

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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
F-000	<p>INITIAL COMMENTS</p> <p>A Standard/Extended, and an Abbreviated/Partial Extended Survey Investigating ARO KY00014436 was initiated on 02/18/10 and concluded on 02/27/10. A Life Safety Code Survey was conducted on 02/26/10.</p> <p>Immediate Jeopardy was identified on 02/23/10 and was determined to exist on 01/20/10. The facility was notified of the Immediate Jeopardy on 02/23/10.</p> <p>ARO KY00014436 was substantiated and deficiencies were cited under 42 CFR 483.10 Resident Rights, F 167 at a Scope and Severity (S/S) of a "K"; 42 CFR 483.20 Resident Assessments, F 281 at a S/S of a "K"; 42 CFR 483.20 Resident Assessments, F 282 at a S/S of a "J"; 42 CFR 483.25 Quality of Care, F 300 at a S/S of a "J"; 42 CFR 483.25 Quality of Care, F 328 at a S/S of a "J"; 42 CFR 483.25 Quality of Care, F 333 at a S/S of a "J"; 42 CFR 483.75 Administration, F 400 at a S/S of a "K"; 42 CFR 483.75 Administration, F 502 at a S/S of a "J"; and 42 CFR 483.75 Administration, F 520 at a S/S of a "K".</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/26/10. The Immediate Jeopardy was verified to be removed on 02/27/10.</p> <p>During the survey, an additional ARO was received and the investigation of ARO KY00014469 was initiated on 02/23/10 and concluded on 02/27/10 with deficiencies cited under 42 CFR 483.10, Resident Rights; 42 CFR 483.15, Quality of Life; 42 CFR 483.20 Resident Assessment; and 42 CFR 483.25, Quality of</p>	F-000	<p><i>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Providence Pavillion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavillion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as proscribed by the regulations. This plan of correction shall operate as Providence Pavillion's written credible allegation of compliance.</i></p> <p><i>By submitting this plan of correction, Providence Pavillion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavillion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding.</i></p> <p>RECEIVED APR 10 2010 BY: _____</p>	

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

[Signature]

TITLE
[Signature]

(X6) DATE
4/19/10

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 000	Continued From page 1 Care.	F 000		
F 156 89=C	ARO KY 00014470 was re-opened for further investigation after supervisory review, on 03/15/10. On site investigation at the facility on 03/16/10 through 03/17/10 revealed the allegation was substantiated and Past Jeopardy identified to exist on 01/24/10 with the Immediate Jeopardy removed and deficiency corrected on 01/28/10. The Past Immediate Jeopardy was identified to exist at 483.28 Quality of Care, F323 at a S/S of "J". An amended Statement of Deficiencies was issued on 03/26/10. 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(3) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156	F 156 No residents were identified to have been affected by the deficient practice. Guidelines on how to apply for Medicaid and Medicare were posted in a prominent area of the facility on 2/26/10. Facility staff was educated on the posting of Medicare and Medicaid information on 3/5/10 by the Administrator. In order to ensure compliance, the Administrator will monitor required postings in accordance with state and federal regulations (2) times per week for (4) weeks. Any identified issues will be corrected immediately. Results will be reviewed weekly at the quality assurance committee meeting for further recommendation	4/13/10

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F 156	<p>Continued From page 2</p> <p>the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and</p>	F 156	and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	

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F 150	<p>Continued From page 3</p> <p>misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. Those requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently display written information about how to apply for and use Medicare and Medicaid benefits.</p> <p>The findings include:</p>	F 150			

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F 156	Continued From page 4 Observation during tour of facility on 02/24/10 at 11:12 AM, revealed no evidence the facility displayed the required written information regarding how to apply for and use Medicare and Medicaid benefits. Interview with the Administrator on 02/24/10 at 11:14 AM, revealed he was aware this information needed to be posted. However, he was unaware the facility had not posted the signage.	F 156			
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	F 157 Resident # 1 was discharged to the hospital on 1/21/10 for evaluation and returned on 1/27/10. Resident # 7's missed doses of Antibiotics were reported to the physician and responsible party on 3/8/10 with no new orders received. Resident # 13 expired. Resident # 15's Coumadin administration and PTINR issues were reviewed with the physician on 2/19/10 with new orders received and implemented. The Director of Nursing and Licensed Nurse designee conducted an audit on 2/24/10 and 2/25/10 to evaluate change of condition and physician notification. No other residents were identified. LPN # 1 was suspended and then terminated in relation to performance of job duties. Licensed Nursing staff was	4/13/10	

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F 167	<p>Continued From page 5 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to notify the Physician and/or Responsible Party related to change in condition and/or need to alter treatment for four (4) of twenty-four (24) sampled residents (Resident #13, #1, #15, and #7).</p> <p>Resident #13 had a physician's order to hold Coumadin on 01/27/10, however, facility records indicate the Coumadin was administered. The facility failed to notify the physician after the Coumadin was administered. In addition, Resident #13 had a physician's order to obtain a Prothrombin/International Normalized Ratio (PT/INR) on 01/28/10. Even though the blood was obtained for the laboratory testing, there was no evidence the facility followed up to obtain the results of the testing, and did not notify the physician regarding the lack of results. The laboratory testing was obtained on 01/29/10 and revealed the PT results were greater than 100 (normal range 0.0-11.4 seconds), and an INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0), and the resident received Vitamin K on 01/29/10.</p> <p>Resident #1 experienced an elevated blood pressure on 01/20/10 of 228/108. The facility failed to notify the Physician of the elevated blood pressure. The resident was transferred to the</p>	F 167	<p>educated on procedures for the following: physician orders, medication transcription, lab tracking, physician notification of medication omission, and physician notification of change of condition on 2/22/10, 2/23/10, 3/5/10, 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or designee.</p> <p>Certified Nursing Assistants were educated by the Director of Nursing and/or designee on change of condition on 2/25/10 and 3/5/10.</p> <p>The 24 hour report was revised and implemented 2/20/10 by the Director of Nursing and Administrator. The tracking of change of condition, physician notification, and appropriate monitoring includes the following process:</p> <ol style="list-style-type: none"> 1) Charge nurses will complete the 24 hour report assigned to their group. Any changes of condition will be reported to the physician by the charge nurse upon discovery, noted on the 24-hour report, monitored, documented in the nursing notes, and reviewed with the next shift. 2) In order to ensure compliance, the Director of Nursing and/or Licensed Nurse designee will review the 24 hour report and resident's clinical record (including active nursing notes and new physician orders) on a daily basis to ensure 	

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F-167	<p>Continued From page 6</p> <p>hospital on 01/21/10, and diagnosed with a Cerebrovascular Accident (CVA).</p> <p>The facility failed to administer physician ordered Coumadin and obtain physician ordered laboratory testing for Resident #16. The facility failed to notify the physician regarding the medication or laboratory testing omissions.</p> <p>Additionally, the facility failed to notify the Physician, on two (2) separate occasions, when Resident #7 failed to receive physician ordered antibiotics.</p> <p>The facility's failure to notify residents' Physicians related to change in condition and/or medications, or laboratory testing, not provided placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>1. Record review revealed Resident #13 was admitted to the facility on 01/19/10, with diagnoses which included Cerebrovascular Accident (CVA) with left sided Hemiplegia, Atrial Fibrillation, right elbow Fracture and left wrist Fracture.</p> <p>Review of the Physician's Orders revealed Resident #13 received Coumadin. An order dated 01/27/10, revealed the resident's Coumadin (an anticoagulant) was to be held on 01/27/10, with a PT/INR and CBC obtained on 01/26/10. Review of the Interdisciplinary Progress Note dated 01/27/10, timed 0:30 PM revealed Resident #13's Coumadin was to be held that night and laboratory testing obtained on 01/28/10.</p>	F 167	<p>that resident change of condition is appropriately documented, monitored, and reported to the physician. Issues identified will be corrected immediately. Licensed Nursing staff will be disciplined as warranted.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p> <p>The quality assurance committee meeting met on 2/23/10, 3/2/09, 3/9/09, and 3/17/10 to review change of condition, 24 hour tracking process, and physician notification. Plan of correction was reviewed with Medical Director on 2/24/10 and 3/17/10.</p>		

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F 157	<p>Continued From page 7</p> <p>Review of the MAR (Medication Administration Record) revealed the Coumadin was administered on 01/27/10. Review of the Interdisciplinary Progress Notes revealed no documented evidence the Physician was notified after Resident #13 received the Coumadin.</p> <p>Interview on 02/18/10, at 4:55 PM with Licensed Practical Nurse (LPN) #1, revealed she received a verbal order from the resident's physician on 01/27/10, to hold (not administer) Coumadin to the resident on 01/27/10. The LPN stated she was unable to recall why she didn't transcribe the order onto the MAR and could not recall if the Physician had been notified after Resident #13 received the Coumadin.</p> <p>Interview on 02/24/10, at 8:30 AM with Resident #13's Physician revealed he should have been notified after the resident received Coumadin on 01/27/10.</p> <p>Review of the lab reports revealed no documented evidence of a lab report for a PT/INR and CBC on 01/28/10. Further review of the lab reports revealed results of a PT/INR were received on 01/29/10 and were defined as critical on the lab report. The PT was noted to be greater than 100 seconds (normal range 9.0-11.4 seconds) and the INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0). Review of the Physician's Orders, dated 01/29/10, revealed an order for Vitamin K (to congregate blood) 10 mg/ml (milligram/milliliter) times one dose. Review of the Interdisciplinary Progress Notes revealed the Vitamin K was administered at 4:00 PM on 01/29/10. Further review of the Notes revealed on 01/30/10, at 4:00 AM the resident was found without a pulse, blood pressure, or</p>	F 157			

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F 167	<p>Continued From page 8</p> <p>respirations. The resident was pronounced dead.</p> <p>Interview on 02/21/10, at 8:37 PM with Licensed Practical Nurse (LPN) #4 revealed the blood was obtained for the physician ordered labs on 01/28/10, however results were not received and the Physician was not notified of this information.</p> <p>Interview on 02/22/10, at 2:15 PM with Registered Nurse (RN) #2, the current Director of Nursing (DON), revealed the Physician should have been notified when the resident's lab results were not received on 01/28/10. The DON indicated there was no system in place to ensure labs were followed up on and the results reported to the Physician.</p> <p>Additionally, interview on 02/24/10, at 8:30 AM with the Physician revealed he should have been notified when PT/INR lab results were not received on 01/28/10. He stated he was not informed of this information until 01/29/10.</p> <p>2. Review of Resident #1's clinical record revealed diagnoses which included Mental Retardation, Hypertension, Diabetes, and Coronary Artery Disease. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/03/09, revealed the facility assessed Resident #1 as requiring no assistance with transfers, ambulation, dressing, range of motion and only required set-up assistance with meals. Review of the MDS revealed Resident #1 tolerated a regular diet and thin liquids, and had no problems with speech or communicating his/her needs.</p> <p>Observation of Resident #1 on 02/18/10 at 12:30 PM revealed the resident in a wheelchair in the dining room eating lunch. Resident #1 was not</p>	F 167		

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F 167	<p>Continued From page 9</p> <p>utilizing his/her left arm and left hand. Resident #1's left foot was on the wheelchair foot pedal and the resident was eating a pureed (food had been blended to a pureed consistency) diet with thickened liquids. The resident's face had a left facial droop. Observation on 02/23/10 at 3:20 PM revealed Resident #1 was in the wheelchair and propelling the wheelchair utilizing his right hand and right foot only. During that observation Resident #1 had difficulty speaking.</p> <p>Record review revealed Resident #1 had a history of Hypertension and Chest Pain, and was sent to the hospital on 12/20/09 related to an elevated blood pressure and chest pain.</p> <p>Review of the Comprehensive Care Plan revealed the facility noted a problem related to Hypertension with intermittent complaints of chest pain. Interventions included: alert Physician as needed, medications and labs as ordered, monitor blood pressure readings and notify Physician of any adverse reactions.</p> <p>Record review and interview on 02/22/10 at 12:10 PM, with Licensed Practical Nurse (LPN) #1, the nurse assigned to Resident #1 on 01/20/10, revealed on 01/20/10 at 8:45 PM, Resident #1 became dizzy in the Dining Room. According to LPN #1, the LPN assessed the resident and identified the resident's blood pressure was 228/108 (resident's average blood pressure 134/70), and blood sugar was 622 (resident's average blood sugar 255). Record review and interview with LPN #1 revealed the Physician was notified regarding the elevated blood sugar, and a physician's order received to administer 18 units of regular insulin, keep resident hydrated and obtain a Urinalysis for Culture and Sensitivity.</p>	F 157		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 491 EAST 28TH STREET COVINGTON, KY 41014	
(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
F 157	<p>Continued From page 10</p> <p>Further record review revealed no documented evidence the physician was notified of Resident #1's elevated blood pressure.</p> <p>Interview with LPN #1 on 02/22/10 at 12:10 PM revealed she did not re-assess the resident's vital signs, including the blood pressure, for Resident #1 until 9:30 PM, two (2) hours and twenty-five (25) minutes later. The LPN stated no interventions were implemented related to the elevated blood pressure.</p> <p>Interview on 02/19/10 at 9:30 AM, with LPN #5, the nurse who came on duty at 11:00 PM on 01/20/10, revealed she was informed of the elevated blood pressure and glucose. Review of the progress note, and interview with LPN #5, revealed at 12:45 AM on 01/21/10, the LPN assessed the resident. At that time, Resident #1 complained of not being able to move the left hand, had a weak grasp, limp left arm, and difficulty moving his/her left leg. Resident #1 was transported to the hospital by Life Squad. Review of the hospital emergency room record, dated 01/21/10, revealed Resident #1 was diagnosed with Acute Cerebrovascular Accident (CVA) with left side hemiparesis.</p> <p>Interview with Resident #1's Physician on 02/22/10 at 12:00 PM revealed he recalled the incident with Resident #1 on 01/20/10. He stated he was not notified of the elevated blood pressure. He stated if he had been informed Resident #1's blood pressure was 220/100, he would have ordered medication for the elevated blood pressure and sent the resident to the hospital.</p> <p>Interview with Resident #1's Guardian on</p>	F 157		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 157	<p>Continued From page 11</p> <p>02/23/10 at 2:45 PM revealed the facility left a message for him/her on 01/20/10 at 7:00 PM that Resident #1 had fallen, had reddened knuckles and a blood sugar over 500 with no mention of the elevated blood pressure.</p> <p>3. Review of Resident #15's clinical record revealed an admission date of 01/30/10. The resident's diagnoses included Atrial Fibrillation, Congestive heart Failure, and History of Cerebrovascular Accident. According to the medical record, Resident #15 was receiving Coumadin Therapy prior to admission.</p> <p>Review of the 01/30/10 admission physician's orders revealed an order to hold (not administer) the resident's Coumadin until the 01/31/10 laboratory (lab) testing results were obtained. The physician's orders included an order for a PT/INR to be obtained on 01/31/10, and notify the physician with the results.</p> <p>Review of the results of the PT/INR, faxed to the facility on 01/31/10 at 1:31 PM, revealed results of the lab testing included a PT of 32.2 (normal range 10.6-13.0) and INR 2.6 (normal range .66-1.22). Review of the progress notes revealed the Physician was not notified of the 01/31/10 lab results until 02/01/10 at 1:30 PM, at which time a physician's order was obtained to administer Coumadin 2 mg daily and repeat the PT/INR on 02/05/10.</p> <p>Interview with Registered Nurse RN #1 (Director of Nursing), on 02/10/10 at 2:00 PM revealed the Physician should have been notified when the results of the lab testing were received on 01/31/10 at 1:31 PM. Review of the Medication Administration Record (MAR), at the time of the</p>	F 157		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 157	<p>Continued From page 12</p> <p>Interview, revealed no documented evidence the Coumadin 2 milligram (mg) was administered on 02/01/10, 02/02/10, 02/03/10 and 02/04/10. RN #1 stated she had not notified the Physician that the Coumadin was not given for four (4) days.</p> <p>Record review revealed a physician's order, dated 02/08/10, to increase the Coumadin to 8 mg at bedtime. Review of the MAR revealed the facility did not administer the 8 mg dose on 02/09/10. Review of the medical record revealed there was no evidence the Physician was notified of the missed dose.</p> <p>Review of the physician's orders revealed an order on 02/11/10 to increase the Coumadin dosage to 10 mg daily. Review of the MAR revealed Resident #15 did not receive the ordered dose of Coumadin 10 mg on 02/11/10. Interview with LPN #1 on 02/22/10 at 12:10 PM revealed she did not give the Coumadin 10 mg on 02/11/10. There was no evidence the physician was notified of the missed dose of Coumadin.</p> <p>Review of the PT/INR results from 02/15/10 revealed Resident #15's PT was 86.6 (normal range 10.-13.6) and the INR was 6.0 (normal range 0.85-1.22). The Physician was notified and ordered to hold Coumadin and repeat PT/INR on 02/16/10. Record review revealed no evidence the PT/INR was completed on 02/16/10. However there was no documented evidence the facility notified the Physician that the lab was not obtained.</p> <p>Interview with the Physician on 02/19/10 at 3:15 PM revealed he was not notified that Resident #15 had missed multiple doses of the ordered Coumadin. He stated he should have been</p>	F 157		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 157	<p>Continued From page 13</p> <p>notified. The Physician stated Coumadin therapy needed to be monitored closely and was concerned that the facility staff were not administering the medication as ordered.</p> <p>4. Review of the clinical record revealed Resident #7 was admitted on 12/23/00 with diagnoses which included Recent Fracture of Right Arm, Diabetes Mellitus Type II, Hypertension and Depression.</p> <p>Review of the Physician's Orders dated 01/08/10 revealed an order to obtain a urinalysis (urine test). Further review of the Physician's orders revealed an order, dated 01/11/10, for Omnicel (antibiotic) 300 milligrams (mg) to be administered every twelve (12) hours for seven (7) days, and obtain a urinalysis, with culture and sensitivity, after completion of the antibiotic.</p> <p>Review of the Medication Administration Record (MAR) dated January, 2010 revealed no documented evidence Resident #7 received the first three (3) scheduled doses of the ordered antibiotic. The MAR revealed the resident received the first dose of the ordered antibiotic, Omnicel, on 01/13/10.</p> <p>Continued review of the Physician's Orders dated 02/11/10 revealed an order for a urinalysis (urine test) to be obtained by a straight catheter.</p> <p>Review of the Physician's Orders dated 02/12/10 revealed an order for Cipro (antibiotic) 250 milligrams (mg) to be administered twice a day.</p> <p>Review of the MAR dated February, 2010 revealed the first dose of the Cipro (antibiotic) medication was scheduled to be administered on 02/12/10 at 8:00 PM. Continued review revealed no documented evidence the resident received</p>	F 157			

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 157	<p>Continued From page 14</p> <p>the first three (3) scheduled doses of the Cipro (antibiotic). According to the MAR the resident received the first dose of the ordered antibiotic on 02/14/10.</p> <p>Review of Resident #7's medical record revealed no evidence the physician was notified in January, or February, 2010, when the resident's antibiotics were not initiated as ordered.</p> <p>The facility was unable to provide evidence of a policy or procedure related to Physician notification.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/26/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following:</p> <p>Record reviews revealed the Physician was being notified of pertinent information. Inservices were provided for the licensed nursing staff related to notification of the Physician and responsible party of changes in condition.</p> <p>Interview on 02/27/10, with five (5) licensed staff and three (3) CNAs revealed they had attended the inservices and were familiar with the changes. Interview with the Director of Nursing revealed she was monitoring the nursing staff daily to ensure continued compliance.</p> <p>The facility provided documented evidence that a procedure was developed and education provided to staff related to notification of the Physician.</p> <p>Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued</p>	F 157		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(U) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 15 with the Scope and Severity lowered to an "E" based on the facility's need to evaluate the effectiveness of quality assurance activities related to notification of Physicians.	F 157		
F 167 SS=0	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that survey results and any plans of correction were readily accessible to residents. The findings include: During tour of the facility with the Administrator on 02/24/10 at 3:00 PM, revealed the facility had a sign posted indicating where the results from previous surveys was located. Observation of this location revealed it was not easily accessible to residents. The survey binder was located in the middle section of the credenza in the Private Dining Room, which would require residents to move a chair in order to gain access. Observation on 02/26/10 at 8:15 AM, revealed the	F 167	F 167 No residents were identified to have been affected by the deficient practice. The lock from the private dining room door was removed on 3/15/10. Upon further review, the survey binder was relocated to the coffee table in the central foyer area for improved accessibility on 3/18/10. Posting of the change of location was displayed on 3/16/10. In order to ensure compliance, the Administrator will monitor accessibility of survey results in accordance with state and federal regulations (2) times per week for (4) weeks. Any identified issues will be corrected immediately. Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	4/13/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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)	(X6) COMPLETION DATE
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F 167	Continued From page 10 Private Dining Room was locked and was not accessible for residents to obtain the survey results.	F 167		
F 202 6S-D	Interview with the Maintenance Director on 02/28/10 at 8:30 AM, revealed the Private Dining Room should not have been locked. 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the clinical record contained documentation related to transfer and/or discharge for one (1) of twenty-four (24) sampled residents (Resident #14). The findings include: Record review revealed Resident #14 was admitted to the facility on 01/02/10 with diagnoses which included severe Degenerative Joint Disease. Continued review revealed the resident was admitted while awaiting Left Total Hip Replacement surgery. Resident #14 was	F 202	F 202 Resident # 14 no longer resides at the facility. The Director of Nursing and designee conducted an audit on active residents on 2/26/20 to evaluate appropriate discharge of a resident. No other residents were identified to be affected by the deficient practice. Facility Licensed Nursing staff was educated on the process of transferring/discharging a resident from the facility on 3/10/10, 3/11/10, 3/12/10 by the Director of Nursing and/or Licensed Nurse designee. IDT was educated on the discharge summary process on 3/17/10 by the Administrator. In order to ensure compliance, the Resident Services Coordinator and/or designee will monitor resident discharges (2) times per week for (4) weeks to ensure proper documentation was completed. Issues identified will be corrected immediately.	4/13/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 202	<p>Continued From page 17</p> <p>discharged from the facility to the hospital to have the Hip Replacement surgery on 02/01/10.</p> <p>Review of the Physician's Orders revealed no order for transfer to the hospital or discharge from the facility. Further review of the closed clinical record revealed no Transfer Form, and no Discharge Summary had been completed. Review of the Physician's Progress Notes revealed the last physician entry was on 01/19/10, thirteen (13) days before Resident #14 left the facility. In addition, the last Nurse's Note was on 01/26/10, four (4) days prior to discharge.</p> <p>During interview on 02/26/10 at 8:30 PM, Licensed Practical Nurse (LPN) #4 revealed she was the nurse responsible for Resident #14 on the day of discharge. She confirmed the resident was discharged to the hospital for surgery and was not expected to return. She stated she did not fill out a transfer form because the resident was leaving for a scheduled appointment. She further stated she did not know what the process was for the physician completing a discharge summary. Continued interview revealed LPN #4 did not remember if she documented when the resident left the facility. She stated it was unusual for there to be no Nurse's Notes for four (4) days and she could not explain it.</p> <p>Interview with the Director of Nursing (DON) on 02/25/10 at 4:00 PM revealed she would expect to see nursing documentation, as well as a completed transfer form in the clinical record when a resident was discharged from the facility. She further stated she did not know if a physician's order was required for a planned discharge.</p>	F 202	Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.		

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 202	Continued From page 18 Interview with the Social Services Director on 02/26/10 at 4:45 PM revealed there should have been a transfer form completed. She stated she did not know anything about the discharge summary requirements. Interview with Medical Records staff on 02/26/10 at 5:08 PM revealed she had no knowledge of discharge summary requirements. She further stated there should have been a discharge order signed by the physician. Continued interview revealed she there was no system in place to ensure all documents were signed and in the resident's medical record.	F 202		
F 241 88-E	403.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents received care in a manner that maintained or enhanced each resident's dignity in full recognition of his or her individuality for one (1) of twenty-one (21) sampled residents (Resident # 21) and four (4) un-sampled residents (#1, #2, #3, #4) related to residents' cultural needs for hair grooming. The findings include: Review of the clinical record revealed Resident #21 was admitted to the facility with diagnoses	F 241	F 241 Resident # 21 and (4) unsampled residents; # 1, # 2, # 3, and # 4 were re-evaluated by nursing staff for individual grooming needs on 2/25/10 and interventions were implemented. The Director of Nursing and designee reviewed active residents on 2/25/10 for individual grooming needs. No other residents were identified to be affected by the deficient practice. Facility staff was educated on 3/5/10 on dignity, respect, and individuality by the Director of Nursing and Administrator. Certified Nursing Assistants were further instructed on individual grooming needs by the Director of Nursing and/or designee. In order to ensure compliance, the	4/13/10

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0930-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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F 241	<p>Continued From page 10</p> <p>which included Profound Mental Retardation, Quadriplegia and Aphasia. Review of the Admission Minimum Data Set (MDS) dated 12/14/09 revealed the facility assessed the resident as being totally dependent in activities of daily living (ADL).</p> <p>Review of the clinical record revealed Resident #21 attended High School five (5) days a week via public school bus for the handicapped.</p> <p>Observation on 02/25/10 at 12:50 PM revealed Resident #21 was seated in a wheelchair in the dining room with two other residents. Resident #21's braided hair was observed to be poorly groomed with braids being matted and containing several pieces of white particles. The resident's hair was observed to be dry. In addition, multiple hairs were observed to be on the resident's upper clothing.</p> <p>Further observation on 02/25/10 at 3:00 PM revealed unsampled Residents #1 and #3's hair was matted and unkempt. Unsampled Residents #2 and #4's hair was dry and sticking straight out.</p> <p>The five residents were not able to be interviewed regarding their grooming.</p> <p>Interview on 02/25/10 at 3:00 PM with Certified Nursing Assistant (CNA) #12 revealed she was normally assigned to the unit where Resident #21 resided. She stated she was aware Resident #21 and four (4) other unsampled residents' hair was a mess. The CNA indicated three (3) of the five (5) residents attended school (off the facility premises) daily. The CNA stated "I have children and there is no way I would let them go out anywhere looking like that. It has to affect them</p>	F 241	<p>administrator and/or designee will audit the (5) identified residents in the survey, plus (5) randomly selected residents regarding grooming needs and overall appearance (3) times per week for (4) weeks. Any identified issues will be corrected immediately.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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

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FORM APPROVED
OMB NO. 0938-0301

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 241	Continued From page 20 to look that way". She stated she informed the facility the residents required a different hair care program other than shampooing and blow drying every day but nothing had ever been done. She stated Resident #21 and the four (4) other residents required a relaxer approximately every six (6) weeks, and a moisturizer every week. The CNA indicated she was unaware if training had been provided related to grooming hair for residents with "different hair needs". Interview on 02/26/10 at 3:45 PM with the Director of Nursing (DON) revealed no training had been provided by the facility for grooming hair for residents who required hair care other than shampooing and blow drying the hair. She indicated she was aware of the concern and had planned to take care of the situation.	F 241		
F 250 88=0	483.16(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide medically-related social services related to arranging transportation for scheduled surgery for one (1) of twenty-four (24) sampled residents (Resident #14). The findings include:	F 250	F 250 Resident # 14 no longer resides at the facility. The Director of Nursing and Licensed Nurse designee conducted an audit on active residents on 2/26/20 to evaluate appropriate discharge of a resident. No other residents were identified to be affected by the deficient practice. No other residents were identified to be affected by the deficient practice. Resident Services Coordinator was educated on responsibility for setting up transportation and appointments on 3/5/10 by the Administrator. A "resident transportation" calendar book has been implemented to	4/13/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 250	<p>Continued From page 21</p> <p>Record review revealed Resident #14 was admitted to the facility on 01/02/10 with diagnoses which included severe Degenerative Joint Disease. Continued review revealed the resident was admitted while awaiting Left Total Hip Replacement surgery. Resident #14 was discharged from the facility to the hospital for the surgery on 02/01/10. Continued record review revealed no documented evidence of the means by which the resident was transported to the hospital.</p> <p>Interview with the Social Services Director on 02/23/10 at 4:15 PM revealed she was responsible for arranging transportation of residents to scheduled appointments. She stated there was a "miscommunication" between nursing and social services regarding Resident #14's transport needs. Continued interview revealed the nurse should have informed her transportation was required, when the resident's surgery was scheduled. She further stated she knew Resident #14 had a scheduled surgery but was never told the resident needed transportation.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 revealed she was responsible for Resident #14 on the day the resident was discharged to the hospital. She stated after arriving for work on the morning of discharge (02/01/10), at approximately 7:20 AM, she observed the resident and a family member entering the elevator and both appeared to be angry. Resident #14's Certified Nursing Assistant (CNA) reported to her the resident stated he/she was supposed to be at the hospital by 7:30 but no one from the ambulance service came to the facility to get the resident.</p>	F 250	<p>ensure appropriate communication between resident services coordinator and nursing. Facility staff was educated on the transportation calendar book and appointment process on 3/5/10 by the Administrator.</p> <p>In order to ensure compliance, the Resident Services Coordinator and/or designee will monitor transportation via transportation compliance log on a daily basis during the week and notify nursing staff as appropriate. Identified issues will be corrected immediately.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 250	Continued From page 22 Continued interview revealed Social Services was responsible for making transportation arrangements. LPN #4 stated she did not know why the arrangements were not made. Further interview revealed she recalled the resident's appointment time was posted on the "communication board" in the Social Services office but she did not know if anyone had verbalized to Social Services about the need for transportation for Resident #14.	F 250		
F 200 88=17	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to revise the Care	F 200	F 200 Resident # 2's care plan was reviewed and updated to include a perimeter mattress and half side rails. Resident # 3's care plan was reviewed and updated to reflect the discontinuation of the catheter. Director of Nursing and/or Licensed Nurse designee conducted a care plan audit for active residents on 2/25/10. Identified issues were corrected. Licensed Nursing staff was educated on updating care plans on 3/18/10 by the Director of Nursing and/or Licensed Nurse designee. Nursing staff from agency and/or new nursing staff will be educated on the process prior to assignment on the floor. In order to ensure compliance, MDS nurse and/or designee will review new orders to ensure care plans are updated to reflect current orders. In addition, (5) random charts will be	4/13/10

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 280	<p>Continued From page 23</p> <p>Plans for two (2) of twenty-four (24) sampled residents (Resident #2 and #3). Resident #2's Care Plan failed to include the use of a perimeter mattress and half side rails. Resident #3's Care Plan was not revised to reflect the discontinuation of a catheter.</p> <p>The findings include:</p> <p>The facility's policy entitled "Assessment Care Plans" dated September 2009, revealed the facility would assess each resident, upon admission, re-admission, quarterly or with a significant change of condition, and an individualized plan of care would be developed from the information gathered during the assessment. In addition, the policy revealed Care Plans would be reviewed at least quarterly and revised as indicated.</p> <p>1. Review of the clinical record revealed Resident #2 was admitted with diagnoses which included Mental Illness and a History of Cerebrovascular Accident.</p> <p>The Quarterly Minimum Data Set (MDS) dated 01/10/10, revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making and as requiring extensive assistance with transfer and toileting. Review of the Resident Assessment Protocol Summary (RAPS) dated 12/14/09, revealed the facility indicated the resident experienced a fall in the past thirty-one (30) days.</p> <p>Observation on 02/23/10 at 4:00 PM, revealed the resident's bed contained a perimeter mattress and two (2) half side rails.</p>	F 280	<p>reviewed (4) times per week for (4) weeks by the Director of Nursing and/or Licensed Nurse designee. Issues identified will be corrected immediately.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE .401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 200	<p>Continued From page 24</p> <p>Review of the Comprehensive Care Plan dated 01/27/10, revealed the facility identified Resident #2 as having a potential for falls. Interventions included use non-skid socks and assist with transfers. Record review revealed no documented evidence Resident #2's Care Plan included the use of a perimeter mattress and half side rails.</p> <p>Interview on 02/26/10 at 6:25 PM, with the MDS Nurse revealed she was responsible for revising Resident #2's Care Plan. She indicated she should have revised the Care Plan to include the perimeter mattress and half side rails.</p> <p>2. Record review revealed Resident #3 was admitted to the facility on 12/01/09 with diagnoses which included Malignant Prostatic Neoplasm and Dementia. Review of the Annual Minimum Data Set (MDS) Assessment dated 12/14/09 revealed Resident #3 was assessed by the facility as having short- and long-term memory loss; moderately impaired in decision-making abilities; and, required extensive assistance with Activities of Daily Living (ADLs). In addition, the resident was assessed as having an indwelling catheter for bladder management.</p> <p>Review of the hospital records for 02/18/10 through 02/22/10 revealed the catheter had been removed. Continued review revealed Resident #3's spouse and Power of Attorney had refused further catheterization.</p> <p>Review of the Physician's Orders received when Resident #3 returned to the facility from the hospital revealed no order for a catheter. Review of the Care Plan revealed it had not been revised</p>	F 200		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 280	Continued From page 25 to reflect discontinuation of the catheter.	F 280		
F 281 BS=K	<p>Interview with the Director of Nursing (DON) on 02/25/10 at 10:10 AM revealed the nurse who transcribed the orders should have updated the Care Plan at that time. Continued interview revealed the DON, during the current survey, had implemented daily chart audits whereby she would check each chart for new orders and revise the Care Plan as indicated.</p> <p>403.20(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, interview and record review, it was determined the facility failed to ensure Physicians' orders were implemented therefore, failed to provide services to meet professional standards of quality for six (6) of twenty-four (24) sampled residents (Residents #13, #15, #7, #4, #3, #5).</p> <p>Resident #13 had an order to hold his/her Coumadin on 01/27/10. There was no documented evidence the order was transcribed to the Medication Administration Record (MAR) and the resident subsequently received the Coumadin. Laboratory (lab) testing, performed on 01/29/10, revealed Resident #13's lab values measuring the thickness of the blood were at a critical level (indicating the resident's blood was too thin), and Vitamin K (for blood coagulation) was administered.</p>	F 281	<p>F 281</p> <p>Resident # 3's skin assessment was completed. Resident # 4's care plan was reviewed and pelvic restraint was validated to be administered per order immediately. Resident # 5's skin assessment was completed. Resident # 7's missed doses of Antibiotics were reported to the physician and responsible party on 3/8/10 with no new orders received. Resident # 13 expired. Resident # 15's Coumadin administration and PTINR issues were reviewed with the physician on 2/19/10 with new orders received and implemented. Resident # 16's care plan was developed on 2/19/10 to address anticoagulant therapy.</p> <p>LPN # 1 was suspended and then terminated in relation to performance of job duties.</p> <p>The Director of Nursing and/or Licensed Nurse designee conducted an audit on physician orders for</p>	4/13/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 BABY 20TH STREET COVINGTON, KY 41014	
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F 281	<p>Continued From page 28</p> <p>Resident #15's Physician ordered daily Coumadin therapy however, the facility failed to administer the Coumadin as ordered on 02/01/10 through 02/05/10, on 02/09/10 and again on 02/18/10. The Physician was not made aware of the missed dosages and increased the Coumadin based on laboratory values. The resident's lab values were at a critical level and the resident required Vitamin K.</p> <p>Resident #7 had physician orders for antibiotics on two (2) separate occasions. The facility failed to ensure the antibiotics were administered as ordered and the resident missed the first three (3) doses of antibiotics on both occasions. Resident #4 had a physician's order for a pelvic restraint which the facility failed to ensure was applied as ordered. The facility failed to follow Physician's orders for Residents #3 and #5 related to completing weekly skin assessments.</p> <p>In addition, the facility failed to develop initial care plans to meet the needs of newly admitted residents for two (2) of twenty-four (24) sampled residents (Resident #15 and #13).</p> <p>The facility's failure to provide services to meet professional standards of quality, as evidenced by the facility failure to follow physician's orders placed residents in the facility at risk for serious injury, harm, impairment or death (Refer to F-308 and F-329).</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Care Standards" dated September 2009, revealed the facility would ensure care and services were provided according to accepted standards of</p>	F 281	<p>active residents on 2/26/10, 2/27/10, 2/29/10, 3/13/10, and 3/14/10. Identified issues were corrected.</p> <p><u>Skin Assessments</u></p> <p>The Director of Nursing and/or Licensed Nurse designee completed an in-house audit on all resident skin on 3/12/10. Identified issues were addressed.</p> <p>Licensed Nursing staff was educated on completion of skin assessments on 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or Licensed Nurse designee.</p> <p>In order to ensure compliance, Director of Nursing and/or Licensed Nurse designee will audit the completion of skin assessments (4) times per week for (4) weeks. Issues identified will be corrected immediately.</p> <p><u>Care Plans</u></p> <p>Director of Nursing and/or Licensed Nurse designee conducted a care plan audit for active residents on 2/25/10. Identified issues were corrected.</p> <p>Director of Nursing and/or Licensed Nurse designee completed an audit on restraints in accordance with physician orders for residents on</p>	

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 201	<p>Continued From page 27 clinical practice.</p> <p>1. Record review revealed Resident #13 was admitted to the facility on 01/19/10, with diagnoses which included Cerebrovascular Accident (CVA) with left-sided hemiplegia and right elbow fracture. The resident was receiving Coumadin therapy when admitted to the facility. Admission orders revealed the Physician ordered a PT/INR (Prothrombin Time/International Normalized Ratio) to be obtained on 01/20/10. Review of the lab report dated 01/20/10, revealed the PT was 22.4 (normal 10.5-14.1 seconds) and an INR of 1.0 (normal for standard anticoagulant use is 2.0-3.0)</p> <p>Review of a Physician's Order written on 01/27/10, revealed the resident's Coumadin was to be held that night. Review of the Medication Administration Record (MAR) revealed no documented evidence the order to hold the Coumadin was transcribed to the MAR. Further review of the MAR revealed Resident #13 received the Coumadin on 01/27/10.</p> <p>Review of the Physician's Orders revealed an order dated 01/27/10, to have a PT/INR obtained on 01/28/10. Record review revealed no documented evidence the lab tests had been obtained on 01/28/10. Review of the MAR revealed Resident #13 received Coumadin on 01/28/10. The lab report dated 01/29/10, revealed the resident had critical lab values, a PT greater than 100 seconds (normal range 9.0-11.4 seconds) and an INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0). Resident #13's Physician was notified and ordered Vitamin K, which was administered subcutaneously as ordered.</p>	F 201	<p>3/12/10. Identified issues were corrected.</p> <p>Licensed Nursing staff was educated on the development of initial care plans on 2/25/10. Licensed Nursing staff was educated on the development and implementation of comprehensive care plans on 3/10/10, 3/11/10, 3/12/10, and 3/18/10 by the Director of Nursing and/or designee.</p> <p>In order to ensure compliance of care plans, new admissions and (5) random charts will be reviewed (4) times per week for (4) weeks by the Director of Nursing and/or Licensed Nurse designee. Issues identified will be corrected immediately.</p> <p><u>Medication Administration</u></p> <p>The Licensed Pharmacist reviewed all medication records and medications to ensure availability on 2/24/10 and 3/15/10. Identified issues were corrected.</p> <p>Licensed Nursing staff was educated on medication administration on 2/20/10, 2/21/10, 2/22/10, 2/23/10, and 2/24/10 by the Administrator and/or Director of Nursing.</p> <p>Licensed Nursing staff was educated on following physician's</p>		

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 281	<p>Continued From page 28</p> <p>Interview on 02/18/10, at 4:55 PM with Licensed Practical Nurse (LPN) #1 revealed she was unable to recall why she did not transcribe the 01/27/10 order to hold Resident #13's Coumadin onto the MAR. She further stated she should have done this to ensure the physician's order was implemented.</p> <p>Interview on 02/21/10, at 8:37 PM with Licensed Practical Nurse (LPN) #4, who worked on the unit where Resident #13 had resided, revealed lab results were never received, for the PT/INR ordered on 2/18/10, related to the specimen being left at the facility by the lab tech. According to LPN #4, the specimen was to be picked up on 02/20/10, by a courier who was to deliver it to the lab. LPN #4 stated another lab tech found the specimen on the morning of 01/20/10 and obtained a specimen from Resident #13 for testing on 1/20/10.</p> <p>Interview on 02/25/10, at 10:16 AM, with the Regulatory Manager of the lab revealed the lab was not contacted by the facility related to the 01/28/10 blood draw. The Regulatory Manager stated blood was drawn on 01/28/10, however it was to be picked up by a courier. According to the Regulatory Manager, the courier did not pick up the blood specimen. She stated the facility's nursing staff did not call to inquire why no results were received on 01/28/10.</p> <p>Interview on 02/22/10 at 2:15 PM with Registered Nurse (RN) #2, the current Director of Nursing (DON), revealed licensed nursing staff should have transcribed the order to hold the Coumadin to the MAR to ensure the order was followed. The DON stated nurses should have notified the</p>	F 281	<p>orders and medication transcription 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or Licensed Nurse designee.</p> <p>The pharmacy and medication monitoring system was implemented on 2/24/10 by the Director of Nursing and Administrator and includes the following process:</p> <ol style="list-style-type: none"> 1) Charge nurse receives the order. 2) Charge nurse documents orders in the progress notes. 3) Charge nurse notifies the family. 4) Charge nurse places the order on the MAR and/or TAR. 5) Charge nurse to fill out lab requisition if lab ordered. 6) Charge nurse will fax order to the pharmacy. 7) Charge nurse will place top copies and place in the "Medication Orders/Refill" folder. 8) Charge nurse receiving medications will validate each medication with the order/refill sheet when medications arrive. 9) Charge nurse will verify that the medication was received. If the medication was not received, charge nurse will call the pharmacy and order the medication STAT. <p>In order to ensure compliance, the Director of Nursing or Licensed Nurse designee will pick up the folder labeled "Medication Order/Refill" found in the central</p>	

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 281	<p>Continued From page 29</p> <p>lab when no results were received on 01/28/10.</p> <p>Interview on 02/19/10, at 4:30 PM with Registered Nurse (RN) #1, the former DON revealed there was no system in place to ensure labs were completed as ordered and the results reported to the Physician. An additional interview on 02/24/10 at 3:20 PM, with the former DON, revealed the facility had no documented evidence of any staff training related to transcribing orders. She also stated there was no system in place to ensure physician orders were transcribed to the MARs.</p> <p>Interview on 02/24/10, at 8:30 AM with Resident #13's Physician revealed the resident's Coumadin should have been hold as ordered on 01/27/10. The Physician stated he should have been notified when the lab results were not received on 01/28/10.</p> <p>2. Record review revealed Resident #15 was admitted to the facility on 01/30/10 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, and History of Cerebrovascular Accident. The resident was receiving Coumadin Therapy upon admission.</p> <p>On the 01/30/10 admission orders, the Physician ordered to hold the resident's daily Coumadin 2 mg dose until the 01/31/10 results of the PT/INR had been sent to him. Review of the PT/INR results, faxed to the facility on 01/31/10 at 1:31 PM revealed, PT-32.2 (normal range 10.5-13.8) and INR-2.6 (normal range for standard anticoagulant therapy 2.0-3.0). Review of the progress notes and Physician's orders revealed no evidence the Physician was notified of the</p>	F 281	<p>nurses station and validate that the medications/labs have been received/completed on a daily basis. In addition, the Director of Nursing and/or Licensed Nurse designee will audit MARS, TARS (4) times per week for (4) weeks. Issues identified will be corrected immediately.</p> <p><u>Lab Tracking</u></p> <p>The Director of Nursing and/or Licensed Nurse designee completed an audit on lab orders and results for residents on 2/25/10. Issues identified were corrected.</p> <p>Licensed Nursing staff was educated on the lab tracking process and medication administration on 2/20/10, 2/21/10, 2/22/10, 2/23/10, and 2/24/10 by the Administrator and/or Director of Nursing.</p> <p>The lab tracking process and monitoring system was implemented on 2/20/10 and includes the following:</p> <ol style="list-style-type: none"> 1) Lab order is received by the charge nurse from the physician. 2) Lab requisition will be completed and placed in the lab box under the corresponding date by the charge nurse. 3) Labs will be drawn and the pink copy of the lab requisition will be 	

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 201	<p>Continued From page 30</p> <p>results until 02/01/10 at 1:30 PM, at which time an order was obtained to resume Coumadin 2 mg daily and to repeat the PT/INR on 02/05/10.</p> <p>Review of the Medication Administration Record (MAR) revealed the Coumadin 2 mg, ordered daily by the resident's physician, was not administered on 02/01/10, 02/02/10, 02/03/10, 02/04/10, as ordered. Interview with LPN #1, the nurse assigned to administer medications on those days, revealed the medication was not given because it was not available in the medication cart. She further stated the medication was not available in the Emergency Box. However, review of the Pharmacy delivery record revealed fourteen (14) 2 mg Coumadin tablets were delivered to the facility on 02/01/10. Interview with RN #1, DON at the time the Coumadin was not administered, on 02/10/10 at 2:00 PM, revealed she was not aware the Coumadin was not given for four (4) days and there was no system in place to ensure Physician's orders were followed.</p> <p>Record review revealed on 02/05/10 the Physician ordered Coumadin 4 mg daily and repeat the PT/INR on 02/08/10. Review of the MAR revealed Coumadin 4 mg was not given on 02/05/10. On 02/08/10 the Physician ordered to increase the Coumadin to 8 mg daily at bedtime and to repeat the PT/INR on 02/11/10. Review of the MAR revealed Resident #15 failed to receive the Coumadin 8 mg on 02/09/10.</p> <p>Record review revealed on 02/11/10 the Physician ordered Coumadin 10 mg daily at bedtime and to repeat the PT/INR on 02/16/10. Review of the MAR revealed Resident #15 did not receive the Coumadin 10 mg on 02/11/10 as</p>	F 201	<p>returned to the lab box under the corresponding date.</p> <p>4) When lab results are returned they are to be taken off the fax machine. The charge nurse will fax results to the physician. A follow up call will be placed to the physician to ensure the lab was received.</p> <p>5) Critical labs or results that require any type of medication adjustment will be called to the physician for further clarification. If the physician does not respond back after an hour, additional follow up from the nurse will occur.</p> <p>6) Once the physician has been notified, the charge nurse will file in the medical records.</p> <p>In order to ensure compliance, the Director of Nursing and/or Licensed Nurse designee will review new orders and lab requisitions on a daily basis. Issues identified will be corrected immediately.</p> <p>All identified areas above will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 2B1	<p>Continued From page 31</p> <p>ordered. Interview with LPN #1 revealed she did not give the Coumadin 10 mg on 02/11/10 because the medication was not available. However, review of the Pharmacy delivery record revealed fourteen (14) Coumadin-10 mg tablets were delivered on 02/11/10.</p> <p>Review of the PT/INR results from 02/15/10 revealed Resident #15's PT was 80.8 (normal range 10-13.8) and the INR was 6.9 (normal range .66-1.22). The Physician was notified, issued orders to hold the Coumadin and repeat the PT/INR on 02/16/10. Record review revealed no evidence the PT/INR was drawn on 02/16/10.</p> <p>Interview with the Administrator and the DON on 02/19/10 at 2:30 PM revealed the lab did not come to the facility that day due to inclement weather. However there was no evidence the facility obtained the lab or notified the Physician that the lab was not obtained.</p> <p>Record review revealed on 02/16/10 at 9:30 AM, Resident #15 was sent to the hospital with complaints of Chest Pain and Shortness of Breath. Review of the PT/INR from the hospital emergency record revealed PT-131.9 and INR-10.3. Resident #16 returned to the facility and required a Vitamin K 20 mg subcutaneous injection (used for blood clotting) at 5:30 PM. The Physician ordered to repeat the PT/INR on 02/17/10. Record review revealed no evidence the PT/INR was drawn on 02/17/10. Interview with the DON on 02/19/10 at 2:30 PM revealed she felt there was a system breakdown with obtaining the physician ordered labs. Further record review revealed the Physician ordered a second Vitamin K injection of 10 mg on 02/17/10.</p>	F 2B1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(K4) 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)	(K5) COMPLETION DATE
F 201	<p>Continued From page 32</p> <p>Record review revealed a Physician's order on 02/18/10 to resume Coumadin 2 mg daily. Review of the MAR revealed the Coumadin 2 mg was not provided on 02/18/10, as ordered. Interview with LPN #1, assigned to medication administration on 02/18/10 revealed she did not give the Coumadin 2 mg because it was not available.</p> <p>Interview with the resident's Physician on 02/19/10 at 3:16 PM revealed he was unaware Resident #15 had missed multiple doses of the ordered Coumadin. He stated he should have been notified. The Physician stated Coumadin Therapy needed to be monitored closely and it was a concern to him that facility staff were not administering the medication as ordered.</p> <p>3. Review of the clinical record revealed Resident #7 was admitted to the facility with diagnoses which included Diabetes Mellitus, Hypotension and Depression. Review of the Admission Minimum Data Set (MDS) dated 01/05/10 revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/05/10, and the Comprehensive Care Plan dated 01/11/10, revealed the facility assessed the resident as having a urinary tract infection. Interventions included administer antibiotic or treatment as ordered by the Physician.</p> <p>Review of the Physician's Order dated 01/11/10 revealed an order for Omnicof (antibiotic) 300 milligrams every twelve (12) hours for seven (7) days. Review of the Medication Administration</p>	F 201		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 281	<p>Continued From page 33</p> <p>Record (MAR) for January, 2010 revealed the first dose of the antibiotic was scheduled to be administered on 01/11/10. However, there was no documented evidence Resident #7 received the first three (3) scheduled doses of the ordered antibiotic.</p> <p>Continued review of the Physicians's Order dated 02/12/10, revealed an order for Cipro (antibiotic) 250 milligrams (mg) to be administered two times a day. Review of the MAR for February, 2010, revealed the first dose of the antibiotic was scheduled to be administered on 02/12/10. Further review revealed no documented evidence Resident #7 received the first three scheduled doses of the Cipro (antibiotic) as ordered.</p> <p>Interview on 02/25/10 at 3:45 PM with the current Director of Nursing (DON) revealed she was the Charge Nurse on the unit where Resident #7 resided prior to accepting the position of DON. She indicated she was aware the resident had missed the first three (3) scheduled doses of the Omnicef (antibiotic) and had no explanation as to why the resident did not receive the antibiotic. She indicated at the time the antibiotics were ordered, she failed to utilize the pharmacy's emergency stock box which contained the antibiotics due to not having clear guidance on how to use the emergency box. She stated the resident should have received the antibiotics as scheduled.</p> <p>4. Review of Resident #4's clinical record revealed diagnosis which included Mental Retardation, Seizure Disorder, History of Developmental Delay, and Tubercous Sclerosis. Based on the resident's most recent full Minimum</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 501 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 201	<p>Continued From page 34</p> <p>Data Set (MDS), completed on 12/14/09, the facility assessed the resident as having severe cognitive impairment and required extensive to total assistance with all ADLs (Activities of Daily Living). Further review of this assessment revealed the resident was assessed to be able to walk with extensive assistance of two staff, the resident's customary mode of locomotion consisted of the use of a specialized wheelchair with extensive assistance of one staff person.</p> <p>Review of the fall risk assessment, dated 01/20/10, revealed Resident #4 continued to be at high risk for falls. As a result, several interventions had been put into place to guard against falls which included the use of an "over-the-shoulder harness" and "pelvic leg restraints" used when the resident was up in the wheelchair. The use of both devices were incorporated into the resident's care plan under "restrictive devices".</p> <p>Review of the monthly Physician's orders, dated 02/01/10, revealed an order for "over-the-shoulder harness" and "pelvic leg restraints" used when the resident was up in the wheelchair to maintain position.</p> <p>Observation of Resident #4 on the evening of 02/23/10 at 6:30 PM revealed the shoulder harness and pelvic restraint to be in place. On the following day (02/24/10) at 2:00 PM the resident was observed in the hall just outside the unit's dining room, with head leaning forward, sitting up in the wheelchair. Closer observation revealed the right shoulder strap of the harness had slipped midway down the right arm. In addition, no pelvic restraint was observed to be in place at that time, as ordered. The resident</p>	F 201			

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 201	<p>Continued From page 35</p> <p>continued to remain in that state for approximately one hour with no attempt by staff to correct the position of the shoulder harness or apply the pelvic restraint.</p> <p>On 02/25/10, at approximately 4:00 PM, the resident was observed sitting up in the wheelchair with both the shoulder harness and pelvic restraints in place. During an interview with RN #3 at 4:10 PM, the nurse confirmed the shoulder harness was necessary to maintain proper alignment and posture for the resident when sitting up in the wheelchair, and the pelvic restraint was intended to prevent the resident from sliding down in the chair.</p> <p>5. Review of Resident #3's clinical record revealed diagnoses which included Diabetes, Dementia, and Malignant Prostatic Neoplasm. Review of the Admission Minimum Data Set (MDS) Assessment dated 12/14/10 revealed the facility assessed Resident #3 as being moderately impaired related to decision-making abilities; incontinent of bowel and bladder, and required extensive assistance with all Activities of Daily Living (ADLs).</p> <p>Based on the MDS, the facility assessed Resident #3 as being at risk for skin breakdown. Review of the Comprehensive Care Plan reveal a potential for alteration in skin integrity related to incontinence, requiring extensive assist with bed mobility and toileting. Review of the Physician's Orders for February, 2010 revealed Resident #3 had an order to complete weekly skin assessments.</p> <p>Interview on 02/23/10, at 7:50 PM with Licensed</p>	F 201			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 201	<p>Continued From page 30</p> <p>Practical Nurse (LPN) #4, who worked on the unit where Resident #3 resided, revealed all residents were to have weekly skin assessments, with or without a doctor's order.</p> <p>Record review revealed no documented evidence the skin assessments were completed as ordered by Resident #3's physician.</p> <p>6. Resident #5 was readmitted to the facility on 12/01/09 with diagnoses which included Diabetes and Dementia. Review of the Initial MDS Assessment dated 12/14/09 revealed Resident #5 was assessed by the facility to be moderately impaired for decision-making abilities, required moderate to extensive assistance with ADLs, and was frequently incontinent of bowel and bladder.</p> <p>Review of the Physician's Orders for February, 2010 revealed Resident #5 was to have weekly skin assessments.</p> <p>Record review of the TAR for 02/10 revealed no documented evidence that the weekly skin assessments were completed as ordered. Interview with the DON on 02/24/10 at 2:00 PM revealed, Resident #3 should have had weekly skin assessments as ordered and they should have been documented on the TAR.</p> <p>Additionally, the following two examples reflect the failure of the facility to develop an initial care plan when residents were admitted.</p> <p>Review of the facility policy on Assessment and Care Plans, dated September 2009, revealed an admission care plan will be initiated to address the residents most immediate needs with twenty-four (24) hours of the admission.</p>	F 201			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 281	<p>Continued From page 37</p> <p>7. Record review revealed Resident #13 was admitted to the facility on 01/19/10, with diagnoses which included Cerebrovascular Accident (CVA) with left-sided hemiplegia, Hypertension (HTN), Diabetes, Atrial Fibrillation (A-fib), and a fractured right elbow. The resident was receiving Coumadin Therapy and Tube Feeding upon admission.</p> <p>Further review of the record revealed no documented evidence the facility developed an initial care plan to address interventions associated with A-fib, Diabetes, HTN, CVA with left-sided hemiplegia, fracture right elbow, use of anticoagulants and tube feeding.</p> <p>8. Record review revealed Resident #15 was admitted to the facility on 01/30/10 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, Hypertension, and History of Cardiovascular Accident. The resident was receiving Coumadin Therapy upon admission.</p> <p>Record review revealed the facility failed to ensure the development of an initial care plan to address interventions associated with Atrial Fibrillation, Congestive Heart Failure, Hypertension, History of Cardiovascular Accident and the use of anticoagulants.</p> <p>Interview with RN #1, DON at the time, on 02/18/10 at 2:00 PM, revealed an initial care plan should be developed to guide the treatment for each resident admitted to the facility. She stated the admitting nurse would be responsible for the development of the initial care plans. Interview further revealed Resident #15 should have had an initial care plan for the anticoagulant therapy.</p>	F 201		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 201	Continued From page 38 RN #1 stated the facility had not provided training related to the developing initial care plans for newly admitted residents. An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/26/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following: Record review of new admissions revealed initial care plans were developed and implemented. All licensed nursing staff were inserviced on following physician's orders, documenting on the 24 hour report, physician notification, laboratory orders and testing, and initial nursing care plans. Interview with five (5) licensed staff and three (3) CNAs, on 02/27/10, revealed they had attended the inservices and were familiar with all the changes. Interview with the Director of Nursing (DON) revealed she was monitoring the nursing staff daily for continued compliance. Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "E" based on the facility's need to evaluate the effectiveness of quality assurance activities related to professional standards of quality, such as notification of Physicians and development of initial care plans.	F 201		
F 202 386J	489.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 202	F 282 Resident # 1 was discharged to the hospital for evaluation on 1/21/10 and returned to the facility 1/27/10. Resident # 4's care plan was reviewed and pelvic restraint was validated to be administered per order.	4/13/10

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 202	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the Comprehensive Plans of Care were implemented for two (2) of twenty-four (24) sampled residents (Resident #1 and Resident #4).</p> <p>Resident #1 had a diagnosis of Hypertension with care plan interventions to monitor blood pressure and alert the Physician of adverse reactions. The facility failed to implement the Plan of Care by failing to notify the resident's Physician, and continuing to monitor the resident's blood pressure, after the resident complained of dizziness and the facility assessed a blood pressure of 228/108 on 1/20/10. Resident #1 was sent to the hospital on 1/21/10 and diagnosed with a Cerebrovascular Accident (CVA).</p> <p>In addition, the facility failed to follow the Comprehensive Care Plan for Resident #4 related to restrictive devices.</p> <p>The facility's failure to ensure quality of care was provided in accordance with the Comprehensive Care Plans placed residents in the facility at risk for serious harm, injury, impairment or death. (Refer to F309)</p> <p>The findings include:</p> <p>1. Record review revealed Resident #1 was admitted to the facility with diagnoses which included Mental Retardation, Hypertension, Diabetes, and Coronary Artery Disease.</p>	F 202	<p>Director of Nursing and/or Licensed Nurse designee observed residents on 3/15/10, 3/16/10, 3/17/10, 3/18/10, and 3/19/10 to validate the implementation of interventions in accordance with the care plan. Identified issues were corrected.</p> <p>Director of Nursing and/or Licensed Nurse designee completed an audit on restraints in accordance with physician orders for residents on 3/12/10. Identified issues were corrected.</p> <p>LPN # 1 was suspended and then terminated in relation to performance of job duties.</p> <p>Licensed Nursing staff was educated on the development of initial care plans on 2/25/10. Licensed Nursing staff was educated on the development and implementation of comprehensive care plans on 3/10/10, 3/11/10, 3/12/10, and 3/18/10 by the Director of Nursing and/or designee.</p> <p>In order to ensure compliance of implementation of interventions in accordance with care plans, new admissions and (3) random charts will be reviewed (4) times per week for (4) weeks by the Director of Nursing and/or Licensed Nurse designee. Issues identified will be corrected immediately.</p>	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 282	<p>Continued From page 40</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/09/09, revealed the facility assessed Resident #1 as requiring no assistance with transfers, ambulation, dressing, range of motion and only required set-up assistance with meals. Review of the MDS revealed Resident #1 tolerated a regular diet and thin liquids. Further review revealed the facility assessed Resident #1 as having no problems with speech or communicating his/her needs.</p> <p>Record review revealed Resident #1 had a history of Hypertension and Chest Pain and was sent to the hospital on 12/20/09 related to an elevated blood pressure and complaint of chest pain.</p> <p>Review of the Comprehensive Care Plan, no development date, with a target date of 03/20/10, revealed the facility had identified a problem related to Hypertension with Intermittent complaints of chest pain. The care plan included interventions to alert the Physician as needed, medications and labs as ordered, to monitor blood pressure readings and notify Physician of any adverse reactions.</p> <p>Record review and interview with Licensed Practical Nurse (LPN) #1, on 02/22/10 at 12:10 PM revealed on 01/20/10 at 0:45 PM, Resident #1 became dizzy in the Dining Room. LPN #1 assessed the resident and identified the resident's blood pressure was 220/100 (resident's average blood pressure 134/70). Record review revealed no documented evidence of intervention to address the elevated blood pressure, as per the Comprehensive Care Plan.</p> <p>Interview with LPN #1 on 2/22/10 at 12:10 PM</p>	F 202	Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 282	<p>Continued From page 41</p> <p>revealed she did not re-assess the vital signs including the blood pressure for Resident #1 until 8:30 PM, two (2) hours and twenty-five (25) minutes later and implemented no intervention related to the elevated blood pressure.</p> <p>Interview on 02/18/10 at 8:30 AM, with LPN #5, the nurse who came on duty at 11:00 PM on 01/20/10, revealed she was informed of the incident involving Resident #1 and was made aware of the elevated blood pressure. She stated LPN #1 reported the resident's blood pressure had not been monitored. Interview with LPN #8 and review of the progress note dated 01/21/10 at 12:45 AM, revealed at this time Resident #1 was assessed by LPN #5, and complained of not being able to move the left hand, had a weak grasp, limp left arm, and difficulty moving his left leg. Resident #1 was transported to the hospital by Life Squad. Review of the hospital emergency room record revealed Resident #1 was diagnosed with Acute Cerebrovascular Accident (CVA) with left side hemiparesis.</p> <p>Observation of Resident #1 on 02/18/10 at 12:30 PM revealed the resident was in a wheelchair in the dining room eating lunch. Resident #1 was unable to use his/her left arm and left hand. Resident #1's left foot was on the wheelchair foot pedal and the resident was eating a pureed (food had been blended to a pureed consistency) diet with thickened liquids. Observations further revealed Resident #1 had a left facial droop.</p> <p>Observation on 02/23/10 at 3:20 PM revealed Resident #1 was in a wheelchair and was propelling the wheelchair with his right hand and right foot. Further observation revealed Resident #1 had difficulty speaking and expressing his needs.</p>	F 282		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 282	<p>Continued From page 42</p> <p>Interview with Resident #1's Physician on 02/22/10 at 12:00 PM revealed he recalled the incident with Resident #1 on 01/20/10. He stated he was not made aware of the elevated blood pressure and if he had been informed of a blood pressure of 228/108 he would have ordered medication for the elevated blood pressure. The resident's Physician indicated he would have ordered the resident be sent to the hospital, related to the elevated blood pressure.</p> <p>2. Review of Resident #4's clinical record revealed diagnoses which included Mental Retardation, Seizure Disorder, History of Developmental Delay, and Tuberculous Sclerosis. Based on the resident's most recent full Minimum Data Set (MDS), completed on 12/14/09, the facility assessed the resident as having severe cognitive impairment and required extensive to total assistance with all ADLs (Activities of Daily Living). Further review of this assessment revealed, resident was assessed to be able to walk with extensive assistance of two staff, the resident's customary mode of locomotion consisted of the use of a specialized wheelchair with extensive assistance of one staff person.</p> <p>Based on a fall risk assessment, dated 01/20/10, Resident #4 continued to be at high risk for falls. Review of the Plan of Care, development date unknown with a target date of 03/28/10, revealed interventions related to the risk of falls which included the use of an "over-the-shoulder harness" and "pelvic leg restraints" to be used whenever the resident was up in the wheelchair.</p> <p>Observation of Resident #4 on 02/23/10 at 8:30 PM revealed the shoulder harness and pelvic restraints were in place. On 02/24/10 at 2:00 PM,</p>	F 282			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 108036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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
F 282	<p>Continued From page 43</p> <p>the resident was observed sitting in a wheelchair in the hallway and appeared to be asleep, with eyes closed and his/her head leaning forward. Resident #4's right shoulder strap of the harness was observed to have slipped midway down the right arm. In addition, no pelvic restraint was observed to be in place at that time, per the Plan of Care. The resident continued for approximately one hour with no staff observed to correct the position of the shoulder harness, or apply the pelvic restraint.</p> <p>During an interview with RN #3 on 02/26/10 at 4:10 PM, the nurse explained Resident #4's shoulder harness was necessary to maintain proper alignment and posture for the resident when sitting up in the wheelchair. RN #3 stated the pelvic restraint was intended to prevent the resident from sliding down in the chair.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/20/10, prior to exit. Facility actions taken and verified by the survey team through interview and record review revealed the following: Record review revealed care plans were developed and implemented. All licensed nursing staff were inservice on following the Comprehensive Care Plan.</p> <p>Interview with five (5) licensed staff and three (3) CNAs revealed they had attended the inservice and were familiar with the changes. Interview with the Director of Nursing (DON) revealed she was monitoring the nursing staff daily for continued compliance.</p> <p>Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued</p>	F 282		

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

PRINTED: 03/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 282	Continued From page 44 with the Scope and Severity lowered to a "D" based on the facility's need to evaluate the effectiveness of quality assurance activities related to the implementation of residents' care plans.	F 282		
F 309 98-J	183.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure care and services were provided to attain and maintain the resident's highest practicable physical well-being for four (4) of twenty-four (24) sampled residents, Residents #1, #2, #14 and #5. The facility failed to ensure care and services were provided for Resident #1 who was assessed by the facility to have a blood pressure of 228/108 on 1/20/10. There was no evidence the physician was notified and no evidence of intervention or continued monitoring of Resident #1. The resident was hospitalized on 1/21/10 with a Cerebrovascular Accident (CVA). Further the facility failed to have a bowel monitoring system in place for Resident #2, #14, and #5. Resident #2 went seven (7) days with no evidence of a bowel movement and no	F 309	F 309 Resident # 1 was discharged to the hospital for evaluation on 1/21/10 and returned to the facility on 1/27/10. Resident # 2's plan of care was reviewed and placed on an effective bowel monitoring program. Resident # 5's plan of care was reviewed and placed on an effective bowel monitoring program. Resident # 14 no longer resides at the facility. LPN # 1 was suspended and then terminated in relation to performance of job duties. Licensed Nursing staff was educated on change of condition, and physician notification on 2/22/10, 2/23/10 and 2/24/10 by the Director of Nursing. Licensed Nursing staff was educated on resident assessment, reassessment, monitoring, and following physician orders on 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or designee. New bowel monitoring flow sheets were implemented by the Director of	4/13/10

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 309	<p>Continued From page 45</p> <p>Intervention. Resident #14 went ten (10) days without a bowel movement and no evidence of intervention. Resident #5 went nine (9) days with no evidence of a bowel movement and no intervention.</p> <p>The facility's failure to provide care and services in accordance with acceptable standards of practice related to continuous monitoring of residents with a change in condition, placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>1. Record review revealed Resident #1 was admitted to the facility with diagnoses which included Mental Retardation, Hypertension, Diabetes, and Coronary Artery Disease.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/03/09, revealed the facility assessed Resident #1 as requiring no assistance with transfers, ambulation, dressing, and range of motion. The facility assessed the resident as requiring set-up assistance with meals.</p> <p>Record review revealed Resident #1 had a history of Hypertension and Chest Pain and had been treated at the hospital on 12/29/09 for elevated blood pressure and chest pain.</p> <p>Review of the Comprehensive Care Plan, with no development date and a target date of 03/20/10, revealed a problem of Hypertension with intermittent complaints of chest pain. Interventions included alert Physician as needed, medications and labs as ordered, monitor blood</p>	F 309	<p>Nursing and/or Licensed Nurse designee on 3/15/10. Nursing staff was educated on the new bowel process and interventions as needed on 3/15/10.</p> <p>The 24 hour report was revised and implemented 2/20/10 by the Director of Nursing and Administrator. The tracking of change of condition, physician notification, and appropriate monitoring includes the following process:</p> <p>1) Charge nurses will complete the 24 hour report assigned to their group. Any changes of condition will be reported to the physician by the charge nurse upon discovery, noted on the 24 hour report, monitored, documented in the nursing notes, and reviewed with the next shift.</p> <p>2) The Director of Nursing and/or Licensed Nurse designee will review the 24 hour report and resident's clinical record (including active nursing notes and new physician orders) on a daily basis to ensure that resident change of condition is appropriately documented, monitored, and reported to the physician. Issues identified will be corrected immediately. Licensed Nursing staff will be disciplined as warranted.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 300	<p>Continued From page 48</p> <p>pressure readings, and notify Physician of any adverse reactions.</p> <p>Record review and interview with on 02/22/10 at 12:10 PM with Licensed Practical Nurse (LPN) #1, revealed the LPN routinely cared for Resident #1. LPN #1 stated on 1/20/10, Resident #1 complained of dizziness while in the dining room. LPN #1 assessed the resident and identified the resident's blood pressure was 228/108 (resident's average blood pressure 134/70). According to the LPN, the resident's blood sugar was 522 (resident's average blood sugar 255). Record review and interview with LPN #1 revealed the Physician was notified and issued an order to administer Regular Insulin 10 Units. In addition, the physician's order stated to maintain the resident's hydration, and included laboratory testing of the resident's urine. Further record review revealed no documented evidence of intervention to address the elevated blood pressure. Review of the Interdisciplinary Progress Notes, for 01/20/10, revealed Resident #1 was taken to his/her room via wheelchair to rest in bed at 7:10 PM.</p> <p>Interview with LPN #1 on 2/22/10 at 12:10 PM revealed she did not reassess Resident #1's vital signs including the blood pressure until 9:30 PM, two (2) hours and twenty-five (25) minutes later. LPN #1 indicated she had not implemented any interventions related to the elevated blood pressure.</p> <p>Interview on 02/19/10 at 9:30 AM, with LPN #5, revealed the LPN came on duty at the facility on 01/20/10 at 11:00 PM. LPN #5 stated she was informed of the incident with Resident #1 and was aware that both the resident's blood sugar and</p>	F 300	<p>In order to ensure compliance, the Director of Nursing and/or Licensed Nurse designee will audit bowel monitoring documentation (4) times per week for (4) weeks. Identified issues will be corrected immediately. In addition, Director of Nursing and/or Licensed Nurse designee will review charts on a daily basis to evaluate nursing notes, physician notification, care plans, labs, and new orders. Issues identified will be corrected immediately. Licensed Nursing staff will be disciplined as warranted.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 309	<p>Continued From page 47</p> <p>blood pressure had been elevated. She further stated LPN #1 reported the resident's blood pressure had not been monitored. Review of the progress note and interview with LPN #5 revealed on 01/21/10 at 12:45 AM, Resident #1 was assessed by the LPN. At that time Resident #1 complained of not being able to move the left hand, had a weak grasp, limp left arm, and difficulty moving his/her left leg. Resident #1 was transported to the hospital by Life Squad. Review of the hospital emergency room record revealed Resident #1 was diagnosed with an Acute Cerebrovascular Accident (CVA) with left side hemiparesis.</p> <p>Observation of Resident #1 on 02/18/10 at 12:30 PM revealed the resident was in a wheelchair in the dining room eating lunch. Resident #1 was unable to use his/her left arm and left hand. Resident #1's left foot was on the wheelchair foot pedal and the resident was eating a pureed (blended food) diet with thickened liquids. Record review revealed prior to the CVA the resident tolerated a regular diet and thin liquids. Observations further revealed Resident #1 had a left facial droop. Observation on 02/23/10 at 3:20 PM revealed Resident #1 was in a wheelchair and propelling the wheelchair with his/her right hand and right foot only.</p> <p>Interview with Resident #1's Physician on 02/22/10 at 12:00 PM revealed he recalled the incident with Resident #1 on 01/20/10. He stated he was not made aware of the elevated blood pressure. He stated that if he had been informed of a blood pressure of 220/100 he would have ordered medication for the elevated blood pressure and would have ordered the resident be sent to the hospital for evaluation of the elevated</p>	F 309		

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 309	<p>Continued from page 48 blood pressure.</p> <p>Interview with Certified Nursing Assistant (CNA) #8 on 02/23/10 at 3:30 PM, revealed she was assigned to Resident #1 on 01/20/10. Interview revealed she took Resident #1's blood pressure before assisting the resident to bed but did not recall the time or what the reading of the blood pressure was. She stated she reported the blood pressure to LPN #1 and did not recall taking any further blood pressures on Resident #1 for the remainder of the shift.</p> <p>Review of the facility policy on Care and Services revealed facility staff would be provided educational opportunity and demonstrate competency in applicable standards of clinical practice. However, Interview with RN #1, the former Director of Nursing (DON) while reviewing the policy on 02/24/10 at 3:20 PM, revealed the facility had no formal orientation process or competency evaluation for nursing staff.</p> <p>2. Review of the clinical record revealed Resident #2 was admitted with the diagnoses which included Mental Illness and Cerebrovascular Accident.</p> <p>The Admission Minimum Data Set (MDS) dated 12/14/09 was reviewed and revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making and as being incontinent of bowel. Review of the Resident Assessment Protocol Summary (RAPS) dated 12/14/09 revealed the facility assessed the resident required extensive assistance with toileting and utilized briefs.</p>	F 309			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 26TH STREET COVINGTON, KY. 41014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
E-309	<p>Continued From page 40</p> <p>The Comprehensive Care Plan dated 01/21/10 revealed the facility identified the resident as having a potential for constipation. Interventions included to alert the Physician as needed, medications as ordered and to monitor for bowel movements every shift.</p> <p>Review of the Physician's order February, 2010, revealed an order for Dulcolax suppositories (laxative) every day as needed (PRN) for constipation; Milk of Magnesium (laxative) 30 milliliters (ml) every day PRN for constipation and a Floate onama (laxative) daily PRN for constipation.</p> <p>Review of the Medication Administration Record (MAR) dated February, 2010 revealed no documented evidence Resident #2 had a bowel movement for seven (7) days (02/09/10 through 02/16/10). Resident #2's clinical record revealed no documented evidence the facility implemented any interventions regarding Resident #2's failure to have a bowel movement for seven (7) days.</p> <p>Interview on 02/24/10 at 3:20 PM with Licensed Practical Nurse (LPN) #4 revealed she was assigned to the unit where Resident #2 resided. She stated the nurse was responsible for monitoring residents' bowel movements. LPN #4 stated if a resident did not have a bowel movement in three (3) days, then the nurse would administer the ordered medication. The LPN stated Resident #2 should have received the PRN medication when the resident did not have a bowel movement in three (3) days.</p> <p>3. Clinical Record review revealed Resident #14 was admitted on 01/02/10 with diagnoses which</p>	F 309		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188030	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 309	<p>Continued From page 50</p> <p>Included Severe Degenerative Joint Disease. Review of the Admission Minimum Data Set (MDS) Assessment dated 01/14/10 revealed the facility assessed Resident #14 as being continent of bowel and bladder and required extensive assistance with toileting.</p> <p>Review of the Medication Administration Record (MAR) for January 2010 revealed no documented evidence Resident #14 had a bowel movement for ten (10) days, from 02/10/10 to 02/25/10. The Physician's Orders revealed no order for a laxative. Review of the Interdisciplinary Progress Notes, for this timeframe, revealed no documented evidence the physician was notified or any interventions initiated related to the lack of bowel movements.</p> <p>4. Clinical Record review revealed Resident #5 was readmitted to the facility on 12/01/09 with diagnoses which included Alzheimer's Dementia. Review of the Admission MDS Assessment dated 12/14/09 revealed the facility assessed Resident #5 as being moderately impaired in decision-making skills, frequently incontinent of bowel and required extensive assistance with toileting.</p> <p>Review of the MAR for February 2010 revealed no documented evidence Resident #5 had a bowel movement from 02/09/10 through 02/17/10, or nine (9) days. Further review revealed the following physician's orders for laxatives were in place: Milk of Magnesia (MOM) thirty (30) milliliters (ml) every day as needed if no bowel movement in three (3) days; Bisacodyl, ten (10) milligram (mg) suppository daily for constipation not relieved by MOM; and enema daily as needed for constipation not relieved by</p>	F 309		

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

PRINTED: 03/26/2010
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 309	<p>Continued From page 61</p> <p>the Bleacodyl. Continued review revealed no documented evidence laxatives were administered to Resident #6 during the nine days without a bowel movement.</p> <p>Interview on 02/26/10 at 6:30 PM, with Licensed Practical Nurse (LPN) #4, who worked on this resident's unit, revealed the facility protocol for bowel management included administering MOM, then a suppository, then an enema if a resident had no bowel movement for three (3) or four (4) days. If the resident had no results from those interventions, the nurse should call the physician for further orders. LPN #4 stated the physician should be notified if a resident did not have orders for as needed laxatives.</p> <p>Interview with the Director of Nursing on 02/25/10 at 4:00 PM revealed the nurse assigned to administer medications should review the MAR to identify if a resident required a laxative. She further stated if no laxatives were ordered, the nurse should call the physician.</p> <p>The facility was unable to locate a bowel management policy.</p> <p>An acceptable allegation of compliance related to the Immediate Jeopardy was received on 02/26/10, prior to exit. Facility actions taken and verified by the survey team through record review and interview with five (5) licensed staff and three (3) CNAs, on 02/27/10 revealed all nurses and CNA's were educated on change of condition, physician notification, and monitoring. Tite 24 hour report was revised and implemented to track changes in condition, physician notification and appropriate monitoring.</p>	F 309		

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

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FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 309	Continued From page 52 Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "E" based on the facility's need to evaluate the effectiveness of quality assurance activities related to professional standards of quality, use of the 24 hour report book to ensure changes of condition are reported and monitored.	F 309		
F 323 89KJ	483.25(h) FREE OF ACCIDENT 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 the facility failed to ensure a hazard free environment and failed to ensure residents received adequate supervision to prevent elopement for one (1) of twenty-four (24) sampled residents, Resident #3. On 01/24/10, Resident #3 exited the facility without staff knowledge and was found in the parking lot by a visitor who was leaving the facility. The facility's failure to ensure a safe environment and adequate supervision placed residents in the facility at risk for serious injury, harm, impairment or death. Past Immediate Jeopardy was identified related to the facility's failure. The Immediate Jeopardy was determined to exist on 01/24/10, and determined to be removed with	F 323	Past noncompliance: no plan of correction required.	

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186030	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(K4) 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)	(K5) COMPLETION DATE
F 323	<p>Continued From page 53</p> <p>deficient practice corrected on 01/28/10.</p> <p>The findings include:</p> <p>Review of Resident #3's clinical record revealed diagnoses which included Dementia. Review of the Admission Minimum Data Set (MDS), dated 12/14/09 revealed the resident was assessed by the facility as having both long and short term memory problems, and being moderately impaired for daily decision making. Record review further revealed the facility assessed Resident #3 as requiring the use of a wheelchair. There was no evidence Resident #3 exhibited wandering or exit seeking behaviors.</p> <p>Review of the facility's investigation summary, dated 01/28/10 revealed, on 01/24/10, Resident #3 exited the facility, without staff knowledge, and was found in the parking lot by a visitor who was leaving the facility at 8:00 PM. Further review of the facility investigation revealed the facility was unable to determine the means and location of exit for the resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #17, on 03/17/10 at 11:15 AM, revealed the CNA was assigned to provide care for Resident #3 on 01/24/10. The CNA stated Resident #3 was last observed in the dining room at 6:30 PM, on 01/24/10, and staff discovered the resident was missing at 7:00 PM. According to the CNA, staff began searching for Resident #3 at 7:00 PM.</p> <p>Interview with the Administrator on 03/17/10 at 9:15 AM, revealed the facility reviewed video surveillance during the facility investigation, and the video surveillance showed Resident #3 exiting the facility, via wheelchair, through the service</p>	F 323		

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

PRINTED: 03/20/2010
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X4) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 54</p> <p>exit on the first floor of the building at 7:12 PM. According to the Administrator the video surveillance had not been retained and was no longer available for viewing. Further review of the facility investigation, and interview on 03/17/10, with staff who worked the evening shift on 01/24/10, revealed Resident #3 was seen by a visitor approximately seventy-five (75) yards from the front entrance of the facility at approximately 8:00 PM. Review of Resident #3's medical record revealed the resident was brought back to the unit, assessed to have no injury, and one-to-one supervision was initiated.</p> <p>Observation, on 03/18/10 at 2:30 PM, revealed nine (9) elevators and exit doors located on the unit. The elevators were observed to have a code pad beside the elevator, to be utilized for elevator operation. Observation of the exit doors revealed five (5) fire exit doors with red alarm boxes.</p> <p>Interview with the Maintenance Director, on 03/18/10 at 3:00 PM revealed prior to the 01/24/10 incident with Resident #3, codes for the elevator operation were changed monthly. The Maintenance Director stated staff were aware the code to operate the elevator should not be shared with anyone except facility staff. However, the Maintenance Director continued that he was aware the code had been shared with visitors in the past.</p> <p>Further interview with the Director of Maintenance on 03/18/10 at 3:00 PM, revealed a code alarm system was installed on one of the exit doors on 12/01/09, when the facility initially opened, however the alarm system had a manual "off" switch, which deactivated the alarm. He further</p>	F 323		

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

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OMB NO. 0930-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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
F 323	<p>Continued From page 66</p> <p>stated all the door alarms were monitored weekly, and he sometimes found the code alarm system on this exit door in the "off" position, with the alarm deactivated. According to the Director of Maintenance, he did not inform administration when he found the alarm deactivated, but just re-activated the alarm.</p> <p>Observation on 03/16/10 at 3:15 PM, revealed the exit door with the manual alarm system led to a hallway where an un-alarmed elevator was located. The un-alarmed elevator provided transport to the first floor, with the elevator doors located just down the hallway from the service exit on the first floor of the facility.</p> <p>The survey team validated the following corrective actions taken by the facility:</p> <ol style="list-style-type: none"> 1. Record review revealed Resident #3 was placed on one to one supervision on 01/24/10. 2. On 01/26/10, Resident #3's Comprehensive Care Plan and CNA care plan was revised to include the risk of elopement. Interventions included: Assess resident for exit seeking behavior; Provide one to one care for resident as needed when verbalizing 'wanting to go home'; Identify potential triggers such as family visits, evening time wandering, exit seeking behaviors; Call wife or daughters to speak with resident when exhibiting these behaviors. 3. Record review and interview with the Administrator revealed on 01/25/10 the manual alarm was altered to prevent deactivation of the alarm. 	F 323		

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 108030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 323	<p>Continued From page 56</p> <p>4. Observation of the exit door with the manual alarm, on 03/10/10 at 3:00 PM and 03/17/10 at 1:30 PM revealed the alarm was active and unable to be deactivated.</p> <p>5. Interview with the facility Administrator on 03/16/10 at 2:30 PM revealed an elopement binder of high risk elopement residents was placed at the nurse's station, front desk, dietary department and laundry on 01/24/10. Observation on 03/16/10 revealed the elopement binders were in place with Resident #3 identified to be an elopement risk in the binder.</p> <p>6. Review of Inservice Education Records revealed on 01/25/10 current staff working were re-educated on the elopement policy and the elopement binders. Further review revealed competency testing was conducted after the inservice training regarding the content of the training. Further review revealed staff were required to review the inservice and take the competency test prior to working on the unit.</p> <p>7. Interviews with six (6) licensed staff and seven (7) direct care staff, on 03/16/10 and 03/17/10 revealed staff were aware of the content of the inservice training and were aware of the elopement risk binders. In addition, staff stated the elevator codes were being changed daily, and staff were aware they should not share the elevator code with anyone other than facility staff.</p> <p>8. Interview with the facility Administrator, on 03/17/10 at 2:30 PM revealed the Quality Assurance committee met on 01/25/10 to discuss interventions implemented related to elopement, identify any other residents who were at risk, and ensure the deficiency was corrected.</p>	F 323		

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 323	Continued From page 57	F 323			
F 329 88=)	<p>9. Record review of Resident #3 and five (5) additional residents revealed no evidence of further elopements from the facility.</p> <p>483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS.</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue those drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective system in place to ensure residents receiving Coumadin therapy received adequate laboratory</p>	F 329	<p>F 329</p> <p>Resident # 13 expired. Resident # 15's Coumadin administration and PTINR issues were reviewed with the physician on 2/19/10 with new orders received and implemented.</p> <p><u>Unnecessary Drugs</u></p> <p>The Director of Nursing and/or Licensed Nurse designed completed an audit on 4/8/10 and 4/9/10 to ensure active residents' medications ordered have current diagnoses. All identified issues were corrected.</p> <p>The Licensed Pharmacist reviewed residents' medications on 4/9/10 and 4/10/10 to ensure the following: 1) Medication ordered is appropriate and necessary for the resident. 2) Medication ordered has appropriate diagnoses. 3) Medications which require monitoring had lab orders completed and/or make a recommendation to order labs. All identified issues will be reviewed with the physician for further action.</p> <p>The facility changed pharmacies effective 3/15/10. Emergency box for medications was updated on 3/15/10 to ensure improved availability of medications.</p>	4/13/10	

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 329	<p>Continued From page 58</p> <p>monitoring, in order to assure monitoring of therapeutic levels and appropriate dosage of Coumadin was maintained. This failure resulted in significantly increased PT/INR (Prothrombin Time/International Normalized Ratio) results to levels associated with life-threatening bleeding for two (2) of twenty-four (24) sampled residents (Resident #13 and #16).</p> <p>Resident #13 had a physician's order dated 01/27/10 to hold his/her Coumadin that evening and have a PT/INR obtained on 01/28/10. There was no documented evidence the order to hold the Coumadin was transcribed to the MAR, and the resident received the Coumadin. The facility failed to follow up the physician ordered PT/INR, and no results were received on 01/28/10. The physician was not notified that the PT/INR was not completed on 01/28/10, and Resident #13 again received Coumadin. The PT/INR was obtained on 01/29/10, and results were a PT greater than 100 seconds (normal range 9.0-11.4 seconds) and an INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0). Both of the lab results were noted to be critical levels. The Physician was notified and orders were received to administer Vitamin K (for blood coagulation) subcutaneously times one (1) dose. The Vitamin K was administered as ordered at 4:00 PM on 01/29/10.</p> <p>Resident #16 had orders for Coumadin therapy upon admission. The facility failed to ensure Resident #16 received the Coumadin as ordered and failed to ensure the Physician was notified of missed doses. The Physician continued to increase the resident's Coumadin dosage amount based on PT/INR results obtained, even though the resident had not received the physician</p>	F 329	<p>In order to ensure compliance, the Licensed Pharmacist will review resident medications on a monthly basis. The Director of Nursing and/or Licensed Nurse designee will review pharmacy recommendations with the physician on a monthly basis and track the response.</p> <p><u>Medication Administration</u></p> <p>The Director of Nursing and/or Licensed Nurse designee reviewed the medication administration record on 2/24/10 to ensure medications were being provided as ordered by the physician. Identified issues were corrected.</p> <p>Licensed Nursing staff was educated on medication administration on 2/20/10, 2/21/10, 2/22/10, 2/23/10, and 2/24/10 by the Administrator and/or Director of Nursing.</p> <p>Licensed Nursing staff was educated on following physician's orders and medication transcription 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or Licensed Nurse designee.</p> <p>The pharmacy and medication monitoring system was implemented on 2/24/10 by the Director of Nursing and Administrator and includes the following process:</p>	

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0301

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 320	<p>Continued From page 59</p> <p>ordered dosage of Coumadin prior to having the PT/INR obtained. The resident required Vitamin K injections as a result of PT/INR results, which were elevated to a critical level on 02/10/10.</p> <p>Based on the above findings, it was determined the facility's failure to have an effective system in place to ensure residents receiving Coumadin therapy received adequate laboratory monitoring, in order to assure therapeutic levels and appropriate dosage of Coumadin was maintained placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>1. Review of Resident #13's medical record revealed an admission date of 01/19/10, and diagnoses which included Cerebrovascular Accident (CVA) with left sided Hemiplegia, Atrial Fibrillation, right elbow Fracture and left wrist Fracture. Continued review revealed no documented evidence of a Minimum Data Set (MDS) assessment, as the resident expired before the fourteenth (14th) day. Review revealed no documented evidence of an initial care plan to address Resident #13's conditions. Review of the admission Nursing Assessment dated 01/19/10, revealed the resident was alert and oriented to person, had a flaccid left side, and was dependent on staff for wheeling his/her wheelchair. Review of the Interdisciplinary Progress Note dated 01/20/10, timed 12:00 AM revealed the nurse noted the resident was total assist with Activities of Daily Living (ADL).</p> <p>Review of the Physician's Orders revealed Resident #13 had an order dated 01/21/10, for 2.5 mg (milligram) of Coumadin Monday through</p>	F 320	<ol style="list-style-type: none"> 1) Charge nurse receives the order. 2) Charge nurse documents orders in the progress notes. 3) Charge nurse notifies the family. 4) Charge nurse places the order on the MAR and/or TAR. 5) Charge nurse to fill out lab requisition if lab ordered. 6) Charge nurse will fax order to the pharmacy. 7) Charge nurse will place top copies and place in the "Medication Orders/Refill" folder. 8) Charge nurse receiving medications will validate each medication with the order/refill sheet when medications arrive. 9) Charge nurse will verify that the medication was received. If the medication was not received, charge nurse will call the pharmacy and order the medication STAT. <p>In order to ensure compliance, the Director of Nursing or Licensed Nurse designee will pick up the folder labeled "Medication Order/Refill" found in the central nurses station and validate that the medications/labs have been received/completed on a daily basis. In addition, the Director of Nursing and/or Licensed Nurse designee will audit MARS, TARS (4) times per week for (4) weeks to ensure proper documentation and medication administration. Issues identified will be corrected immediately.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 180038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 328	<p>Continued From page 60</p> <p>Friday and Coumadin 5 mg on Saturday and Sunday. Review of the MAR revealed the resident received 2.5 mg 01/21/10, 01/22/10, and on 01/25/10 through 01/26/10. Resident #13 received Coumadin 5 mg on 01/23/10 and 01/24/10 (Saturday and Sunday) as ordered.</p> <p>Review of an Interdisciplinary Progress Note dated 01/27/10, timed 9:00 AM revealed the nurse noted the resident had a scabbed area which was open and bleeding. She documented the Physician was present and new orders were received. Review of a Physician's Order dated 01/27/10, revealed staff were to hold pressure times five (5) minutes for bleeding and if the bleeding continued the resident was to be sent to the hospital. Resident #13 was transported to the hospital at 9:00 AM on 01/27/10. Interdisciplinary Notes at 2:00 PM on 01/27/10, revealed Resident #13 returned to the facility, and the Physician ordered a STAT (Immediate) PT/INR and CBC (Complete Blood Count). Review of the Physician's Order dated 01/27/10, at 2:00 PM revealed an order for a STAT PT/INR and CBC to be obtained. The nurse documented at 3:00 PM, the resident went out for an appointment and the laboratory (lab) representative came to the facility to obtain a specimen for the lab testing, but was unable to obtain the specimen because the resident was at the physician appointment. The progress notes did not indicate the time the resident returned to the facility from the appointment.</p> <p>However, a note dated 01/27/10, timed 8:30 PM revealed Resident #13's Coumadin was to be held that night and a PT/INR and CBC was to be obtained on 01/28/10. Review of the Physician's Orders revealed an order was received, on</p>	F 328	<p><u>Lab Tracking</u></p> <p>The Director of Nursing and/or Licensed Nurse designee completed an audit on lab orders and results for residents on 2/25/10. Issues identified were corrected.</p> <p>Licensed Nursing staff was educated on the lab tracking process and medication administration on 2/20/10, 2/21/10, 2/22/10, 2/23/10, and 2/24/10 by the Administrator and/or Director of Nursing.</p> <p>The lab tracking process and monitoring system was implemented on 2/20/10 and includes the following:</p> <ol style="list-style-type: none"> 1) Lab order is received by the charge nurse from the physician. 2) Lab requisition will be completed and placed in the lab box under the corresponding date by the charge nurse. 3) Labs will be drawn and the pink copy of the lab requisition will be returned to the lab box under the corresponding date. 4) When lab results are returned they are to be taken off the fax machine. The charge nurse will fax results to the physician. A follow up call will be placed to the physician to ensure the lab was received. 5) Critical labs or results that require any type of medication adjustment 		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 328	<p>Continued From page 61</p> <p>01/27/10, to hold Resident #13's Coumadin that evening and have the PT/INR and CBC obtained on 01/28/10.</p> <p>Review of Resident #13's clinical record and lab report revealed no documented evidence the PT/INR and CBC were performed as ordered, on 01/28/10. Review of the MAR revealed no documented evidence of the order to hold the Coumadin on 01/27/10. The nurse documented 2.5 mg of Coumadin was administered on 01/27/10. According to the MAR, the resident received 2.5 mg of Coumadin on 01/28/10.</p> <p>Interview on 02/10/10 at 4:55 PM with Licensed Practical Nurse (LPN) #1 revealed she received the verbal order from the Physician to hold the resident's Coumadin on 01/27/10, and to have the labs obtained on 01/28/10. She stated she did not recall why she did not transcribe the order to the MAR, but stated she should have.</p> <p>Interview on 02/24/10, at 8:37 PM with Licensed Practical Nurse (LPN) #4 revealed a blood specimen for the PT/INR and CBC were obtained on 01/28/10 by a lab tech (laboratory technician). LPN #4 stated the lab tech left the vials of blood for a lab courier to pick up. She stated the blood was not picked up by a lab courier, however this was not discovered until another lab tech found the blood on the morning of 01/29/10.</p> <p>Interview on 02/10/10 at 1:20 PM with the Regulatory Manager at the lab revealed there was no evidence in the lab computer system of blood being obtained by a lab tech on 01/28/10. In an additional interview on 02/25/10, at 10:15 AM the Regulatory Manager stated the lab was not contacted by the facility related to the 01/28/10</p>	F 328	<p>will be called to the physician for further clarification. If the physician does not respond back after an hour, additional follow up from the nurse will occur.</p> <p>6) Once the physician has been notified, the charge nurse will file in the medical records.</p> <p>In order to ensure compliance, the Director of Nursing and/or Licensed Nurse designee will review new orders and lab requisitions on a daily basis. Issues identified will be corrected immediately. Issues identified will be corrected immediately. Licensed Nursing staff will be disciplined as warranted.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 329	<p>Continued From page 82</p> <p>blood being drawn. She stated the facility did not call to inquire about why no results were received on 01/28/10.</p> <p>Interview on 02/22/10, at 2:15 PM with Registered Nurse #2, the current Director of Nursing (DON), revealed the order to hold the Coumadin should have been transcribed to the MAR to ensure the order was followed. The DON stated licensed nursing staff should have followed up on the 01/28/10 PT/INR lab and inquired as to why no results were received. The DON indicated there was no system in place to ensure labs were followed up on and the results reported to the Physician.</p> <p>Further interview with LPN #4 revealed on the morning of 01/28/10, a lab tech obtained another blood specimen which was transported to the laboratory (lab). The LPN stated the CBC was completed "and something was wrong with the PT/INR, so they (lab) had to come and draw it again".</p> <p>Further interview on 02/19/10, at 1:20 PM with the Regulatory Manager of the lab revealed there was a specimen obtained on 01/28/10, for a PT/INR and CBC. The Regulatory Manager stated the specimen was "questionable" for the PT/INR, so the facility was contacted regarding obtaining a second blood draw for the PT/INR. According to the Regulatory Manager, a specimen was obtained and results were called to the facility.</p> <p>Review of a lab report dated 01/29/10, revealed results were received at 3:44 PM, and indicated Resident #13 had critical values. The PT was noted to be greater than 100 seconds (normal range 9.0-11.4 seconds) and the INR greater than</p>	F 329			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 329	<p>Continued From page 63</p> <p>11 (normal for standard anticoagulant use is 2.0-3.0). Continued review of the Physician Orders revealed an order dated 01/20/10, timed 4:00 PM for 10 mg/ml (milligram/milliliter) Vitamin K (for blood coagulation) subcutaneously times one (1) dose. Review of the Interdisciplinary Progress Note dated 01/20/10, timed 6:55 PM revealed a new order was received for Vitamin K. The nurse noted the Vitamin K was administered as ordered at 4:00 PM on 01/20/10.</p> <p>In interview LPN #4 indicated the PT/INR results came back on 01/20/10, LPN #3 took the telephone call from the lab and notified the Physician of the results. LPN #4 stated the Physician gave an order for Vitamin K and LPN #3 administered it as ordered.</p> <p>Review of the Note dated 01/30/10, timed 4:00 AM, revealed the night shift nurse noted the resident was found without a blood pressure, respirations or pulse and was cool to touch. The resident expired at the facility, cause unknown.</p> <p>Interview on 02/18/10, at 4:30 PM with Registered Nurse (RN) #1, the former DON, revealed there was no system in place to ensure labs were completed as ordered and the results reported to the Physician. An additional interview on 02/24/10, at 3:20 PM with RN #1 revealed the facility had no documented evidence of any staff training related to transcribing orders and had no documented procedure in place for the transcription of physician orders. She stated there was no system in place to ensure physician orders were transcribed to the MARs.</p> <p>Interview on 02/22/10, at 2:15 PM with Registered Nurse (RN) #2, the current Director of Nursing (DON), revealed licensed nursing staff should</p>	F 329		

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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
F 320	<p>Continued From page 64</p> <p>have transcribed the order to hold the Coumadin to the MAR, to ensure the order was followed. The DON stated nurses should have notified the lab when the facility had not received results of the PT/INR and CBC on 01/28/10. She indicated there was no system in place for the monitoring of labs.</p> <p>Interview on 02/24/10, at 8:30 AM with Resident #13's Physician revealed the Coumadin should have been held as ordered on 01/27/10 and he should have been notified after it had been administered. According to the Physician, he should have been notified the facility did not obtain the labs as ordered on 01/28/10. He stated he was not notified of this information until 01/29/10.</p> <p>2. Record review revealed Resident #15 was admitted to the facility on 01/30/10 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, and History of Cardiovascular Accident. The resident was receiving Coumadin Therapy upon admission.</p> <p>On the 01/30/10 admission orders, the Physician ordered hold Coumadin 2 mg daily until 01/31/10, ordered a PT/INR (lab test) to be drawn on 01/31/10 and to call him with the results. Review of the results, faxed to the facility on 01/31/10 at 1:31 PM revealed, PT-32.2 (normal range 10.5-13.8) and INR-2.0 (normal range for standard anticoagulant therapy 2.0-3.0). Review of the progress notes revealed the Physician was not notified of the 01/31/10 lab results until 02/01/10 at 1:30 PM at which time an order was obtained to resume Coumadin 2 mg daily and to repeat the PT/INR on 02/08/10. Interview with the</p>	F 320		

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 320	<p>Continued From page 65</p> <p>Registered Nurse RN #1, Director of Nursing (DON) at the time, on 02/19/10 at 2:00 PM revealed the Physician should have been notified when the results were received on 01/31/10 at 1:31 PM.</p> <p>Review of the Medication Administration Record (MAR) revealed the Coumadin 2 mg was not administered on 02/01/10, 02/02/10, 02/03/10, and 02/04/10. Interview with LPN #1 revealed the medication was not given because it was not available in the medication cart. The Nurse stated the medication was not available in the Emergency Box and she did not notify the Physician the Coumadin was not given for four (4) days. However, review of the Pharmacy delivery record revealed fourteen (14) 2 mg Coumadin tablets were delivered to the facility on 02/01/10, for this resident. Interview with RN #1, DON at that time, on 02/19/10 at 2:00 PM revealed she was not aware the Coumadin was not given for four (4) days and there was no check system in place to ensure Physician's orders were followed.</p> <p>Record review revealed a PT/INR was drawn on 02/06/10 with results of PT- 15.2 and INR-1.3. Record review revealed the Physician was notified on 02/05/10 and ordered Coumadin 4 mg daily and repeat the PT/INR on 02/08/10. Review of the MAR revealed Coumadin 4 mg was not given on 02/05/10. Review of the results of the PT/INR from 02/08/10 revealed PT-13.5 and INR-1.2. At that time, the Physician ordered to increase the Coumadin to 8 mg daily at bedtime and to repeat the PT/INR on 02/11/10. Review of the MAR revealed Resident #15 missed the Coumadin 8 mg dose on 02/09/10.</p> <p>Review of the PT/INR results on 02/11/10</p>	F 320		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F-329	<p>Continued From page 00</p> <p>revealed PT-15.0 and INR 1.3. Record review the Physician was notified on 02/11/10 at 3:40 PM and ordered Coumadin 10 mg daily at bedtime and repeat the PT/INR on 02/15/10. Review of the MAR revealed Resident #15 did not receive the Coumadin 10 mg on 02/11/10 as ordered. Interview with LPN #1 revealed she did not give the Coumadin 10 mg on 02/11/10 because the medication was not available. However, review of the Pharmacy delivery record revealed the fourteen (14) Coumadin 10 mg tablets were delivered on 02/11/10.</p> <p>Review of the PT/INR results from 02/16/10 revealed Resident #15's PT was 00.0 (normal range 10.-13.0) and the INR was 0.8 (normal range .85-1.22). The Physician was notified and ordered to hold Coumadin and repeat PT/INR on 02/16/10. Record review revealed no evidence the PT/INR was drawn on 02/16/10. Interview with the Administrator and the DON on 02/19/10 at 2:30 PM revealed the lab did not come to the facility that day due to inclement weather. However there was no evidence that the facility obtained the lab or notified the Physician the lab was not obtained.</p> <p>Record review revealed on 02/16/10 at 9:30 AM, Resident #15 was sent to the hospital with complaints of Chest Pain and Shortness of Breath. Review of the PT/INR from the hospital emergency record revealed PT-131.0 and INR-10.3. Resident #15 was sent back to the facility and given an injection of Vitamin K 20 mg (used to clot the blood) at 5:30 PM. The Physician ordered to repeat the PT/INR on 02/17/10. Record review revealed no evidence the PT/INR was drawn on 02/17/10. Interview with the DON on 02/19/10, at 2:30 PM revealed</p>	F 329		

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 320	<p>Continued From page 67</p> <p>who felt there was a serious system breakdown with getting the ordered labs. Further record review revealed the Physician ordered another Vitamin K injection of 10 mg on 02/17/10.</p> <p>Interview with the Physician on 02/19/10 at 3:15 PM revealed he was not notified Resident #15 had missed multiple doses of the ordered Coumadin. He stated he should have been notified. The Physician stated that Coumadin Therapy needed to be monitored closely and it was a definite concern to him that the facility staff were not administering the medication as ordered because he was increasing the Coumadin dosage based on the PT/INR lab results, unaware that the resident missed multiple doses of Coumadin.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/26/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following:</p> <p>Record reviews revealed PT/INR tracking was being monitored daily by the Administrator and DON. Record review revealed all nurses were involved on the lab tracking process. Interviews with six (6) licensed nursing staff on 02/27/10 revealed they had been educated and were aware on the lab tracking system.</p> <p>Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "D" based on the facility's need to evaluate the effectiveness of quality assurance activities related to residents on Coumadin therapy who required laboratory monitoring to ensure therapeutic levels and appropriate doses of</p>	F 320		

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

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F 329	Continued From page 60 Coumadin were maintained.	F 329		
F 333 SS-1	403.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for four (4) of twenty (24) sampled residents (Residents #13, #15, #7 and #8). Resident #13 had a Physician's order to hold Coumadin on 01/27/10, however, the Coumadin was administered on that date. On 01/29/10 Resident #13's PT/INR was at a critical level and required a Vitamin K injection. Resident #15 failed to receive six (6) doses of Coumadin, the Physician was not made aware and subsequently continued to increase the Coumadin dosage until the resident's PT/INR was at a critical level, and the resident required Vitamin K injections. Additionally, Resident #7 failed to receive the first three doses of an antibiotic on two separate occasions for a total of six (6) missed doses. Resident #3 failed to receive the first two doses of Proscar (used to improve symptoms of an enlarged prostate). The facility's failure to ensure residents were free from significant medication errors placed	F 333	F 333 Resident # 3's missed dose's of medication was reported to the physician on 3/8/10. Resident # 7's missed dose's of medication was reported to the physician on 3/8/10. Resident # 13 expired. Resident # 15's Coumadin administration and PT/INR issues were reviewed with the physician on 2/10/10 with new orders received and implemented. The Licensed Pharmacist reviewed MAR's and medications stocked for residents on 2/24/10. Issues identified were reported to the physician and corrected. LPN # 1 was suspended and then terminated in relation to performance of job duties. Licensed Nursing staff was educated on following physician orders and medication transcription on 3/10/10, 3/11/10, and 3/12/10 by the Director of Nursing and/or designee. Licensed Nursing staff was educated on availability of Coumadin in emergency box on 2/20/10, 2/21/10, 2/22/10, 2/23/10 and 2/24/10 by the Administrator and/or Director of Nursing.	4/13/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/PROPELLER/OLIA IDENTIFICATION NUMBER: 188030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 333	<p>Continued From page 69</p> <p>Residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>1. Review of Resident #13's medical record revealed diagnoses which included Cerebrovascular Accident (CVA) with left sided Hemiplegia, Atrial Fibrillation, right elbow Fracture and left wrist Fracture.</p> <p>Review of the Physician's Orders revealed Resident #13 had an order dated 01/27/10, to hold the Coumadin that evening. Review of the Interdisciplinary Progress Note, dated 01/27/10, revealed Resident #13's Coumadin was to be held that night, however review of the Medication Administration Record (MAR) revealed the order was not transcribed to the MAR. Further review of the MAR revealed the Coumadin was documented as given on 01/27/10.</p> <p>Review of a laboratory (lab) testing report, dated 01/29/10, revealed results were received at 3:44 PM, and indicated Resident #13 had critical values. The PT was noted to be greater than 100 seconds (normal range 9.0-11.4 seconds) and the INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0). Review of the lab report dated 01/20/10, revealed Resident #13's prior PT was 22.4 and INR was 1.0.</p> <p>Continued review of the Physician Orders revealed an order dated 01/29/10, for one dose of Vitamin K (for blood coagulation) 10 mg/ml (milligram/milliliter) subcutaneously. Review of the MAR revealed the Vitamin K was administered at 4:00 PM. Review of the Interdisciplinary Progress Note dated 01/29/10,</p>	F 333	<p>The pharmacy and medication monitoring system was implemented on 2/24/10 by the Director of Nursing and Administrator and includes the following process:</p> <ol style="list-style-type: none"> 1) Charge nurse receives the order. 2) Charge nurse documents orders in the progress notes. 3) Charge nurse notifies the family. 4) Charge nurse places the order on the MAR and/or TAR. 5) Charge nurse to fill out lab requisition if lab ordered. 6) Charge nurse will fax order to the pharmacy. 7) Charge nurse will place top copies and place in the "Medication Orders/Refill" folder. 8) Charge nurse receiving medications will validate each medication with the order/refill sheet when medications arrive. 9) Charge nurse will verify that the medication was received. If the medication was not received, charge nurse will call the pharmacy and order the medication STAT. <p>In order to ensure compliance, the Director of Nursing or Licensed Nurse designee will pick up the folder labeled "Medication Order/Refill" found in the central nurses station and validate that the medications/labs have been received/completed on a daily basis. In addition, the Director of Nursing and/or Licensed Nurse designee will</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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)	(K6) COMPLETION DATE
F 333	<p>Continued From page 70</p> <p>lined 6:55 PM revealed a new order was received for Vitamin K, which the nurse noted was administered at 4:00 PM. Further review of the interdisciplinary Progress Notes revealed at 4:00 AM, on 01/30/10 the resident was found without a blood pressure, respirations or pulse, and was cool to touch.</p> <p>Interview on 02/10/10, at 4:55 PM with Licensed Practical Nurse (LPN) #1 revealed she had taken the order to hold the Coumadin on 01/27/10. She stated she could not recall why she did not transcribe the order to the MAR, but should have.</p> <p>Interview on 02/24/10, at 3:20 PM with RN #1, the former DON, revealed the facility had no documented evidence of any staff training related to transcribing orders and had no documented procedure in place for the transcription of physician orders. She also stated there was no system in place to ensure physician orders were transcribed to the MARs. Interview on 02/22/10, at 2:15 PM with Registered Nurse (RN) #2, the current Director of Nursing (DON), revealed licensed nursing staff should have transcribed the order to hold the Coumadin to the MAR to ensure the order was followed.</p> <p>Interview with the Physician revealed the Coumadin should have been held as ordered on 01/27/10, until the results of the ordered PT/INR were obtained on 01/28/10.</p> <p>2. Record review revealed Resident #15 was admitted to the facility on 01/30/10 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, and History of Cardiovascular Accident. The resident was receiving Coumadin</p>	F 333	<p>audit MARS and TARS (4) times per week for (4) weeks to ensure proper documentation and medication administration. Issues identified will be corrected immediately.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 833	<p>Continued From page 71 Therapy upon admission.</p> <p>On the 01/30/10 admission orders, the Physician ordered to hold the Coumadin 2 mg daily until 01/31/10 and ordered PT/INR test to be drawn on 01/31/10 and to call him with the results. Review of the results, faxed to the facility on 01/31/10 at 1:31 PM revealed, the PT was 32.2 (normal range 10.5-13.8) and the INR was 2.0 (normal range for standard anticoagulant therapy 2.0-3.0). Review of the progress notes revealed the Physician was not notified of the 01/31/10 lab results until 02/01/10 at 1:30 PM at which time an order was obtained to resume Coumadin 2 mg daily and to repeat the PT/INR on 02/05/10.</p> <p>Review of the Medication Administration Record (MAR) revealed no evidence the resident's Coumadin 2 mg was administered on 02/01/10, 02/02/10, 02/03/10, and 02/04/10. Interview with LPN #1, responsible for medication administration on those days, revealed the Coumadin was not given because it was not available in the medication cart or in the Emergency Box and she did not notify the Physician the Coumadin was not given for four (4) days. However, review of the Pharmacy delivery record revealed fourteen (14) 2 mg Coumadin tablets were delivered to the facility on 02/01/10. Interview on 02/10/10 at 2:00 PM with RN #1, DON at the time, revealed she was not aware the Coumadin was not given for four (4) days and there was no check system in place to ensure medications were provided as ordered.</p> <p>Record review revealed a PT/INR was drawn on 02/09/10 with results of PT- 15.2 and INR-1.3. Record review revealed the Physician was notified on 02/08/10 and ordered Coumadin 4 mg</p>	F 333		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 333	<p>Continued From page 72</p> <p>daily and repeat the PT/INR on 02/08/10. Review of the MAR revealed Coumadin 4 mg was not given on 02/09/10, rather it was started on 02/08/10. Review of the results of the PT/INR from 02/08/10 revealed PT-13.6 and INR-1.2. At that time the Physician ordered to increase the Coumadin to 8 mg daily at bedtime and to repeat the PT/INR on 02/11/10. Review of the MAR revealed Resident #15 missed the Coumadin 8 mg dose on 02/08/10. Interview with the Physician on 02/10/10 at 3:15 PM revealed he was increasing the Coumadin in order to reach the INR normal range for standard anticoagulant therapy of 2.0-3.0.</p> <p>Review of the PT/INR results on 02/11/10 revealed PT-15.0 and INR 1.3. Record review revealed the Physician was notified on 02/11/10 at 3:40 PM and ordered Coumadin 10 mg daily at bedtime and repeat the PT/INR on 02/15/10. Review of the MAR revealed Resident #15 did not receive the Coumadin 10 mg on 02/11/10, as ordered. Interview with LPN #1 revealed she did not give the Coumadin 10 mg on 02/11/10 because the medication was not available. However, review of the Pharmacy delivery record revealed the Toujeon (14) Coumadin 10 mg tablets were delivered on 02/11/10.</p> <p>Review of the PT/INR results from 02/15/10 revealed Resident #15's PT was 80.8 (normal range 10.-13.8) and the INR was 8.8 (normal range for standard anticoagulant therapy 2.0-3.0).</p> <p>Record review revealed on 02/16/10 at 9:30 AM, Resident #15 was sent to the hospital with complaints of Chest Pain and Shortness of Breath. Review of the PT/INR from the hospital emergency record revealed PT-131.9 and</p>	F 333			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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	
F 333	<p>Continued From page 73</p> <p>INR-10.3. Resident #15 returned to the facility and was administered Vitamin K 20 mg Injection (used for blood clotting) at 5:30 PM on 02/16/10, and on 02/17/10 the Physician ordered another Vitamin K Injection of 10 mg.</p> <p>Record review revealed a Physician's order dated 02/18/10 to resume Coumadin 2 mg daily. Review of the MAR revealed the Coumadin 2 mg was not given on 02/18/10. Interview with LPN #1, assigned to medication administration on 02/18/10 revealed she did not give the Coumadin 2 mg because it was not available. She further stated she did not notify the Pharmacy of the missing medication.</p> <p>Interview with the Physician on 02/10/10 at 3:15 PM revealed he was not notified Resident #15 had missed multiple doses of the ordered Coumadin and should have been notified. The Physician stated Coumadin Therapy needed to be monitored closely. He went on to say that it was a definite concern to him related to facility staff not administering the medication as ordered because he was increasing the Coumadin dosage based on the PT/INR lab results.</p> <p>Interview with LPN #1 on 02/23/10 at 5:10 PM, revealed the facility did not properly train her on medication administration as she was assigned to the medication cart on her second day of employment. She stated she received no training from the facility on taking physicians orders, transcribing orders, the facility's policy and procedure related to medications, or ordering and receiving medications from the Pharmacy.</p> <p>Interview with RN #1, DON at the time, on 02/24/10 at 3:20 PM revealed she had no</p>	F 333			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41011		
(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	
F 333	<p>Continued From page 74</p> <p>documented evidence staff were trained on medication administration, Physician's orders, or obtaining medications from the Pharmacy. She further stated she did not have a competency evaluation for medication administration or a check system in place to ensure medication orders were being carried out.</p> <p>3. Record review revealed Resident #7 was admitted to the facility on 12/23/09 with diagnoses which included Diabetes Mellitus, Hypertension and Depression. Review of the Admission Minimum Data Set (MDS) dated 01/08/10 revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making and as requiring extensive assistance with toileting. Further review revealed the facility assessed the resident as being continent of bowel and bladder and as having a urinary tract infection in the past thirty (30) days.</p> <p>Review of the Comprehensive Care Plan dated 01/11/10 revealed the facility assessed Resident #7 as receiving antibiotic therapy related to a urinary tract infection. Interventions included administer antibiotic or treatment as ordered by the Physician.</p> <p>Review of the Physician's Orders dated 01/08/10 revealed an order for a urinalysis (urine test) with culture and sensitivity. Further review of the Physician's order dated 01/11/10 revealed an order for Omnicef (antibiotic) 300 milligrams (mg) to be administered every twelve (12) hours for seven (7) days.</p>	F 333			

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

PRINTED: 03/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10503B	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 333	<p>Continued From page 75</p> <p>Review of the Medication Administration Record (MAR) dated January, 2010 revealed no documented evidence the resident received the first three (3) scheduled doses of the ordered antibiotic. The MAR revealed the resident did not receive the first dose of the ordered antibiotic, Omnicel, until two (2) days later (01/13/10).</p> <p>In addition, continued review of the Physician's Orders dated 02/11/10 revealed an order for a urinalysis (urine test) to be obtained by a straight catheter. Review of the Physician's Orders dated 02/12/10 revealed an order for Cipro (antibiotic) 250 milligrams (mg) to be administered twice a day. Review of the MAR dated February, 2010 revealed the first dose of the Cipro (antibiotic) medication was scheduled to be administered on 02/12/10 at 9:00 PM. However, record review revealed no documented evidence the resident received the scheduled antibiotic until two days later on 02/14/10 at 9:00 AM, for a total of six (6) missed doses.</p> <p>Observation on 02/25/10 at 3:00 PM of the facility's emergency pharmacy stock box revealed the stock box contained eight (8) tablets of Omnicel (antibiotic) 300 milligrams (mg) and twelve (12) tablets of Cipro 250 mg.</p> <p>Interview on 02/25/10 at 3:45 PM with Registered Nurse (RN) #2 revealed she was currently the acting Director of Nursing (DON), however, she</p>	F 333		

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

PRINTED: 03/26/2010
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 393	<p>Continued From page 76</p> <p>had previously been assigned as the charge nurse to the unit where Resident #7 resided. She indicated the Omnicel (antibiotic) and Cipro (antibiotic) were not administered due to not being available from pharmacy. The RN stated the antibiotics were in the emergency pharmacy stock box, however, she did not have clear guidance on how to use it so she did not utilize the emergency pharmacy stock box. RN #2 indicated the resident should have received the antibiotics as ordered. She stated there was no explanation as to why the resident did not receive the medication as ordered. She indicated since she had been the DON, she had in-serviced the staff on how to use the emergency box.</p> <p>4. Resident #3 was readmitted on 12/01/09 with diagnoses which included Malignant Prostatic Neoplasm and Dementia. Review of the Annual Minimum Data Set (MDS) Assessment dated 12/14/09 revealed Resident #3 was assessed to have short and long-term memory loss and moderately impaired in decision-making abilities. In addition, the resident required extensive assistance with Activities of Daily Living (ADLs).</p> <p>Review of the Physician's Orders dated 02/22/10 revealed Resident #3 was to receive Proscar five (5) milligram (mg) every day. Proscar is prescribed to improve the symptoms of an enlarged prostate. Review of the Medication Administration Record (MAR) revealed the medication was not provided on 02/23/10 or 02/24/10. Review of nursing documentation</p>	F 393			

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 333	<p>Continued From page 77</p> <p>dated 02/24/10 revealed Proscar was unavailable.</p> <p>Telephone interview with the Pharmacist on 02/25/10 at 4:30 PM revealed the medication was delivered on 02/23/10 at 5:00 AM. The Pharmacist revealed the drug was reordered by the facility on 02/24/10 and delivered that evening for the second time.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 02/26/10 at 3:40 PM revealed Resident #3 did not receive the Proscar on 02/23/10 or 02/24/10. She stated fourteen (14) pills were delivered from the pharmacy on the evening of 02/24/10 and the first dose was given on 02/25/10. She further stated she did not know if the Pharmacy delivered any medication on 02/23/10 and could not locate the delivery receipt for that day.</p> <p>An acceptable Allegation of Compliance, related to the Immediate Jeopardy, was received on 02/23/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following:</p> <p>Record reviews and interviews with five (5) licensed nursing staff on 02/27/10, revealed all MARS were reviewed by the Pharmacist and the medication stock for each resident was reviewed for accuracy. Interview and record review revealed the Pharmacist conducted a medication pass audit and all nurses were educated on the Pharmacy and Medication Administration tracking process.</p> <p>Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "D" based on the facility's need to evaluate the</p>	F 333		

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

PRINTED: 03/20/2010
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 333	Continued From page 78 effectiveness of quality assurance activities related to ensuring residents received medications as ordered in accordance with the newly adopted policy.	F 333		
F 371 SS+E	489.36(l) FOOD-PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure food was stored, prepared and served utilizing sanitary conditions in the facility's kitchen and in the Resident's Kitchenette. The findings include: Observation during the initial tour on 02/23/10 at 2:10 PM revealed three (3) baking trays were stored wet and four (4) steam table pans were stored wet. Additional observation of the walk-in refrigerator revealed a container of macaroni and cheese dated 02/18/10; a container of cheese pizza dated 02/18/10 and a large serving tray which contained a cake with icing uncovered and undated. Observation of the dry storage revealed a large container of thickener uncovered and a dented can (#2) of peaches.	F 371	F 371 No resident were identified to be affected by the deficient practice. Baking trays and steam table pans were removed from service on 2/23/10 by the Food Service Director. Macaroni cheese, cheese pizza, cake, and thickener, and dented can were removed from service on 2/23/10 by the Food Service Director. All items observed on 2/23/10 to be noted in the kitchenette were discarded on 2/23/10 by the Food Service Director. Dietary staff was educated on proper food storage, safe food handling, and sanitation on 3/4/10 by the Food Service Director and Administrator. In order to ensure compliance, the Dietary Manager and/or designee will conduct a sanitation audit (4) times per week for (4) weeks. Administrator will review the results weekly to determine any need for additional follow up. Identified issues will be corrected immediately.	4/13/10

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

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F 371	<p>Continued From page 79</p> <p>Interview on 02/23/10 at 2:30 PM with the Dietary Manager (DM) revealed the baking trays and the steam table pans should not be stored wet. She indicated the pans should be air dried. Additional interview revealed the leftover macaroni and cheese and the cheese pizza should have been discarded after three (3) days. She indicated the dented can of peaches should not have been placed on the shelf. Further interview revealed the container of thickener should not have been uncovered.</p> <p>Observation on 02/23/10 at 3:10 PM of the Resident's Kitchenette revealed a cart which contained dirty trays placed next to a cart of clean trays which were prepared for the next meal. The kitchenette refrigerator contained undated brownies wrapped in cellophane; four (4) opened undated containers of soft drinks and a quart container of orange juice, undated. Continued observation of the kitchenette revealed a cereal dispenser, which contained four (4) types of dry cereal, was undated. In the refrigerator crisper drawer an open bag contained an umbrella, gloves, a hat, a scarf, a cooked hamburger, two (2) slices of bread, one (1) slice of cheese and an opened bottle of vitamin water.</p> <p>Interview on 02/24/10 at 3:00 PM with the Dietary Manager (DM) revealed she was responsible for monitoring the Resident's Kitchenette every day. She revealed she cleaned the Kitchenette every day. The DM indicated the food in the refrigerator should be dated and the personal items should not be in the refrigerator crisper. Further interview indicated the clean trays were brought to the Resident's Kitchenette prior to meals. She indicated the clean trays should not be next to the</p>	F 371	Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	

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

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OMB NO. 0938-0391

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F 371	Continued From page 80 dirty trays.	F 371			
F 465 SS-E	<p>Review of the facility's policy entitled "Dietary Services" undated, revealed all leftovers would be properly sealed, dated and labeled. The policy revealed leftovers would be used within a safe time period. In addition, the policy indicated the macaroni and cheese should be used within three (3) days of refrigeration.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable and homelike environment.</p> <p>The findings include: During the environmental tour on 02/24/10 at 6:52 AM, observations revealed three (3) unlocked electrical breaker boxes on walls in the front hallway with one electrical breaker box door opened. In addition, the doors to the electrical room, biohazard room and soiled utility were unlocked. The electrical room contained a shower chair, a computer control panel and different sized batteries. Two metal braces were attached to the wall adjacent to room 437 and contained sharp edges. An uncovered electrical</p>	F 465	<p>F 465</p> <p>No residents were identified to be affected by the deficient practice.</p> <p>Environmental rounds were conducted 2/25/10 by the Maintenance Director and Administrator. No other issues were identified.</p> <p>Electrical boxes, electrical room door, and soiled utility room door were re-locked by the Maintenance Director on 2/24/10.</p> <p>Biohazard door lock was installed on 2/26/10 by a contractor.</p> <p>Hall railings outside of room 437 were repaired on 2/26/10 by the Maintenance Director. Electrical box outlet cover was installed on 2/26/10 by the Maintenance Director.</p> <p>Edges on the lower chair railing on the columns were repaired on</p>	4/13/10	

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

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F 465	<p>Continued From page 81</p> <p>box outlet was observed in the shower stall in the unlocked multipurpose room. In addition, splintered and rough edges were observed on the lower chair railing on the columns located in the main foyer. Observation of the Back Main Dining Room (also known as the Children's Dining Room) revealed two (2) long cords from the mini blinds hanging two feet from the floor with a knot tied in the end of the cords.</p> <p>Interview on 02/24/10 at 10:30 AM with the Maintenance Director revealed the electrical breaker boxes and the door to the electrical room were supposed to be locked at all times. He indicated the construction/remodeling workers had been using the electrical breaker boxes and left the breaker boxes unlocked. Additional interview with the Maintenance Director revealed the two (2) metal braces would be removed from the wall and the mini blind cords would be shortened.</p> <p>Continued observations on 02/24/10 revealed the Resident's Shower Room located on the Front Hall, contained unlabeled toiletries which included shaving cream, razors and a blow dryer. The Resident's Shower Room revealed no evidence of availability of hand drying supplies. A missing wall panel was observed to be next to the residents' shower stall. The Front Main Dining Room countertop contained a large box of plastic food wrapping with exposed sharp and jagged cutting edges.</p> <p>Interview on 02/24/10 at 8:27 AM and 10:30 AM with the Administrator revealed the Resident's Shower Room was used by residents and staff and should contain hand drying supplies. He stated the razors, shaving cream and the blow</p>	F 465	<p>3/18/10 by the Maintenance Director.</p> <p>Blinds from the children's dining room were removed on 3/15/10 by the Maintenance Director.</p> <p>Shaving cream, razor, and blow dryer were removed from the shower room on 2/24/10 by the Maintenance Director.</p> <p>Paper towel dispenser was installed in the shower room on 3/15/10 by the Maintenance Director.</p> <p>Wall panel in the shower room was repaired on 3/15/10 by the Maintenance Director.</p> <p>Plastic wrap box was removed from the central dining room on 2/24/10 by the Maintenance Director.</p> <p>Facility staff was educated on 3/5/10 regarding potential hazards by the Administrator and Director of Nursing.</p> <p>In order to ensure compliance, the Administrator and/or designee will audit the facility for potential hazards (chemical in rooms/common areas, hand rails, outlet covers/electrical panels, locked doors, and any other items that may contribute to resident hazard) (4) times per week for (4) weeks.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
(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
F 485	Continued From page 02 dior should not be in the shower room. The Administrator indicated the box of plastic food wrap should not be out on the counter in the Front Main Dining Room. Ho indicated the wall panel would be reattached to the wall.	F 485	Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.	
F 400 SS=K	403.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility's Administration failed to ensure resources were utilized effectively and efficiently to ensure the delivery of required care and services to residents. This lack of oversight to ensure residents' care needs were not resulted in Substandard Quality of Care (SQC) and placed residents at risk for serious injury, harm, impairment or death. The findings include: The facility failed to have an effective system in place to ensure reporting changes in residents' conditions to the Physician which impacted the physical well-being of residents. (Refer to F157) The facility failed to to have an effective system in place to ensure Physicians' orders were transcribe onto the MAR and implemented therefore, failed to provide services to meet	F 400	F 400 Residents identified in F 157, F 281, F 282, F 309, F 329, F 333, and F 502 have been reviewed and corrected as stated in plan of correction for each corresponding citation. The facility changed the administrative position of Director of Nursing on 2/22/10. The Facility implemented an effective system to address physician notification for change of condition. Refer to plan of correction (F 157). The facility implemented an effective system to ensure physicians' orders were transcribed onto the MAR and implemented. Refer to plan of correction (F 201). The facility implemented an effective system to ensure services were provided in accordance with each	4/18/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 400	<p>Continued From page 83 professional standards. (Refer to F2B1)</p> <p>The facility failed to have an effective system in place to ensure services were provided by qualified staff in accordance with each residents' written Plan of Care by failing to ensure care plan interventions were followed. (Refer to F282)</p> <p>The facility failed to provide the necessary care and services in order to attain or maintain the highest practicable physical well-being for each resident by failing to have an effective system in place to ensure residents were assessed and monitored. The facility also failed to ensure nursing staff were trained and knowledgeable related to residents' change in conditions, in order to notify the Physician(s). (Refer to F309)</p> <p>The facility failed to have an effective system in place to ensure residents receiving Coumadin therapy received adequate laboratory monitoring, in order to ensure monitoring of therapeutic levels and appropriate dosage of Coumadin was maintained. This failure resulted in significantly increased PT/INR results to levels associated with life-threatening bleeding. (Refer to F329)</p> <p>The facility failed to have an effective system in place to ensure residents were free from significant medication errors. The facility failed to ensure staff were trained and/or their competency evaluated related to medication administration. (Refer to F333)</p> <p>The facility failed to have an effective system in place to ensure residents received laboratory services in a timely manner, as ordered by the Physician. (Refer to F502)</p>	F 400	<p>residents written plan of care. Refer to plan of correction (F 282)</p> <p>The facility implemented an effective system to ensure residents were appropriately assessed and monitored and staff was appropriately trained on change of condition with physician notification. Refer to plan of correction (F 309)</p> <p>The facility implemented an effective system to ensure residents receiving Coumadin therapy receive adequate laboratory monitoring. Refer to plan of correction (F 329)</p> <p>The facility implemented an effective system to ensure staff was trained on medication administration. Refer to plan of correction (F 333).</p> <p>The facility implemented an effective system to ensure residents received laboratory services in a timely manner in accordance with physician orders. Refer to plan of correction (F 502)</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>	

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 490	<p>Continued From page 84</p> <p>Example: Resident #13 had a physician's order dated 01/27/10 to hold his/her Coumadin that evening and have a PT/INR obtained on 01/28/10. There was no documented evidence the order to hold the Coumadin was transcribed to the MAR. No results were received for the PT/INR on 01/28/10, which resulted in the Physician not being notified and Resident #13 received Coumadin. The PT/INR was obtained on 01/29/10; and results were a PT greater than 100 seconds (normal range 9.0-11.4 seconds) and an INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0), both of these labs were noted to be critical levels. The Physician was notified and orders were received to administer Vitamin K (for blood coagulation) subcutaneously times one (1) dose. The Vitamin K was administered as ordered at 4:00 PM on 01/29/10. At 4:00 AM on 01/30/10, the night shift nurse noted the resident was found without a blood pressure, respirations or pulse and was cool to touch. The resident was pronounced dead.</p> <p>Example: Resident #16 had orders for Coumadin therapy upon admission. The facility failed to ensure that Resident #16 received the Coumadin as ordered and failed to ensure the Physician was notified of missed doses. The Physician continued to increase the resident's Coumadin. Further the resident required Vitamin K injections as a result of the PT/INR results.</p> <p>Example: On 01/20/10 at 6:45 PM, Resident #1 became dizzy. The facility assessed the resident and identified the resident's blood pressure was 228/108 (resident's average blood pressure 134/70) and blood sugar was 622 (resident's average blood sugar 255). The facility notified</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
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F 490	<p>Continued From page 85</p> <p>the Physician regarding the resident's elevated blood sugar and received an order for 18 Units of regular insulin. Interview with the resident's Physician revealed he was not notified of the Resident #1's elevated blood pressure at that time. The Physician stated he would have ordered medication for the elevated blood pressure and would have ordered the resident be sent to the hospital. Additionally, there was no documented evidence the facility assessed the resident or monitored the blood pressure for the next two (2) hours and twenty-five (25) minutes. On 01/21/10, at 12:45 AM, LPN#5 documented Resident #1 complained of not being able to move the left hand, had a weak grasp, limp arm, and difficulty moving the left leg. At that time, Resident #1 was transported to the hospital by Life Squad and was hospitalized on 01/21/10, with a diagnosis of Acute Cardiovascular Accident (CVA) with left hemiparesis.</p> <p>Interview with the former Director of Nursing (DON) revealed the facility had no documented procedure in place for the transcription of physician orders and had no documented evidence of any staff training related to transcribing orders. She also stated there was no system in place to ensure physician orders were transcribed to the MARs. The former DON further indicated there was no system in place to ensure labs were completed as ordered and the results reported to the Physician. The current DON was interviewed and revealed the order to hold the Coumadin should have been transcribed to the MAR to ensure the order was followed, and stated licensed nursing staff should have inquired as to why the facility had not received the results of labs (PT/INR).</p>	F 490			

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014		
(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
F 490	<p>Continued From page 88</p> <p>Interview with RN #1/ current DON, on 02/18/10 at 4:30 PM revealed the facility had identified problem issues related to ordered laboratory test being completed and the results reported to the Physician in a timely manner. She stated there was no check system in place to ensure labs were completed and report as ordered. Further interview revealed the facility had initiated a lab tracking book, however review of this book revealed inconsistencies and incompleteness. She stated in interview the facility had not provided any education to the nursing staff related to the procedure of the lab tracking book.</p> <p>Review of the facility policy on Care and Services revealed facility staff would be provided educational opportunity and demonstrate competency in applicable standards of clinical practice. However, interview with the Director of Nursing (DON) revealed the facility had no formal orientation process or competency evaluation for nursing staff. Additionally, the facility was unable to provide evidence that they had developed and implemented a policy and procedure on physician notification or provided training to the nursing staff regarding physician notification.</p> <p>Interview with the Administrator, on 02/23/10 at 7:00 PM, revealed he felt the DON had a check system in place to ensure Physician's orders were being transcribe onto the MARs correctly and timely. He further stated that a system failure had been identified with the laboratory test tracking process and felt the DON had corrected the system by instituting a lab tracking book. However, he was unaware staff had not been trained regarding the use of the tracking book.</p> <p>An acceptable Allegation of Compliance, related</p>	F 490		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2010
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 26TH STREET COVINGTON, KY 41014		
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F 490	Continued From page 87 to the Immediate Jeopardy, was received on 02/20/10, prior to exit. Facility actions taken and verified by the survey team through interviews and record review revealed the following: Facility actions taken and verified by the survey team through interviews with five (5) licensed nursing staff and record review revealed all nurses and CNAs were educated on change of condition, Physician notification, and monitoring. The 24 hour report was revised and implemented to track changes in condition, physician notification and appropriate monitoring. Interview with the Administrator revealed the lab monitoring system and tracking process for medications and pharmacy were reviewed and adopted into the policy and procedure manual for the facility. Immediate Jeopardy was determined to be removed on 02/27/10. Noncompliance continued with the Scope and Severity lowered to an "E" based on the facility's need to evaluate the effectiveness of quality assurance activities related to ensuring residents received medications and labs as ordered in accordance with the newly adopted policy.	F 490			
F 502 88-J	Surveyor: Harrison, Sherry A. 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502	F 502 Resident # 7's delayed urinalysis was reported to the physician on	4/13/10	

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F 502	<p>Continued From page 80 of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective system in place to ensure residents received laboratory services in a timely manner for three (3) of twenty-four (24) sampled residents (Residents #13, #15, and #7).</p> <p>The Physician ordered a Prothrombin Time/International Normalized Ratio (PT/INR) for Resident #13 on 01/27/10, and again on 01/28/10, however the facility failed to ensure these laboratory (lab) tests were obtained. Review of the lab report dated 01/29/10, revealed Resident #13 had critical lab results related to PT greater than 100 (normal 9.0 to 11.4 seconds) and INR greater than 11 (normal for standard anticoagulant use is 2.0-3.0).</p> <p>Resident #15 had physician's order for a PT/INR on 02/16/10, and on 02/17/10; however, the facility failed to ensure these labs were obtained.</p> <p>Additionally, Resident #7 had a Physician's Order dated 01/08/10 to obtain an urinalysis (urine test) to include a culture and sensitivity. The urinalysis was not obtained until two (2) days later.</p> <p>The facility's failure to have an effective system to obtain physician's ordered labs placed residents at risk for serious injury, harm, impairment or death.</p>	F 502	<p>3/8/10. Resident # 13 expired. Resident # 15's Coumadin administration and PT/INR's were reviewed with the physician on 2/19/10 and new orders were received and implemented.</p> <p>Licensed Nursing staff was educated on the lab tracking process and medication administration on 2/20/10, 2/21/10, 2/22/10, 2/23/10, and 2/24/10 by the Administrator and/or Director of Nursing.</p> <p>The lab tracking process and monitoring system was implemented on 2/20/10 and includes the following:</p> <ol style="list-style-type: none"> 1) Lab order is received by the charge nurse from the physician. 2) Lab requisition will be completed and placed in the lab box under the corresponding date by the charge nurse. 3) Labs will be drawn and the pink copy of the lab requisition will be returned to the lab box under the corresponding date. 4) When lab results are returned they are to be taken off the fax machine. The charge nurse will fax results to the physician. A follow up call will be placed to the physician to ensure the lab was received. 5) Critical labs or results that require any type of medication adjustment will be called to the physician for 	

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F 502	<p>Continued From page 88 The findings include:</p> <p>1. Review of Resident #13's medical record revealed an admission date of 01/19/10, and diagnosis which included Cerebrovascular Accident (CVA) with left sided Hemiplegia, Atrial Fibrillation, right elbow Fracture and left wrist Fracture.</p> <p>Review of the Physician's Orders revealed on 01/27/10, at 2:00 PM an order was received to have a STAT (immediate) PT/INR and CBC performed.</p> <p>Review of the clinical record revealed the nurse documented, on 01/27/10 at 3:00 PM, the resident went out for an appointment and the lab representative came to obtain the blood specimen for the STAT labs while Resident #13 was out of the facility. There was no documented evidence of the time the resident returned to the facility from the appointment.</p> <p>Review of a Physician's Order dated 01/27/10, revealed an order was received to hold the resident's Coumadin that evening and have the PT/INR and CBC obtained on 01/28/10. Interview on 02/19/10, at 3:00 PM with the Physician revealed he was at the facility on 01/27/10, at approximately 8:00 PM and gave an order to hold the resident's Coumadin that night and have the PT/INR and CBC obtained on 01/28/10. He stated he gave this order as it was late and the resident was stable. He further stated ideally it would have been good if the STAT PT/INR had been obtained as ordered earlier that day.</p> <p>Further record review revealed no documented evidence Resident #13's PT/INR and CBC were</p>	F 502	<p>further clarification. If the physician does not respond back after an hour, additional follow up from the nurse will occur.</p> <p>6) Once the physician has been notified, the charge nurse will file in the medical records.</p> <p>In order to ensure compliance, the Director of Nursing and/or Licensed Nurse designee will review new orders and lab requisitions on a daily basis. Issues identified will be corrected immediately. Issues identified will be corrected immediately. Licensed Nursing staff will be disciplined as warranted.</p> <p>Results will be reviewed weekly at the quality assurance committee meeting for further recommendation and determination of frequency for future monitoring. Identified issues and recommendations will be reviewed with the Medical Director on a weekly basis.</p>		