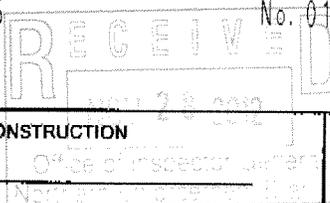


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 11/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated survey investigating KY 19244 was initiated on 10/22/12 and concluded on 10/24/12. The Division of Health Care substantiated the allegation. Regulatory violations were identified. After supervisory quality review, the investigation was re-opened on 11/07/12. An abbreviated survey was conducted from 11/07 - 11/08/12 and found the complaint substantiated and regulatory violations identified with deficiencies cited.</p>	F 000	<p>The submission of this plan of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Glen Ridge. The facility recognized it's obligation to provide legally and medically necessary care and services to it's residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements for participation in Title 18/19 programs. To this end, this plan of correction shall serve as the credible allegation of</p>	
F 272 SS=D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                  Identification and demographic information;                  Customary routine;                  Cognitive patterns;                  Communication;                  Vision;                  Mood and behavior patterns;                  Psychosocial well-being;                  Physical functioning and structural problems;                  Continence;                  Disease diagnosis and health conditions;                  Dental and nutritional status;                  Skin conditions;                  Activity pursuit;                  Medications;</p>	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rachel C. Bufford</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11-28-12</i>
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A 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 272 Continued From page 1  
Special treatments and procedures;  
Discharge potential;  
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and  
Documentation of participation in assessment.

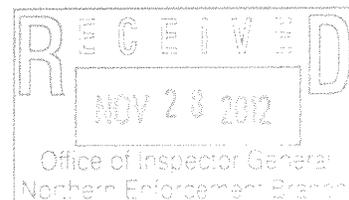
This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and facility policy review, it was determined the facility failed to conduct an accurate initial assessment for one (1) of three (3) sampled and two (2) unsampled residents. Resident #1's surgical incision was not assessed at time of admission.

The findings include:  
Review of the facility's policy regarding Admission Nursing Assessment and Data Collection revealed the purpose of the admission assessment was to assess and document the resident's current medical status and identify risk factors for additional complications or safety concerns. The comprehensive head to toe assessment addresses each body system and should be completed within seventy two hours of admission.  
Review of the facility's policy, regarding Other Assessment Guidelines, revealed the form should

F 272 compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.

1. Resident #1 was a direct admit to the hospital from MD office on 10/10/12 related to Deep Vein Thrombosis which was identified by facility on 10/9/12. Treatment was initiated at that time. Lumbar surgical incision was identified on 9/30/12 and orders recieved for dry dressing to site and change daily. Facility was to also monitor for signs and symptoms of infection. Orders were also given to contact surgeon for further

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F 272 Continued From page 2  
be initiated when an area of impairment, (e.g.; skin tear, rash, excoriation, abrasion, burn cut, open lesion, bruise and/or surgical wound) is identified.

Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 09/26/12 at 2:30 PM, with diagnoses of after care for a Lumbar Laminectomy (an open spinal decompression to alleviate pain caused by nerve impingement) and Spinal Stenosis. The initial assessment contained no mention of a dressing or incision on the resident's back. Skin Impairment sheets dated 09/26/12, the day of admission, did not indicate an incision on the back or the presence of a dressing.

Interview with LPN #1, on 10/24/12 at 4:30 PM, revealed she vaguely remembered Resident #1. She stated the day of admission was the only day she saw the resident. She stated she accompanied the resident to her room at time of admission and she and another nurse completed the assessment together. LPN #1 stated she completed the paperwork and the other nurse did the physical assessment and completed the Skin Impairment Sheets. She stated she was aware the resident was being admitted for post operative care but she did not look at the wound or check to see if there were any dressings. She stated she assumed the other nurse looked at the incision and completed the Skin Impairment Sheets. She stated she did not remember indicating on the assessment that there was a not a dressing and she stated she also did not remember whether or not she thought it odd that a post operative resident would come to the facility with no dressing.

F 272 did not return to facility.

2. All resident records admitted during November have been reviewed by DHS, ADHS, MDS and Unit Manager to insure that admission assessments were accurate to reflect any surgical incisions and/or any other skin issues. Any inaccuracies were corrected and MD orders, care plans and CNA assignment sheets revised to reflect current condition of residents.

3. Executive Director and Nurse Managers were reeducated by Clinical Support Nurses on 11/6/12 related to completion of comprehensive admission assessments. Nurses were reeducated by DHS related admission nursing assessments with emphasis on skin assessment and documentation on 10/28, 11/1, 11/2, 11/9, & 11/14/12. The



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F 272 Continued From page 3

Interview with RN #3, on 11/08/12 at 1:21 PM, revealed she remembered Resident #1 and took care of her on several occasions. She stated she assisted in the admission process for Resident #1, however she did not perform the physical assessment. RN #3 stated that on 09/26/12, LPN #1 was doing the admission assessment for Resident #1 and RN #3 went to the room to take notes for LPN #1 as she performed the assessment. RN #3 stated she never examined Resident #1 on the day of admission. She stated she was unaware of Resident #1's admitting diagnosis as she was just assisting LPN #1. She stated Resident #1's back incision should have been noted on the Admission Assessment and a Skin Impairment Sheet should have been initiated during the initial assessment.

F 272 The importance of consistency in documentation was also discussed with examples presented to the nurses. Nurses involved with assessment for this resident were counseled by DHS.

Interview with the Director of Health Services (DHS), on 10/24/12 at 2:30 PM, revealed the expectation was that all documentation should be accurate and there should not be areas of documentation that conflict with each other. She stated in-services had been conducted on documentation and she had offered organizational hints for staff. She stated she did not have an answer for the breakdown in the system for this resident.

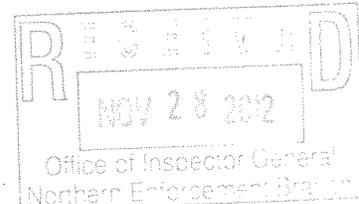
4. Ongoing compliance will be achieved by 100% audits by Nurse Managers daily in clinical meeting of new admission records to insure assessments are accurate and complete. Nurses not complying with policies will be disciplined as necessary. These audits will be ongoing and discussed at Quality Assurance meetings for 6 months. Any ongoing noncompliance will require development of action plan and further education/counseling to address.

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.

F 281 Assurance meetings for 6 months. Any ongoing noncompliance will require development of action plan and further education/counseling to address.

This REQUIREMENT is not met as evidenced



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F 281 Continued From page 4  
by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop an initial plan of care to adequately meet the needs of one (1) of three (3) sampled and two (2) unsampled residents. The facility failed to address with goals and interventions on the initial plan of care the surgical wound of Resident #1 which consequently became infected and the resident had to be hospitalized.

The findings include:

Review of the facility's policy regarding Admission Nursing Assessment and Data Collection revealed the purpose of the admission assessment was to assess and document the resident's current medical status and identify risk factors for additional complications or safety concerns and implement a temporary plan of care to address problem areas.

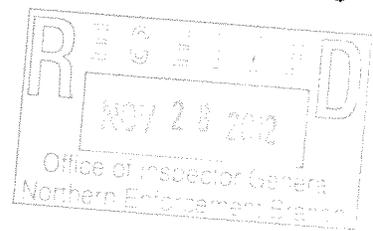
Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 09/26/12 at 2:30 PM, with diagnoses of after care for a Lumbar Laminectomy (an open spinal decompression to alleviate pain caused by nerve impingement) and Spinal Stenosis. The initial care plan, dated 09/26/12, did not contain any reference to a dressing or incision on the resident's back. There are no goals or interventions related to Resident #1's incision listed on the plan of care.

Review of the information provided to the Office of Inspector General (OIG) on 10/18/12 by the resident's family member revealed Resident #1's

F 281

1. Resident #1 was admitted to hospital from MD office on 10/10/12 related to Deep Vein Thrombosis which was identified by facility on 10/9/12. Resident did not return. Care Plan was updated to reflect surgical incision
2. All residents admitted to facility during November have been reviewed by Nurse Managers to insure initial plans of care have been implemented to reflect resident needs. Any inaccuracies were corrected and MD orders, care plans and CNA assignment sheets revised to reflect resident needs.
3. Nurses were reeducated

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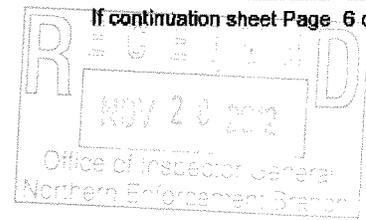
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F 281 Continued From page 5  
family member observed bloody drainage on the resident's pajamas on 10/02/12. The family member stated she showed those bloody pajamas to a nurse and also reported to the nurse the resident had reported her linens were bloody earlier from her incision leaking. The family member reported that Resident #1's incision continued to leak from 10/02/12-10/09/12. On 10/09/12 Resident #1 called the family member and reported the incision was infected.

Continued review of the closed clinical record for Resident #1 revealed the Admission Nursing Assessment, dated 09/26/12, did not indicate a dressing or incision site to the back. Review of the treatment record revealed dressing changes to the back were completed every day. Further review of the treatment record revealed no assessment of the incision site. On 09/30/12 a physician's order was written to call the surgeon the next day to clarify the dressing change order. There was no further follow-up documented. The Skilled Assessments dated 10/04, 10/05, 10/06 and 10/07 did not indicate a surgical wound was present and it was marked no or left blank if a dressing was present. On 10/08, 10/09 and 10/10 the assessments identified a surgical wound with a dressing; however, no remarks were documented regarding the bloody drainage reported by the family. The next physician order related to the incision and wound care was written on 10/09/12 at which time the order was written to clean the incision with peroxide and start the resident on intravenous (IV) Kefzol, an antibiotic which was given intravenously through a PICC line (Peripheral Inserted Central Catheter).  
Review of the Other Skin Impairment

F 281  
by DHS  
on  
10/28, 11/1, 11/2, 11/9, and 11/14 related to admission assessments with emphasis on the importance of care plan development. Nurses that were noncompliant on this assessment were counseled. Resident #1 care plan was updated on 9/30 to reflect incision on back and treatment.

4. Ongoing compliance will be achieved by 100% audits by Nurse Managers in clinical meeting daily of new admission records. This will insure that initial care plans reflect resident condition. Nurses not complying will be educated and or counseled as needed. New nurses hired will be given additional days of orientation on required



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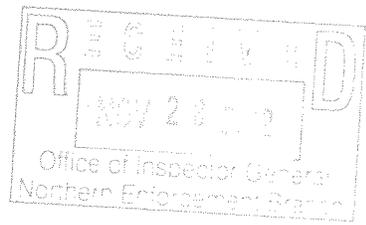
F 281 Continued From page 6

Assessments completed on 10/10/12 revealed the surgical site had thick yellow drainage, in addition, a new open area was identified. No measurements were documented; however, it was noted to have thick yellow drainage also. Resident #1 was seen in the surgeon's office on 10/10/12 and admitted to the hospital for a deep vein thrombosis (blood clot in the leg) and wound infection.

Interview with LPN #1, on 10/24/12 at 4:30 PM, revealed she vaguely remembered Resident #1. She stated the day of admission was the only day she saw the resident. She stated she accompanied the resident to her room at time of admission and she and another nurse completed the assessment together. LPN #1 stated she completed the paperwork and the other nurse did the physical assessment. She stated she was aware the resident was being admitted for post operative care but she did not look at the wound or check to see if there were any dressings, and did not address these in the initial care plan.

Interview with the Director of Health Services (DHS), on 10/24/12 at 2:30 PM, revealed the initial plan of care was based on the admission assessment. The form had two columns, the first column was for the assessment and the second column was for the plan of care which was based on the assessment. She stated the plan of care was only as good as the person doing the assessment, because if the information was not listed in the assessment it will not transfer over to the plan of care. The DHS stated the admission forms were reviewed by management the next day, but again stated the information was only as good as the person completing the

F 281 admission paperwork. Quality Assurance committee will review audits for 6 months and ongoing noncompliance will require development of action plans and further education/counseling to address.

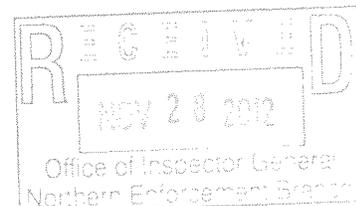


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F 281  F 282 SS=D	<p>Continued From page 7                      assessment/plan of care. She stated Resident #1's initial assessment and plan of care should have included information on the incision and dressing, that was the expectation. She stated in-services had been conducted on documentation and she had offered organizational hints for staff. She stated the system broke down for this resident.</p> <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:                      Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to follow the plan of care for one (1) of three (3) sampled and two (2) unsampled residents. The facility failed to administer pain medication when requested by Resident #1.</p> <p>The findings include:                      Review of the facility's policy on Emergency Pharmacy Service and Emergency Kits revealed an emergency supply of medication was supplied to the facility. When an emergency dose of a controlled medication was needed the nurse would confer with the prescriber to determine whether the order was a true emergency and</p>	F 281  F 282	<p>1. Resident #1 no longer resides in facility. She was discharged on 10/10/12.</p> <p>2. All resident records admitted during November have been reviewed by DHS, ADHS, MDS and Unit Manager to insure that MARS/TARS and CNA assignment sheets reflect plan of care and that it is being followed. Records were also reviewed to insure that pain medication was ordered and administered as needed.</p> <p>3. Nurses were reeducated by DHS</p>	12-14-12



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F 282 Continued From page 8  
then the prescriber would fax a complete prescription to the facility and pharmacy or communicate the verbal order to both the nurse and directly to the pharmacist.

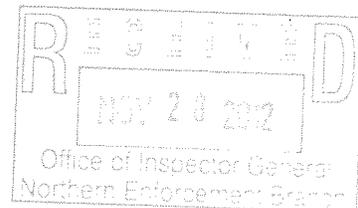
Review of the Perpetual Inventory For Scheduled Medications in the Emergency Kit revealed MS Contin 15 mg and Norco 10/325 mg were not stocked in the emergency kit. The emergency kit did contain Hydrocodone and APAP 5/500 mg (which is the generic medication for Norco but at a lower dose).

Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 09/26/12 at 2:30 PM, with diagnoses of after care for a Lumbar Laminectomy (an open spinal decompression to alleviate pain caused by nerve impingement) and Spinal Stenosis. Admission orders included MS Contin 15 mg every twelve hours and an order for Norco 10/325 mg every four hours as needed for pain. The resident was assessed with a score of 14 on the admission Brief Interview of Mental Status (BIMS) on the Resident Assessment Instrument (MDS) completed on 10/03/12, which indicated the resident was cognitively intact. Review of the medication administration record (MAR) revealed the first dose of MS Contin was given at 8:00 PM on 09/26/12 (even though the medication was not delivered until 11:55 PM).

Review of the Initial Care Plan for Resident #1, completed on 09/26/12, revealed the facility had initiated a care plan to include the intervention to administer pain medication per physician's order.

F 282 on 10/28, 11/1, 11/2, 11/9, and 11/14 related Following care plans, Medication Administration/ documentation, Emergency Drug kits and pain assessment/interventions and documentation. The nurses involved in not following care plan were counseled.

4. ongoing compliance will be maintained by Nurse Managers completing 100% audits of admission records during morning CQI. These audits will include review of MARS and TARS to insure medication administered as ordered. Medication carts will be checked to insure medications were delivered from pharmacy. The



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/08/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>
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F 282

Continued From page 9

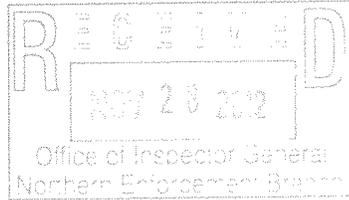
Interview with Resident #1, on 11/08/12 at 9:30 AM, revealed at the time of admission to the facility her pain was under control. At 11:00 PM on 09/26/12 Resident #1 requested pain medication due to having pain in his/her back. Resident #1 stated someone on the nursing staff reported the medication had not yet arrived. The facility did not offer the resident any other alternative. Resident #1 stated the medicine was finally given to her at 12:20 AM on 09/27/12. The medication relieved the pain and he/she went to sleep. Resident #1 reported the pain was controlled for the rest of his/her stay at the facility.

Interview with the Pharmacist, on 10/23/12 at 3:50 PM, revealed the pharmacy received the faxed orders, which included the orders for MS Contin and Norco, for Resident #1 at 5:55 PM. The cut off delivery time was at 5:00 PM for routine delivery. The pharmacy delivered the medications ordered for Resident #1 at 11:55 PM. The pharmacist stated the facility had an Emergency Drug Kit (EDK) for use when a resident was in need of a medication right away. She stated the EDK did not contain MS Contin or Norco 10/325 mg; however, it did contain Hydrocodone and APAP 5/500 mg. She stated if a resident was in pain the facility could have called the physician to obtain an order to administer the Hydrocodone and APAP 5/500 mg until the Norco 10/325 mg and MS Contin could be delivered.

Interview with RN #2, 10/23/12 at 4:15 PM, stated if an ordered pain medication was not available due to the resident being a new admission, she would call the physician for an order to give a

F 282

Ambassador Program has been revised to include daily contact with new admissions to insure that all needs are being met. Any issues will be communicated to ED or DHS for follow up. Quality Assurance Committee will review admissions during regular meetings for 6 months.



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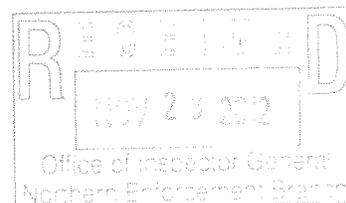
F 282 Continued From page 10  
 pain medication that was available in the EDK until the pharmacy delivered the original medication. RN #2 stated the goal was to always keep the resident comfortable.

Interview with LPN #1, on 10/24/12 at 4:42 PM, revealed she was the one that completed the admission assessment for Resident #1 on 09/26/12. She revealed at the time of admission the resident did not request any medication for pain. She stated she knew there was an EDK for emergent medication needs.

Interview with LPN #3, on 11/07/12 at 6:13 PM, revealed she was assigned to care for Resident #1 beginning at 10:30 PM on 09/26/12. LPN #3 stated she could not remember Resident #1 requesting pain medication but she knew she would have called the physician and gotten a one time order for a pain medication that would have been in the EDK. She stated she would not let the resident be in pain. LPN #3 stated she gave the resident an ordered MS Contin 15 mg at 12:20 AM on 09/27/12 after it arrived from the pharmacy.

Interview with the Director of Health Services (DHS), on 10/24/12 at 2:30 PM, revealed as soon as a resident arrived at the facility, the admitting nurse should have verified the orders with the physician and faxed those orders to the pharmacy and that should generally occur within the first hour of arrival to the facility. She stated that if the nurses were busy there was always help available to ensure a resident received what was needed. She stated if a resident expressed having pain the expectation would be for the admitting nurse to contact the physician and

F 282



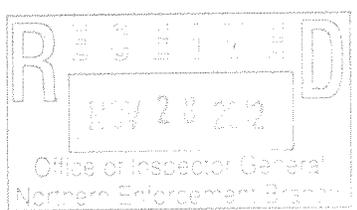
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F 282  F 309 SS=D	<p>Continued From page 11</p> <p>obtain an order for medication contained in the EDK in order to address the pain immediately, while waiting for the other medication to arrive from the pharmacy. The DON stated the pain medication could not have been administered at 8:00 PM as it was not delivered until 11:55 PM.</p> <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: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to follow physician orders related to pain medication for one (1) of three (3) sampled and two (2) unsampled residents. The facility failed to administer pain medication to Resident #1 for one hour and twenty minutes after the pain was reported to staff.</p> <p>The findings include:</p> <p>Review of the facility's policy on Emergency Pharmacy Service and Emergency Kits revealed an emergency supply of medication was supplied to the facility. Emergency needs for medication were met by using the facility's approved</p>	F 282  F 309	<p>1. Resident #1 no longer resides in facility. She was discharged on 10/10/12.</p> <p>2. All resident records admitted during November have been reviewed by DHS, ADHS, MDS and Unit Manager. All MARS and MD orders will be reviewed to ensure pain medication is ordered and administered as needed/ordered and that it is being followed.</p> <p>3. Nurses were reeducated by DHS</p>	12-14-12



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F 309 Continued From page 12  
emergency medication supply or by special order from the provider pharmacy. When an emergency dose of a controlled medication was needed the nurse would confer with the prescriber to determine whether the order was a true emergency and then the prescriber would fax a complete prescription to the facility and pharmacy or communicate the verbal order to both the nurse and directly to the pharmacist.

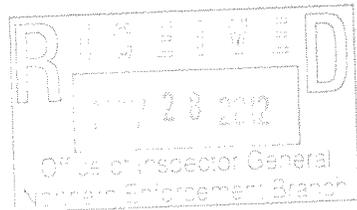
Review of the facility's policy, Guidelines for Pain Assessment and Management, revealed each resident's pain including its origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be assessed/reassessed and documented according to the needs of each individual. Care Plan would be initiated and implemented related to pain and approaches to assist with pain management.

Review of the closed clinical record for Resident #1 revealed the facility admitted the resident, on 09/26/12 at 2:30 PM, with diagnoses of after care for a Lumbar Laminectomy (an open spinal decompression to alleviate pain caused by nerve impingement) and Spinal Stenosis. Admission orders included MS Contin 15 mg every twelve hours and an order for Norco 10/325 mg every four hours as needed for pain. Review of the Initial Nursing Assessment, completed on 09/26/12 (no time indicated on form), revealed the facility assessed the resident as alert and oriented to person, place and time, with the resident stating his/her pain was at a level 6/10. Review of the medication administration record (MAR) revealed the first dose of MS Contin was given at 8:00 PM on 09/26/12 (even though the

F 309 on 10/28, 11/1, 11/2, 11/9, and 11/14 related Following care plans, Medication Administration/ documentation, Emergency Drug kits and pain assessment/interventions and documentation. The nurses involved in not following care plan were counseled.

4. ongoing compliance will be maintained by Nurse Managers completing 100% audits of admission records during morning CQI.

These audits will include review of MARS and TARS to insure medication administered as ordered. Medication carts will be checked to insure medications were delivered from pharmacy. The Ambassador Program has



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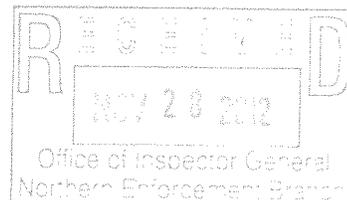
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**F 309** Continued From page 13  
medication was not delivered until 11:55 PM). The resident was assessed with a score of 14 on the admission Brief Interview of Mental Status (BIMS) on the Resident Assessment Instrument (MDS) completed on 10/03/12, which indicated the resident was cognitively intact. Review of the nursing notes revealed one entry on the day of admission 09/26/12, and no more entries until 09/30/12.

Interview with Resident #1, on 11/08/12 at 9:30 AM, revealed at the time of admission to the facility her pain was under control. At 11:00 PM on 09/26/12 Resident #1 requested pain medication due to having pain in his/her back. Resident #1 stated someone on the nursing staff reported the medication had not yet arrived. The facility did not offer the resident any other alternative. Resident #1 stated the medicine was finally given to her at 12:20 AM on 09/27/12. The medication relieved the pain and he/she went to sleep. Resident #1 reported the pain was controlled for the rest of his/her stay at the facility.

Interview with the Pharmacist, on 10/23/12 at 3:50 PM, revealed the pharmacy received the faxed orders, which included the orders for MS Contin and Norco, for Resident #1 at 5:55 PM. The cut off delivery time was at 5:00 PM for routine delivery. The pharmacy delivered the medications ordered for Resident #1 at 11:55 PM. The pharmacist stated the facility had an Emergency Drug Kit (EDK) for use when a resident was in need of a medication right away; however, the EDK did not contain MS Contin or Norco 10/325 mg. The EDK did contain Hydrocodone and APAP 5/500 mg. She stated if a

**F 309** been revised to include daily contact with new admissions to insure that all needs are being met. Any issues will be communicated to ED or DHS for follow up. Quality Assurance Committee will review admissions during regular meetings for next 6 months.



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F 309 Continued From page 14  
resident was In pain the facility could have called the physician for an order to administer the Hydrocodone and APAP 5/500 mg until the Norco 10/325 mg and MS Contin could be delivered.

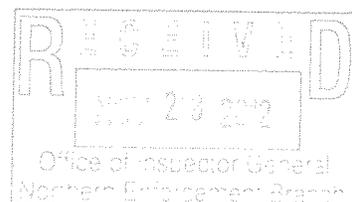
Interview with RN #2, 10/23/12 at 4:15 PM, revealed if a pain medication was not available due to the resident being a new admission she would call the physician for an order to give a pain medication that was available in the EDK. RN #2 stated the goal was to always keep the resident comfortable.

Interview with LPN #1, on 10/24/12 at 4:42 PM, revealed she completed the admission assessment for Resident #1 on 09/26/12. She completed the verbal part of the assessment and another nurse did the physical assessment. She stated she knew there was an EDK for emergent medication needs but the EDK was not accessed the night Resident #1 was admitted.

Interview with LPN #3, on 11/07/12 at 6:13 PM, revealed she was assigned to care for Resident #1 beginning at 10:30 PM on 09/26/12. LPN #3 stated she could not remember Resident #1 requesting pain medication but she knew she would have called the physician and gotten a one time order for a pain medication that would have been in the EDK. She stated she would not let the resident be in pain. LPN #3 stated she gave the resident an ordered MS Contin 15 mg at 12:20 AM on 09/27/12 after it arrived from the pharmacy.

Interview with the Director of Health Services (DHS), on 10/24/12 at 2:30 PM, stated as soon as a resident arrived at the facility, the admitting

F 309



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F 309 Continued From page 15  
nurse should verify the orders with the physician and fax those orders to the pharmacy. That should generally occur within the first hour of arrival to the facility. She stated if the nurses were busy there was always help available to ensure a resident received what was needed. She expected the admitting nurse to contact the physician and obtain an order for a medication contained in the EDK in order to address the pain immediately while waiting for the other medication to arrive from the pharmacy. She stated she knows the system failed for Resident #1, the resident should have received pain medication in a timely manner, not one hour and twenty minutes later.

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, it was determined the facility failed to maintain an accurately documented clinical record for one (1)

F 309

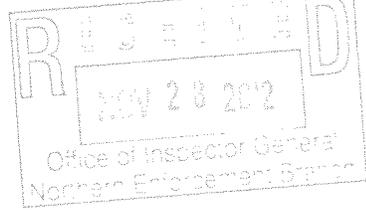
F 514

1. Resident #1 no longer resides in facility. She was discharged on 10/10/12.

2. All resident records admitted during November have been reviewed by DHS, ADHS, MDS and Unit Manager. All MARS and MD orders will be reviewed to ensure pain medication is ordered and administered as needed/ordered and that admission assessments are accurate to reflect any surgical incisions and/or any other skin issues. any inaccuracies were corrected and MD orders, care plans and CNA assignment sheets revised to reflect current condition of residents.

3. Nurses were reeducated by DHS

12-14-12



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F 514 Continued From page 16 of three (3) sampled and two (2) unsampled residents. The facility failed to document an incision site and dressing for Resident #1 and failed to accurately document the time of administration of a pain medication for Resident #1.

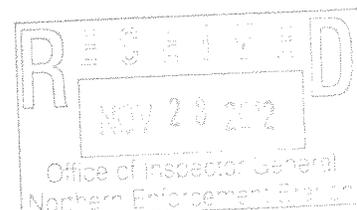
The findings include:

The facility did not provide a policy on accuracy of documentation; however, review of the facility's policy regarding Admission Nursing Assessment and Data Collection revealed the purpose of the admission assessment was to assess and document the resident's current medical status and identify risk factors for additional complications or safety concerns. The comprehensive head to toe assessment addresses each body system and should be completed within seventy two hours of admission.

Review of the facility's policy, regarding Other Assessment Guidelines, revealed the form should be initiated when an area of impairment, (e.g.; skin tear, rash, excoriation, abrasion, burn cut, open lesion, bruise and/or surgical wound) is identified.

Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 09/26/12 at 2:30 PM, with diagnoses of after care for a Lumbar Laminectomy (an open spinal decompression to alleviate pain caused by nerve impingement) and Spinal Stenosis. The initial assessment contained no indication of a dressing or incision on the resident's back and it did not indicate the time the assessment form was completed. Skin Impairment sheets dated

F 514 on 10/28, 11/1, 11/2; 11/9, and 11/14 related Following care plans, Medication Administration/ documentation, Emergency Drug kits and pain assessment/interventions and and documentation with an emphasis on accurate documentation of medications and skin impairments including incisions. The nurses involved in not following care plan were counseled.



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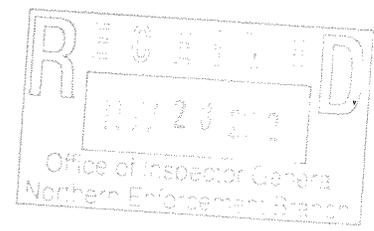
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F 514 Continued From page 17  
09/26/12, the day of admission, did not indicate a back incision or dressing. Nurse's note, dated 9/26/12 at 2:30 PM, revealed the physician was called, orders reviewed and faxed to pharmacy. However, there was no request to administer a pain medication from the EDK until the prescribed pain medications were received. In addition, there was no documentation related to the surgical wound on the back or the dressing. Review of the medication administration record (MAR) revealed the first dose of MS Contin was administered at 8:00 PM on 09/26/12 (even though the medication was not delivered until 11:55 PM). The documentation on the nursing assessment 10/01 and 10/02/12 indicated there was no dressing and did not describe the incision site. The first Skin Impairment Sheet was completed on 10/03/12 and it indicated a dressing was to be applied every day until there was no drainage. Nursing assessments dated 10/04, 10/05, 10/06 and 10/07 did not indicate there was a surgical wound and either had no dressing marked or left it blank even though the Treatment Record indicated the dressing was changed everyday from 10/01-10/09/12.

Interview with RN #3, on 11/08/12 at 1:21 PM, revealed she stated Resident #1's back incision should have been noted on the Admission Assessment and a Skin Impairment Sheet should have been initiated during the initial assessment. She stated her documentation was inaccurate and did not paint a picture of what was going on with the resident.

Interview with LPN #3, on 11/07/12 at 6:13 PM, revealed she was assigned to care for Resident #1 beginning at 10:30 PM on 09/26/12. LPN #3

F 514 4. ongoing compliance will be maintained by Nurse Managers completing 100% audits of admission records during morning CQI. These audits will include review of MARS and TARS to insure medication administered as ordered. Medication carts will be checked to insure medications were delivered from pharmacy. The Ambassador Program has



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stated she gave the resident MS Contin at 12:20 PM on 09/27/12 but charted that she gave the medication at 8:00 PM on 09/26/12. She stated she should have documented the accurate time of when she administered the MS Contin.

Interview with the Director of Health Services (DHS), on 10/24/12 at 2:30 PM, revealed the expectation was that all documentation should be accurate and there should not be areas of documentation that conflict with each other. The DON stated the pain medication could not have been administered at 8:00 PM as it was not delivered until 11:55 PM. She stated in-services had been conducted on documentation and she had offered organizational hints for staff. She stated she did not have an answer for the breakdown in the system for this resident. Continued interview with the Director of Health Services (DHS), on 11/08/12 at 2:50 PM, revealed the medical records were audited to ensure forms are completed and in the medical record, but not on the content of the form to check for accuracy or conflicting information.

F 514 been revised to include daily contact with new admissions to insure that all needs are being met. Any issues will be communicated to ED or DHS for follow up. Quality Assurance Committee will review admissions during regular meetings for the next 6 months.

