

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

PRINTED: 01/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/15/2013
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241	
(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)

F 000 INITIAL COMMENTS

F 000

An abbreviated survey was initiated on 01/14/13 and concluded on 01/15/13 to investigate KY19626. The Division of Health Care unsubstantiated the allegation; however, a related deficiency was cited.

This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

F 309

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.

F309

1/25/13

The Facility maintains that it provides the necessary care and services to attain and 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 interview, record review and facility policy review, it was determined the facility failed to follow MD orders for one (1) of four (4) sampled residents, Resident #4. The facility failed to follow MD orders to administer Lipitor 10 mg daily to Resident #4.

How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:

The findings include:

The physician reviewed Resident #4s medications and discharged the Lipitor order as it was not necessary.

Review of the facility's policy, regarding MD Order Verification, revealed when a nurse receives a written order from an MD, a nurse will transcribe the order according to accepted, standard nursing practice. Orders will be reviewed by the ADON/Unit Manager/RN Supervisor for accuracy.

The Director of Nursing reviewed Resident #4s medical record to assure that there were no other issues with medications and orders that needed clarification. No other medication issues were identified.

Review of the clinical record for Resident #4,

How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice:

The Director of Nursing reviewed all of the

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

TITLE

(X6) DATE

X Richard Brown

X Administrator

X 2/5/13

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.

FEB 05 2013

If continuation sheet Page 1 of 3
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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			(X5) COMPLETION DATE

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revealed the facility admitted the resident on 10/23/12 with diagnoses of Atrial Fibrillation, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. The Discharge Summary, dictated and transcribed 10/23/12, revealed the discharge medications included Lipitor 10 mg daily. The Discharge Medication Reconciliation form revealed the discharge medications included Lipitor 10 mg daily. Resident #4's Medication Administration Record (MAR) indicated the resident had not received Lipitor since admission, eighty four days ago. There were no cholesterol levels listed in the clinical record.

Interview with LPN #1, on 01/15/13 at 3:35 PM, revealed she had processed new resident admissions in the past. She stated the discharge summary and hospital medication reconciliation form were used to initiate medication orders for new resident admissions. She revealed those orders were then reviewed with the Nurse Practitioner to confirm those orders. She was not sure if there was a check system to ensure orders were transcribed correctly. She stated she thought the nurse on the next shift would also check the new orders. LPN #1 stated it was possible, but not probable, that a medication would be missed when taking off those orders. She further stated consequences for a resident, who missed medication, would depend on the medication that was missed.

Interview with Unit Manager (UM), on 01/15/13 at 4:07 PM, revealed medication orders for new residents were obtained from the discharge summary or medication reconciliation form. Those orders were reviewed with the Nurse

F 309

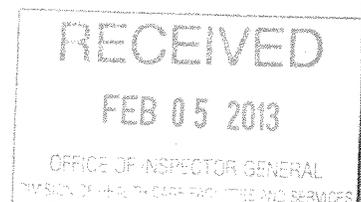
new admissions for the Facility for the past three months to determine if there were any other issues with medications and transcription of orders. No further issues were identified.

What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur:

The Director of Nursing or weekend supervisor have been added to monitor beyond the Unit Manager and Admitting Nurse to serve as a triple check system from what was a double check system to assure this alleged deficient practice does not recur.

The DON or weekend supervisor will review and validate transcribed medicines on new admissions within 24 hours beginning 1/23/2013.

The Staff Development Nurse educated the staff nurses as to this systemic change with the Director of Nursing or weekend supervisor being added to the process of checking transcribed medicine orders on 1/21/2013. The content of the education also included having the staff nurses verbally demonstrate their understanding of appropriate medicine transcription procedure with questions and answers at the end of the education.



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Practitioner (NP) and once confirmed were then sent to the pharmacy and entered into the computer. She stated usually the floor nurse was the one who completed the admission process, including verifying medication orders, and the UM did double check for discrepancies. If a discrepancy were found, it would be clarified with the NP. The UM reviewed the clinical record for Resident #4 and confirmed Lipitor 10 mg daily was ordered at time of discharge and was on both the discharge summary and medication reconciliation form. She stated she did not understand how the Lipitor order could have been missed by two staff members. The UM stated the medication Lipitor was for Hyperlipidemia (high cholesterol) and it could cause cholesterol levels to rise if the medication was not taken.

Interview with the Director of Nursing (DON), on 01/15/13 at 5:30 PM, revealed there was an order for Lipitor 10 mg daily on the discharge summary and medication reconciliation form from a local hospital for Resident #4. She stated there was no documentation concerning the medication reconciliation for Resident #4. She stated she thought the discharge orders from the hospital were in error but there was no documentation that any clarification of the orders had been done. The DON stated there had been no laboratory testing of cholesterol levels since Resident #4's admission, so the outcome of the missed medication was unknown. She stated it was unlikely that in the last three months Resident #4's cholesterol level had changed significantly; however, if the error had not been caught the cholesterol level could have increased.

F 309
How the Facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Nursing will add this to the Quality Assurance program to monitor medication transcription and administration for the next two quarters and then adjust as necessary depending upon the achievement of thresholds.

Responsible Party(ies): Administrator, Director of Nursing.

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