

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

PRINTED: 12/07/2010  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185338 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>11/19/2010 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>PEMBROKE NURSING & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>124 WEST NASHVILLE ST<br>PEMBROKE, KY 42266 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000         | INITIAL COMMENTS<br><br>An annual survey and five abbreviated surveys (KY #15354, KY #14979, KY #15424, KY 15594 and KY #15596) were conducted 11/17-19/10. Deficiencies were cited with the highest scope and severity being "D".  | F 000 | <p><b>Plan of Correction Disclaimer for Pembroke Nursing and Rehab Center</b><br/>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.</p> |   |
| F 282<br>SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, it was determined the facility failed to implement care plan interventions for one resident (#1), in the selected sample of 14, related placement of a safety alarm and monitoring for symptoms of constipation. Findings include:</p> <p>Record review revealed Resident #1 was admitted to the facility, on 06/12/10, with diagnoses to include Cerebral Vascular Accident, Dementia, Delusional Psychosis and Left Leg Amputee.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 09/19/10, revealed the facility identified Resident #1 as moderately cognitively impaired and incontinent of bowel.</p> <p>A review of the physician's orders, dated 11/01-31/10, revealed orders included the use of a bed alarm, to alert staff of the resident's unsafe</p> | F 282 |  | <p>F282 483.20(k) (3) (ii) SERVICES BY QUALIFIED PERSON/PER CARE PLAN</p> <ol style="list-style-type: none"> <li>On 11/19/10, RI #1's Care Plan and Certified Nursing Assistant (CNA) assignment sheets were updated to reflect current assessment and interventions and a bed alarm was placed on RI #1's bed. On 11/19/10 RI #1 was assessed by licensed nurse and was administered a laxative.</li> <li>On 11/19/10 the Director of Nursing (DON), Education and Training Director (ETD), and Assistant Director of Nursing (ADON) reviewed and updated all careplans and CNA assignment sheets of all residents residing in the center to ensure appropriate interventions for safety were included on the care plan and the CNA</li> </ol> |

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

TITLE

(X6) DATE

*[Signature]*

Administrator

12/19/10

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 282 | <p>Continued From page 1</p> <p>transfer attempts. The checks for placement and function of the bed alarm was ordered for every shift.</p> <p>A review of the "Safety Device" care plan, dated 05/07/09, revealed interventions included the use of a bed alarm while the resident was in bed, due to the medical symptoms related to the diagnosis of Cerebral Vascular Accident (Stroke) and unsafe practice exhibited by the resident. However, a review of the "Nursing Assistant Assignment" worksheet, dated 11/18/10, revealed no intervention for a bed alarm was included.</p> <p>Observations, on 11/17/10 at 10:28 AM and at 1:50 PM and on 11/19/10 at 10:05 AM, at 1:30 PM and at 3:20 PM, revealed there was no bed safety alarm utilized for Resident #1.</p> <p>Interviews with Certified Nursing Assistant (CNA) #4, and Licensed Practical Nurse (LPN) #1, on 11/18/10 at 3:20 PM, revealed they were unable to locate the resident's bed alarm and were unaware the resident's care plan included an intervention for a bed alarm. LPN# 1 stated she referred to the CNA care plan to identify interventions, due to the fact the Comprehensive Care Plan was inside the chart and not available for use by the CNA.</p> <p>An interview with the Director of Nursing (DON), on 10/28/10 at 5:00 PM, revealed the bed alarm should have been utilized for Resident #1. Nurses and CNAs were responsible for ensuring residents had bed/chair alarm utilized in accordance with care plans. She acknowledged the CNA care plan was incomplete and stated the care plan should be updated to reflect the use of a bed alarm.</p> | F 282 | <p>assignment sheet and that all safety interventions were implemented per the plan of care. On 11/19/10 all residents bowel activity was reviewed by DON/ETD to ensure no residents had greater than three days without bowel movement without intervention. Assessment was conducted on any resident who had not had a bowel movement in 3 days and interventions implemented.</p> <p>3. All nursing staff were re-educated by the DON/ADON and or ETD by 11/30/10 regarding the requirement that all care planned interventions must be implemented per the plan of care and CNA assignment sheets. All licensed nurses were re-educated by DON/ETD on 11/30/10 regarding requirement to review the no BM/small BM in last 9 shifts report from Care Tracker every shift and to assess and provide interventions to any resident who has not had a bowel movement in the last 9 shifts.</p> <p>4. The DON/ADON/Unit Manager will conduct rounds 5 days a week for 2 weeks, then 3 days a week for 2 weeks, then weekly to ensure all care planned interventions for safety are in place. CNA assignment sheets will be updated daily at the Daily Clinical Review meeting with any new interventions and distributed to staff. The DON, ADON and or Unit Manager will review the No BM in last 9 shifts report daily for 3 months to ensure that any resident without a bowel movement in 9 shifts receives appropriate bowel assessment and treatment. All results will be forwarded to QA committee monthly for review and further recommendations.</p> | 12/24/2010 |
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| F 282  | Continued From page 2<br><br>Additionally, a review of the facility policy, "Bowel and Bladder Program", dated January 2009, revealed constipation was defined as three or more days without a bowel movement. Standard bowel care to relieve constipation (in the absence of a bowel obstruction) with a provider order might include the use of Milk of Magnesia (laxative) 30 cc PO every third day without BM. If no results, Bisacodyl Suppository rectally should be used. If no results, Fleets Enema rectally should be used.<br><br>A review of the "Alteration in Bowel Elimination" care plan, updated on 11/16/10, revealed interventions included monitoring bowel elimination using the "CareTracker" and provision of medication as ordered, to aid in elimination as ordered, due to a history of constipation.<br><br>A review of Resident #1's "Bowel and Bladder Detail Report" revealed the resident did not have a recorded bowel movement, during the period of 10/05/10 through 10/16/10.<br><br>A review of the Medication Administration Record, dated 10/01-31/10, revealed Resident #1 did not receive a PRN (as needed) laxative, during the period of 10/05/10 through 10/16/10.<br><br>Interviews with three CNAs (#1, #2 and #3), on 11/18/10 at 10:17 AM, at 10:32 AM and at 10:50 AM, respectively, revealed CNAs were assigned responsibility to record residents' bowel movements on the "kiosk" and notify the nurse caring for the resident, if an irregular bowel pattern such as diarrhea or constipation was noted. CNAs (#1 and #2) stated that Resident #1 was unable to inform staff of a bowel movement. | F 282  |   |  |

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| F 282 | <p>Continued From page 3</p> <p>CNA #3 stated Resident #1 ate poorly for two weeks, during the month of October 2010.</p> <p>An interview with LPN #3, on 11/18/10 at 4:40 PM, revealed the CNAs notified her when a resident did not have a bowel movement. She performed a bowel assessment if the resident's abdomen was distended, if the resident complained of a stomach ache or if the resident had no bowel movement for two days.</p> <p>An interview with LPN# 1, on 11/19/10 at 4:43 PM, revealed she performed a bowel assessment if the resident complained of abdominal pain, backache, if the resident's abdomen felt distended or if the resident had no bowel movement for three days.</p> <p>An interview with RN #2, on 11/19/10, at 4:47 PM, revealed she performed a bowel assessment if the resident complained of abdominal or back pain, vomited or if the resident had no bowel movement for three days.</p> <p>An interview with the DON, on 11/18/10, at 9:35 AM, revealed the facility's computer program for the residents' activities of daily living generated a "Care Tracker" list of residents who had no bowel movement for nine shifts. The nurses recorded their interventions and results on the sheet and returned the record. She stated she placed the generated sheets in a folder and discarded the records after one month. She stated she had no record of monitoring of bowel patterns and interventions for Resident #1 for the period of 10/05/10 through 10/16/10.</p> <p>An interview with the Education Training Director (ETD), on 11/18/10 at 9:50 AM, revealed the Care</p> | F 282 |  |  |
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| F 282         | <p>Continued From page 4</p> <p>Tracker list was distributed every day after a staff meeting by either the DON or the Assistant Director of Nursing (ADON). Staff were asked to administer a laxative for residents if a bowel movement did not occur. The laxatives were administered after 2:00 PM.</p> <p>An interview with the Regional Director of Clinical Services, on 11/17/10 at 2:40 PM, revealed the "kiosks" were not capable of a look back past the current date. She stated the Care Tracker generated a report of residents who had no bowel movement in the past nine shifts. There was no record available for the interventions and outcomes for Resident #1, during the period of 10/05/10 through 10/16/10.</p>  | F 282 |  |  |
| F 309<br>SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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:<br/>Based on observation, interviews and record review, it was determined the facility failed to ensure the necessary care and services were provided for one resident, (#1), in the selected sample of 14. The facility failed to provide an on-going assessment with monitoring of bowel movements for Resident #1 and to intervene to address the resident's symptoms related to constipation. Findings include:</p> | F 309 | <p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <ol style="list-style-type: none"> <li>1. On 11/19/10 RI #1 was assessed by licensed nurse and was administered a laxative.</li> <li>2. On 11/19/10 all residents bowel activity was reviewed by DON/ADON/ ETD to ensure no residents had greater than three days without bowel movement without intervention. Assessment was conducted on any resident who had not had a bowel movement in 3 days and interventions implemented</li> <li>3. All licensed nurses were re-educated by DON on 11/30/10, regarding requirement to review the no BM/small BM in last 9 shifts report from Care Tracker every shift and to assess and provide interventions to any resident who has not had a bowel movement in the last 9 shifts.</li> </ol> |  |

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| F 309  | Continued From page 5<br><br>Record review revealed Resident #1 was admitted to the facility, on 06/12/10, with diagnoses to include Cerebral Vascular Accident, Dementia, Delusional Psychosis and Left Leg Amputee.<br><br>A review of the quarterly Minimum Data Set (MDS), dated 09/19/10, revealed the facility identified Resident #1 as moderately cognitively impaired and incontinent of bowel.<br><br>A review of the facility policy, "Bowel and Bladder Program" dated January 2009 revealed, constipation was defined as three or more days without a bowel movement. Standard bowel care to relieve constipation (in the absence of a bowel obstruction) with a provider order might include the use of Milk of Magnesia (laxative) 30 cc PO every third day without BM. If no results, Bisacodyl Suppository rectally should be used. If no results, Fleets Enema rectally should be used.<br><br>A review of the physician's orders, dated 10/01-31/10, revealed Resident #1 had an order for Milk of Magnesium Suspension and Miralax (laxatives) to be administered daily, due to a history of constipation.<br><br>A review of the resident's "Alteration in Bowel Elimination" care plan, updated on 11/16/10, revealed Interventions included monitoring bowel elimination using the "CareTracker" and provision of medication as ordered, to aid in elimination, due to a history of constipation.<br><br>A review of Resident #1's "Bowel and Bladder Detail Report" revealed the resident did not have a recorded bowel movement during the period of | F 309  | 4.. The DON, ADON and or Unit Manager will review the No BM in last 9 shifts report daily for 3 months to ensure that any resident without a bowel movement in 9 shifts receives appropriate bowel assessment and treatment. All results will be forwarded to QA committee monthly for review and further recommendations. | 12/24/2010                                   |

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| F 309  | <p>Continued From page 6<br/>10/05/10 through 10/16/10.</p> <p>A review of the Medication Administration Record, dated 10/01-31/10, revealed Resident #1 did not receive a PRN (as needed) laxative, during the period of 10/05/10 through 10/16/10, as ordered.</p> <p>Interviews with three CNAs (#1, #2 and #3), on 11/18/10 at 10:17 AM, at 10:32 AM and at 10:50 AM, respectively, revealed CNAs were assigned responsibility to record residents' bowel movements on the "kiosk" and notify the nurse caring for the resident, if an irregular bowel pattern such as diarrhea or constipation was noted. CNAs (#1 and #2) stated that Resident #1 was unable to inform staff of a bowel movement. CNA #3 stated Resident #1 ate poorly for two weeks, during the month of October 2010.</p> <p>An interview with LPN#3, on 11/18/10 at 4:40 PM, revealed the CNAs notified her when a resident did not have a bowel movement. She would perform a bowel assessment if the resident's abdomen was distended, if the resident complained of a stomach ache or if the resident had no bowel movement for two days.</p> <p>An interview with LPN #1, on 11/19/10 at 4:43 PM, revealed she would perform a bowel assessment if the resident complained of abdominal pain, backache, if the resident's abdomen felt distended or if the resident had no bowel movement for three days.</p> <p>An interview with RN #2, on 11/19/10, at 4:47 PM, revealed she would perform a bowel assessment if the resident complained of abdominal or back pain, vomited or if the resident had no bowel movement for three days.</p> | F 309  |   |  |

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| F 309  | Continued From page 7<br><br>An interview with the DON, on 11/18/10, at 9:35 AM, revealed the facility's computer program for the residents' activities of daily living generated a "Care Tracker" list of residents who had no bowel movement for nine shifts. The nurses recorded their interventions and results on the sheet and returned the record to the DON. She stated she placed the generated sheets in a folder and discarded the records after one month. She had no record for Resident #1's "Care Tracker" for the period of 10/05/10 through 10/16/10.<br><br>An interview with the Education Training Director (ETD), on 11/18/10 at 9:50 AM, revealed the Care Tracker list was distributed every day after a staff meeting by either the DON or the Assistant Director of Nursing (ADON). Staff were asked to administer a laxative for residents if a bowel movement did not occur for a period of three days. The laxatives were administered after 2:00 PM.<br><br>An interview with the Regional Director of Clinical Services, on 11/17/10 at 2:40 PM, revealed the "kiosks" were not capable of a look back past the current date. The Care Tracker generated a report of residents who had no bowel movement for the past nine shifts. There was no record available for the interventions and outcomes for Resident #1, during the period of 10/05/10 through 10/16/10. | F 309  |   |                      |  |
| F 322<br>SS=D  | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services   | F 322  |   |                      |  |

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| F 322  | <p>Continued From page 8</p> <p>to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interviews and record review, it was determined the facility failed to ensure appropriate treatment and services were provided two residents (#17 and #18), not in the selected sample of 12, related to Gastrostomy (G-tube) tubes. Observations revealed two nurses failed to verify proper placement of the tubes, prior to administration of medication. Findings include:</p> <p>A review of the facility policy and procedure, "Enteral Tubes" dated January 2001, revealed procedures included verification of G-tube placement by instillation of 10 - 20 cc of air into the tube, while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope, to validate air movement in the stomach. A second procedure included aspiration of 2 - 10 cc of gastric contents with re-installation into the stomach.</p> <p>1. Resident #18 was admitted to the facility, on 08/19/10, with a diagnosis of Gastrostomy Tube.</p> <p>An observation, on 11/18/10 at 1:40 PM, during a medication pass, revealed Licensed Practical Nurse (LPN) #2 did not verify placement of the G-tube, prior to administration of Ativan 0.5 mg and 60 ccs of water.</p> <p>An interview with LPN #2, on 11/18/10 at 2:00</p> | F 322  | <p>F322 483.25(g)(2)NG<br/>TREATMENT/SERVICES-RESTORE<br/>EATING SKILLS</p> <p>1. On 11/18/10 and 11/19/10, RI #17 &amp; RI # 18 were fully assessed by licensed nurse and appropriate placement of gastrostomy tube was validated. Neither residents exhibited s/s of aspiration or other complications r/t g tube placement not being confirmed prior to medication administration. LPN 1 and 2 were reeducated on the requirement to check g-tubes placement prior to medication administration on 11/18/10 by Director of Nursing. RI #17 &amp; RI #18 physicians were notified on 11/18/10 and 11/19/10 that placement was not verified prior to medication administration.</p> <p>2. On 11/18/10 and 11/19/10, the DON and ADON reviewed all residents with g-tubes to ensure placement was verified prior to medication administration.</p> |                      |  |

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| F 322  | Continued From page 9<br>PM, revealed she "forgot" to verify placement of the G Tube, prior to the medication administration. LPN #2 stated if the G-tube was not in proper placement, any substance administered through the tube would go into the resident's abdominal cavity.<br><br>2. Resident #17 was admitted to the facility, on 11/02/06, with diagnoses that included Gastrostomy Tube (G-tube).<br><br>An observation, on 11/18/10 at 2:25 PM, during a medication pass, revealed LPN #1 did not verify proper placement of the resident's G-tube prior to administration of Xanax 0.5 mg and Motrin 400 mg, crushed and mixed with 60 ccs of water.<br><br>An interview with LPN #1, on 11/18/10 at 3:10 PM, revealed she was aware she did not check placement of the G Tube, prior to administration of medication and stated she should have verified placement.<br><br>An interview with the Director of Nursing, on 11/18/10 at 2:15 PM, revealed she expected nursing staff to verify placement of G-tubes prior to administering medications or feedings and failure to do so could cause the resident complications. | F 322  | 3. All licensed nurses were re-educated by 11/30/10 by the DON, regarding requirement to check all g-tubes for placement by instilling 10-20 cc of air into the tube, while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach. The DON conducted competency testing on all licensed nurses by 11/30/10 to ensure competency in medication administration via g-tube<br><br>4. DON/ ADON/ Unit Manager will observe g-tube administration on random shifts three times a week times one month, then monthly for 2 months to ensure that placement is being checked with results forwarded to QA committee monthly for review and further recommendations. | 12/24/2010           |  |
| F 333<br>SS=D  | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record, and interview, it  | F 333  |   |                      |  |

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| F 333 | <p>Continued From page 10</p> <p>was determined the facility failed to ensure one resident (#7) in the selected sample of 14, was free from significant medication error related to inappropriate administration of intravenous antibiotic. Findings include:</p> <p>Record review revealed Resident #7 was admitted to the facility on 10/08/10, with diagnoses to include Encephalopathy, Urosepsis, Pancreatitis, and Respiratory Failure.</p> <p>A review of hospital discharge orders, dated 11/12/10, revealed Resident #7 was admitted to the facility with orders for Colistin (Antibiotic) IV to be administered three times a day (TID), due to a diagnosis of Urinary Tract Infection.</p> <p>A review of the Medication Administration Record, dated 11/12-30/10, revealed Colistin 150 mg IV TID was scheduled for 7:00 AM, 1:00 PM, and 7:00 PM, with a start date of 11/12/10, related to a Urinary Tract Infection, which was resistant to several oral antibiotics.</p> <p>A observation and review of the IV antibiotic label dated 11/16/10 revealed instructions, "Infuse 150 milligrams/100 milliliters over 60 minutes every eight hours for ten days."</p> <p>An observation and resident interview, on 11/19/10 at 11:15 AM, revealed an IV antibiotic was to be administered at 7:00 AM and the resident stated the antibiotic wasn't hung, "Until a few minutes ago". Observation at the time of the interview revealed the IV antibiotic was infusing at 88 milliliters an hour, via a IV pump. Resident #7 stated the rate should be 100 milliliters an hour.</p> <p>An interview with the facility's pharmacist, on</p> | F 333 | <p>F333 483.25 (m) (2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <ol style="list-style-type: none"> <li>On 11/19/10, RI #7's physician was notified of the medication error and a clarification order was received to administer the IV antibiotic every 8 hours per the pharmacist's recommendation. RI #7 was placed on increased monitoring to ensure no negative effects occurred as a result of the medication error.</li> <li>On 11/19/10 the Director of Nursing reviewed all IV medications requiring therapeutic levels to ensure given at the appropriate times and that IV medications were hung at ordered rates. No IV medications requiring therapeutic levels were identified.</li> <li>All licensed nursing staff will be reeducated by 11/30/10 by DON/ ETD on medication administration and the five rights, including requirement to hang IV medications at prescribed rate within one hour of scheduled administration time and to notify MD for clarification if any medication labels do not match physician order for IV medications.</li> </ol> |  |
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| F 333  | Continued From page 11<br>11/19/10 at 12:40 PM, revealed the IV antibiotic "definitely" should be administered every eight hours. At the current administration times scheduled for 7:00 AM, 1:00 PM, and 7:00 PM, the resident received 150 percent of the concentration of the medication, due to the every six hour interval. The pharmacist stated the resident would have a significant decrease in the drug level in the resident's blood, due to the twelve hour window after the last infusion (7:00 PM to 7:00 AM). He stated the facility's current administration schedule would result in "erratic" blood levels, which would affect the drug's effectiveness. The drug should "definitely" be spaced out every eight hours, as ordered.<br><br>An interview with RN #1, on 11/19/10 at 2:30 PM, revealed she was instructed by the floor Licensed Practical Nurse (LPN) to administer Resident #7's IV antibiotic, due to the fact the LPN was unauthorized to administer an IV antibiotic through a Central Venous Line. She stated she should have clarified with the primary physician the IV antibiotic administration times.<br><br>An interview with the Director of Nursing, on 11/19/10 at 2:10 PM, revealed she expected staff to administer medications as ordered and reflected on the Medication Administration Record.<br><br>An interview with the Regional Director of Clinical Services, on 11/19/10 at 2:10 PM, revealed she expected staff to extend the administration of the IV antibiotic to every eight hours. Furthermore, she expected staff to contact the primary physician for clarification of orders. | F 333  | 4.. DON/Unit Managers/RN supervisor to check telephone order sheets q daily to ensure that orders are being transcribed correctly onto MARs/TARs. DON/Unit Managers will check administration of IV medications to ensure they are being hung at the appropriate times and rates. This will be completed on random shifts 3 times a week for one month and q monthly for 2 months. All results will be forwarded to QA committee monthly for review and further recommendations. | 12/24/2010           |  |
| F 441<br>SS=D  | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  | F 441  |  |                      |  |

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| F 441  | Continued From page 12<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441  | F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>1. Resident #1, #15, and #16 were assessed and exhibit no s/s of infection r/t staff blowing on food. C.N.A #2 reeducated on 11/19/10 by Director of Nursing that staff should never blow in resident food.<br><br>2. Meal observation was conducted on 11/19/10 by Nutritional Service Manager and no observations of staff blowing on food were observed.<br><br>3. All staff were re-educated on the requirement to allow food to cool naturally and not to blow on resident food prior to serving by DON/NSM on November 19, 200.<br><br>4. The DON/ADON/NSM/Unit Manager will monitor dining room daily for one week, then 3 times a week for four weeks, then weekly to ensure that no staff blow on residents' food. All results will be forwarded to QA committee monthly for review and further recommendations. | 12/24/2010                                   |

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| F 441  | <p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure infection control procedures were followed to prevent the transmission of disease for two residents (#1 and #14), in the selected sample of 14 and one resident (#15), not in the selected sample. Observation and staff interview revealed a staff member blew on the residents' food and then fed the food to the residents. Findings include:</p> <p>1. Resident #1 was admitted to the facility, on 09/26/06, with diagnoses to include Hypertension and Cerebrovascular Accident.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 09/17/10, revealed the facility assessed the resident as moderately cognitively impaired and required extensive assistance with eating.</p> <p>2. Resident #15 was admitted to the facility, on 01/18/03, with diagnoses to include Senile Dementia, Aspiration Pneumonia and Convulsions.</p> <p>A review of the quarterly MDS, dated 06/17/10, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with eating.</p> <p>3. Resident #16 was admitted to the facility, on 05/09/07, with diagnoses to include Congestive Heart Failure and Renal Insufficiency.</p> <p>A review of the quarterly MDS, dated 08/18/10, revealed the facility identified the resident as</p> | F 441  |   |                      |  |

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| F 441  | Continued From page 14<br>moderately cognitively impaired and totally dependent on staff members for eating.<br><br>Observation, on 11/17/10 at 7:15 AM, revealed Certified Nurse Aide (CNA) #2 was in the general dining room, seated between Resident #1 and Resident #15. CNA #2 was observed to repeatedly blow onto the spoons filled with food with her mouth, prior to offering the food to Residents #1 and #15. Resident #15 was heard to state, "It's too hot." and CNA #2 responded by stating, "I'm blowing it off for you".<br><br>An interview with CNA #2, on 11/17/10 at 12:00 PM, revealed she frequently blew on the food belonging to Residents #1 and #15, after they complained their food was hot. She stated she also blew on food belonging to Resident #16, after complaints the food was hot.<br><br>A second interview with CNA #2 on 11/17/10 at 2:00 PM, revealed she realized she should have allowed the food to cool naturally or used another method to cool the residents' food.<br><br>An interview with the Director of Nursing/Infection Control, on 11/18/10 at 4:45 PM, revealed staff should never blow on residents' food to cool it off. The residents' food should be at the correct temperature when served or returned to the kitchen and another tray requested. | F 441  |   |                      |  |
| F 502<br>SS=D  | 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY<br><br>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.   | F 502  |   |                      |  |

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| F 502 | <p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interviews, it was determined the facility failed to obtain ordered laboratory services for one resident (#11), in the selected sample of 14. Findings include:</p> <p>A review of the facility policy, "Laboratory/Diagnostic Test Values-monitoring", dated April 2008, revealed a "Test Tracking" binder and a tracking tool entitled, "Laboratory/Diagnostic Test Tracking Sheet" was utilized. The binder was arranged by month with a number tab for each day of the month. The lab/test requisition was inserted under the number of the day due. Each nurse transcribing a new lab order, added the order to the tracking sheet and the Treatment Administration Record (TAR). The night shift nurse or designee prepared monthly requisitions and transcribed the monthly labs on the new month's tracking sheet. The night shift nurse or designee was responsible for nightly audits of the TARs, ensuring scheduled tests had a requisition and was in the tracking binder under the correct date and the test was entered on the test tracking sheet.</p> <p>A record review revealed Resident #11 was admitted to the facility, on 02/24/09, with diagnoses to include, Right Leg Cellulitis, Left Above the Knee Amputation, Coronary Artery Disease, History of Cerebrovascular Accident, Hypertension, Lipidemia and Diabetes.</p> <p>A review of current orders, dated 11/01/10, revealed laboratory tests ordered for Fasting Lipid Panel (FLP), Comprehensive Metabolic Profile (CMP) and Complete Blood Count(CBC) to be</p> | F 502 | <p>F502 483.75(j) (1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</p> <ol style="list-style-type: none"> <li>1. RI #11's physician was notified on 11/20/10 that the ordered labs were not obtained every 6 months as ordered. A new order was received to obtain on 11/20/10. The labs were obtained on 11/21/10.</li> <li>2. 100% audit of routine labs will be completed by DON/ADON on all residents for the last 6 months by 12/13/10 to ensure that all labs have been obtained and are in charts. Physicians will be notified of any labs not obtained as ordered.</li> <li>3. All nursing staff were reeducated by DON/ADON on requirement to obtain labs per physician orders and the use of the "Laboratory/Diagnostic Test Tracking sheet"</li> <li>4. All routine labs will be added to the lab test tracking sheet by the first of every month and the DON/ADON and or Unit Manager will audit the lab test tracking sheet daily Mon-Fri to ensure all labs are obtained as ordered. All results will be forwarded to QA committee monthly for review and further recommendations.</li> </ol> | 12/24/2010 |
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| F 502  | <p>Continued From page 16</p> <p>obtained every six months with a due date of 09/10. A review of the Flow Sheet record, dated 09/07/10, revealed initials which indicated the specimen was obtained for the CBC, CMP and FLP, on 09/07/10; however, there were no reports included in the resident's clinical record. The most current report for the FLP was dated 04/13/10 and the most current reports for the CBC and CMP were dated 03/11/10.</p> <p>An interview with Licensed Practical Nurse #4, on 11/19/10 at 1:30 PM, revealed the transcribing nurse signed off the order and transcribed the request on the lab tracking sheet. The night shift nurse was responsible to review the tracking sheet and individual orders every night and to complete any requisitions required. One copy of the requisition was placed in the lab box for the technician and one copy was placed in the chart.</p> <p>An interview with the Director of Nursing, on 11/19/10 at 1:45 PM, revealed no lab reports dated 09/07/10 were found in the facility's medical records department and the laboratory services provider had no record of the test being ordered. She stated it was the night shift nurses' responsibility to ensure lab work was drawn and initials on the the lab sheet flow record indicated the lab specimens were drawn.</p> <p>Attempts to contact LPN #5 were unsuccessful on 11/19/10 at 2:40 PM. LPN #5 was identified as the nurse assigned to the unit on 09/07/10 and whose initials appeared on the lab flow sheet record.</p> | F 502  |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185338</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br>B. WING _____                         |                      | (X3) DATE SURVEY COMPLETED<br><br><b>11/18/2010</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PEMBROKE NURSING &amp; REHABILITATION CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>124 WEST NASHVILLE ST<br/>PEMBROKE, KY 42266</b>                    |                      |   |
| (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 |   |
| K 000   | <p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and conducted on 11/1810 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p> | K 000   |   |                      |   |

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

TITLE

(X6) DATE

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.