

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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/27/2012
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NAME OF PROVIDER OR SUPPLIER REGIS WOODS CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An abbreviated survey was initiated on 09/25/12 and concluded on 09/27/12 to investigate KY 19094. The Division of Health Care substantiated the allegation as verified by the evidence with deficiencies cited.

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility failed to provide a safe environment free from accident hazards for one (1) of six (6) sampled residents. One facility staff member stored personal belongings (a purse) which included multiple medications, in the unlocked closet of Resident #1.

The findings include:

Review of the facility's policies revealed there was no policy for storage of staff personal items.

Record review for Resident #1 revealed diagnoses of Alzheimer's Disease, Dementia with Behaviors, Essential Hypertension, and Anxiety.

F 000

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regis Woods Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 323

F Tag 323:

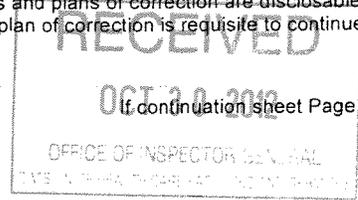
1. Employee purse was removed from the room of Resident #1 with no items missing from the purse by the employee on 9-7-12. The employee was re-educated to the risk of storing personal belongings in resident rooms and instructed that lockers were available to secure personal belongings by Administrator on 9-14-12. Disciplinary action was also completed on the employee on 9-16-12 by the Administrator.

2. Facility rounds were completed by Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social workers, Maintenance Director, Activity supervisor, Housekeeping supervisor and Medical records Director of each resident room to determine that no other staff personal belongings were stored in the residents rooms on 9-14-12. No other concerns were identified.

3. The Administrator, Director of Nursing, Assistant Director of Nursing, Staffing Development Coordinator and Unit Managers completed re-education with nursing, housekeeping, dietary, therapy, and maintenance staff on storing personal belongs and the availability/location of staff lockers on 10-26-12. New staff will be made aware of the availability of lockers for storage of personal belongings during the Orientation process by the Staff Development Coordinator or Administrator. Locks with keys are available and provided to each employee that desires to have an lock.

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John S. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10-26-12</i>
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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 323 Continued From page 1

The facility determined Resident #1 was unable to complete or cooperate with the Brief Interview for Mental Status (BIMS) score and required maximum assist to transfer.

Observation, on 09/25/12 at 12:40 PM, revealed there were residents on the NF1 Unit who were capable of ambulation with assistive devices, and some residents were capable of self-propelling in a wheelchair through the facility.

Interview, on 09/27/12 at 8:55 AM, with the NF1 Unit Manger (UM) revealed she was told by the family of Resident #1 that a staff member's purse was found stored in the resident's closet. The UM was not sure of any action taken by the facility to ensure resident safety from unsecured personal items brought into the facility by staff members.

Interview, on 09/27/12 at 11:54 AM, with the Assistant Director of Nursing (ADON) revealed she was told the family of Resident #1 found a staff member's purse that contained medications stored in the resident's closet. The ADON said the facility did not have a policy which detailed how staff were to store and secure personal belongings in the facility. Staff were supposed to use lockers provided by the facility to secure personal belongings. The ADON stated that the staff member was known to have sever hypertension and said the staff member preferred to keep their medications close at hand and said the staff member must have considered the resident's closet to be a safe place to store the purse since Resident #1 did not ambulate independently. The ADON said it was not safe to store the purse in Resident #1's closet because

F 323

4. The Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social workers, Maintenance Director, Activity supervisor, Housekeeping supervisor and Medical records Director will complete facility rounds and document findings, which will include looking in resident rooms to determine that employee belongings are being stored properly and staff awareness of availability and locations of lockers weekly for 3 weeks, monthly x2, and then quarterly x3. Any issues identified will be corrected upon identification. The results of these facility rounds will be submitted to the Administrator for review when completed. The Administrator will submit a summary of these findings to the Performance Improvement Committee monthly for 3 months then quarterly x3 for further review and recommendation.

5. Compliance date 10-27-12



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F 323 Continued From page 2
other residents had access to the medications that were not secured, and said the medications posed a potential risk for harm to other residents.

F 323

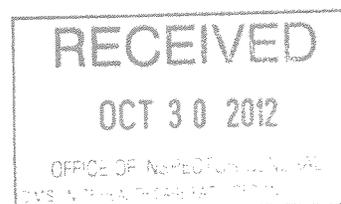
Interview, on 09/27/12 at 1:00 PM, with RN #5 who was employed for three (3) months revealed she was not aware of the lockers available for staff use to secure personal items. RN #5 stated she did not bring a purse into the facility because she would not be able to secure or maintain the safety of her personal items.

Interview, on 09/27/12 at 2:35 PM, with the Director of Nursing, (DON) revealed she was aware the family of Resident #1 found a purse stored in the resident's closet which contained multiple medications. The staff member explained they had some money stolen in the past, and considered the purse to be safe and secure in Resident #1's closet. The DON stated the storage of staff medications and personal item in resident's rooms presented a risk of harm to any resident who was capable of entering the resident's room.

Interview on 09/27/12 at 3:00 PM, with the Administrator revealed he was told by the family of Resident #1 that a purse containing multiple medications was found stored in the resident's closet. The Administrator said he determined the purse belonged to a staff member and said when he spoke with her, she admitted she stored her purse in the resident's closet. The Administrator said the facility did not have a sufficient number of lockers currently.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR
SS=D RATES OF 5% OR MORE

F 332



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F 332 Continued From page 3
The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure residents received medications as prescribed, and failed to maintain an error rate less than five (5) percent for the forty-one (41) opportunities administered during a medication pass observation which resulted in an error rate of 7.3%. Three unsampled residents, Unsampled Resident A, B and C did not receive medications as ordered by the physician.

The findings include:

Review of the facility's policy regarding Medication Administration revealed all required vital signs and/or monitoring must be obtained and documented on the medication administration record before the nurse administered the medication. The policy also stated medications were to be given at the time ordered, or within sixty (60) minutes before or after the designated time.

Observation, on 09/26/12 at 7:45 PM, revealed Unsampled Resident A was provided Metoprolol 50 mg after LPN #1 obtained and documented the blood pressure. Review of the Medication Administration Record (MAR) revealed no heart rate was obtained or recorded on the medication record.

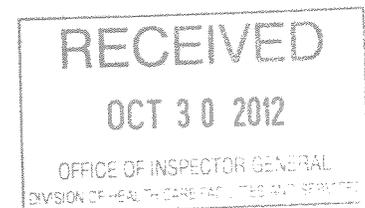
F 332

F TAG 332:

1. A heart rate was obtained on resident A by a licensed nurse 9-27-12 and determined to be within acceptable range. The physician for resident A was notified on 9-28-12 by a licensed nurse of the heart rate not being obtained prior to medication administration with no new orders obtained. The Medication Administration Record for resident B was replaced to include the Floranex on 9-27-12 by a licensed nurse. The physician for resident B was notified by a licensed nurse of the medication error and gave new orders for the Floranex to be discontinued on 10-8-12. The physician for resident C was notified by a licensed nurse on 9-28-12 of the omitted Astelin dose with no new orders received. Licensed Nurse #1 re-education and skills validation Medication Administration practices was completed on 10/12/12 by Staff development.

2. The Unit Managers completed an audit of all Medication Administration Records on 10-16-12 to determine that all pages of the Medication Administration Records are intact, that vital signs (ie heart rate) are being obtained and documented as ordered, and that medications are administered as ordered. No other concerns were identified.

3. The Director of Nursing, Assistant Director of Nursing, Staffing Development Coordinator and Unit Managers completed re-education with all licensed nurses on prevention of medication errors, medication administration, and the 24 chart check process on 10-19-



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F 332 Continued From page 4

Observation, on 09/26/12 at 8:10 PM, of a medication pass by LPN #1 revealed Unsampld Resident B was not provided a dose of Floranex, one (1) tablet. Record review of the physician orders for Resident B, revealed Floranex one (1) tablet was to be given twice daily at 8:00 AM and 8:00 PM, with an order date of 09/07/12. The Floranex order was not documented on the MAR for Unsampld Resident B.

Observation, on 09/26/12 at 8:20 PM, of a medication pass by LPN #1 revealed Unsampld Resident C was not provided Astelin nasal spray as indicated on the MAR. Record review of the MAR for Unsampld Resident C, revealed an order for Astelin two (2) sprays per each nares to be administered at 8:00 AM and 8:00 PM.

Interview, on 09/26/12 at 9:10 PM, with LPN #1 revealed she had provided all medications for Unsampld Resident B, and stated that all of the medications due at 8:00 PM were to be given orally, and said there were no residents who received medications by any other route on the unit.

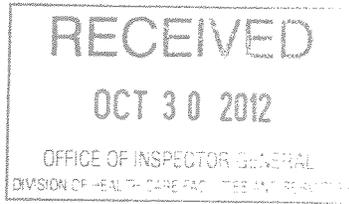
Interview, on 09/27/12 at 8:55 AM, with the NF1 Unit Manager (UM) revealed she was not aware staff nurses were not obtaining and documenting the blood pressure and the heart rate on the MAR for Unsampld Resident A in a consistent manner. The UM stated it was important for the staff nurse to perform the vital signs to ensure the resident was not hypertensive or bradycardic prior to administration of Metoprolol, as the medication could cause the blood pressure and heart rate to further decline to dangerous levels. The UM

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12. The licensed nurses as assigned will complete a 24 hour chart check that includes a daily review of the residents physician orders and medication administration records to determine that orders have been transcribed as appropriate, administered as ordered, that blood pressures and/or pulses are documented as ordered, to address issues identified and then sign off on the 24 hour chart check sheet to indicate that the chart check was completed.

4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will complete an audit of the 24 hour chart check for current residents x3 weekly x4 weeks, monthly x2 months and then quarterly x3 to determine that they are accurately completed. Any concerns noted will be addressed as indicated when identified. The audits will be submitted to the Director of Nursing and Administrator upon completion for review. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x3 months and then quarterly x3 for further review and further recommendation.

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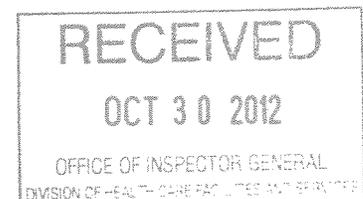
F 332 Continued From page 5

stated that she performed random audits of the MARs but there was no schedule or specific audit tool. The UM stated the Floranex, which was ordered for Unsampled Resident B on 09/07/12, was on the first page of the MAR. The UM said she determined the first page of the MAR was missing from the MAR binder on the medication cart. The UM stated the facility ensured orders were correct and complete by performing the required daily chart checks. The UM stated the night shift nurse should have identified the missing order when the twenty-four (24) hour chart checks were done each night, and stated this was the method the facility utilized to audit the physician orders to ensure the orders were complete and correct.

Further interview, on 09/27/12 at 10:00 AM, with the UM revealed doses of Floranex had been given to Unsampled Resident B, because she found the medication was stocked on the medication cart and doses were missing. The UM stated there was no documentation by nurses on the MAR to indicate the medication had been provided since the MAR was not included in the MAR binder on the medication cart.

Interview, on 09/27/12 at 11:54 AM, with the Assistant Director of Nursing (ADON) revealed that she was not aware the staff nurses had not been documenting the blood pressure and heart rate for Unsampled Resident A, and stated it was important for the staff to document the information to ensure resident safety. The ADON stated there was no routine audit to ensure the MAR included all medications ordered. The ADON was not sure why the first page of Unsampled Resident B's MAR with the order for

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F 332 Continued From page 6

Floranex was not in the MAR binder on the medication cart. The ADON said the UM told her Unsampld Resident B had received the medication, as the medication was stored on the cart, and there were doses missing which indicated the resident had received the medication. The ADON stated there was no record of the doses of Floranex which had been given, and therefore the facility could not ensure the resident received the medication as ordered by the physician.

Interview, on 09/27/12 at 2:35 PM, with the Director of Nursing (DON) revealed she was not aware staff were not consistently documenting blood pressure and heart rate as stated in the physician orders and said it was important to obtain and document the vital signs to maintain resident safety. The DON stated staff nurses were responsible for entering orders for their residents into the computerized system, then the night shift staff nurse was responsible to do the twenty-four (24) hour checks to ensure the MAR's were accurate. The DON said staff were trained to do the audits during orientation to the units. The DON stated the missing page of the MAR for Unsampld Resident B should have been identified during the nightly audits.

F 332

