

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

PRINTED: 07/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245
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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 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/14/15 and concluded on 07/16/15 with deficiencies cited at the highest scope and severity of a "D".	F 000	"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of twenty (20) sampled residents and one (1) unsampled resident, Unsampled Resident A. LPN #3 left a cup ten (10) medications unattended on the overbed table of Unsampled Resident A. The findings include: Review of the facility's policy, Medication Administration - General Guidelines, dated 12/18/12, revealed medications were prepared only by licensed nursing or other personnel authorized by state laws and regulations to prepare medications, the resident was always observed after administration to ensure the dose was completely ingested and residents were allowed to self-administer medications when specifically authorized by the attending physician. Observation, on 07/16/15 at 9:25 AM, revealed	F 281	Oaklawn ensures services provided meet professional standards of quality for the residents in accordance with State and Federal laws. This includes licensed nursing to obtain authorization by the attending physician to allow residents to self-administer medications as appropriate. This also consists of licensed nursing or other personnel authorized by state laws and regulations to ensure complete ingestion following administration of medications. On 7-16-15, the primary care physician gave authorization for Resident A to self-administer medications. The Unit Manager completed an assessment of the resident, to be safe to self-administer her medications. On 7-16-15, The Director of Nursing re-educated LPN #3 on the facility policy and procedure regarding Medication Administration.	8-17-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

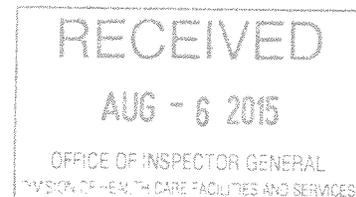
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
AUG 6 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245		
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F 281	<p>Continued From page 1</p> <p>Unsampled Resident A seated upright on the side of the bed in his/her room with a pill cup of medications and a food tray on the overbed table. Further observation at that time revealed no licensed nurse or other facility personnel were present in the room.</p> <p>Review of Unsampled Resident A's clinical record revealed the facility admitted the resident on 07/07/15 with diagnoses to include Thrombocytopenia, Hypothyroidism, Urinary Tract Infection and Muscle Weakness. Review of the Brief Interview for Mental Status, dated 07/13/15, revealed the facility assessed Unsampled Resident A with a score of thirteen (13) indicating the resident was interviewable. Review of physician orders, dated July, 2015, revealed no physician order for Unsampled Resident A's self-administration of medications.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/16/15 at 9:42 AM, revealed she was responsible to pass medications to Unsampled Resident A on 07/16/15. She stated the 8:00 AM medications which she left on Unsampled Resident A's overbed table were Docusate Sodium 100mg., Floranex Chewable Tablet, Furosemide 20mg. (2) , Niferex 150mg., Levofloxacin 500mg., Omeprazole 40mg., Oyster Calcium w/Vitamin D UD 500mg./200, Potassium Chloride ER (extended release) 20meq., Pristiq ER 50mg. LPN #3 further stated she should not have left Unsampled Resident A's room until she had observed the resident take all of the medications.</p> <p>Interview with Unit Manager (UM) #1, on 07/16/15 at 9:50 AM, revealed nurses should observe residents when administering their medications to</p>	F 281	<p>The training and education included the requirement to obtain authorization by the attending physician for resident to self-administer medications when applicable to a resident. Training further included the need to observe the resident following medication administration to ensure complete ingestion.</p> <p>On 7-16-15, Unit Managers reviewed all residents to determine if there were any other residents requesting medications be left at bedside for self-administration; none were identified.</p> <p>The Director of Nursing and Assistant Director of Nursing will re-educate all Nurses and Certified Medication Technician's on the facility policy and procedure regarding Medication Administration – General Guidelines by 8-16-15.</p>	8-17-15	



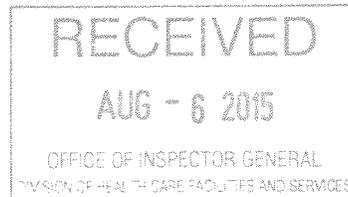
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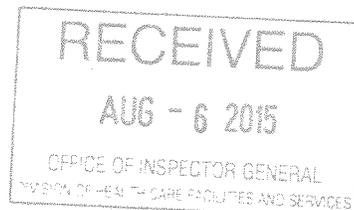
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F 281	Continued From page 2 ensure all of the medications had been ingested. In addition, UM #1 stated nurses were to explain the purpose of the residents' medications and were to observe residents for any adverse effects of the medications they were taking. Interview with the Director of Nursing (DON), on 07/16/15 at 10:57 AM, revealed a nurse should witness a resident take their medications to ensure the ingestion of the medications, to answer any questions the resident might have and to observe the resident for any adverse reactions. The DON stated the UM was responsible for annual monitoring of the unit nurses' performance for correct medication administration technique and the UM's had not reported any concerns regarding medication administration techniques to her.	F 281	The training and education will include the requirement to obtain authorization by the attending physician for resident to self-administer medications when applicable to a resident. Training will also include the need to observe the resident following medication administration to ensure complete ingestion. There will be completion of a monthly check during a medication pass on each unit to ensure the Nurse or Certified Medication Technician is observing the resident following medication administration to confirm complete ingestion. There will also be a monthly check of residents able to interview and self-administer medications to validate authorization by the attending physician is in the medical record. There will be a report of the checks to the Quality Assurance committee on a quarterly basis until achievement and maintenance of substantial compliance for two quarters.	8-17-15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F 514	



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F 514	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain the clinical record for one (1) of twenty (20) sampled residents and one (1) unsampled resident, Unsampled Resident A, in accordance with accepted professional standards. LPN #5 documented medications had been administered when they had not.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Administration - General Guidelines, dated 12/18/12, revealed the individual who administered the medication recorded the administration on the resident's Medication Administration Record (MAR) directly after the medication was given.</p> <p>Review of the facility's policy regarding Specific Procedures For All Medications (not dated), revealed after medication administration (the nurse) was to document the administration in the MAR.</p> <p>Review of the Lippincott Nursing Center, e-News, June 2015, revealed the eight rights of medication administration, number 6, the Right Documentation of the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory valuse or vital sign that needed to be checked before giving the drug. Document administration AFTER giving the ordered medication.</p> <p>Observation, on 07/16/15 at 9:25 AM, revealed Unsampled Resident A seated upright on the side</p>	F 514	<p>Oaklawn maintains clinical records on each resident in accordance with accepted professional standards and practices that reflect accurate documentation.</p> <p>On 7-16-15, the Unit Manager interviewed Resident A to ensure timely ingestion of medications due at 8:00 AM.</p> <p>On 7-16-15, the Director of Nursing re-educated LPN #3 on the facility policy and procedure for Medication Administration. The training and education included the requirement to document administration directly after giving and ensuring ingestion of ordered medication on the Medication Administration Record.</p> <p>On 7-16-15, a check of all residents able to interview and self-administer medications received a review to ensure accurate documentation following medication administration. There were no other residents affected by the deficient practice.</p>	8-17-15



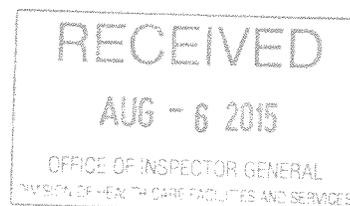
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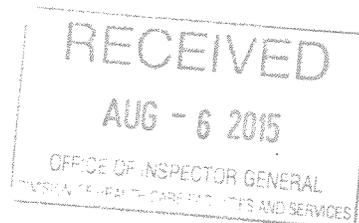
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F 514	<p>Continued From page 4 of the bed in his/her room with a pill cup of medications and a food tray on the overbed table. Further observation, at that time, revealed no licensed nurse or other facility personnel were present in the room.</p> <p>Review of Unsampld Resident A's clinical record revealed the facility admitted the resident on 07/07/15 with diagnoses of Thrombocytopenia, Hypothyroidism, Urinary Tract Infection and Muscle Weakness. Review of the Brief Interview for Mental Status, dated 07/13/15, revealed the facility assessed Unsampld Resident A with a score of thirteen (13) indicating the resident was interviewable. Review of physician orders, dated July, 2015, revealed no physician order for Unsampld Resident A's self-administration of medications. Review of the July, 2015 MAR for Unsampld Resident A revealed Licensed Practical Nurse (LPN) #3 had initialed as given on 07/16/15 the 8:00 AM medications: Docusate Sodium 100mg.; Floranex Chewable Tablet; Furosemide 20mg. (2); Niferex 150mg.; Levofloxacin 500mg.; Omeprazole 40mg.; Oyster Calcium w/Vitamin D UD 500mg./200; Potassium Chloride ER (extended release) 20meq.; and, Pristiq ER 50mg.</p> <p>Interview with LPN #3, on 07/16/15 at 9:42 AM, revealed she was responsible to pass medications to Unsampld Resident A on 07/16/15 at 8:00 AM. LPN #3 further stated she should not have left Unsampld Resident A's room until she had observed the resident take all of the medications she left on the overbed table.</p> <p>Further interview with LPN #3, on 07/16/15 at 1:15 PM, revealed she had charted the 8:00 AM medications on the MAR before she took the</p>	F 514	<p>The Director of Nursing and Assistant Director of Nursing will re-educate all Nurses and Certified Medication Technicians on the facility policy and procedure regarding Medication Administration – General Guidelines by 8-16-15. The training and education will include the requirement to document administration directly after giving and ensuring ingestion of ordered medication on the Medication Administration Record.</p> <p>There will be completion of a monthly check during a medication pass on each unit to ensure the Nurse or Certified Medication Technician is accurately documenting medication administration directly after giving and ensuring ingestion of ordered medication on the Medication Administration Record. There will be a report of the checks to the Quality Assurance committee on a quarterly basis until achievement and maintenance of substantial compliance for two quarters.</p>	8-17-15



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F 514	<p>Continued From page 5</p> <p>medications to Unsampled Resident A's room indicating they had been given even though she had not witnessed Unsampled Resident A taking the medications. She also stated she did not return to Unsampled Resident A's room to see if the resident had taken all of the medications she had left on his/her overbed table.</p> <p>Interview with Unit Manager (UM) #1, on 07/16/15 at 9:50 AM, revealed nurses should not document on the MAR the administration of medications which they had not observed as it would be inaccurate documentation and facility policy would not be followed.</p> <p>Interview with the Director of Nursing (DON), on 07/16/15 at 10:57 AM, revealed nurses were trained in accurate clinical record documentation as a standard of professional practice and in the facility orientation program which included facility policies regarding medication administration. The standard of professional practice and the facility orientation program directed nurses to document medication administration after medications had been given. The DON stated it was against facility policy to document medication administration prior to ensuring the medications had been administered and LPN #3 had inaccurately documented on Unsampled Resident A's MAR.</p>	F 514		



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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 2005 SURVEY UNDER: 2000 New FACILITY TYPE: SNF TYPE OF STRUCTURE: Two (2) stories, Type II (111). SMOKE COMPARTMENTS: Five (5) per floor (story). FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Automatic, wet sprinkler system, hydraulically designed. GENERATOR: Type II, 600 KW generator, fuel source is diesel. A Recertification Life Safety Code Survey was conducted on 07/16/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000			

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

TITLE

(X6) DATE

Tommy Brock

ADMINISTRATOR

8/3/15

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.

