on the back of the MAR, except for a notation on 12/02/10 (no time noted) which stated pharmacy was notified related to the Prednisone not received yet.</p> <p>Interview on 01/19/10 at 10:00 AM with the Unit Manager/Assistant Director of Nursing (ADON) assigned to the resident, confirmed the Ibuprofen had been ordered on 12/01/10 and was not administered according to the MAR until 12/03/10 (two days later), and the Prednisone which was ordered on 12/01/10 was not administered according to the MAR until 12/04/10 (three days later). Further interview revealed the nurse who received the order from the physician was to fax the order to pharmacy and if the order was received before 5:00 PM, it would be delivered the same evening. Observation of the emergency box in the medication room on the unit with the ADON revealed both medications were available. The ADON stated if the medication was not available from pharmacy, the nurses should have obtained the medication from the Emergency Box. Continued interview revealed the Ibuprofen and Prednisone were ordered for pain, and this would be a significant medication error.</p> <p>Interview on 01/19/10 at 11:00 AM with Licensed Practical Nurse (LPN) #3 revealed she had transcribed the order to the MAR on 12/01/10 after receiving the order from the Physician. She stated the order was written due to the resident having an episode of an increased heart rate and sweating which Hospice determined was a pain</p>	F 333		

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F 333	<p>Continued From page 16</p> <p>issue. Continued interview revealed she had faxed the order to pharmacy on 12/01/10 and again on 12/04/10 after realizing the medication had not been received from pharmacy. Further interview revealed she did not think the medications were available in the Emergency Box.</p> <p>Interview with LPN #4 on 01/20/11 at 5:00 PM revealed she had circled the Ibuprofen on 12/03/10 at 6:00 AM to denote the medication was unavailable to administer. She stated she had documented on the back of the MAR on 12/02/10 to denote pharmacy was notified the Ibuprofen and Prednisone were unavailable. Continued interview revealed when the initials were circled, this would mean the medication was not administered. She stated the medications were unavailable in the Emergency Box.</p> <p>Interview on 01/20/11 at 2:30 PM with the Director of Nursing (DON) revealed medications should be administered the same day they were ordered. She stated the Physician's Orders was to be faxed to pharmacy and pharmacy would deliver medications daily between 9:00 PM and 10:30 PM. She further stated the facility also had a back up pharmacy for stat medications and for medications needed sooner. Continued interview revealed the nurses should have checked the Emergency Box to find out if the medications were available. She also stated the nurses should have documented a reason why the medication was not administered as ordered when circling their initials on the MAR. Continued interview revealed it was a significant medication error to not administer the Ibuprofen and Prednisone as ordered.</p>	F 333		

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F 333	Continued From page 17 Interview on 01/20/11 at 4:00 PM with the pharmacist revealed he did not receive an emergency box slip denoting Ibuprofen was obtained; however, did receive an emergency box slip on 12/04/10 denoting one dose of Prednisone 10 milligrams was obtained. He further stated the pharmacy had no record of receiving a Physician's Order on 12/01/10 for Ibuprofen and Prednisone and did not receive the order until 12/04/10.	F 333	483.35 (I)	2-28-11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure sanitary conditions were maintained in the kitchen as evidenced by tray tickets being handled by staff and then placed on empty plates on the tray line. The findings include: Observation on 01/18/11 at 5:30 PM revealed servers on the tray line placing tray tickets on the empty plates as they passed the plates down the tray line to be filled with food. Further observation	F 371	F371 Food procure, store/prepare/serve-Sanitary Corrective Action for Residents affected: (1.) No specific residents were identified. The dietary manager stopped the practice of placing tray tickets on plates on the tray line immediately upon identification of the concern. Identification of residents with potential to be affected: (1.) Residents being served from the tray line have the potential to be affected by the deficient practice. Measures or system changes to prevent reoccurrence: (1.) Dietary staff received in-service education provided by the Dietary Manager on 1-18-2011 regarding not placing the tray tickets on the plate during tray line service to decrease the risk of cross contamination. The dietary manager will monitor tray line service five times weekly to ensure tray tickets are not being placed on plates during tray line service. Findings of the audit will be forwarded to the Administrator weekly to ensure completion.	

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F 371	Continued From page 18 revealed the servers sent approximately eight (8) plates down the tray line in this manner before the surveyor questioned this practice. Interview with the Dietary Manager on 01/18/11 at 5:35 PM, revealed she did not think this was a good practice because of the danger of "cross-contamination" from the servers hands on the tray tickets to the plate surfaces about to be filled with food. Interview with the Head Cook on 01/18/11 at 5:40 PM revealed he did not think this was a good practice. Interview with the Dietary Manager on 01/18/11 at 5:45 PM revealed she would immediately implement another method of service for plates and the placement of the tray tickets.	F 371	Monitoring changes/system to ensure no deficient practice: (1.) Findings of the audit by the dietary manager will be discussed at the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a safe, functional, sanitary and comfortable environment for residents, staff and the public. The findings include: Observations on 01/18/11, 01/19/11 and 01/20/11 revealed interior doors of resident rooms had	F 465	483.70(h) F465 Safe/Functional/Sanitary/Comfortable Environment Corrective Action for Residents affected: (1.) The maintenance director completed rounds throughout the facility on 2-10-2011to identify interior doors of residents' rooms, and exterior hallway doors with scuffs, gouges and peeling veneer. Repairs will be completed as indicated. Rounds were completed by the Maintenance Director on 2-10-2011 to identify missing or loose baseboards in resident rooms. Repairs or replacement will be completed as indicated. Lavatories in rooms #7, #13, #16 and #50 will be repaired or replaced and appropriately secured to the wall. Shower tiles will be replaced in room #38. Plaster repairs will be completed in rooms #8, #41, and #61. The fan/vent coverings will be secured to the ceilings in rooms #11, #41 and #58. Holes in the bathroom walls will be repaired in resident rooms #51, #56, and #62	2-28-11

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F 465	<p>Continued From page 19</p> <p>scuffs, gouges and peeling veneer which had been taped up. The exterior hallway doors of resident rooms and facility areas were also scuffed, gouged and taped. Baseboards were either missing or peeling loose in resident rooms and on exterior walls through out the facility. Lavatories in resident rooms #7, #13, #16 and #50 were loose and pulling away from the wall. Room #38 was observed to have missing shower tiles. Resident rooms #8, #41, #58, and #61 had cracked, peeling and/or falling plaster. The fan/vent covering in rooms #11, #41, and #58 were not secured to the ceiling. Resident rooms #51, #56, and #62 had holes in the bathroom walls.</p> <p>Interview with the Maintenance Director on 01/19/11 at 10:45 AM revealed nursing and housekeeping staff were to inform maintenance of environment issues. He further stated, residents would also let Maintenance know if they had an issue. The Maintenance Director indicated he also had "spot checks" done to identify issues. He stated his department was currently working through the work orders for the resident rooms.</p> <p>Interview with the Maintenance Technician, on 01/20/11 at 3:05 PM revealed he did random checks in resident rooms for missing baseboards and touched up the paint as needed.</p> <p>Interview with a Housekeeper #1, on 01/20/11 at 3:10 PM revealed she had deep cleaned room 61 yesterday and forgot to put the work order in for the plaster to be repaired.</p> <p>Interview with the Administrator, on 01/20/11 at 4:00 PM revealed the environmental consultant</p>	F 465	<p>Identification of residents with potential to be affected:</p> <p>(1.) The administrator completed rounds with maintenance director on 2 10-2011 to identify other resident and hallway doors in need of repair, loose or missing baseboards, lavatories not appropriately attached to the wall, missing shower tiles, plaster in need of repair, fan/vent coverings that are not appropriately secured, and holes in bathroom walls. Repairs/replacements will be completed as indicated.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) The maintenance supervisor and Administrator will complete rounds throughout the facility weekly to identify areas in need of repair. Facility staff received in-service education provided by the administrator by 2-28-2011 regarding notification of Maintenance through use of a maintenance request when an area of needed repair is identified. Maintenance requests will be reviewed in the morning meeting five days per week. Follow up to each request will be discussed the following day to ensure repairs have been completed as required.</p> <p>Monitoring Changes/Systems to ensure no deficient practice:</p> <p>(1.) Findings of the facility rounds and follow up from maintenance requests will be reviewed in the Quality Assurance meeting monthly for recommendations and further follow up as indicated.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2011
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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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 465	Continued From page 20 told him the Southeast wing had "settled" more after all these years. He further stated they were working on room #61 and several others identified down that wing regarding the ceiling plaster issue.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain clinical records for one (1) unsampled resident (Unsampled Resident A) related to route of administration for medications. The findings include: Observation of medication administration on 01/19/11 at 2:40 PM revealed Licensed Practical Nurse (LPN) #6 administered Norvasc 10mg via Gastrostomy Tube (G-tube) to Unsampled Resident A. Interview with LPN #6 at that time revealed the resident took nothing by mouth and all medication were administered via G-tube.	F 514	483.75(1) F514 Clinical Records Corrective Action for Residents Affected (1.) Physician orders for un-sampled resident A were clarified by the physician on 1-19-2011 per the ADON. All medications are to be given per G-tube. Identification of Residents with potential to be affected (2.) All MAR'S of residents with a G-tube were checked with the chart on 1-19- 2011 by ADONs/DON to ensure that medications are being administered by the proper route. No other residents identified. Measures or system changes to prevent reoccurrence (1.) MARS will be checked monthly with the physician orders to ensure that all medications are being given by the proper route by the DON, ADON, wound care nurse, SDC, MDS and Restorative Nurse and will be checked a second time for accuracy by one of the above. (2.) ADONS, SDC, wound nurse and MDS Nurses were educated on 1-19-2011 by the DON on checking the medication routes monthly, when completing changeover and checking over the physician's orders. Licensed staff were in-serviced on checking physician orders to ensure that route of medication administration is transcribed correctly on the MAR.	2-28-11

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F 514	<p>Continued From page 21</p> <p>Review of the MAR for Unsampled Resident A revealed Norvasc 10mg tablet, 1 tablet by mouth three times per day. Further review revealed three (3) other medication were noted to be given by mouth.</p> <p>Review of the January 2011 Physician's Orders revealed three (3) medications were ordered to be given per G-tube and four (4) medication were ordered to be given by mouth.</p> <p>Interview with the Unit Manager on 01/19/11 at 3:00 PM revealed Unsampled Resident A was to have nothing by mouth and received all medications via G-tube. She stated this was a clinical record error that should have been identified during the monthly change over by the management person who conducted the record audits.</p> <p>Interview with the Minimum Data Set (MDS) Nurse on 01/19/11 at 4:00 PM revealed she was responsible for reviewing the orders and the MARs each month for accuracy and should have identified the error.</p>	F 514	<p>(3.) An audit of current G-tube residents MARS will be completed monthly for three months by the DON/ADON'S to ensure the MAR matches the physician's orders.</p> <p>Monitoring changes/systems to ensure no deficient practices</p> <p>(1.) Findings of the above stated audits will be reviewed by the QA committee monthly for three months for recommendation and further follow-up as indicated.</p>	
F 520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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 facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify</p>	F 520	<p>483.75(0) (1)</p> <p>F520 QAA Committee – Members/Meet Quarterly Plans</p> <p>(1.) The Quality Assurance committee will meet on 2-24-2011 and review the care plan, MAR and physicians orders for un-sampled resident to ensure that medications are being administered as ordered.</p> <p>(2.) The Quality Assurance committee will meet on 2-24-2011 and review the care plan, Mar, physician orders and nurses notes for resident #7 to ensure that all episodes of change of condition are monitored and that family and MD have been notified. MAR, physician orders and nurses notes to reviewed to ensure the resident is receiving medications as ordered.</p>	2-28-11

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F 520	<p>Continued From page 22</p> <p>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 and record review it was determined the facility failed to ensure there was an effective Quality Assessment and Assurance Program in order to develop and implement appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure the physician was notified of changes in resident's condition and the facility's failure to ensure the residents were free of significant medication errors.</p> <p>The findings include:</p> <p>1. Based on interview and record review, it was determined the facility failed to have an effective system to ensure the physician was notified of changes in residents condition. This is a repeat deficiency which was cited on the 07/22/10 survey; deficiency cited related to the facility failing to immediately inform the Responsible</p>	F 520	<p>Identification of Residents with potential to be affected</p> <p>(1.) Because all facility residents have the potential to be affected by this alleged deficient practice, a Quality Assurance meeting will be held on 2-24-2011. Attendees include the Medical Director, Administrator, Director of Nursing, MDS coordinators, Environmental Services Director, Activities Director, Admissions Director, Business Office Manager, Staff Development Coordinator and Nurse Consultant. The committee will discuss concerns related to notification of family and physician with any change of condition and medication administration pertaining to following physician orders.</p> <p>Measure or system changes to prevent reoccurrence:</p> <p>(1.) The administrator, director of nursing and the quality assurance committee members received in-service education provided by the regional nurse consultant on 1-24-2011, regarding the requirements of the quality assurance (QA) process and the roles of each QA committee member. Facility staff is receiving in-service education by the staff development coordinator, ADONS and DON to be completed by 2-28-2011, regarding the QA process to develop and implement plans for identified concerns during the quality assurance meeting. The QA process will include interdisciplinary team communication which will encourage facility wide involvement and accountability for</p>	

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F 520	<p>Continued From page 23</p> <p>Party/Power of Attorney of a significant medication error involving one resident.</p> <p>Review of the facility plan of correction with a compliance date of 08/23/10 revealed nursing management would conduct inservices for all licensed staff regarding physician and family notification when a change in a resident's condition and/or changes in Physician's Orders occurred.</p> <p>However, the facility failed to ensure the physician was notified of Resident #7's change in condition on 11/11/10 when the resident was assessed to have sweating, grimacing, a temperature of 101, and a pulse rate of 122. There was no documented evidence the physician was notified until 11/15/10 when a chest x-ray was ordered.</p> <p>Interview with the Administrator and Director of Nursing on 01/21/11 at 2:00 PM revealed "hot charts" or acute charting was reviewed daily Monday through Friday by medical records personnel and now was being reviewed by a nurse or social worker. Further interview revealed they were not sure why the lack of physician notification was missed.</p> <p>2. Based on interview and record review, it was determined the facility failed to have an effective system to ensure residents were free of significant medication errors. This was a repeat deficiency which was cited on the 07/22/10 survey; deficiency was cited related to the facility's failure to ensure a resident received levothyroxine as ordered. As a result of a transcription error, the resident did not receive the ordered dose of Levothyroxine 0.125 mg. for twenty-one consecutive days during July 2010.</p>	F 520	<p>the maintenance and oversight of facility systems. Concerns are discussed in the morning meeting attended by department managers and the administrator. The identified concern is assigned to the appropriate department manager for follow up. A plan to correct the identified concern is developed by the department manager, along with other staff, as indicated. Audits are completed to evaluate the effectiveness of the plan. Findings are discussed by the QA committee for recommendations and further follow up. The administrator initiated a quality assurance plan on 1-24-2011 to review and ensure follow up with the change of condition system to include physician and family notification, and on following all physician orders during medication administration. The change of condition form will be utilized to document appropriate resident assessment following a change of condition, and to document physician and family notification. Change of condition will be identified on the 24-hour report and reviewed by the Interdisciplinary team and Weekend Supervisor to ensure appropriate assessment, notification and follow-up. Resident charts will be checked daily for any new orders to ensure orders are transcribed on the MAR/TAR and administered</p>	

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NAME OF PROVIDER OR SUPPLIER

BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3576 PIMLICO PARKWAY
LEXINGTON, KY 40517

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F 520	<p>Continued From page 24</p> <p>Review of the facility's plan of correction revealed licensed nursing staff would receive an inservice by the Director of Nursing (DON) regarding the importance of ensuring transcription of Physician Orders to the Medication Administration Record (MAR) was accurate and the requirement of two nurses reviewing transcription to ensure accuracy. New orders would be reviewed by the interdisciplinary team in the clinical meeting five days a week and by the weekend supervisor on weekends and compared to the Medication Administration Record.</p> <p>However, the facility failed to ensure medications were administered as ordered for one resident. Physician's Orders were received for Resident #7 on 12/01/10 for Ibuprofen and Prednisone related to pain and Rheumatoid Arthritis. There was no documented evidence the resident received the Ibuprofen until 12/03/10 and the Prednisone until 12/04/10 resulting in a significant medication error.</p> <p>Interview with the Administrator and Director of Nursing on 01/20/11 2:00 PM revealed Physician Orders were reviewed every day in the morning clinical meeting to ensure transcription of the order to the Medication Administration Record. Further interview revealed Resident #7's Physician's Order for Ibuprofen and Prednisone written on 12/01/10 must not have been flagged or must have been lost. Further interview revealed if the facility was unaware the Physician's Order had been written, it would not be reviewed. Continued interview revealed there was no system in place to ensure all resident records were checked each day for any Physician's Orders which may have been written,</p>	F 520	<p>accordingly. The findings will be reported to the DON weekly to ensure appropriate completion and follow-up. Audits of corrective and plans regarding concerns brought to the QA committee by other department managers will be reviewed by the QA committee. Assignments will be routinely completed regarding monitoring of corrective actions to ensure continued compliance.</p> <p>(2.) The Medical Director attends the QA meeting monthly and medication errors will be discussed at each meeting. The Medical Director will be proactive to ensure audits are being completed and any areas of concern are immediately addressed.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>Findings of audits identified in this plan of correction and the process for following physician orders and managing the change of condition system with physician and family notification will be reviewed by the QA committee monthly for recommendations and follow up as indicated.</p>	

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F 520	Continued From page 25 but not flagged for the nurse to pull the order to send to pharmacy and to the administrative nurses.	F 520		

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K 000

INITIAL COMMENTS

K 000

Bluegrass Care and Rehab does not believe and does not admit that any deficiencies exist, before, during and after survey. The Bluegrass Care and Rehab reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Bluegrass Care and Rehab reserves all right to raise possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potential applicable Peer Review, Quality Assurance or self critical examination privileges which the Bluegrass Care and Rehab does not waiver, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceedings. Bluegrass Care and Rehab offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.

K 018
SS=E

NFPA 101 LIFE SAFETY CODE STANDARD

K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure there were no impediments to the closing of corridor doors and that corridor doors had a means suitable to keeping the corridor doors closed, according to NFPA standards. The



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517	
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K 000	INITIAL COMMENTS	K 000		
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure there were no impediments to the closing of corridor doors and that corridor doors had a means suitable to keeping the corridor doors closed, according to NFPA standards. The</p>	K 018		

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

TITLE

(X6) DATE

Nilai Sahay, NHA

Administrator

2-11-11

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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K 018	<p>Continued From page 1</p> <p>deficiency affected four (4) smoke compartments and the potential to effect the facility's sixty residents (60) residents, and staff.</p> <p>The findings include:</p> <p>Observations during the Life Safety Code Survey on 01/20/2011 between the hours of 12:50 PM and 3:20 PM, revealed trash cans were being used to hold resident room doors open. The resident room doors included rooms #11, #28, #32, #43, #56 and #66. Further observation revealed resident room #21 had a chair blocking the closing of the door and resident room #46 would not latch when shut. The observations were confirmed with the Maintenance Director.</p> <p>During an interview on 01/20/2011 at 12:50 PM, with the Maintenance Director he indicated he would begin working on removing the impediments to the doors, and the other issues with the doors which were identified during the observations.</p>	K 018	<p>K018 NFPA 101 Life Safety Code Standard</p> <p>Corrective action for residents affected</p> <p>(1). Rooms #11, #28, #32, #43, #56, #66, and #46 have had the impediments removed, as of 1-24-11. Room #21 had the chair moved to remove the impediment, as of 1-20-11.</p> <p>Identification of residents with potential to be affected:</p> <p>(2). An audit was completed by the Maintenance Director/Assistant Director on 1-21-11 to identify any additional resident doors with an impediment. Identified doors were corrected by 2-04-11.</p> <p>Measures or system changes to prevent reoccurrences</p> <p>(1). Resident rooms will be assessed daily during team rounds to ensure there are no impediments to the closing of the doors.</p> <p>(2). Staff will be educated by the Maintenance Director/Assistant by 2-28-11 on ensuring that no impediments to the closing of corridor/resident doors exist. Staff will also be educated on the use of maintenance request shall any impediments be found.</p> <p>(3). Maintenance director/Assistant director will monitor the maintenance log request, report findings during an meeting and correct impediments identified.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1). Administrator/Maintenance Director will review team rounding sheets and maintenance log sheet monthly for compliance. Findings to be reported in monthly safety meeting and forwarded</p>	2-28-11
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p>	K 029	<p>to QA committee for further recommendations.</p>	

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all hazard areas were protected, according to NFPA standards. The deficiency affected one (1) smoke compartment. The findings include: Observation on 01/20/2011 at 3:10 PM, with the Maintenance Director, revealed the Maintenance office did not have a self closer on the door. This area was considered a hazardous area due to the fuel load being different from that of a health care facility. Interview on 01/20/2011 at 3:10 PM, with the Maintenance Director, revealed he would place a self closer on the door.	K 029	K029 NFPA 101 Life Safety Code Standard Corrective action for residents affected (1). No residents were affected. The Maintenance shop door has been corrected as of 2-04-11 and now has a self closure on the door. Identification of residents with potential to be affected: (1.) An audit will be completed by the Maintenance Director by 2-11-11 to determine any other doors that meet the criteria for self closure. Any identified doors to be corrected by 2-25-11. Measures or system changes to prevent reoccurrences (1.) Maintenance door will be monitored daily to ensure self closure remains intact. (2.) Staff will be educated by 2-28-11 on the importance of self-closing doors and the process of completing a maintenance request sheet if an identified door does not self-close. (3.) Safety Committee to conduct monthly walking rounds to ensure that doors leading to "hazardous areas due to fuel load" have a working self closer on the door. Monitoring changes/systems to ensure no deficient practice: (1). Safety committee will report any findings to the QA committee monthly for three months for recommendations and further follow-up as needed.	2-28-11
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Sprinkler Raiser Room was equipped with a permanent heat source. The deficiency affected four (4) smoke compartments and had the potential to effect the facility's sixty residents (60), and staff.	K 062		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517	
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K 062	Continued From page 3 The findings include: Observation on 01/20/2011 at 1:20 PM, with the Maintenance Director, revealed the Sprinkler Raiser Room was being heated with a portable space heater. Interview on 01/20/2011 at 1:20 PM, with the Maintenance Director, revealed the wall mounted heating unit for the Sprinkler Raiser Room had quiet working and the portable space heater was being used because he had not had the time to repair it. Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing.	K 062	K062 NFPA 101 Life Safety Code Standard Corrective action for residents affected (1). The original heat source was replaced with a new wall-mounted unit as of 2-04-11. Identification of residents with potential to be affected (1). No other Raiser room exists therefore no further potential residents to be affected. Measures or system changes to prevent reoccurrences (1.) Raiser room will continue to monitored for appropriate temperatures during the cold months. Raiser room will also be checked weekly to ensure permanent heat source is in working order. Immediate action will be taken shall on any findings.	2-28-11
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure decorations used in the facility were not of a highly flammable character. The deficiency affected one (1) smoke compartment and the potential to effected the facility's eight (8) residents, staff and visitors. The findings Include:	K 073	(2.) Safety Committee to check Raiser Room on a monthly basis to ensure compliance with Life Safety Code and NFPA 13. (3.) Maintenance Director/Assistant Director educated on NFPA 13 4-2.5.2 by Regional Plant Director on 2-04-11. Monitoring changes/systems to ensure no deficient practice: (1). Safety committee will report any findings to the QA committee monthly for three months for recommendations and further follow-up as needed.	

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K 073	<p>Continued From page 4</p> <p>Observation on 01/20/2011 at 1:00 PM, revealed on the doors of resident rooms #58 and #52 wreaths were being used as decorations. Further observations revealed on the door of resident room #60, flag bunting was being used as a decoration, and resident room #13 had several large pictures and posters on the door. The observations were confirmed with the Maintenance Director.</p> <p>Interview on 01/20/2011 at 1:00 PM, with the Maintenance Director, revealed that he had become aware of the requirements for decorations about a week ago, but had not treated the decorations yet with any type of spray to make the decorations noncombustible.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was according to NFPA standards. The deficiency affected one (1) smoke compartment, and had the potential to effect two (2) residents, staff and residents</p> <p>The findings include:</p> <p>Observation on 01/21/2011 at 3:38 PM, with the Maintenance Director, revealed in resident room number 55 there was an oxygen nebulizer plug</p>	K 073	<p>K073 NFPA 101 Life Safety Code Standard</p> <p>Corrective action for residents affected</p> <p>(1). No residents were affected Decorations of resident rooms #58, #52, #60, and #13 have been treated with noncombustible spray or removed, as of 1-31-11.</p> <p>Identification of residents with potential to be affected</p> <p>(1). An audit was conducted of decorations on resident doors. Items identified as "highly flammable" were sprayed with noncombustible spray, tagged or removed; audit completed 2-07-11.</p> <p>Measures or system changes to prevent reoccurrences</p> <p>(1). Maintenance Director/Assistant Director will conduct staff in-services by 2-28-11 to educate on the process for residents/families/staff to notify maintenance prior to a decoration is added to a door to ensure they are not of highly flammable character.</p> <p>(2). Residents will be notified of the process and a letter will be mailed to responsible parties by 2-18-11 to further explain the facility process for decorations. It will also be addressed upon admission.</p> <p>(3). Safety committee to conduct monthly walking rounds to ensure door decorations are appropriate and tagged.</p> <p>Monitoring changes/systems to ensure no deficient practice</p> <p>(1). Safety committee will report any findings to the QA Committee monthly for recommendations and further follow-up as needed.</p>	2-28-11
K 147 SS=D		K 147		

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 FIMLICO PARKWAY LEXINGTON, KY 40517
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K 147	<p>Continued From page 5 Into a power strip.</p> <p>Interview on 01/20/2011 at 3:38 PM, with the Maintenance Director, revealed staff were not to plug medical equipment into power strips.</p> <p>Reference: NFPA 99 1999 edition</p> <p>3-3.2.1.2 D</p> <p>2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>K147 NFPA 101 Life Safety Code Standard</p> <p>Corrective action for residents affected</p> <p>(1). No residents were affected. Room #55 had the oxygen nebulizer plugged into the wall outlet.</p> <p>Identification of residents with potential to be affected</p> <p>(1). Room audits completed by the Maintenance Director and Assistant Director on 1-20-11 to ensure that medical equipment was not plugged into power strips. None identified.</p> <p>Measures or system changes to prevent reoccurrences</p> <p>(1). Weekly audits to be completed by the Maintenance Director/Assistant Director/ or team rounds to ensure compliance with medical equipment plugged into wall outlets.</p> <p>(2). Maintenance Director/Assistant Director will conduct staff in-services by 2-28-11 to educate on the process that medical equipment is not to be plugged into power strips.</p> <p>(3). Residents will be notified of the process and a letter will be mailed to responsible parties by 2-18-11 to further explain the facility process for power strips and electrical appliances. It will also be addressed upon admission.</p> <p>(4). Safety committee to conduct monthly walking rounds to ensure compliance.</p> <p>Monitoring changes/systems to ensure no deficient practice</p> <p>(1). Safety committee will report any findings to the QA Committee monthly for recommendations and further follow-up as needed.</p>	2-28-11
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