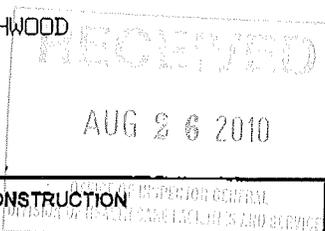


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/19/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/05/2010
NAME OF PROVIDER OR SUPPLIER  THE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 08/03/10 - 08/05/10 and a Life Safety Code Survey was conducted on 08/06/10. Deficiencies were cited with the highest scope and severity of a "D" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure accepted standards of practice were provided during a medication pass for Resident #14. Fourteen (14) medications were left at Resident #14's bedside. One (1) of the fourteen (14) medications was a controlled medication, and the fourteen (14) medications were signed on the Medication Administration Record by LPN #6 as having been administered.</p> <p>The findings include: Review of the facility policy on 08/04/10 "Medication Administration - General Guidelines" (undated) revealed. . . "11 residents are allowed to self-administer medications when specifically authorized by the attending physician" and "#14) the resident is always observed after administration to ensure that the dose was completely ingested." Review of the facility policy 08/04/10 "Disposal of Medications and. . ."</p>	F 281	<p><b>F-281: Facility Plan of Correction</b></p> <p><b>1. The facility took specific measures to correct the violation on August 3, 2010</b></p> <p>1.1. The facility addressed the medication error for resident #14 at the time of the observation on 8/3/10.</p> <p>1.2. The resident's physician and responsible party were immediately notified of the resident's missed medication.</p> <p>1.3. Medications were destroyed.</p> <p><b>2. The facility utilized a comprehensive audit to identify any potential/additional medication administration errors-</b></p> <p>2.1. All other residents on the unit (Unit A, 100-300 hallways) were assessed to ensure medications were administered as ordered.</p> <p>2.2. No other medication errors were identified during this audit.</p> <p><b>3. The facility took measures to ensure that the violation would not reoccur-</b></p> <p>3.1. The licensed nursing staff was immediately in-serviced by the Staff</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T. McA... TITLE: Administrator / Executive Director (X6) DATE: 8.25.10

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 281	Continued From page 1 revealed "B. When a dose of a controlled medication is removed from the container for administration and not given for any reason. . .it is destroyed in the presence of two (2) licensed nurses or a nurse and pharmacist."  Review of a nursing department in-service regarding Medication Pass and Medication Errors on 08/04/10 which was conducted by the facility Pharmacist on 04/29/10 revealed "You are documenting on the Medication Administration Record that the resident has taken the medications." Review of a facility form trained in this in-service revealed "10. Resident observed (during medication pass) to ensure medications are swallowed." "12. Medications are not left at the resident's bedside" and "24. Medications are administered per facility policies and procedures." Review of a nursing department in-service dated 04/14/10 revealed "Only sign-off on medications after you give them."  Observation during the facility initial tour of a standard health survey on 08/03/10 at 10:20am with LPN #6 revealed fourteen (14) medications (to include a controlled medication (Ativan) were left on the bedside table of Resident #14, who was not in their room at the time. LPN #6 picked up the medications and discarded them in the sharps container in the resident's room.  Record review for Resident #14 on 08/03/10 revealed the resident was admitted to the facility on 01/08/07 with diagnoses to include Left Above Knee Amputation, Right Below Knee Amputation, Peripheral Vascular Disease, and Diabetes Mellitus. The record for Resident #14 did not reveal assessments or physician orders for Resident #14 to self-administer any of the	F 281	Development Nurse and the Pharmacy Consultant on August 3, 2010 on medication administration and destruction of medications if not taken, including controlled substances.  3.2. The remaining staff was in-serviced by the Staff Development Coordinator by August 24, 2010.  3.3. The Quality Assurance Nurse will audit one hallway per week of medication administration. Audits will be weekly for 3 months, then quarterly until the QA/CQI Committee determines it is no longer necessary.  4. The facility QA/CQI Committee has directed specific measure and assignments to ensure the violation will not reoccur-  4.1. The Director of Nursing Services will be responsible for overseeing surveillance/monitoring & compliance with this regulation.  4.2. The QA Nurse shall conduct monthly trending reports focused on medication administration/error rate  4.3. The Staff Development Coordinator shall, under the direction of the Director of Nursing, provide both individual and group training for medication administration	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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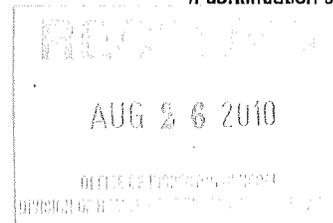
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F 281	<p>Continued From page 2</p> <p>fourteen (14) medications left at the resident's bedside. The Minimum Data Sheet for Resident #14 revealed a cognition score of 0 which indicates the resident is independent in daily decision-making and may be interviewed.</p> <p>Interview with LPN #6 on 08/03/10 at 11:25am revealed she did leave the medications on the bedside table of Resident #14, she realized this was an error, and she realized that she was not following facility policy or accepted standards of nursing practice regarding administration of medications. LPN #6 stated she had been in-serviced on facility policy and she did know accepted standards of nursing practice but that she felt she could rely on Resident #14 to take the medications. She stated this was not her usual practice.</p> <p>Interview with the facility Pharmacist on 08/03/10 at 1:55pm revealed side effects most likely to occur if other residents ingested the medications left at the bedside for Resident #14 would be drowsiness, nausea, hypotension, increased fall risk, or hypersensitivity. The Pharmacist did review the medication regimen for Resident #14's roommate (who could self-propel in a wheelchair in the room) and stated this unsampled resident could be at increased risk for hypotension or falls if this resident ingested Resident #14's medications.</p> <p>Interview with the Director of Nursing (DON) at 12noon on 08/02/10 revealed she was aware this was a medication error. She stated LPN #6 was recently in-serviced on medication errors, and the LPN had been observed in a medication pass in the past month and had no errors. The DON stated LPN#6 was off duty for a few days and</p>	F 281	<p>4.4. The D.O.N. shall present the "compliance summary," related to this regulation, to the QA/CQI Committee.</p> <p>4.5. The QA/CQI Committee shall review the D.O.N.'s "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation.</p> <p><b>Substantial Compliance Completion</b></p>	08/25/10
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<p>F 281</p> <p>F 323</p> <p>SS=D</p>	<p>Continued From page 3</p> <p>would be re-trained upon return to duty.</p> <p>Interview with Resident #14 on 08/05/10 at 1:30pm revealed medications were often (in a week's time) left at the bedside and the nurse does not always observe him/her taking the medications.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide adequate supervision or assistive devices to prevent falls for two (2) of twenty-one (21) sampled residents (Residents #1 and #8). Resident #1 and Resident #8 were observed to have no footrests on their wheelchairs when staff were pushing residents in the wheelchairs, even though both residents had sustained falls from the wheelchairs in the past.</p> <p>The findings include:</p> <p>Observation of Resident #8 on 8/3/10 at 4:45 PM revealed CNA #2 propelled the resident to the dining room in a wheelchair that did not have footrests attached. Resident #8 was verbally prompted to lift his/her feet off the floor by the</p>	<p>F 281</p> <p>F 323</p>	<p>0323 FACILITY IS FREE OF ACCIDENT HAZARDS:</p> <p><b>F-323: Facility Plan of Correction</b></p> <ol style="list-style-type: none"> <li>The residents identified in the 2567 form were treated by nursing staff at the time of the incident per orders obtained by the physician.</li> <li>All residents who use their feet for mobility will be re-assessed by the therapy rehabilitation department for positioning and mobility; this shall be directed by the therapy manager.             <ol style="list-style-type: none"> <li>All residents who have had falls within the last thirty days will be assessed by August 31, 2010 by the therapy rehabilitation department as directed by the therapy manager.</li> <li>All other residents shall be screened by therapy by September 15, 2010 for positioning, proper assistive devices, and make recommendations to the physician.</li> </ol> </li> <li>The facility has taken specific measures to correct the violation and ensure the violation does not recur.             <ol style="list-style-type: none"> <li>All staff members were in-serviced related to resident safety practices/policy (this includes positioning, fall prevention, and policy &amp; procedures) related to wheelchairs and leg rests by the Staff</li> </ol> </li> </ol>	
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AUG 26 2010

OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
DIVISION OF HEALTH SERVICES REGULATION

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

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F 323	<p>Continued From page 4 CNA.</p> <p>Record review for Resident #8 revealed the resident was admitted to the facility on 12/10/09 with diagnoses to include Hypertension, Senile Dementia and Osteoarthritis.</p> <p>Review of a facility investigation revealed Resident #8 sustained a fall from the wheelchair on 6/23/10. The investigation stated Resident #8 was being taken to breakfast by a staff member when the resident's foot went under the wheelchair, and the resident fell, face forward, out of the wheelchair. The investigation continued that there were no footrests in use on the wheelchair at the time of the fall. Interventions to be implemented, as a result of the investigation, included footrests on the resident's wheelchair when being propelled by staff.</p> <p>Review of a history and physical report from the hospital revealed the resident was admitted to the hospital on 6/23/10 following a fall at the facility. The report indicated Resident #8 had a right frontal scalp hematoma. Resident #8 remained in the hospital from 6/23/10 to 6/24/10, with a follow-up Computerized Tomography(CT) scan, wound care and pain control.</p> <p>Review of the resident's comprehensive care plan revealed footrests should be applied to the wheelchair for any staff-propelled transport.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 8/4/10 at 9:45 AM, revealed she was unaware Resident #8, or any other residents who were assessed as capable of self-propelling a wheelchair, were to have footrests applied to the wheelchair when staff propelled the wheelchair. The CNA stated "most" facility residents</p>	F 323	<p>Development Coordinator. This task was completed as of August 24, 2010.</p> <p>3.2. The QA Committee has directed that the incidents and accidents be monitored by the Director of Nursing daily.</p> <p>3.3. The QA Committee has directed that the QA Nurse compile trend data for accidents with emphasis on root-cause analysis and individualized interventions</p> <p>4. The Director of Nursing Services will be responsible for overseeing surveillance/monitoring &amp; compliance with this regulation.</p> <p>4.1. The D.O.N. shall present the "compliance summary," related to this regulation, to the QA/CQI Committee.</p> <p>4.2. The QA/CQI Committee shall review the D.O.N.'s "compliance summary", monitor trends and issue recommendations to ensure compliance with this regulation</p> <p>Substantial Compliance Completion</p>	09/15/10
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AUG 26 2010  
OFFICE OF ASSISTANT SECRETARY  
FOR INSURANCE AND HEALTH SERVICES

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

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F 323	<p>Continued From page 5</p> <p>self-propelled their wheelchairs, except for mealtime, when staff would push the residents to the dining room.</p> <p>Interview with CNA #3, on 8/4/10 at 11:05 AM, revealed the CNA was unaware of the need to apply footrests on residents' wheelchairs when staff were propelling the residents. He was unaware Resident #8 had an intervention on the care plan to apply footrests to the resident's wheelchair to prevent falls.</p> <p>Interview with the Dietary Manager, on 8/5/10 at 3:15 PM, revealed the Dietary manager was pushing Resident #8's wheelchair on 6/23/10, when the resident sustained a fall. The Dietary Manger was unaware she should utilize footrests for the wheelchair when the resident was being staff propelled.</p> <p>Interview with a Physical Therapy Assistant (PTA), on 8/5/10 at 9:40 AM, revealed wheelchair footrests were available to staff at all times, and if staff were propelling residents, footrests should be on the wheelchair.</p> <p>Interview with the Director of Nursing, on 8/5/10 at 2:45 PM, revealed she thought the intervention for wheelchair footrests for Resident #8 had been discontinued. However, the DON was unable to provide evidence the intervention had been discontinued. In addition, the DON stated staff had received training related to utilizing footrests on wheelchairs, however, there was no evidence the staff had received the training.</p> <p>2. Observation of Resident #1 on 8/3/10 at 3:40 PM, revealed the resident was sitting in a wheelchair near the nurse's station. There were</p>	F 323		
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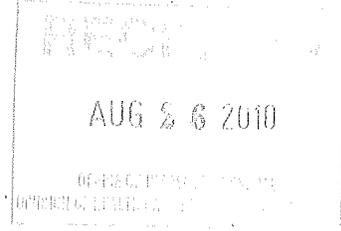
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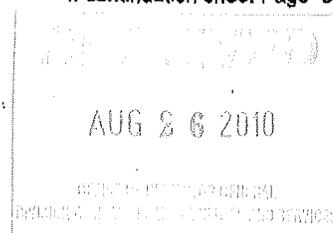
F 323	<p>Continued From page 6 no footrests observed on the wheelchair.</p> <p>Review of Resident #1's medical record revealed the resident was admitted to the facility on 7/11/08 with diagnoses including Dementia, Anxiety, Urinary Tract Infection, Gastric Intestinal Hemorrhage and Osteoarthritis. A review of the Minimum Data Set (MDS), dated 6/10/10 revealed Resident #1 had experienced a decline in the resident's condition.</p> <p>Review of nurse's notes, dated 6/18/10 revealed a CNA was pushing the resident to the room and the resident leaned forward, and fell to the floor, face first, before the CNA was able to stop the wheelchair. Resident #1 sustained a hematoma to the forehead and bruises to the left hand.</p> <p>Review of the comprehensive care plan for Resident #1 revealed the resident was resistive to care, at times, curses, disturbed other residents, with cueing and re-direction often ineffective. Interventions on the care plan to prevent falls, prior to 6/18/10, included hip protectors and clip alarm at all times. The care plan was updated on 6/18/10, after Resident #1's fall, to include staff placing one hand on the resident's shoulder to prevent the resident from leaning forward out of the wheelchair. The care plan was updated 7/25/10, to include a lap buddy for positioning, when the resident was in the wheelchair.</p> <p>Interview with the DON, on 8/5/10 at 2:45 PM, revealed a verbal inservice training was conducted for staff related to staff placing their hand on the resident's shoulder while pushing the resident in the wheelchair.</p> <p>Interview with Licensed Practical Nurse (LPN) #1,</p>	F 323		
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F 323	Continued From page 7 on 8/5/10 at 10:45 AM, revealed the CNAs were instructed to obtain footrests and put them on a wheelchair when staff were transporting a resident.  Interview with CNA #4, on 8/5/10 at 10:00 AM, revealed she routinely provided care for Resident #1. The CNA stated he/she was unaware Resident #1 had fallen from a wheelchair when being pushed by a staff member. The CNA thought it was acceptable to transport residents via wheelchair without a footrest if the resident was able to understand directions.  Interview with CNA #5, on 8/5/10 at 11:00 AM, revealed the CNA was unaware footrests should be added to wheelchair when staff are propelling the wheelchair.	F 323	<b>F-332: Facility Plan of Correction</b>  <b>1. The facility took specific measures to correct the violation on August 3, 2010</b>  1.1. The facility addressed the medication error for resident #14 at the time of the observation on 8/3/10.  1.2. The resident's physician and responsible party were immediately notified of the resident's missed medication.  1.3. Medications were destroyed.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  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, record review, and interview, it was determined the facility failed to maintain a medication error rate of five (5) per-cent (%) or less. An initial tour observation during the standard health survey on 08/03/10 revealed a medication error of fourteen (14) medications (including a controlled medication (Ativan) left at Resident #14's bedside by LPN #6. The medication pass opportunities were increased to forty-five per guidelines and the facility error rate was 31%.	F 332	<b>2. The facility utilized a comprehensive audit to identify any potential/additional medication administration errors-</b>  2.1. All other residents on the unit (Unit A, 100-300 hallways) were assessed to ensure medications were administered as ordered.  2.2. No other medication errors were identified during this audit.  <b>3. The facility took measures to ensure that the violation would not reoccur-</b>  3.1. The licensed nursing staff was immediately in-serviced by the Staff	



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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 332	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the facility policy on 08/04/10 "Medication Administration - General Guidelines" (undated) revealed. . . "11) residents are allowed to self-administer medications when specifically authorized by the attending physician and. . . 14) the resident is always observed after administration to ensure that the dose was completely ingested." Review of the facility policy 08/04/10 "Disposal of Medications and. . ." revealed "B. When a dose of a controlled medication is removed from the container for administration and. . . not given for any reason. . . it is destroyed in the presence of two (2) licensed nurses or a nurse and pharmacist."</p> <p>Review of a nursing department in-service regarding Medication Pass and Medication Errors on 08/04/10 which was conducted by the facility Pharmacist on 04/29/10 revealed "You are documenting on the Medication Administration Record that the resident has taken the medications." Review of a facility form trained in this in-service revealed "10. Resident observed (during medication pass) to ensure medications are swallowed. 12. Medications are not left at the resident's bedside and 24. Medications are administered per facility policies and procedures."</p> <p>Observation during the facility initial tour of a standard health survey on 08/03/10 at 10:20am. with LPN #6 revealed fourteen (14) medications (to include a controlled medication [Ativan]) were left on the bedside table of Resident #14. LPN #6 picked up the medications and discarded them in the sharps container in the resident's room.</p>	F 332	<p>Development Nurse and the Pharmacy Consultant on August 3, 2010 on medication administration and destruction of medications if not taken, including controlled substances.</p> <p>3.2. The remaining staff was in-serviced by the Staff Development Coordinator by August 24, 2010.</p> <p>3.3. The Quality Assurance Nurse will audit one hallway per week of medication administration. Audits will be weekly for 3 months, then quarterly until the QA/CQI Committee determines it is no longer necessary.</p> <p>4. The facility QA/CQI Committee has directed specific measure and assignments to ensure the violation will not reoccur-</p> <p>4.1. The Director of Nursing Services will be responsible for overseeing surveillance/monitoring &amp; compliance with this regulation.</p> <p>4.2. The QA Nurse shall conduct monthly trending reports focused on medication administration/error rate</p> <p>4.3. The Staff Development Coordinator &amp; ADON shall, under the direction of the Director of Nursing, provide both individual and group training for medication administration</p>	
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