

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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>AMENDED</p> <p>An Abbreviated Survey investigating complaints #KY00016128 and #KY00016130 was initiated on 03/22/11 and concluded on 03/29/11. Complaint #KY00016128 was substantiated, with no deficient practice identified. Complaint #KY00016130 was substantiated with deficiencies cited.</p> <p>Immediate Jeopardy was identified on 03/25/11, and was determined to exist on 02/25/11 and is ongoing. The facility failed to ensure admission orders were verified by a physician and to ensure resident's were free of significant medication errors. On 02/25/11 at 9:00 PM, the facility administered medication Suboxone (opioid dependency treatment) to Resident #5, resulting in a significant medication error. The resident experienced acute respiratory failure caused by the medication Suboxone requiring intubation and respiratory failure management [intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p> <p>Deficiencies cited were CFR 483.20 Resident Assessment, F-271 and F-281 at a S/S of a "K"; CFR 483.25 Quality of Care, F-333 at a S/S of a "J"; 483.60, F-425 at a S/S of a "J"; CFR 483.75, F-490 and F-520 at a S/S of a "K". Substandard Quality of Care was identified at CFR 483.25, F-333.</p>	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident;</p>	F 157		

RECEIVED
MAY 19 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5/17/11
---	-------------------------------	-----------------------------

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.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 1</p> <p>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).</p> <p>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 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 interview and record review it was determined the facility failed to notify the Physician of a medication error related to the incorrect dosage of Vancomycin (antibiotic) administered to an Unsampled Resident.</p>	F 157	<p>All current resident charts were checked on 3/30/11 for any medication administration errors, none were found.</p> <p>This error occurred in Oct 2011. The nurse involved has since been terminated. <i>Resident D/c'd Oct '11</i></p> <p>The Facility DON provided mandatory training and competency testing for all nursing staff that administer drugs on 3/31/11 and 4/1/11. Individual one-on-one education sessions were provided on 3/31/11 and 4/1/11, and individually with 2 staff members that could not attend. These nurses were not allowed to work in the facility until this training had been completed.</p> <p>The training consisted of the Kentucky Board of Nursing's scope of practice with regard to the registered nurse and licensed practical nurses' responsibility in medication administration in addition to facility policies on medication administration, monitoring side effects and adverse reactions. The policies also instruct the nurse to notify the Physician if a medication is given in error and if there is a suspected adverse reaction. Immediately after the training, staff were administered a written test for verification of understanding of all material presented. All nursing staff that administers drugs will be required to have completed the training and test on medication administration before working in the facility. The DON will track the staffing schedule to make sure all have this competency on file before they can work in the facility. Going forward, all new hires and hospital float staff will also need to have this competency on file before working in the facility. This will be tracked by the facility DON.</p>	
-------	---	-------	--	--

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 157	<p>Continued From page 2</p> <p>The findings include:</p> <p>Review of the facility policy titled "Accident and Incident Reports.....", with a reviewed date of 04/20/09, revealed a written report shall be made of any accident or incident in which a resident is involved and the attending physician, or physician on call shall be notified.</p> <p>A review of Unsampled Resident A's medical record revealed the facility admitted the resident on 10/06/10 with diagnoses, which included Throat Tumors and Facial Cellulitis.</p> <p>Review of the Admission Orders, dated 10/06/10, revealed an order for Vancomycin 1200 milligrams (mg) Intravenous (IV) administration to be infused over a two (2) hour period every twenty-four (24) hours.</p> <p>Review of the Medication Administration Record (MAR), dated 10/10/10, revealed an order for Vancomycin 1200 mg IV administration every twenty-four (24) hours.</p> <p>Review of the Physician Order Form, dated 10/11/10, revealed an order from Pharmacy to reduce the dose of Vancomycin to 1000 mg IV administration every twenty-four (24) hours, per protocol related to Unsampled Resident A's Vancomycin levels in the blood.</p> <p>Review of the Medication Administration Record (MAR), dated 10/11/10, revealed an order for Vancomycin 1000 mg IV every twenty-four (24) hours. Further review revealed the medication was signed off as given on 10/11/10.</p> <p>Review of the Medication Safety Reporting Form</p>	F 157	<p>The facility requires incident reports to be filled out on each medication error and results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and to take appropriate and immediate action. The data was reported to the Facility QA Committee on 4/8/11. The committee concluded the process is in place to notify the physician of a medication error and had no further recommendations. The Committee will continue to analyze Medication Safety Reports and concurrent monitoring of physician notification by the DON and Administrator to assure the process remains consistent.</p> <p>The Facility QA Committee reports quarterly to the hospital Patient Care Committee for organizational analysis, trending and actions for improvement, as needed.</p>	4/9/11
-------	--	-------	---	--------

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 157	Continued From page 3 dated 10/11/10 revealed the Vancomycin dose had been decreased to 1000 mg IV every twenty-four (24) hours from 1200 mg IV every twenty-four (24) hours. The report continued to state the original dose of Vancomycin was in Unsampld Resident A's medication bin. Further review of the Medication Safety Reporting Form revealed an area to mark if the Physician was notified and if the Pharmacy was notified. The form indicated Pharmacy was notified, however, it did not indicate the Physician was notified. Review of the Nursing Notes dated 10/11/10 revealed no documentation the Physician was notified of the decreased dosage. Interview with the Administrator on 03/29/11 revealed the Medication Safety Report Form, reporting the incident, was forwarded to pharmacy for review and it did not appear the Physician was notified.	F 157		
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. 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 involuntary	F 223	The door in question is Room 506. Resident #2 was discharged on 3/25/11. The room was taken out of service immediately after the resident's discharge. A specialized electronic magnet system was installed 4/29/11. This allows the door to be open as needed by the resident, but will close when the fire alarm is triggered. No other doors are part of the smoke barrier therefore no other residents were affected.	4/9/11

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 223	<p>Continued From page 4</p> <p>seclusion for one (1) of eight (8) sampled residents, Resident #2. Observations revealed Resident #2's door was closed throughout the investigation. Interviews revealed Resident #2 had requested the door be opened, however, it was impossible as the door was part of the facility's fire wall and could not be propped open do to fire hazard risks.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property," with a reviewed date of 10/2009, revealed; "if a resident is receiving emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staff or others in the facility), this is not considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, and is being done according to the resident needs and not for staff convenience".</p> <p>Record review revealed the facility admitted Resident #2 on 03/11/11 with diagnoses which included status post(s/p) Pacemaker and Sick Sinus Syndrome (heart condition).</p> <p>The facility assessed the resident on 03/11/11, per review of the General Admissions Information Instructions form, as having no behavioral issues, being alert/oriented (person, place and time) and able to ambulate with the assistance of a device or person.</p> <p>Observation on 03/22/11 at 11:00 AM, 2:30 PM,</p>	F 223		

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(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 223	Continued From page 5 4:30 PM and 5:30 PM revealed Resident #2's door was closed. Observation on 03/23/11 at 8:30 AM, 10:40 AM, 10:52 AM and 3:00 PM revealed Resident #2's door was closed. Observation on 03/24/11 at 9:00 AM revealed Resident #2's door was closed. Interview on 03/22/11 at 3:30 PM with the Administrator revealed Resident #2 complained he/she wanted the door open, but the door could not be open because it was part of the fire wall. Further interview revealed the Centers for Medicare and Medicaid (CMS) told her, when they were in the facility doing a follow up survey last year, there were different things the facility could do to remedy the situation. She indicated CMS had described using the magnetic holders so if the fire alarm went off the door would close. She continued to state the magnetic piece to hold the fire door open, which was an acceptable remedy, was expensive and she did not know what she could do short of propping the door open. Which she stated would be a fire hazard.	F 223		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	RN #2 - a background check was conducted and received on 3/31. There were no issues. All current TCU employee files were checked by HR and the DON, no other background checks were found to be missing. All new hires to St Claire Regional Medical Center are given background checks automatically. The DON will request a background check specifically if an employee is transferred from another part of the hospital. This will ensure that we catch employees that were hired by the hospital system prior to the law of background checks. This has been added to the dept orientation checklist.	4/9/11

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(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 226	<p>Continued From page 6</p> <p>Based on observation, interview and record review it was determined the facility failed to follow its policy related to conducting a background screen for all employees. The facility failed to ensure one (1) of seventeen (17) employees' files (RN #2) had a background check completed. RN #2 did not have a completed background check prior to employment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property", with a reviewed date of 10/2009 revealed "all potential employees are screened for a history of abuse, neglect or mistreating residents by inquiry made to the State Nurse Aide registry or licensing authorities and conducting a criminal background check.....". The policy continued to state, "the facility conducted periodic reviews to ensure compliance with the requirement of screening".</p> <p>Record review of employee files on 03/24/11 revealed RN #2 was hired on 03/08/09. There was no evidence of a completed criminal background check located in her file.</p> <p>Interview with the Administrator on 03/24/11 at 2:30 PM revealed RN #2 had been working for the hospital since the year 1987 but began working on the Skilled Unit about two (2) years ago. The Administrator further indicated the background check in RN #2's employee file had been missed.</p>	F 226		
F 271 SS=K	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	F 271	All current resident charts were checked for complete and signed admission orders and were determined to be compliant as of 3/25/11. The Administrator or Resident #4 - was deceased therefore orders could not be amended. The new admission procedure noted below will prevent this from happening to future residents	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 271	<p>Continued From page 7</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy it was determined the facility failed to ensure seven (7) of eight (8) sampled residents (Residents # 1, 3, 4, 5, 6, 7 and 8) had orders that were verified as accurate and signed by a physician upon admission to the facility. The facility failed to follow the Admissions Policy General when facility staff signed admission orders without calling the Physician to verify admission orders prior to or on the day the facility admitted the residents. The facility failed to ensure staff was knowledgeable to the Admissions Policy. On 02/25/11, the Intake Coordinator/LPN #2 signed the Admission Orders for Resident #5 without calling Resident #5's Physician, who also served as the facility's Medical Director, to verify and obtain verbal orders for the admission. The facility used these unverified orders, which included an order for the medication Suboxone (medication used for opiate dependency). The facility administered this medication without a physician's order on 02/25/11 at 9:00 PM. After receiving this medication, Resident #5 was diagnosed on 02/26/11, with respiratory failure secondary to respiratory distress caused by the medication Suboxone. On 02/26/11 at 7:20 PM, the resident was transferred to the intensive Care Unit for intubation and further management related to the diagnosis of acute respiratory failure [intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p>	F 271	<p>Resident # 5 – had been discharged and was home therefore orders could not be amended. The new admission procedure noted below will prevent this from happening to future residents</p> <p>Residents # 1 – order was signed by the attending physician on 3/18/11</p> <p>Residents # 2 – order was signed by the attending physician on 3/11/11</p> <p>Residents # 3 – order was signed by the attending physician on 3/18/11</p> <p>Residents # 6 – order was signed by the attending physician on 3/22/11</p> <p>Residents # 7 – order was signed by the attending physician on 3/25/11</p> <p>Resident #8 – order was signed by the attending physician on 3/25/11</p> <p>The TCU Admission policy, #14-0909-38, was revised on 3/29/11 to incorporate changes on the new TCU admission process.</p> <p>The Administrator educated the four designated admitting physicians and intake nurse that the admission process requires complete, signed physician orders or a verbal order, with read back and verify, before a resident is admitted to the unit. The Administrator reviewed the process with the intake nurse, the nursing staff members that will cover the intake nurse on her days off, and the physicians. The Administrator verbally verified their understanding of</p>	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 271 Continued From page 8

In addition, the facility failed to ensure Residents # 1, 3, 4, 6, 7 and 8 had signed Physician Admission Orders prior to or upon admission to the facility.

Based on the above findings it was determined the facility failed to ensure each resident admitted had Physician orders for the residents' immediate care which was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/25/11 and was determined to exist on 02/25/11, and is ongoing.

The findings include:

Review of the facility's policy titled "Admissions Policy General", effective 06/03/09, stated prior to or on the day of admission, a completed and signed medication reconciliation sheet would be obtained in order to process the admission. The facility's policy further stated "the physician order sheet would be completed by the Case Manager (Intake Coordinator/LPN #2) using the medication reconciliation sheet (once completed and signed by the Physician), and any other Physician orders (that will be verified verbally with Physician)". Further review of the policy revealed the facility's Physician order sheet would then be signed by the attending Physician within forty-eight (48) hours.

Interview with the Intake Coordinator/LPN #2 on 03/25/11 at 10:45 AM, revealed she had an understanding with Resident #5's Physician, who also served as the facility's Medical Director. She indicated this agreement allowed her to review the orders from the hospital and continue the medications when the residents were admitted to

F 271 the new admission process again on 3/28/11 and 3/29/11.

The DON reviewed the admitting RN's responsibility to check that the physician orders are complete, signed and verified if not clear, upon the patient's admission to the facility. This was completed during the mandatory nurse training held on 3/31/11 and 4/1/11 and individually with 2 staff members that could not attend. These nurses were not allowed to work in the facility until this training had been completed.

On 3/30/11 the Chief Medical Officer limited admissions to TCU to four (4) physicians to ensure policies and practices are followed. These physicians were educated on the requirement to provide complete, signed physician orders or a verbal order, with read back and verify, before a resident is admitted to the unit. Verbal education, by the CMO, was completed by 3/30/11 with each individual physician. Going forward, the CMO, Administrator, DON or intake nurse will educate new physicians that admit to the facility prior to admitting patients, once they have been approved by Administrator and CMO.

Monitoring Plan: The Administrator observed the admission process for complete and signed physician orders on 3/29/11 and 03/30/11. The Administrator or Facility DON will concurrently review 100% of admission orders for completeness and signature at the time of admission from 3/29/11 and ongoing. In their absence the designee will be the MDS Coordinator. The facility admits patients from 8.30am to 4.30pm Monday through Friday only.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	--

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 271 Continued From page 9
the unit, without notifying the facility's physician. She stated she did not verify the Admission Orders with Resident #5's Physician before the resident was admitted. She further stated she did not verify Admission Orders with the Physicians for Residents #'s 1, 3, 4, 6, 7 and 8.

Interview with the previous Director of Nursing (DON) on 03/25/11 at 11:30 AM revealed each resident must have physician orders for his or her immediate care. If orders from the hospitalization were utilized, the Physician would need to be contacted, orders reviewed and verified. In addition, medication orders must be read back and confirmed to continue, discontinue or change the order. She further indicated Registered Nurse (RN) #3 administered Suboxone after receiving a verbal order to hold the medicine from the Physician.

Interview with Resident #5's Physician on 03/29/11 at 2:25 PM revealed she was aware the Admission Orders were created by the Intake Coordinator/LPN #2 and indicated she was putting a lot of faith in "the system". Further interview revealed she was aware the Intake Coordinator was signing the Admission Orders and medications were being given before she (a physician) reviewed reviewed the Admission Orders.

1. Review of Resident #5's medical record revealed the facility admitted Resident #5 on 02/25/11, with diagnoses which included Cerebrovascular Accidents (CVA), Transient Ischemic Attacks (TIA), Atrial Fibrillation, and Bell's Palsy.

Review of the Admission Orders for Resident #5

F 271 For incomplete orders, the Administrator or Facility DON or MDS Coordinator will ensure complete, signed orders are in hand prior to admission. A check sheet will be used for each admission, listing required elements and a signature from DON/Administrator or MDS Coordinator to verify orders are signed by physician or a verbal order with read back and verify prior to admission. The checklist will be continued to ensure compliance. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and take appropriate and immediate action; Findings will be reported to the facility QA committee on a quarterly basis. The Facility QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.

The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.

4/9/11

PRINTED: 04/13/2011
FORM APPROVED
OMB NO: 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 271	<p>Continued From page 10</p> <p>revealed on 02/25/11, the Intake Coordinator/LPN #2 received the Discharge Orders from the hospital for Resident #5 and signed the Admission Orders. The facility used these unverified orders, which included an order for the medication Suboxone (medication used for opiate dependency). The facility administered this medication without a physician's order on 02/25/11 at 9:00 PM per Nurse's Notes.</p> <p>Interview with RN #3, on 03/23/11 at 3:28 PM, revealed she did question the use of Suboxone and acknowledged she had received report from RN #1 on 02/25/11. However, she stated she administered the medication with no further explanation given.</p> <p>Review of Resident #5's Nurse's Notes dated 02/25/11 revealed at 9:00 PM, RN #3 administered Suboxone. Further review of Nurse's Notes dated 02/26/11, revealed at 1:00 AM, RN #3 noted Resident #5 "was not arousing". At 5:00 AM and again at 5:30 AM, the Physician was paged as Resident #5 was not communicating verbally. At 6:30 AM, the Physician assessed the resident and ordered a Computerized Tomography (CT) Scan. Review of the Physician Discharge Summary dated 02/26/11, revealed at 8:06 PM Resident #5 was diagnosed as having developed respiratory failure secondary to the respiratory distress caused by the medication Suboxone. The Discharge Summary further indicated the resident was being transferred to the Intensive Care Unit (ICU) for intubation and further management related to the diagnosis of Acute Respiratory Failure.</p> <p>2. Review of Resident #1's medical record revealed the facility admitted the resident on</p>	F 271		
-------	--	-------	--	--

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ST. CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 271	<p>Continued From page 11</p> <p>03/17/11, with diagnoses which included Debility, Acute Polynephritis and Urinary Tract Infection (UTI).</p> <p>Review of the Admission Orders revealed orders for Specialized Therapy, medications and Dietary. The Admission Orders were dated 03/17/11 at 3:06 PM however, were not signed by Physician #9 until 03/18/11 at 8:01 AM.</p> <p>Interview with Physician #9, on 03/29/11 at 1:45 PM, revealed she could not state she was contacted to verify Admission Orders.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 03/18/11, with diagnoses which included Acute Renal Disease, Diabetes Mellitus, Depression, Dementia, Atrial Fibrillation, and Hypertension.</p> <p>Interview with Resident #3's Physician, who also served as the facility's Medical Director, on 03/29/11 at 2:25 PM revealed she was aware the Intake Coordinator/LPN #2 was signing the Admission Orders and medications were being given before she had reviewed and signed the Admission Orders.</p> <p>4. Review of Resident #4's medical record revealed the facility admitted the resident on 02/14/11, with diagnoses which included Chronic Heart Failure, Acute Renal Insufficiency and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Admission Orders revealed orders for Specialized Therapy, medications and Dietary. The Admission Orders were dated 02/14/11 at 3:30 PM; however, these orders were not signed by Physician #15 until 02/15/11 at 12:15 PM.</p>	F 271		

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361
--	---

(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 271	<p>Continued From page 12</p> <p>5. Review of Resident #6's medical record revealed the facility admitted the resident on 03/22/11 at 11:20 AM, with diagnoses which included Chronic Heart Failure, Chronic Renal Insufficiency, and Hypothyroidism.</p> <p>Review of the Admission Orders revealed orders for Specialized Therapy, Dietary, and Lab work to be done. The Admission Orders were dated 03/22/11 at 11:20 AM; however, record review completed on 03/29/11 of the resident's Admission Orders revealed these orders had not been signed by Physician #10.</p> <p>Interview, on 03/29/11 at 1:45 PM, with Physician #10 revealed she was aware Physician Orders were needed and they were available in the computer system for Electronic Signature. She was not sure when she was contacted during the process because she may see residents in the hospital prior to them being admitted to the facility.</p> <p>6. Review of Resident #7's medical record revealed the facility admitted the resident on 03/22/11, with diagnoses which included Lupus, Diabetes Mellitus, Sepsis of Urinary Origin, and Constipation.</p> <p>Review of the Admission Orders revealed orders for Specialized Therapy, Dietary, and Lab work to be done. The Admission Orders were dated 03/22/11 at 3:05 PM; however, review of the Admission Orders revealed they were not signed by Physician #10 until on 03/25/11 at 8:43 AM.</p> <p>7. Review of Resident #8's medical record revealed the facility admitted the resident on</p>	F 271		

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 271	Continued From page 13 03/22/11, with diagnoses which included Acute/Chronic Renal Insufficiency, Chronic Heart Failure, and Hypothyroidism. Interview with the Intake Coordinator/LPN #2 on 03/28/11 at 4:15 PM, revealed she did not verify Admission Orders with the Physicians for Resident #8. Review of LPN #2's employee file, on 03/29/11, revealed no evidence she received training related to the facility's admission process. Further review of her file revealed no evidence she had completed the Departmental Checklist which included "Policy Familiarization".	F 271		
F 281 SS=K	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility policy, Kentucky Nursing Law, and the Kentucky Board of Nursing website it was determined the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure medications were administered in accordance with acceptable standards of practice and per facility policy for one (1) of eight (8) sampled residents (Resident #5). Registered Nurse (RN) #3 administered the medication Suboxone (a medication for opiate dependency) to Resident #5 after receiving a verbal order from the physician to "hold the medication" as the resident did not have a diagnosis related to the drug's indication.	F 281	Resident #5 had been discharged home therefore orders could not be amended. The new admission procedure noted below will prevent this from happening to future residents. All current resident charts were checked for complete and signed admission orders and were determined to be compliant as of 3/25/11. As a result of the medication error investigation, the nurse who administered the suboxone was terminated and reported to the Kentucky Board of Nursing for unsafe practice on 3/3/11.	4/9/11

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 281	<p>Continued From page 14</p> <p>Resident #5 developed respiratory failure secondary to respiratory distress caused by the medication Suboxone. The resident was transferred to the Intensive Care Unit for intubation and further management related to the diagnosis of acute respiratory failure [Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p> <p>In addition, the Intake Coordinator/Licensed Practical Nurse (LPN) #2 failed to obtain physician verified/approved admission orders for seven (7) of eight (8) sampled residents (Residents #1, #3, #4, #5, #6, #7 and #8) prior to or upon admission to the facility.</p> <p>Based on the above findings it was determined the facility failed to ensure physician approved/verified orders were obtained upon admission and failed to ensure physician orders were followed which was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/25/11 and was determined to exist on 02/25/11, and is ongoing.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, "Resident Assessment", facility reviewed on 06/11/09, stated each resident admitted to the facility must have physician orders for his or her immediate care.</p> <p>Review of the facility's policy titled, "Admissions Policy" revealed "the physician order sheet would be completed by the Case Manager (Intake Coordinator/LPN #2) using the medication reconciliation sheet (once completed and signed by the Physician), and any other Physician orders</p>	F 281	<p>The checklist results were documented, analyzed and trended by the DON and Administrator weekly from 3/30/11 to 4/8/11, to identify opportunities for improvement, and to take appropriate and immediate action. Findings were reported to the facility QA committee on 4/8/11. Findings confirmed the checklist and concurrent monitoring of admission orders was effective to assure 100% of admission orders included required elements and a signature from the DON, Administrator or Minimum Data Set Coordinator to verify orders were signed by a physician or a verbal order with read back and verified prior to admission were complete and timely since 3/30/11. The Committee had no further recommendations and will continue to monitor. The DON and Administrator will continue to meet on a monthly basis and the QA Committee will continue to meet quarterly.</p> <p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p> <p>The TCU Admission policy, #14-0909-38, was revised on 3/29/11 to incorporate changes on the new TCU admission process.</p> <p>The Administrator educated the designated admitting physicians and intake nurse that the admission process requires complete, signed physician orders or a verbal order, with read back and verify, before a</p>	
-------	---	-------	---	--

resident is admitted to the unit. The Administrator reviewed the process with the intake nurse, the nursing staff members that will cover the intake nurse on her days off, and the physicians. The Administrator verbally verified their understanding of the new admission process again on 3/28/11 and 3/29/11.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 281	<p>Continued From page 15 (that will be verified verbally with Physician)".</p> <p>Review of the facility's policy titled, "Medication Administration," effective on 04/01/05, stated before administering a medication any significant concerns about the medication should be clarified with the Physician and any other relevant staff involved with the patient's care.</p> <p>Review of the facility's policy titled, "Medication Orders," effective on 10/01/09, stated only medications needed to treat the patient's condition(s) were ordered, as evidenced by information in the medical record, including diagnoses, condition or indication for each drug ordered.</p> <p>Interview with the previous Director of Nursing (DON), on 03/25/11 at 11:30 AM, revealed each resident must have physician orders for his or her immediate care. If orders from the hospitalization were utilized, the Physician would need to be contacted, orders reviewed and verified. In addition, medication orders must be read back and confirmed to continue, discontinue or change them.</p> <p>Review of the Kentucky Nursing Law, KRS 314.021 (2) stated "all individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience in nursing and shall practice nursing with reasonable skill and safety."</p> <p>Review of the Kentucky Board of Nursing's website, titled "www.kbn.ky.gov" revealed physician orders written by an LPN without a legitimate order were falsified medical records</p>	F 281	<p>On 3/30/11 the Chief Medical Officer limited admissions to TCU to four (4) physicians to ensure policies and practices are followed. These physicians were educated on the requirement to provide complete, signed physician orders or a verbal order, with read back and verify, before a resident is admitted to the unit. Verbal education was completed by 3/30/11 with each individual physician. Going forward, the VPMA, Administrator, DON or intake nurse will educate new physicians that admit to the facility prior to admitting patients, once they have been approved by the administrator and the CMO.</p> <p>Monitoring Plan: The Administrator observed the admission process for complete and signed physician orders on 3/29/11 and 03/30/11. The Administrator or Facility DON will concurrently review 100% of admission orders for completeness and signature at the time of admission from 3/29/11 and ongoing. In their absence the designee will be the MDS Coordinator. For incomplete orders, the Administrator or Facility DON or MDS Coordinator will obtain complete, signed orders prior to admission. A TCU Admission check sheet will be used by TCU Intake Nurse for each TCU admission, listing required elements and a signature from DON/Administrator or MDS Coordinator to verify orders are signed by physician or a verbal order with read back and verify prior to admission. The checklist will be continued to ensure compliance. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and take appropriate and immediate action. Analysis is</p>	

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

 PRINTED: 04/13/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED. C 03/29/2011
---	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIR MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 281	<p>Continued From page 16</p> <p>and this practice was outside of his/her scope as an LPN.</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 02/25/11 with diagnoses which included Cerebrovascular Accidents (CVA), Transient Ischemic Attacks (TIA), Atrial Fibrillation and Bell's Palsy. Review of the Admission Orders for Resident #5 revealed on 02/25/11, the Intake Coordinator/Licensed Practical Nurse (LPN) #2 received the Discharge Orders from the hospital for Resident #5 and signed the Admission Orders. The facility used these unverified orders, which included an order for the medication Suboxone (medication used for opiate dependency). Interview with Intake Coordinator/LPN #2, on 03/25/11 at 10:45 AM, revealed she had an understanding with the Medical Director/Resident #5's Physician. She stated she reviewed the orders from the resident's hospitalization and continued those medications and orders when they were admitted to the facility.</p> <p>Interview with Registered Nurse (RN) #1, who was working when Resident #5 was admitted, on 03/22/11 at 5:45 PM revealed she was concerned about the use of the medication (Suboxone) because the resident did not have a related diagnosis of opiate dependency and communicated this concern during shift report, on 02/25/11 at 7:00 PM, to RN #3 who took over the care for Resident #5.</p> <p>Interview with Resident #5's Sitter, on 03/23/11 at 9:00 AM, revealed she informed RN #3 she was familiar with the resident's home medications and indicated the resident had never previously been prescribed the medication and questioned why it</p>	F 281	<p>reported to the Facility Quality Committee on a quarterly basis. The QA committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p> <p>The Facility DON provided mandatory training and competency testing for all nursing staff that administer drugs on 3/31/11 and 4/1/11. Individual one-on-one education sessions were provided on 3/31/11 and 4/1/11, and individually with 2 staff members that could not attend. These nurses were not allowed to work in the facility until this training had been completed.</p> <p>The training consisted of the Kentucky Board of Nursing's scope of practice with regard to the registered nurse and licensed practical nurses' responsibility in medication administration and following physician orders in addition to facility policies on medication administration, monitoring side effects and adverse reactions. Immediately after the training, staff were administered a written test for verification of understanding of all material presented. All nursing staff that administers drugs will be required</p>	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 281	<p>Continued From page 17 was ordered.</p> <p>Review of the Medication Reconciliation - Admission Report (MR-AR), dated 02/25/11 at 8:20 PM, revealed the medication was indicated for opiate dependency.</p> <p>Interview with Resident #5's Physician, who also served as the facility's Medical Director, on 03/23/11 at 3:00 PM, revealed on 02/25/11. Resident #5's Physician gave a verbal order to Registered Nurse (RN) #3 to "hold the medication", before the 9:00 PM dose of Suboxone until the Physician could confirm this medication was intended for Resident #5.</p> <p>Interview with RN #3, on 03/23/11 at 3:28 PM, and review of Nurse's Notes revealed RN #3 administered the Suboxone medication to Resident #5, on 02/25/11 at 9:00 PM, despite the concerns regarding this medication presented by RN #1, the resident's sitter, and a verbal order from the resident's physician to "hold the medication". In additional interview, RN #3 stated the resident's sitter had no knowledge the resident received a sublingual medication for opiate dependency.</p> <p>Review of the Physician Discharge Summary, dated 02/26/11 at 8:06 PM, revealed Resident #5 was diagnosed as having respiratory failure secondary to the respiratory distress caused by the medication Suboxone. The Discharge Summary further indicated the resident was transferred to the Intensive Care Unit (ICU) for intubation and further management related to the diagnosis of acute respiratory failure.</p> <p>Interview with the resident's Physician, on</p>	F 281	<p>to have completed the training and test on medication administration before working in the facility. The DON will track the staffing schedule to make sure all have this competency on file before they can work in the facility. Going forward, all new hires and hospital float staff will also need to have this competency on file before working in the facility. This will be tracked by the facility DON.</p>	4/9/11
-------	---	-------	---	--------

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

 PRINTED: 04/13/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 281	<p>Continued From page 18</p> <p>03/23/11 at 3:00 PM, revealed RN #3 disregarded the Physician's verbal order and administered the 9:00 PM dose of Suboxone which resulted in a significant medication error.</p> <p>2. Review of sampled residents' medical records revealed Admission Orders for six (6) residents (Residents # 1, 3, 4, 6, 7 and 8) which had been signed by the Intake Coordinator/ LPN #2; however, interview with the Intake Coordinator/LPN #2 on 03/24/11 at 10:45 AM revealed she did not verify these orders with the Physicians. (Refer to F271).</p> <p>Continued interview with Intake Coordinator/LPN #2, revealed she reviewed the orders from the resident's hospitalization and continued those medications and orders when they were admitted to the facility. She stated she did not call the Physicians to verify Admission Orders. Further interview revealed she did not obtain or verify orders for Resident's #1, 3, 4, 6, 7 and 8.</p> <p>Review of LPN #2's employee file, on 03/29/11, revealed LPN #2 was transferred to the nursing facility on 08/16/10. Record review revealed no evidence she received training related to the facility's admission process and no documented evidence she had completed the Departmental Checklist which included "Policy Familiarization".</p>	F 281		
F 333 SS=J	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 333	<p>Resident #8- the error was corrected by pharmacy immediately at the time the surveyor pointed it out.</p> <p>Resident #5 - had been discharged home. New processes implemented as described below will prevent this occurring in new and current residents.</p>	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 19</p> <p>Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure residents were free from significant medication errors for two (2) of eight (8) sampled residents (Resident #5 and #8). Resident #5 received Suboxone (a medication for opioid addiction). Pharmacy had, in error, listed this medication on the resident's admission orders; however, the resident had no diagnosis for the use of this medication. The facility administered Suboxone to Resident #5, on 02/25/11 at 9:00 PM. After receiving this medication, Resident #5 developed respiratory failure secondary to the respiratory distress caused by the medication Suboxone. On 02/26/11 at 7:20 PM, the facility transferred Resident #5 to the Hospital's Intensive Care Unit for intubation and further management related to the diagnosis of acute respiratory failure [intubation is the placement of a flexible plastic tube into trachea (windpipe) to maintain an open airway].</p> <p>In addition, Resident #8 had physician orders to receive Novolin Insulin three (3) times a day before meals; however, the facility nursing staff was administering the insulin with meals per the Medication Administration Record (MAR) produced by the Pharmacy.</p> <p>Based on the above findings it was determined the facility failed to have an effective system to ensure staff administered medications to residents free of significant medication errors which was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 03/25/11 and determined to exist on 02/25/11, and is ongoing.</p>	F 333	<p>As a result of the medication error investigation, the nurse who administered the suboxone was terminated and reported to the Kentucky Board of Nursing for unsafe practice on 3/3/11.</p> <p>The medication error rate will be reviewed for the three months prior to the incident on 2/25/11 and then once a month, by nursing and pharmacy following the Administrative Medication Safety Reporting Policy.</p> <p>A TCU Admission check sheet will be used by TCU Intake Nurse for each TCU admission, listing required elements and a signature from DON/Administrator or MDS Coordinator to verify orders are signed by physician or a verbal order with read back and verify prior to admission. The checklist will be continued to ensure compliance. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement. Analysis is reported to the Facility Quality Committee on a quarterly basis. The QA committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p>	
-------	---	-------	---	--

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(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	Continued From page 20 The findings include: 1. Review of the facility's policy titled, "Medication Administration," with the effective date of 04/01/05, stated before administering a medication any significant concerns about the medication should be clarified with the Physician and any other relevant staff involved with the patient's care. Review of the facility's policy titled, "Medication Orders," with the effective date of 10/01/09 stated only medications needed to treat the patient's condition(s) were ordered, as evidenced by information in the medical record, including diagnoses, condition or indication for each drug ordered. Review of the facility's policy titled, "Pharmacy Services for Transitional Care and Inpatient Rehabilitation Units", effective 09/01/10, revealed medications were supplied in the most ready-to-administer form possible, and nursing Medication Administration Records (MARs) were generated from the pharmacy operating system. Review of the facility's policy titled, "Inpatient Drug Distribution System", effective 07/01/10, stated Pharmacy was responsible for interpreting and processing the Physician's order. The procedure was defined as when a Prescriber's new order was received in the Pharmacy, a Pharmacist entered the orders into the computerized system. Review of Resident #5's medical record revealed the facility admitted the resident on 02/25/11 with diagnoses which included Cerebrovascular Accidents (CVA), Transient Ischemic Attacks (TIA), Atrial Fibrillation and Bell's Palsy.	F 333	An additional safeguard has been implemented for medication safety. The TCU intake nurse will compare the TCU admission medication orders with the current active hospital MAR and notify physician of any discrepancies prior to admission to TCU. This process is a "stop" until immediate, independent cross check verification is completed by the admitting physician. The Medication Reconciliation Policy, #A10-0612-03, has been revised to reflect the implemented change. The Director of Pharmacy provided education to the pharmacists on 03/31/11 about the medication error in which a resident on the Transitional Care Unit received a medication that was not ordered. The education consisted of the following: 1. Best practices to prevent entering medication orders on the wrong patient: a. After an interruption, verify that both the electronic document screen (Omnilink Rx) and the pharmacy information system screen (Meditech) are on the same patient b. Limit the number of open screens on the computer monitor c. When you move to the next order in the Omnilink Rx queue, accept all the orders already entered on the patient and re-enter the patient information d. Continue to put your completed orders in the second check queue for another pharmacist to check independently e. Call one of the other pharmacists to review order entry on a high risk patient (chemotherapy or pediatric patient)		

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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

Continued From page 21

Review of the Admission Orders for Resident #5 revealed on 02/25/11, the Intake Coordinator/Licensed Practical Nurse (LPN) #2 received the Discharge Orders from the hospital for Resident #5 and signed the Admission Orders. The facility used these unverified orders, which included an order for the medication Suboxone (medication used for opiate dependency). Review of the Medication Reconciliation - Admission Report (MR-AR), dated 02/25/11 at 8:20 PM, revealed the medication was indicated for opiate dependency.

Interview with the Pharmacy Director, on 03/22/11 at 5:30 PM, revealed printed copy of orders containing the error medication Suboxone for Resident #5 was printed and the Pharmacy was not aware this copy existed until the medication had been administered. She further acknowledged there was a breakdown in the facility's process.

Interview on 03/22/11 at 5:45 PM with Registered Nurse (RN) #1, who was working when Resident #5 was admitted, revealed she did not have Resident #5's home medication list and could not make contact with the Physician to clarify the indication for the use of Suboxone. She further indicated she was concerned about the use of the medication because the resident did not have a related diagnosis of opiate dependency. Further interview revealed this information was communicated during shift report, on 02/25/11 at 7:00 PM, to RN #3 who would be taking over Resident #5's care for the evening.

Interview with Resident #5's Sitter on 03/23/11 at 9:00 AM revealed she informed RN #3 she was

F 333

2. Policy changes to provide uniform response to a medication error:

- a. Medication Safety, 12-0207-05
Whenever the pharmacist is contacted about a medication error, the following steps are taken:
- o The caller is instructed to inform the attending or cross-covering physician about the error.
 - o Monitoring parameters are printed from a drug information resource such as Micromedex or Poisindex and placed in the patient's medical record.
 - o The patient's profile is reviewed to identify any potential drug interactions that could potentiate adverse effects and communicated to the physician or LIP

The Director of Pharmacy will meet individually with those 6 staff members unable to attend before their next scheduled shift.

With regard to the hospital physician's discharge medication reconciliation, the decision to continue the suboxone was referred to the hospital physician's supervisor. Review and follow up of the decision to continue the suboxone upon discharge, was given on 4/1/11.

A quality measure has been implemented to monitor medication reconciliation compliance. SCR quality management department implemented a quality monitor to review the medication reconciliation process of the hospital. For accurate and complete home medications lists, medication orders and discharge/transfer medication lists. On charts with a medication safety report, patient complications or risk management referral data will be analyzed for trends and opportunities for improvement and reported to the Pharmacy and Therapeutics committee. Opportunities for peer review will be reviewed as outlined in the medical staff quality plan.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC 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 22</p> <p>famllar with the resident's home medicatlons and indicated the resident had never previously been prescribed the medication and questioned why It was ordered.</p> <p>Interview with Resident #5's Physcian, who was also the facility's Medical Director, on 03/23/11 at 3:00 PM, revealed on 02/25/11 Resident #5's Physician gave a verbal order to Registered Nurse (RN) #3 to "hold medication", for the 9:00 PM dose of Suboxone until the Physician could confirm this medication was intended for Resident #5.</p> <p>Interview with RN #3, on 03/23/11 at 3:28 PM, and review of Nurse's Notes revealed RN#3 administered the Suboxone medication to Resident #5, on 02/25/11 at 9:00 PM despite the concerns regarding this medication presented by RN #1, the resident's sitter, and a verbal order from the resident's physcian to "hold the medication". Per interview, RN #3 was unable to provide further explanatlon as to why she administered the Suboxone medication to the resident.</p> <p>Review of the Physician Discharge Summary, dated 02/26/11 at 8:06 PM, revealed Resident #5 was diagnosed as having respiratory failure secondary to the respiratory distress caused by the medication Suboxone. The Discharge Summary further indicated the resident was transferred to the Intensive Care Unit (ICU) for intubation and further management related to the diagnosis of acute respiratory failure.</p> <p>Interview with the resident's Physician, on 03/23/11 at 3:00 PM, revealed RN #3 disregarded the Physician's verbal order and administered the</p>	F 333	<p>The Facility DON provided mandatory training and competency testing for all nursing staff that administer drugs on 3/31/11 and 4/1/11. Individual one-on-one education sessions were provided on 3/31/11 and 4/1/11, and individually with 2 staff members that could not attend. These nurses were not allowed to work in the facility until this training had been completed.</p> <p>The training consisted of the Kentucky Board of Nursing's scope of practice with regard to the registered nurse and licensed practical nurses' responsibility in medication administration in addition to facility policies on medication administration, monitoring side effects and adverse reactions. Immediately after the training, staff were administered a written test for verification of understanding of all material presented. All nursing staff that administers drugs will be required to have completed the training and test on medication administration before working in the facility. The DON will track the staffing schedule to make sure all have this competency on file before they can work in the facility. Going forward, all new hires and hospital float staff will also need to have this competency on file before working in the facility. This will be tracked by the facility DON.</p> <p>The Medication Reconciliation Policy # A10-0612-03 has been revised to reflect the implemented changes.</p>		

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 23</p> <p>9:00 PM dose of Suboxone which resulted in a significant medication error.</p> <p>Interview with the Administrator, on 03/25/11 at 2:20 PM, revealed she was aware RN #3 had been unsuccessful with medication administration while working at the hospital; however, she could provide no evidence or action the facility took to ensure RN #3's competence with medication administration prior to assigning the Nurse to the task after her transfer to the facility. Per interview the facility administration continued to utilize RN #3 after RN #3's significant medication error regarding Resident #5.</p> <p>2. Review of the facility's policy titled, "Inpatient Drug Distribution System," with the effective date of 07/01/10, revealed uniform dosing schedules are used to determine the time a drug is to be administered. It was noted the AC (before meals) description of a dosing schedule was not a recognized frequency in the policy.</p> <p>Review of Resident #8's medical record revealed the facility admitted Resident #8 on 03/15/11 with the diagnoses which included Diabetes and Renal Insufficiency. Review of the Physician's orders, dated 03/07/11 at 11:05 AM, revealed an order for Novolog Injection 10 units AC (before meals)/TID (three (3) times a day).</p> <p>Observation of the medication pass, on 03/22/11 at 12:45 PM, revealed Registered Nurse (RN) #1 administered Novolog Injection (Insulin) 10 units with Resident #8's lunch meal.</p> <p>Review of the Medication Administration Record (MAR), dated 03/22/11, revealed an order for Novolog Injection 10 units three (3) times a day</p>	F 333	<p>Monitoring Plan: The hospital and facility follow the Administrative Medication Safety Reporting policy to report near misses (circumstances that have the capacity to cause an adverse outcome but were identified and corrected prior to reaching the patient) or actual medication errors with regard to ordering, transcription, preparation and dispensing, and medication administration. Pharmacy and nursing service investigate and take appropriate action in response to each individual occurrence. Data is trended and reviewed by Pharmacy, Nursing Service, Pharmacy and Therapeutic Committee and Inpatient Forum Committee. SCR medication error rate is significantly less than a 5% error rate.</p> <p>The TCU Unit reports and monitors all medication errors. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and take appropriate and immediate action. Data analysis is reported to the Facility Quality Committee on a quarterly basis for analysis and trending.</p> <p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p>	4/9/11
-------	--	-------	---	--------

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(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	Continued From page 24 with meals. Interview with Licensed Practical Nurse (LPN) #3, on 03/23/11 at 10:30 AM, revealed that a medication ordered AC/TID, such as Insulin, meant to give this medication before the meal started. Further interview revealed the ideal administration time would be at least thirty (30) minutes prior to the start of the meal. Interview with the Pharmacy Director, on 03/23/11 at 4:50 PM, revealed the Pharmacy's computerized software system would not allow for a dosing frequency of AC/TID; therefore, the pharmacy changed the time to WC/TID (with meals) without consulting the physician. Interview with the previous Director of Nursing (DON), on 03/28/11 at 11:25 AM, revealed she was unaware Pharmacy was substituting the dosing frequency of AC/TID to WC/TID related to the Pharmacy's software not allowing for AC/TID to be entered into the system.	F 333			
F 425 SS=J	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425 F 425	Resident #8- the error was corrected by pharmacy immediately at the time the surveyor pointed it out. Resident #5 - had been discharged home. New processes implemented as described below will prevent this occurring in new and current residents. All Resident charts were checked on 3/30/11 for any medication administration errors, none were found. The Administrator and Facility DON are currently reviewing 100% of medication errors reported on incident reports and those found through weekly chart audits. The DON or Administrator will investigate and take any action needed daily when notified of a		

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(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 425	<p>Continued From page 25</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) met the needs for two (2) of eight (8) sampled residents (Resident #5 and #8). Resident #5 received Suboxone (a medication for opioid addiction), when this medication was listed on the resident's admission orders. Interview revealed Suboxone was listed on the resident's admissions orders by Pharmacy in error. Resident #5 received this medication on 02/25/11 at 9:00 PM, and developed respiratory failure secondary to the respiratory distress caused by the medication Suboxone. On 02/26/11 at 7:20 PM, the resident was transferred to the Intensive Care Unit for intubation and further management related to the diagnosis of acute respiratory failure [intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p>	F 425	<p>As a result of the medication error investigation, the nurse who administered the suboxone was terminated and reported to the Kentucky Board of Nursing for unsafe practice on 3/3/11.</p> <p>The medication error rate will be reviewed for the three months prior to the incident on 2/25/11 and then once a month, by nursing and pharmacy following the Administrative Medication Safety Reporting Policy.</p> <p>A TCU Admission check sheet will be used by TCU Intake Nurse for each TCU admission, listing required elements and a signature from DON/Administrator or MDS Coordinator to verify orders are signed by physician or a verbal order with read back and verify prior to admission. The checklist will be continued to ensure compliance. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement. Analysis is reported to the Facility Quality Committee on a quarterly basis. The QA committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p>		

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 425	<p>Continued From page 26</p> <p>In addition, the facility's Pharmacy computerized software system would not allow for a medication dosing schedule before meals (AC). This system failure prevented the facility from administering medications per the physician orders. The facility administered Resident #8's Novolin insulin three (3) times a day (TID) during meals when the physician orders specified the resident was to receive Novolin Insulin three (3) times a day before meals.</p> <p>Based on the above findings it was determined the facility failed to have an effective system to ensure residents received pharmaceutical services that assured the accurate acquisition, receiving and dispensing of drugs and biologicals, which was likely to cause serious harm, injury or death. Immediate Jeopardy was identified on 03/25/11 and was determined to exist on 02/25/11, and is ongoing.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled, "Inpatient Drug Distribution System," effective 07/01/10, stated Pharmacy was responsible for interpreting and processing the Physician's order. The procedure was defined as when a Prescriber's new order was received in the Pharmacy, a Pharmacist entered the order into the computerized system. <p>Interview with the Pharmacy Director, on 03/22/11 at 5:30 PM, revealed medication orders were scanned to the Pharmacist, who then associated the order with a resident, and entered the order into the computerized system. The order was then reviewed a second time by a Pharmacist.</p>	F 425	<p>An additional safeguard has been implemented for medication safety. The TCU intake nurse will compare the TCU admission medication orders with the current active hospital MAR and notify physician of any discrepancies prior to admission to TCU. This process is a "stop" until immediate, independent cross check verification is completed by the admitting physician. The Medication Reconciliation Policy, #A10-0612-03, has been revised to reflect the implemented change.</p> <p>The Director of Pharmacy provided education to the pharmacists on 03/31/11 about the medication error in which a resident on the Transitional Care Unit received a medication that was not ordered. The education consisted of the following:</p> <ol style="list-style-type: none"> 1. Best practices to prevent entering medication orders on the wrong patient: <ol style="list-style-type: none"> a. After an interruption, verify that both the electronic document screen (Omnilink Rx) and the pharmacy information system screen (Meditech) are on the same patient b. Limit the number of open screens on the computer monitor c. When you move to the next order in the Omnilink Rx queue, accept all the orders already entered on the patient and re-enter the patient information d. Continue to put your completed orders in the second check queue for another pharmacist to check independently e. Call one of the other pharmacists to review order entry on a high risk patient (chemotherapy or pediatric patient) 	
-------	--	-------	--	--

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 425	<p>Continued From page 27</p> <p>Review of Resident #5's Medical Record revealed the facility admitted the resident on 02/25/11 with diagnoses which included Cerebrovascular Accidents (CVA), Transient Ischemic Attacks (TIA), Atrial Fibrillation and Bell's Palsy.</p> <p>Review of the Medication Reconciliation - Admission Report (MR-AR) developed by the pharmacy, dated 02/25/11 at 8:20 PM, revealed the order for Suboxone 8-2 milligrams (mg) with a start time of 02/25/11 at 9:00 PM. Further review revealed the medication was indicated for opiate dependency.</p> <p>Review of Resident #5's Nurse's Notes dated 02/25/11 revealed at 9:00 PM, RN #3 administered Suboxone.</p> <p>Review of the Physician Discharge Summary, dated 02/26/11 at 8:06 PM, revealed Resident #5 was diagnosed as having developed respiratory failure secondary to the respiratory distress caused by the medication Suboxone. The facility transferred Resident #5 to the Hospital's Intensive Care Unit (ICU) for intubation and further management related to the diagnosis of acute respiratory failure [Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p> <p>Interview, on 03/29/11 at 2:00 PM, with the Resident #5's Physician revealed she had contacted the pharmacy around 9:00 PM regarding the resident's medication history and was informed that a medication data entry error had occurred. However, the 9:00 PM dose of Suboxone had already been given.</p>	F 425	<p>2. Policy changes to provide uniform response to a medication error:</p> <p>a. Medication Safety, 12-0207-05</p> <p>Whenever the pharmacist is contacted about a medication error, the following steps are taken:</p> <ul style="list-style-type: none"> o The caller is instructed to inform the attending or cross-covering physician about the error. o Monitoring parameters are printed from a drug information resource such as Micromedex or Poisindex and placed in the patient's medical record. o The patient's profile is reviewed to identify any potential drug interactions that could potentiate adverse effects and communicated to the physician or LIP <p>The Director of Pharmacy will meet individually with those 6 staff members unable to attend before their next scheduled shift.</p> <p>With regard to the hospital physician's discharge medication reconciliation, the decision to continue the suboxone was referred to the hospital physician's supervisor. Review and follow up of the decision to continue the suboxone upon discharge, was given on 4/1/11.</p> <p>A quality measure has been implemented to monitor medication reconciliation compliance. SCR quality management department implemented a quality monitor to review the medication reconciliation process of the hospital. For accurate and complete home medications lists, medication orders and discharge/transfer medication lists. On charts with a medication safety report, patient complications or risk management referral data will be analyzed for trends and opportunities for improvement and reported to the Pharmacy and Therapeutics committee. Opportunities for peer review will be reviewed as outlined in the medical staff quality plan.</p>

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIR MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 425	<p>Continued From page 28</p> <p>Continued interview with the Pharmacy Director (Pharmacy covers both the hospital and the nursing facility), on 03/22/11 at 5:30 PM, revealed Resident #5, who had been in the hospital prior to his/her admission to the nursing facility, had been on the same floor as another patient who had an order for Suboxone. She stated there was a breakdown in the facility's process for receiving and entering orders into the computerized system, which allowed an incorrect entry to be implemented prior to the final review and verification of the Medication Administration Record (MAR) by Pharmacy. She further revealed the copy of orders, which contained the medication Suboxone in error for Resident #5, had been printed and the Pharmacy was not aware this copy existed until the medication had been administered.</p> <p>2. Review of the facility's policy titled, "Inpatient Drug Distribution System", effective 07/01/10, revealed uniform dosing schedules were used to determine the time a drug was to be administered. It was noted the AC (before meals) description of a dosing schedule was not a recognized frequency in the policy.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 03/15/11 with the diagnoses which included Diabetes and Renal Insufficiency.</p> <p>Review of the Physician orders, dated 03/07/11 at 11:05 AM, revealed an order for Novolog Injection 10 units AC (before meals)/TID [three (3) times a day]. However, review of the Medication Administration Record (MAR) dated 03/22/11 revealed an order for Novolog Injection 10 units three (3) times a day with meals.</p>	F 425	<p>The Facility DON provided mandatory training and competency testing for all nursing staff that administer drugs on 3/31/11 and 4/1/11. Individual one-on-one education sessions were provided on 3/31/11 and 4/1/11, and individually with 2 staff members that could not attend. These nurses were not allowed to work in the facility until this training had been completed.</p> <p>The training consisted of the Kentucky Board of Nursing's scope of practice with regard to the registered nurse and licensed practical nurses' responsibility in medication administration in addition to facility policies on medication administration, monitoring side effects and adverse reactions. Immediately after the training, staff were administered a written test for verification of understanding of all material presented. All nursing staff that administers drugs will be required to have completed the training and test on medication administration before working in the facility. The DON will track the staffing schedule to make sure all have this competency on file before they can work in the facility. Going forward, all new hires and hospital float staff will also need to have this competency on file before working in the facility. This will be tracked by the facility DON.</p> <p>The Medication Reconciliation Policy # A10-0612-03 has been revised to reflect the implemented changes.</p>	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 425	<p>Continued From page 29</p> <p>Observation of the medication pass, on 03/22/11 at 12:45 PM, revealed Registered Nurse (RN) #1 administered Novolog Injection (Insulin) 10 units with Resident #8's lunch.</p> <p>Interview with LPN #3, on 03/23/11 at 10:30 AM, revealed that a medication ordered AC/TID, such as Insulin, meant the medication was to be given before the meal was started. Further interview revealed the ideal administration time would be at least thirty (30) minutes prior to the start of the meal.</p> <p>Interview with Pharmacy Director, on 03/23/11 at 4:50 PM, revealed the Pharmacy's computerized software system would not allow for a dosing schedule of AC/TID; therefore, the Pharmacy changed the time to TID/WC (with meals) without consulting the physician.</p> <p>Interview with Resident #8's Physician revealed he was not aware Pharmacy changed the administration time of the Novolog medication order, dated 03/07/11 at 11:05 AM. He further stated he would change the order to reflect the administration time of TID/WC per pharmacy recommendations.</p>	F 425	<p>Monitoring Plan: The hospital and facility follow the Administrative Medication Safety Reporting policy to report near misses (circumstances that have the capacity to cause an adverse outcome but were identified and corrected prior to reaching the patient) or actual medication errors with regard to ordering, transcription, preparation and dispensing, and medication administration. Pharmacy and nursing service investigate and take appropriate action in response to each individual occurrence. Data is trended and reviewed by Pharmacy, Nursing Service, Pharmacy and Therapeutic Committee and Inpatient Forum Committee. SCR medication error rate is significantly less than a 5% error rate.</p> <p>The TCU Unit reports and monitors all medication errors. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and take appropriate and immediate action. Data analysis is reported to the Facility Quality Committee on a quarterly basis for analysis and trending.</p>	
F 490 SS=K	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>		<p>The Facility QA committee core members were involved in this whole AOC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.</p>	4/9/11

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361
---	---

(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 30</p> <p>by: Based on observation, interviews and record review, it was determined the facility's Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, related to provision of care in accordance with acceptable Standards of Practice and assurance of resident's being free from significant medication errors. Administration failed to ensure nursing staff administering medications were competent to perform the task in accordance with acceptable nursing standards of practice. The facility Administration was knowledgeable of Registered Nurse (RN) #3's history of poor performance with medication administration prior to transferring to the nursing facility; however, the facility failed to ensure the nurse's competence. On 02/25/11, RN #3 administered Suboxone to Resident #5 despite concerns expressed by RN #1, Resident #5's Sitter and a verbal Physician Order to "hold the medication". Resident #5 was diagnosed with acute respiratory failure. Additionally, the facility administration failed to ensure the safety of its residents when the facility continued to utilize RN #3, after the significant medication error regarding Resident #5, without ensuring the Nurse's competence in medication administration.</p> <p>Based on the above findings it was determined the facility failed to have an effective system regarding medication administration and failed to ensure resident's were free from significant medication errors, which was likely to cause serious harm, injury or death. Immediate Jeopardy was identified on 03/25/11 and was</p>	F 490	<p>As evidenced by the deficiencies found by the OIG the following changes have been implemented to abate immediate jeopardy served on 03/25/11 to the facility administrator.</p> <ul style="list-style-type: none"> ✓ As a result of the medication error investigation, the nurse who administered the suboxone was terminated and reported to the Kentucky Board of Nursing for unsafe practice on 3/3/11. F281/F332-333 ✓ The pharmacy director educated the pharmacy staff on medication safety -- best practices and policy changes F332-333/F425 ✓ Quality Assurance process for hospital medication reconciliation F332-333/F425 ✓ Revision of Medication Reconciliation policy # A10-0612-03 F332-333/F425 ✓ Revised admission process to TCU - Policy # 14-0909-38 F271/F281/F332-333/F425 <ul style="list-style-type: none"> o Process change of admitting residents by changing status of transfer to admission going forward o Process change for intake nurses' role in the admission process ✓ Medication Orders Policy # 12-0209-32 was revised F425 (resident #1 ACS issue) ✓ Medication Safety Policy # 12-0207-05 was revised F332-333/F425 ✓ Concentrated training of Medication Administration and patient follow-up for facility with written testing for verification of comprehension of material F332-333/F425 ✓ Chief Medical Officer closed TCU unit to limited number of physicians to standardize scope of service F271/F281 ✓ The facility has now limited admissions to four selected physicians who have been trained on the admission requirements of the facility. They will have admission orders completed in writing or by verbal order, read back and verified prior to the patient's 	
-------	--	-------	---	--

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 31 determined to exist on 02/25/11, and is ongoing.</p> <p>The findings include:</p> <p>1. Interview and record review revealed the facility failed to ensure medications were administered in accordance with acceptable standards of practice for one (1) of eight (8) sampled residents (Resident #5). Registered Nurse (RN) #3 administered the medication Suboxone (a medication for opioid addiction) to Resident #5 after receiving a verbal order from the physician to "hold medication" as the resident did not have a diagnosis related to the drug's indication. Resident #5 developed respiratory failure secondary to the respiratory distress cause by the medication Suboxone. The resident was transferred to the Intensive Care Unit for intubation and further management related to the diagnosis of acute respiratory failure. Refer to F281.</p> <p>Interview with the previous Director of Nursing (DON) on 03/25/11 at 11:30 AM, revealed Registered Nurse (RN) #3, who was responsible for administering Suboxone to Resident #5 after receiving a verbal order to hold from the Physician, had a history of medication errors prior to being employed at the nursing facility. She stated RN #3 was known to have substandard practice while working at the hospital prior to being transferred for employment with the nursing facility. Continued interview with the previous DON, on 03/25/11 at 3:01 PM, revealed she did not do any individualized training with RN #3 related to the six (6) medication errors which were made at the facility.</p> <p>Interview with the Administrator, on 03/25/11 at</p>	F 490	<p>Monitoring Plan :</p> <p>The Facility Quality Committee monitors the quality of care of residents. Quality indicators have been implemented or revised to ensure the action plans listed above are monitored and reported to the Facility Quality Committee. Indicators include medication errors, medication reconciliation and TCU intake process for complete physician orders. Recommendations to improve processes, quality or patient safety are implemented and reported to the hospital Patient Care Committee, the steering committee for organization-wide quality and safety, on a quarterly basis. The hospital Risk Manager, a member of the hospital Quality Management Department and Patient Care Committee, serves on the TCU Quality Committee to enhance communication and continuity between the Facility Quality Committee and Patient Care Committee. The Patient Care Committee reports monthly to the Medical Staff Executive Committee and to the hospital Board of Directors Quality Management and Credentials/Bylaws Committee and Board of Directors on a quarterly basis</p> <p>The TCU Unit reports and monitors all medication errors and incidents. Results are documented, analyzed and trended by the DON and Administrator monthly to identify opportunities for improvement and take appropriate and immediate action. This includes counseling/training/disciplining of staff.</p> <p>Data analysis is reported to the Facility Quality Committee on a quarterly basis for analysis and trending.</p> <p>The Administrator and Facility DON are currently reviewing 100% of medication errors reported on incident reports and those found through weekly chart</p>	
-------	--	-------	---	--

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 Continued From page 32
2:20 PM, revealed she was aware RN #3 had been unsuccessful with medication administration while working at the hospital. The Administrator could provide no evidence or action the facility took to ensure RN #3's competence with medication administration prior to assigning the Nurse to the task after her transfer to the facility. After RN #3's significant medication error regarding Resident #5, the facility administration continued to utilize RN #3 in full capacity as evidenced by review of the "Facility Daily Assignment" which detailed RN #3 worked on 02/28/11 at the nursing facility and continued to be responsible for medication administration. Continued interview with the Administrator revealed the facility had not provided any additional training to ensure RN #3's competence. The Administrator indicated assigning RN#3, as Charge Nurse, was not a "good choice".

F 520
SS=K 483.75(o)(1) QAA
COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

F 490 The committee concluded the process is in place to report medication errors and near misses and had no further recommendations at this time. The Committee will continue to analyze Medication Safety Reports and concurrent monitoring of by the DON and Administrator to assure the process remains consistent and timely.

The medication errors and error rate is also being reviewed once a month by nursing and pharmacy per the Administrative Medication Safety Reporting Policy. Facility medication errors have been included in the hospital analysis reported to the Pharmacy and Therapeutics Committee for several years and were most recently reported on 4/14/11.

The Administrator and Facility DON are also currently reviewing 100% of admission orders for completeness and signature on the medication reconciliation orders prior to resident's admission. In their absence the designee will be the MDS Coordinator. The facility admits patients from 8.30am to 4.30pm Monday through Friday only. A check sheet is being used for each admission, listing the required elements. A signature is required from the Administrator, DON or MDS Coordinator to verify that orders are complete and signed by physician; or that a verbal order with read back and verify is complete, prior to admission.

The results have been documented, analyzed and trended by the DON and Administrator weekly from 3/30/11 to 4/8/11 to identify opportunities for improvement and to take appropriate and immediate action. Findings were reported to the facility QA committee on 4/8/11. The Facility QA Committee developed and implemented appropriate plans of

action to correct identified quality deficiencies. The DON and Administrator will continue to meet monthly after 4/8/11 and the QA committee will continue to meet quarterly.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 520

Continued From page 33

except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure the quality assessment and assurance committee (QI) was effective in identifying and correcting quality of care issues related to verifying Admission Orders with the physician prior to implementing the orders for seven (7) of eight (8) sampled residents (Residents # 1, 3, 4, 5, 6, 7 and 8). The facility staff signed admission orders without verification from the physician prior to implementing the orders for the residents. Staff on the QI Committee was aware of this practice occurring in the facility; however, there was no evidence the facility took action to correct the practice. On 02/25/11, facility staff signed admission orders without verification from the physician for Resident #5. The orders detailed the drug Suboxone (a medication for opiate dependency) for which the resident had no medical diagnoses or symptom to indicate the need for the drug. Facility staff administered Suboxone to Resident #5 on 02/25/11 at 9:00 PM. After receiving this medication, Resident #5 was diagnosed as having developed respiratory failure secondary to the respiratory distress caused by the medication Suboxone. On 02/26/11 at 7:20 PM, the resident was transferred to the Intensive Care Unit for intubation and further management

F490

The Quality Management Department implemented a quality indicator to monitor the medication reconciliation process for accurate and complete medication orders. The QM department conducts random chart reviews on hospital and facility charts in addition to medication safety reports beginning 4/1/11. Medication Safety Reports are sent to the Administrator and DON. Medication Safety reports have been reviewed by the hospital CNO, Director of Pharmacy and Risk Manager, analyzed/trended, and reported to the P&T Committee and Patient Care Committee for several years.

The consultant pharmacist also conducts random chart audits. A report of findings is given to the DON on a monthly basis. This report was discussed at the DON/Administrator meetings and will be continued in the monthly DON/Administrator meetings. The findings were reported in the QA Committee on 4/8/11.

4/9/11

F520

The Facility QA committee core members were involved in this whole POC process, they gave feedback, approved the new processes and aided in implementing the changes. The core Committee members are Administrator, DON, Medical Director, MDS Coordinator (RN), therapy manager, Pharmacy representative, Manager Risk/Compliance, and activities therapist.

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 520	<p>Continued From page 34</p> <p>related to the diagnosis of acute respiratory failure [Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway].</p> <p>Based on the above findings it was determined the facility failed to have an effective system to identify quality of care issues to ensure residents received quality of care and have Physician approved/verified orders upon admission, which was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/25/11 and was determined to exist on 02/25/11, and is ongoing.</p> <p>The findings include:</p> <p>Based on interview and record review, it was determined the facility failed to ensure seven (7) of eight (8) sampled residents (Residents # 1, 3, 4, 5, 6, 7 and 8) had orders that were verified as accurate and signed by a physician upon admission to the facility. The facility failed to follow the Admissions Policy General when facility staff signed admission orders without calling the Physician to verify admission orders prior to or on the day the facility admitted the residents. On 02/25/11, the Intake Coordinator/Licensed Practical Nurse (LPN) #2 signed the Admission Orders for Resident #5 without calling Resident #5's Physician/Medical Director to verify and obtain verbal orders for the admission. The facility used these unverified orders, which included an order for the medication Suboxone (medication used for opiate dependency). Refer to F271 for specific details regarding Residents #1, 3, 4, 6, 7 and 8's admission orders.</p> <p>Review of the facility's policy "... Quality</p>	F 520	<p>The facility DON developed a new monitoring plan for medication errors/incidences on a daily basis. Every Incident/medication error will be reported on an incident/medication error form and submitted to the DON within 24 hours of the event. The DON will then review the incident, take appropriate action, counsel staff as appropriate, and document in the staff member's employee file. The incident's/errors will be filed in a binder in the DON's office. In the event that the DON is not at the facility, the administrator and/or day shift charge nurse will track the incident/error forms and take appropriate action.</p> <p>All shifts have been trained to call DON or administrator if an incident has occurred which has caused an adverse effect, as soon as the adverse outcome has been identified.</p> <p>Monitoring Plan:</p> <p>The facility DON/day shift charge nurse will track and trend 100% of errors. The administrator and facility DON will meet monthly to review errors/incidents and identify improvement opportunities to develop appropriate action plans to correct quality deficiencies.</p> <p>The DON and Administrator will evaluate the findings on monthly basis and then report the trends to the facilities' Quality Assurance committee quarterly.</p> <p>The facility Quality Assurance committee is composed of the Medical Director; facility administrator; facility DON; MDS coordinator (RN); therapy manager; Manager Risk/Compliance, pharmacy representative and activity therapist. The QA committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p>	

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(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 520	<p>Continued From page 35</p> <p>Improvement (QI) Plan," not dated, revealed the purpose of the facility QI committee is continuous evaluation of facility systems and processes with the primary objectives which included promoting an environment of safety to reduce the risk of unanticipated adverse events and/or outcomes, meeting all licensure, accreditation and regulatory requirements, preventing deviation from care processes from arising, to the extent possible and initiating appropriate corrective action plans for issues/concerns identified.</p> <p>Review of the facility's policy titled "Admissions Policy General", effective 06/03/09, stated prior to or on the day of admission, a completed and signed medication reconciliation sheet will be obtained in order to process the admission. The facility's policy further stated "the physician order sheet would be completed by the Case Manager (Intake Coordinator/LPN #2) using the medication reconciliation sheet (once completed and signed by the Physician), and any other Physician orders (that will be verified verbally with Physician)". Further review of the policy revealed the facility's Physician order sheet would then be signed by the attending Physician within forty-eight (48) hours.</p> <p>Interview with the prior Director of Nursing (DON), on 03/25/11 at 11:30 AM, revealed each resident must have physician orders for his or her immediate care. If orders from the hospitalization were utilized, the Physician would need to be contacted, orders reviewed and verified. In addition, medication orders must be read back and confirmed to continue, discontinue or change them.</p> <p>Interview with the Intake Coordinator/LPN #2, on</p>	F 520		4/9/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
--	---

(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 520	<p>Continued From page 36</p> <p>03/25/11 at 10:45 AM, revealed she had an understanding with Resident #5's Physician, who also served as the facility's Medical Director. She indicated this agreement allowed her to review the orders from the hospital and continue the medications when the residents were admitted to the unit, without notifying the facility's physician. She indicated this agreement allowed her to review the orders from the hospital and continue the medications when the residents were admitted to the unit, without notifying the facility's physician. She stated she did not verify the Admission Orders with Resident #5's Physician before the resident was admitted. She further stated she did not verify Admission Orders with the Physicians for Residents #s 1, 3, 4, 6, 7 and 8.</p> <p>On 03/29/11 at 2:25 PM, interview with Resident #5's Physician, who was the facility's Medical Director and a QI Committee Member, revealed she was aware the Admission Orders were created by the Intake Coordinator/LPN #2 and indicated she was putting a lot of faith in "the system." Further interview revealed she was aware the Intake Coordinator/LPN #2 was signing the Admission Orders and medications were being given before she (a physician) reviewed and gave an order for the Admission Orders. However, review of the facility's policy revealed prior to or on the day of admission, a completed and signed medication reconciliation sheet would be obtained in order to process the admission.</p> <p>The facility was unable to provide evidence that the QI Committee took action to correct identified issues/concerns, despite the Medical Director's knowledge of the facility's Intake Coordinator/LPN#2 signing orders without</p>	F 520		
-------	--	-------	--	--

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
---	---

(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 520	Continued From page 37 Physician verification which was confirmed through interview with the Medical Director. The Administrator, on 03/29/11 at 2:15 PM, revealed she was not aware the Intake Coordinator/LPN #2 was signing the Physician/Admission Orders without having verified the Admission Orders with the Physician. She further indicated the QI Committee had not identified the Intake Coordinator/LPN #2 signing the Admission Orders as a deficient practice. This failure prevented the facility from taking action to correct the issue/concern and impacted the care the facility provided to Resident #5.	F 520		