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

PRINTED: 04/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185446	A. BUILDING B. WING	C 04/14/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3378 PIMLICO PARKWAY LEXINGTON, KY 40517	

RECEIVED
MAY - 5 2011
BY:

(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey Investigation ARO#KY00016250, #KY00016303, #KY00016300 and #KY00016298, was conducted 04/12/11 through 04/14/11. Deficiencies were cited with the highest Scope and Severity of a "D". ARO#KY00016250 was substantiated with no deficiencies. ARO#KY00016303 and ARO#KY00016300 were substantiated with deficiencies. ARO#KY16298 was unsubstantiated with no deficiencies.	F 000	**Bluegrass Care and Rehabilitation does not believe and does not admit that any deficiencies exist before, during and after the survey. 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 rights to raise all 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 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.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		5-16-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Billie Schilling, NHA	Administrator	5-05-11

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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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the physician was notified when a resident refused medications for one (1) of ten (10) sampled residents, (Resident #8). Resident #8 refused his/her 8:00 AM medications; however, there was no documented evidence the physician was notified. Also, the resident's 8:00 AM medications were offered to the resident later in the day, without a Physician's Order to administer the medication at the unscheduled time. The findings include: Review of Resident #8's clinical record revealed diagnoses which included Dementia with Behavioral Disturbance, Seizure Disorder, and Hypertension. Review of the quarterly Minimum Data Set (MDS) Assessment dated 03/01/11 revealed the facility assessed the resident as having no short or long term memory loss. Review of the Nurse's Notes dated 04/07/11 at 9:00 AM, revealed a late entry which stated the patient refused medications after two attempts and voiced "I don't want them now", supervisor aware. Review of the Medication Administration Record (MAR) dated 04/11 revealed the resident's	F 157	**F157 483.10(b) (11) Notify of Changes (Injury/DECLINE/Room/ETC)** **Corrective Action for Residents Affected:** (1.) The physician/ARNP was re-notified on 4-14-2011 by the charge nurse regarding resident #8's refusal of medication and the residents desire to take his medications at his leisure. The physician/ARNP verbally stated that she was aware of the resident taking the medications, per the care plan, later in the day and then gave an order to give the resident his medications at his leisure and document the time at which he takes the medications on the MAR. LPN #2 was educated by the DON on 4-14-2011 that she was the nurse responsible for providing care to resident #8 and ensuring that his needs are met. **Identification of Residents with potential to be affected:** (1.) MARS/TARS were audited on 4-14-2011 by the ADON and DON for any other residents that have a consistent refusal of medications. Those identified had proper notification to the MD/ARNP and family. (2.) On 4-14-11 all assignments were reviewed by the DON and no other residents were identified requiring 2 separate nurses to provide different aspects of care.	5-16-2011

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F 157	Continued From page 2 medications were signed off as administered at 8:00 AM on 04/07/11. Further review revealed the medications included Klor-Con 20 milliquivelents (medication used for potassium replacement), Keppra 2000 milligrams (anti-convulsant medication), Lexapro 10 milligrams (antidepressant medication), Namenda 10 milligrams (medication used for the treatment of Dementia), Lasix 40 milligrams (Diuretic Medication), Advair Diskus 500-50 MCG inhaler (Corticosteroid Inhaler), Aspirin 81 milligrams (medication used for fever, pain, anti-inflammatory), Tegretol 300 milligrams (anti-convulsant medication), Docusate Sodium 250 milligrams (stool softener), Pepcid 20 milligrams (medication used for Gastroesophageal Reflux), Risperidone 0.25 milligrams (anti-psychotic medication), Spiriva 18 MCG Inhaler (used for the treatment of Chronic Obstructive Pulmonary Disease), Flomax 0.4 milligrams (treatment for Benign Prostatic Hyperplasia), and Vitamin C 500 milligrams. Interview on 04/13/11 at 10:00 AM with Resident #8 revealed he/she did not receive his/her morning medication until 3:15 PM on 04/07/11. The resident stated he/she had to ask for his/her medications at 3:15 PM, and was upset because he/she should not have had to ask for the medications. Resident #8 further stated Licensed Practical Nurse (LPN) #1 told him/her the medication was not administered because he/she did not ask for the medication. Further interview revealed when he/she received the morning medications at 3:15 PM, he/she took the cup of pills to the front lobby looking for the Administrator. He/she further stated he left the cup of pills with the Administrator's Secretary and asked her to inform the Administrator he/she had	F 157	**Measures or systems changes to prevent reoccurrence:** (1.) MARS/TARS /24 hour report will be reviewed daily by the ADON, DON, SDC or MDS nurse or weekend supervisor for any refusal of medications or treatments. If any refusals are identified, the medical record will be reviewed to ensure that proper notification to the MD/FAMILY/POA has been made. (2.) Assignments will be made daily by the ADON, Charge nurse DON or weekend supervisor to reflect what cart/hall/residents that each nurse will be assigned. (3.) All licensed staff will be in-serviced by 5-16-2011 by the SDC/DON/ADON on medication administration to include proper notification and documentation upon resident refusal and the nurse assignment sheets. (4.) A 10% audit of MARS/TARS/Orders/Nurses Notes will be completed weekly by the DON or ADON's for any medication/treatment refusals and then proper notification of MD/Family/POA. (5.) The Med Cart assignment sheet will be audited daily by the ADON's, DON or weekend supervisor to ensure the staff is compliant with the med cart assignments.	

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F 157	Continued From page 3 received the morning medications late. Interview on 04/13/11 with the Human Resources Director revealed she remembered the resident bringing a cup of pills to her desk and asking her to let the Administrator know he/she did not receive the medication on time. Further interview revealed she called the resident's unit and spoke with LPN #2 who came to get the cup of pills. She stated LPN #2 told her the Administrator was talking to the resident about the situation. Interview on 04/13/11 at 2:05 PM with the Administrator revealed the resident refused medications often and the nurses would offer the medications at a later time. She stated she remembered the incident on 04/07/11, and the resident consumed the cup of pills in front of her. The Administrator was unsure of the time of day or the nurses involved. Interview on 04/14/11 at 2:30 PM with LPN #1 revealed she was not assigned to the resident due to conflicts with the resident in the past, and if she was assigned to the resident's hallway or assigned to administer medications on the resident's hallway, she would remind the nurse on the other hallway of the need to administer Resident #8's medications and provide care for the resident. She further stated, on 04/07/11 she was assigned to the resident's hallway and was assigned to administer medications on the resident's hallway. Continued interview revealed she asked LPN #2 to administer Resident #8's 8:00 AM medications, and the resident refused. Further interview revealed the resident came up later in the day asking for the medications and LPN #3 offered the medication to the resident. She stated the resident took the cup of pills down	F 157	**Monitoring changes/systems to ensure no deficient practice:** (1.) Findings of the MAR/TAR/Orders/Nurses Notes audits and the assignment audit will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.	

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F 157	Continued From page 4 front. She was not sure of the exact time the medication was offered to the resident. She stated it would have been LPN #2's or LPN #3's responsibility to call the Nurse Practitioner to let her know the resident had refused the medications at 8:00 AM and the medication was being administered late for Resident #8, because she was not assigned to the resident. Interview on 04/13/11 at 3:00 PM and 04/14/11 at 3:00 PM with LPN #2 revealed she was never instructed she was to care for Resident #8 when she was assigned to the opposite hallway. She stated LPN #1 asked her to administer Resident #8's medications on 04/07/11 at 8:00 AM, and when she offered the medications the resident stated he/she would take the medication later. She stated she told LPN #1 the resident refused the medication and was instructed to write the resident's refusal of the medications in the Nurse's Progress Notes, which she did. Continued Interview revealed she assumed LPN #1 would document the resident's refusal of the medication on the MARs. She stated, LPN #3 offered the resident his/her medications later in the day and the resident took the cup of pills to the front desk. She further stated she received a call from the front desk asking her to come and get the cup of pills, which she did. She stated she gave the cup of pills back to LPN #3 and LPN #3 wasted the pills. Interview on 04/13/11 at 4:15 PM with LPN #3 revealed she was asked by LPN #1 to offer the resident his/her 8:00 AM medications later in the day on 04/07/11 around 11:00 AM or 1:00 PM . She stated the resident consumed most of the pills and then left the unit taking the cup containing the rest of the pills to Administration.	F 157		

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 5 She further stated she did not follow the resident to ensure the medication was consumed because she assumed LPN #1 who was sitting at the desk would follow through since she was assigned to the resident. Continued interview revealed she should have made a note on the MAR and in the chart indicating the medication was administered late, because the protocol was to administer the medication one hour before or one hour after the administration time which would be from 7:00 AM until 9:00 AM. However, she stated the Nurse Practitioner was aware Resident #8 refused medications and took them later in the day. LPN #3 further stated it would be an everyday occurrence to notify the physician of the resident's refusal of medications and to request permission to administer the medication late. Interview on 04/14/11 at 2:40 PM with the Unit Manager assigned to Resident #8, revealed LPN #1 was not to be assigned to Resident #8. However, she had never inserviced the staff in reference to LPN #1 not being assigned to Resident #8, and the need for another nurse to administer the resident's medications when LPN #1 was assigned to Resident #8's hallway. Further interview revealed LPN #1 was to remind the nurses she could not be assigned to Resident #8 on the days she was assigned to Resident #8's hallway. She stated she could see how there would be confusion related to which nurse was assigned to the resident when LPN #1 was assigned to the resident's hallway and medication cart. Continued interview revealed if a resident refused a medication the physician should be notified, and if a medication was to be administered at an unscheduled time, an order would need to be obtained. Further interview revealed if a resident refused a medication, the	F 157		

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F 157	Continued From page 6 nurse should circle their initials on the MAR to indicate the medication was not administered and write a note on the back of the MAR. Continued interview revealed if the medication was administered late, this should be indicated on the MAR. Interview on 04/14/11 at 6:21 PM with the Director of Nursing revealed the physician was to be notified of any refusal of medication. She further stated a Physician's Order would need to be obtained in order to administer the medication at an unscheduled time. Continued interview revealed medications could be administered one hour before or one hour after the scheduled administration time. Interview on 04/13/11 at 5:25 PM with the Nurse Practitioner revealed she would need to be notified if a resident refused medications.	F 157		
F 281 SS=E	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 meet professional standards of quality for one (1) of ten (10) sampled residents (Resident #8), and nine (9) unsampled residents (Unsampled Resident A, B, C D, E, F, G, H, and I). Resident #8 refused his/her 8:00 AM medications on 04/07/11; however, there was no documented	F 281	**F281 483.20(k) (3) (I) Services Provided Meet Professional Standards** **Corrective Action for Residents Affected:** (1.) The physician/ARNP was re-notified on 4-14-11 by the charge nurse regarding resident #8's refusal of medication and the residents desire to take his medications at his leisure. The physician noted that he was aware of the resident taking the medications later in the day and an order was given to give the resident his medications at his leisure and document the time at which he takes the medication on the MAR. LPN #2 was educated by the DON on 4-14-2011 that she was the nurse responsible for providing care to resident #8 and ensuring that his needs are met. (2.) The physician/ARNP was notified on 4-14-11 by the ADON regarding the un-sampled residents A, B, C, D, E, F, G, H, and I regarding medication times. Process was changed to divide the medication cart med pass times in half so that half of the residents are due at 8am and 8pm	5-16-2011

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F 281	Continued From page 7 evidence the physician was notified. In addition, the resident's 8:00 AM medications were offered to the resident later in the day, without a Physician's Order to administer the medication at the unscheduled time. Also, the facility failed to ensure the resident consumed the medication when offered at the unscheduled time and was unaware of which medications were consumed and which were refused. In addition, there was a discrepancy in documentation. The Medication Administration Record (MAR) indicated the resident received the 8:00 AM medications on 04/07/11, and the Nurse's Progress Notes indicated the resident refused the 8:00 AM medications on 04/07/11. Further review revealed there was no documented evidence of the 8:00 AM medications being offered at the unscheduled time. In addition, observation of medication pass on 04/13/11 from 7:30 PM until 9:15 PM revealed nine (9) unsampled resident had not received their 8:00 PM medications by 9:00 PM (Unsampled residents A, B, C, D, E, F., G, H, and I). The findings include: 1. Review of Resident #8's medical record revealed diagnoses which included Dementia with Behavioral Disturbance, Seizure Disorder, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) dated 03/01/11 revealed the facility assessed the resident as having no short or long term memory loss. Review of the Care Area Assessment (CAA) Summary dated 11/29/10 revealed the resident was verbally abuse towards staff and had	F 281	and the other half are due at 9am and 9pm. This will ensure that medications are given timely and in compliance. **Identification of Residents with potential to be affected:** (1.) MARS/TARS were audited on 4-14-11 by the ADON or DON for any other residents that have a consistent refusal of medications. (2.) All other medication carts will be reviewed by the ADON and DON by 5-16-11 to ensure that all residents are receiving their medications within the 2 hour period of compliance. (3.) On 4-14-11 all assignments were reviewed by the DON and no other residents were identified requiring 2 separate nurses to provide different aspects of care. **Measures or systems changes to prevent reoccurrence:** (1.) MARS/TARS will be reviewed daily by the ADON, DON, SDC, MDS or weekend supervisor nurse for any refusal of medications or treatments. If any refusals are identified, the medical record will be reviewed by the ADON, DON, SDC or MDS nurse to ensure that proper notification to the MD/FAMILY/POA has been made. (2.) Assignments will be made daily by the ADON, charge nurse or DON to reflect what cart/hall/residents that each nurse will be assigned.	

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F 281	Continued From page 8 requested only certain staff members to provide his/her care. Review of the Comprehensive Plan of Care dated 12/08/10 revealed the resident was verbally abuse, resisted care, and requested to take scheduled medication when he/she desired. The interventions included reporting to the physician changes in behavioral status and administering and monitoring the effectiveness and side effects of medications as ordered. Review of the Nurse's Notes dated 04/07/11 at 9:00 AM, revealed a late entry which stated the patient refused medications after two attempts and voiced "I don't want them now", supervisor aware. Review of the Medication Administration Record (MAR) dated 04/11 revealed the resident's medications were signed off as administered on 04/07/11 at 8:00 AM. The medications included Klor-Con 20 milliquivelents (medication used for potassium replacement), Keppra 2000 milligrams (anti-convulsant medication), Lexapro 10 milligrams (antidepressant medication), Namenda 10 milligrams (medication used for the treatment of Dementia), Lasix 40 milligrams (Diuretic Medication), Advair Diskus 500-50 MCG inhaler (Corticosteroid Inhaler), Aspirin 81 milligrams (medication used for fever, pain, anti-inflammatory), Tegretol 300 milligrams (anti-convulsant medication), Docusate Sodium 250 milligrams (stool softener), Pepcid 20 milligrams (medication used for Gastroesophageal Reflux), Risperidone 0.25 milligrams (anti-psychotic medication), Spiriva 18 MCG Inhaler (used for the treatment of Chronic Obstructive Pulmonary Disease), Flomax 0.4	F 281	(3.) All licensed staff will be in-serviced by 5-16-11 by the SDC/DON/ADON on medication administration to include proper notification and documentation upon resident refusal and never leaving the presence of a resident until the medications are being taken. In-servicing will also include the licensed staff notifying the ADON/DON if they cannot get their medications passed within the 2 hour window. (4.) A 10% audit of MARS/TARS/Orders/Nurses Notes will be completed weekly by the DON or ADON's for any medication/treatment refusals and then proper notification of MD/Family/POA. (5.) The med cart assignment sheet will be audited daily by the ADON's, DON or weekend supervisor to ensure the staff is compliant with their med cart assignments. (6.) A medication pass audit will be completed on 3 separate carts on the 7am and 7pm shift monthly for 3 months by ADON, DON or SDC to ensure medications are being administered within the 2 hour window as required.	

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F 281	Continued From page 9 milligrams (treatment for Benign Prostatic Hyperplasia), and Vitamin C 500 milligrams. Interview on 04/13/11 at 10:00 AM with Resident #8 revealed he/she did not receive his/her morning medication until 3:15 PM on 04/07/11. The resident stated he/she had to ask for the medication because they were not offered. The resident further stated Licensed Practical Nurse (LPN)#1 stated he/she did not receive the medications because he/she did not ask for them. The resident stated, when he/she received the morning medications at 3:15 PM, he/she took the cup of pills to the front lobby looking for the Administrator. The resident stated he/she left the cup of pills with the Administrators Secretary and asked her to inform the Administrator he/she had just received the morning medications. Interview on 04/13/11 at 2:00 PM with the Human Resources Director revealed Resident #8 had brought a cup of pills to her desk and told her to let the Administrator know he/she did not receive his/her pills. She stated she called the resident's unit and spoke with LPN #2 who came to get the cup of pills. She further stated LPN #2 told her the Administrator was talking to the resident about the situation. Interview on 04/13/11 at 2:05 PM with the Administrator revealed the resident was not a morning person, refused medications often when offered, and the nurses would offer the medications at a later time. She further stated she remembered the incident on 04/07/11, and the resident consumed the cup of pills in front of her. She was unsure of the time of day or the nurses involved.	F 281	**Monitoring changes/systems to ensure no deficient practice:** (1.) Findings of the MAR/TAR/Orders/Nurses Notes audits , the med cart assignment sheet audit and the medication pass audit will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.	

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BLUEGRASS CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3676 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)	(X6) COMPLETION DATE
F 281	Continued From page 10 Interview on 04/14/11 at 2:30 PM with LPN #1 revealed she was not assigned to Resident #8 due to conflicts with the resident in the past, and if she was assigned to administer medications on the resident's hallway, she would remind the nurse on the other hallway of the need to administer Resident #8's medications. She further stated, on 04/07/11 she was assigned to administer medications on Resident #8's hallway and asked LPN #2 to administer Resident #8's 8:00 AM medications, which the resident refused. She further stated the resident came up later in the day asking for the medications and LPN #3 offered the medication to the resident. She stated the resident took the cup of pills to the front lobby. She was not sure of the time the medication was offered to the resident. She stated it would have been LPN #2's or LPN #3's responsibility to call the Nurse Practitioner to let her know the resident had refused the medications at 8:00 AM and the medications were being administered late for Resident #8 because she was not assigned to the resident. She stated she assumed LPN #3 would follow up with documentation related to the medication being administered late. Interview on 04/13/11 at 3:00 PM and 04/14/11 at 3:00 PM with LPN #2 revealed she was never instructed she was to care for Resident #8 when LPN #1 was assigned to Resident #8's hallway. She stated LPN #1 asked her to administer Resident #8's medications on 04/07/11 at 8:00 AM, and when she offered the medications the resident stated he/she would take the medication later. She stated she told LPN #1 and was instructed to write the resident's refusal of the medications in the Nurse's Progress Notes. She further stated she assumed LPN #1 would document the resident's refusal of the medication	F 281		

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F 281	Continued From page 11 on the MARs. Continued interview revealed LPN #3 offered the resident his/her medications later in the day and the resident took the cup of pills to the front desk. She further stated she received a call from the front desk asking her to come and get the cup of pills, which she did. She stated she took the cup of pills back to LPN #3 and LPN #3 wasted the medication. Interview on 04/13/11 at 4:15 PM with LPN #3 revealed she was asked by LPN #1 to offer the resident his/her 8:00 AM medications later in the day on 04/07/11 around 11:00 AM or 1:00 PM. She stated the resident consumed most of the pills and then took the cup which contained the rest of the pills to Administration. She further stated she did not follow the resident and was unaware of which pills were consumed because she assumed LPN #1 would follow through since she was assigned to the resident. Continued interview revealed she should have made a note on the MAR and in the chart indicating the medication was administered late. Further interview revealed the protocol was to administer the medication one hour before or one hour after the administration time which would be from 7:00 AM until 9:00 AM. Continued interview revealed the Nurse Practitioner was aware Resident #8 refused medications and took them later in the day. She stated it would be an everyday occurrence to notify the physician of the resident's refusal of medications and to request permission to administer the medication late. Interview on 04/14/11 at 2:40 PM with the Unit Manager assigned to Resident #8, revealed LPN #1 was not to be assigned to Resident #8. She stated she had never inserviced the staff in reference to LPN #1 not being assigned to	F 281		

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F 281	Continued From page 12 Resident #8 and the need for another nurse to administer the resident's medications. However, LPN #1 was to remind the nurses she could not be assigned to Resident #8 on the days she was assigned to Resident #8's hallway. She further stated she could see how there could be confusion related to which nurse was assigned to the resident when LPN #1 was assigned to the residents hallway. She further stated if a resident refused a medication the physician was to be notified, and if a medication was to be administered at an unscheduled time, an order would need to be obtained. Continued interview revealed if a resident refused a medication, the nurse should circle their initials on the MAR to indicate the medication was not administered and write a note on the back of the MAR. Further interview revealed if the medication was administered late, this should be indicated on the MAR. Interview on 04/14/11 at 6:21 PM with the Director of Nursing revealed the physician was to be notified of any refusal of medication and a Physician's Order would need to be obtained in order to administer the medication at an unscheduled time. 2. Observation of medication pass on 04/13/11 from 7:30 PM until 9:15 PM revealed there were two Licensed Practical Nurses passing medications on the North Hall. Interview on 04/13/11 at 9:15 PM with LPN #4, who was passing medications on one wing of the North Hall, revealed she still had to pass medications to residents in rooms 11, 12, 13, 14, 15, 16, and 17. Review of the Medication Administration Record (MAR) revealed there were	F 281		

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F 281	Continued From page 13 nine residents who had not received their scheduled 8:00 PM medications which included unsampled resident A, B, C, D, E, F, G, H, and I. Continued interview revealed the protocol was to administer the medication one hour before or one hour after the scheduled administration time which would be from 7:00 PM until 9:00 PM for the scheduled 8:00 PM medications. She stated she would be out of compliance with administering the 8:00 PM medications after 9:00 PM. Further interview revealed she was usually passing medications on the North Hall until 10:00 PM for the 8:00 PM and 9:00 PM scheduled medications. Phone interview with Registered Nurse #1 on 04/14/11 at 4:00 PM revealed she worked the evening shift on the North Hall and it was constantly busy on the unit from 7:00 PM until 11:00 PM. She stated sometimes medications which were scheduled for 8:00 PM were administered at 10:00 PM. She further stated she was not sure if anyone had informed the Director of Nursing (DON) of the non compliance with medication times. Interview on 04/14/11 at 6:21 PM with the DON revealed medication could be administered one hour before or one hour after the scheduled medication time. She stated the nurses should have let her know they were out of compliance with medication administration on the evening shift for the North Hall. Review of the facility Medication Administration Policy, revealed "medications are administered only as ordered by the physician. "Chart on medication sheet and/or nurse's notes any failure to administer medication, regardless of the	F 281		

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F 281	Continued From page 14 reason".	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of ten (10) sampled residents (Resident #9). Resident #9 complained to the facility in reference to not receiving pain medication as scheduled and not receiving as needed (prn) pain medicine in a timely manner. Observation of medication pass on 04/13/11 from 7:30 PM until 9:15 PM revealed nine (9) unsampled resident had not received their 8:00 PM scheduled medications by 9:00 PM (Unsampled residents A, B, C, D, E, F, G, H, and I) on the North Hallway where Resident #9 resided. The findings include: Review of Resident #9's medical record revealed the resident was re-admitted to the facility on 03/02/11 after hospitalization from 02/22/11	F 309	**F309 483.25 Provide Care/Services for Highest Well Being** **Corrective Action for Residents Affected:** (1.) Resident #9 was assessed for pain on 4-14-11 by the DON. The resident reported no further issues and pain is well managed. (2.) The physician/ARNP was notified on 4-14-11 by the ADON regarding the un-sampled residents A, B, C, D, E, F, G, H, and I regarding the medication times. Process was changed to divide the medication cart med pass times in half so that half of the residents are due at 8am and 8pm and the other half are due at 9am and 9pm. This will ensure that medications are given timely and in compliance. **Identification of Residents with potential to be affected:** (1.) All residents receiving pain medications will be assessed by 5-16-11 by the ADON, DON, MDS nurse, Restorative Nurse or SDC to ensure that they are experiencing adequate pain relief. (2.) All other medication carts will be reviewed by ADON and DON by 5-16-11 to ensure that all residents are receiving their medications within the 2 hour window of compliance.	5-16-2011

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F 309	Continued From page 15 through 03/02/11 for a diagnosis of a Right Distal Femur Fracture and Open reduction and internal fixation of the Right Distal Femur. Review of the Admission Minimum Data Set (MDS) Assessment dated 03/23/11 revealed the facility assessed the resident as having no cognitive impairment. Further review revealed the facility assessed the resident as having frequent moderate pain. Review of the Comprehensive Plan of Care dated 02/02/11 revealed the resident had acute and chronic pain, and complaints of pain. The goal stated the resident would demonstrate relief or reduction in pain intensity within one hour after receiving interventions. The interventions included administering medications and monitoring for effectiveness and for possible side effects for routine and as needed pain medication. Review of the Physician's Orders dated 04/11 revealed orders for Tylenol 650 milligrams every four (4) hours as needed (prn) for pain, and Percocet 10/325 milligrams one (1) tablet every four (4) hours prn for pain. Further review revealed a new Physician's Order written 04/01/11 for Percocet 10 / 325 milligrams, one by mouth twice a day. Review of the March 2011 Medication Administration Record (MAR) revealed the resident received the as needed Percocet pain medication three (3) times most days until 03/26/11 when the resident began receiving the prn Percocet pain medication four (4) times a day. Review of the April 2011 MAR revealed the resident received the scheduled Percocet 10/325	F 309	**Measures or systems changes to prevent reoccurrence:** (1.) All licensed staff will be in-serviced by the DON or SDC by 5-16-11 on medication administration to include administration of prn pain medications within a timely manner. In-servicing will also include the licensed staff notifying the ADON/DON if they cannot get their medications passed within the 2 hour window. (2.) (6.) A medication pass audit will be completed on 3 separate carts on the 7am and 7pm shift monthly for 3 months by ADON, DON or SDC to ensure medications are being administered within the 2 hour window as required (3.) A 10% audit of resident receiving pain medications will be completed monthly for 3 months by the ADON, DON, SDC, Social Service Director or MDS nurse to ensure they are experiencing adequate pain relief and they are receiving their prn pain medications upon request and in a timely manner.	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 16 milligrams at 8 AM and 8 PM and received the prn Percocet 10/325 milligrams two (2) to three (3) times most days. The 8 PM medication times were changed to 9 PM with no date noted for the change in times. Review of the Medication Schedule Policy, revealed medications ordered twice a day (BID) were to be administered at 8AM-4PM, 9AM-5PM, 8AM-8PM, and 9AM-9PM. Review of the Physician's Note dated 03/26/11 revealed the Nurse Practitioner made a notation which stated the resident was having right leg pain which was acute and becoming chronic and was currently on Percocet every four hours as needed and it helped. Further review revealed the resident stated the pain was an 8 out 10 on a scale of 0-10 at times and it radiated. Continued review of the Note revealed the resident stated the medication helped when it was received on time. Interview on 04/13/11 at 6:15 PM with Resident #9 revealed the "aides" answered the call bells timely; however, the nurses on the 7:00 PM to 7:00 AM shift would not follow through with bringing pain medication after the "aides" told the nurses of her/his request for pain medication. She/he further stated some nurses administered medication on time for the 7:00 PM to 7:00 AM shift, and some nurses would administer her/his scheduled 8:00 PM pain medication at 10:00 PM, 11:00 PM, or 12:00 AM. Continued interview revealed the nurses were also slow to respond with the as needed pain medication. She/he further stated she/he had reported it to the "main nurse on the floor several times"; however the problem continued. Further interview revealed	F 309	**Monitoring changes/systems to ensure no deficient practice:** (1.) Findings of the med pass audit and the 10% audit of residents who are receiving prn pain medications will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.	

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F 309	Continued From page 17 the resident had "bad" pain at night and the resident stated she/he suffered in pain due to the nurses being slow to administer pain medications. Interview on 04/14/11 at 2:40 PM with the Unit Manager on the North Hall where Resident #9 resided, revealed she had been informed by Resident #9 some time last week of her/him not receiving pain medication timely during the night. Continued interview revealed the resident complained of one (1) nurse in particular being slow at administering the pain medication, which was Registered Nurse (RN) #2. She further stated, she told the resident she would address it with the nurses. Further interview revealed she did not talk with RN #2 about the concern; however, did make a note on the Twenty-Four (24) Hour Report to ensure pain medications were given on time for all residents. She stated she did not complete a Grievance Form related to the complaint. Further interview revealed she thought the resident was started on scheduled pain medication after the complaint. Interview on 04/14/11 at 6:21 PM with the Director of Nursing (DON) revealed she was unaware of Resident #9's concern of not receiving pain medications timely and unaware of an investigation related to the complaint. Review of a Grievance Complaint Form submitted to the surveyor on 04/25/11, after the survey, revealed on 03/31/11 the resident stated she/he requested a prn pain medication and felt it took "too long" to receive. Under the Investigative Procedures section of the form, there was a notation dated 04/01/11 which stated the resident received scheduled pain medications on 04/01/11 in addition to the prn medications. The Follow Up	F 309		

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F 309	Continued From page 18 section with no date revealed the resident stated there was no further concerns related to administration of medications. The Resolution section dated 04/01/11 revealed the resident was informed of scheduled and prn pain medications and aware of the time necessary between prn doses. The Form was signed by the Administrator. Observation of medication pass from 7:30 PM until 9:15 PM on 04/13/11 revealed there were two Licensed Practical Nurses passing medications on the North Hall where Resident #9 resided. Interview on 04/13/11 at 9:15 PM with Licensed Practical Nurse (LPN) #4 who was passing medications on one wing of the North Hall revealed she was still passing the 9:00 PM medications and had not yet passed the medications to residents in rooms 11, 12, 13, 14, 15, 16, and 17. Review of the Medication Administration Record (MAR) revealed there were nine (9) residents who had not received their scheduled 8:00 PM medications including unsampled residents A, B, C, D, E, F, G, H, and I. Further interview revealed the protocol was to administer the medication within one hour before and one hour after the scheduled administration time which would be from 7:00 PM until 9:00 PM for the scheduled 8:00 PM medications. She further stated she would be out of compliance with administering the 8:00 PM medications after 9:00 PM. Further interview revealed she was usually passing medications on the North Hall until 10:00 PM for the 8:00 PM and 9:00 PM scheduled medications. Phone interview on 04/14/11 at 4:00 PM with	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 309	Continued From page 19 Registered Nurse #1 revealed she worked the evening shift on the North Hall and it was constantly busy on the unit from 7:00 PM until 11:00 PM. She stated, at times medications which were scheduled for 8:00 PM were administered as late as 10:00 PM. Further interview revealed the wing where Resident #9 resided was particularly heavy with medications and at times the residents would have to wait for prn medications; however, she was usually able to administer the prn medications within thirty (30) minutes of the resident's request. She further stated she was not sure if anyone had informed the DON the medications were being administered late. Interview on 04/14/11 at 6:21 PM with the Director of Nursing (DON) revealed medication could be administered one hour before or one hour after the scheduled time. She stated the nurses should have informed her they were out of compliance with medication administration on the evening shift for the North Hall. Continued interview, revealed several medications which were scheduled for 8:00 PM were changed to 9:00 PM on the MAR due to the observation of medication pass by the surveyor on 04/13/11. Review of the facility Pain Management Policy, revealed "pain is a stressor, unrelieved it can cause both physical and psychological strain. Without proper management it can actually lead to pathological changes such as complications with immobility".	F 309		