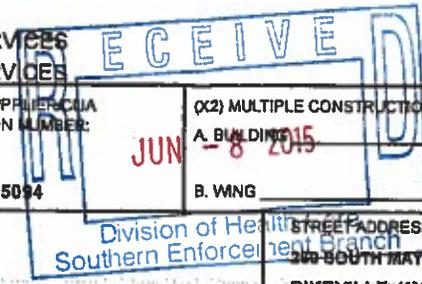


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING # _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/24/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 212 SOUTH MATO TRAIL PIKEVILLE, KY 41601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED: A standard recertification survey in conjunction with an abbreviated standard survey (KY23068 and KY23116) was initiated on 04/14/15. Both complaints were substantiated with deficient practice identified. Immediate Jeopardy was identified on 04/20/15 and was determined to exist on 04/02/15. The facility was notified of the Immediate Jeopardy on 04/20/15. An extended survey was conducted on 04/24/15. Deficiencies were cited at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514) at a Scope and Severity of "K." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F333). Additional deficient practice was identified at F157, F226, F278, F279, F309, and F312 at a "D" level and F371 at an "E" level. An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, prior to exit, which lowered the Scope and Severity to "E" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	Signature HealthCARE of Pikeville does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding.	
F 157	483.10(b)(11) NOTIFY OF CHANGES	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn O'Conner</i>	TITLE Administrator	(X6) DATE 6/8/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 157 SS=D	<p>Continued From page 1 (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</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, record review, and facility policy review, it was determined the facility failed to notify the family member for one (1) of thirty</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> 1. For resident #18 Licensed Practical Nurse (LPN) #2 unsuccessfully attempted to contact interested family member, Foster, on 1/19/15 at 5A to notify them that resident #18 was being sent to PMC ER. This is evidenced by a Physician's Order on 1/19/15. Resident #18 deceased on 1/19/15 at hospital. 2. An audit of all resident's charts was completed on 4/24/15 by the Chief Nurse Executive, Assistant Administrator, Quality Assurance Director, Medical Records Director, Unit Manager, Director of Nursing, Regional Nurse Consultant, Social Services Director, or Regional Vice President to ensure compliance of Federal and State Regulations related to proper notification. Chart audit included, but was not limited to: Physician Orders, SBARs, Progress Notes, History and Physicals, Labs, Social Services Notes, Dietary Notes, Nurse's Notes, and Care Plans. No concerns were identified. 3. Education on the change of resident status policy and procedure, to include MD/POA notification was initiated for licensed staff on 5/13/15 by the Regional Nurse Consultant, Director of Nursing, Staff Development Coordinator, Administrator, Unit Manager, or Regional Vice President. The education will be completed by 5/29/15. Education provided contains the policy for Change in Resident's Condition/MD Notification. Emphasis was placed on notifying the resident's physician of changes in a resident's medical condition and the requirement to notify the resident's physician when a need to significantly alter the resident's medical treatment was identified. 4. The Unit Manager, Director of Nursing, ADON, Staff Development Coordinator will audit all Physician orders completed daily M-F during the clinical meeting to ensure Physician/RP/POA/Interested Family Member are notified of Change in Condition or and notification of the resident's physician when a need to 	5/30/15	

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F 157	<p>Continued From page 2</p> <p>(30) sampled residents (Resident #18) when the resident had a significant change in condition. Review of the medical record for Resident #18 revealed the resident was sent to the hospital on 01/19/15, at 5:25 AM with Cardiopulmonary Resuscitation (CPR) in progress. However, there was no evidence the family was notified that Resident #18 required CPR prior to leaving the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Change in a Resident's Condition or Status," with a revision date of October 2013, revealed the facility would notify a resident's representative promptly with any changes in the resident's medical or mental condition.</p> <p>Review of the medical record for Resident #18 revealed the facility admitted the resident on 01/05/15, with diagnoses that included End Stage Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Pulmonary Hypertension, and Chronic Respiratory Failure. Review of the Nurse's Notes for Resident #18 dated 01/19/15, at 4:30 AM, revealed the resident's oxygen saturation level was documented as being eighty-six percent (86%) with a normal range being ninety-five (95) to one hundred (100) percent. The Nurse's Notes stated the resident agreed for the facility to send him/her to the acute care hospital. According to the medical record, the resident's son was listed as the resident's responsible party. Review of a Nurse's Note dated 01/19/15, at 5:00 AM, revealed the nurse notified the resident's physician and the family of the change in the resident's condition that occurred at that time. The Nurse's Notes</p>	F 157	<p>significantly alter the resident's medical treatment is identified. These audits were initiated on 5/11/15 and will continue for four(4) weeks.</p> <p>Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations to change frequency and duration and further follow up as indicated. Members of the Quality Assurance Committee include but are not limited to: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director.</p> <p>5. Date of Compliance: May 30, 2015</p>		

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F 157	Continued From page 3 revealed on 01/19/15, at 5:25 AM, the nurse was called to Resident #18's room where the resident was unresponsive, CPR was initiated immediately, the ambulance service arrived, and the resident was sent to the acute care hospital. However, there was no documented evidence the family was notified of this further change in condition that required CPR prior to the resident being transferred to the hospital. Interview with Resident #18's family member on 04/17/15, at 9:45 AM, revealed he had not been notified that CPR had been initiated on Resident #18 at the facility. Further interview revealed the acute care hospital notified the resident's family member, after the resident expired at approximately 7:00 AM, that CPR had been initiated at the nursing facility. Several unsuccessful attempts were made to contact the nurse, Licensed Practical Nurse (LPN) #2, who was assigned to care for Resident #18 on 01/19/15. Calls were made on 04/16/15 at 11:00 AM, 04/16/15 at 2:30 PM, and on 04/17/15 at 4:30 PM. Interview with the Director of Nursing (DON) on 04/20/15, at 2:35 PM, revealed staff was required to notify a resident's family with any change in the resident's condition. The DON stated Resident #18's family should have been notified regarding CPR being performed at the facility immediately following the resident leaving the facility.	F 157			
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	F 226	F-226 1. Registered Nurse (RN) #2 is no longer employed by the facility and was not at the time of the survey. 2. A 100% Audit of all stakeholders personnel files was completed on 5/13/15 by the Human Resources	5/30/15	

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F 226	Continued From page 4 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, personnel record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure the past employment work history or reference checks were completed upon hire for one (1) of five (5) personnel records reviewed (Registered Nurse #2). The findings include: Review of the facility's policy, "Abuse, Neglect, and Misappropriation," revised March 2013, revealed interviews and reference checks would be conducted on all employees and volunteers. Review of the personnel record on 04/15/15 at 3:00 PM for RN #2 revealed the employee's hire date was 08/26/14. However, the facility failed to check the past employment work history or personal reference checks to ensure the employee did not have a history of abuse, neglect, or mistreatment of individuals. Interview with the Administrator on 04/15/15 at 3:30 PM, revealed all new hires should have reference checks completed. Further interview revealed the Human Resources Director was responsible for completing reference checks; however, this person was no longer employed by the facility.	F 226	Director to ensure reference checks are present. 3. Education was performed on the Human Resources Director on 5/13/15 by the Special Projects Administrator. Education included the Abuse, Neglect, and Misappropriation Policy with an emphasis on conducting interviews and reference checks on all new hires. Education was provided on 5/12/15 by Todd Bryant, LCSW, LNHA to the Administrator, Director of Nursing, ADON, Unit Manager, Staff Development Coordinator, MDS Coordinators, Director of Dining Services, Business Office Manager, Quality of Life Director, Maintenance Director, Marketing and Admissions Coordinator, Rehab Services Manager, Medical Records Director, Human Resources Director, and Assistant Administrator. Education included Abuse, Neglect, and Misappropriation Policy and definitions of abuse, Types of Abuse, Residents at risk of Abuse, Components of an effective abuse prevention program, Dealing with aggressive and/or catastrophic reactions of residents, Reporting allegations of abuse, signs of burnout, and investigating and reporting abuse. Education was initiated on 5/12/15 for facility stakeholders by the Special Projects Administrator, Assistant Administrator, Director of Nursing, Staff Development Coordinator, ADON, Unit Manager, Housekeeping Supervisor, Director of Dining Services, Rehab Services Manager, Business Office Manager, or Quality of Life Director. Education included Abuse, Neglect, and Misappropriation Policy and definitions of abuse, Types of Abuse, Residents at risk of Abuse, Components of an effective abuse prevention program, Dealing with aggressive and/or catastrophic reactions of residents, Reporting allegations of abuse, signs of burnout, and investigating and reporting abuse. Education will be completed by 5/29/2015. Stakeholders will complete Abuse Post Test and achieve a 100% score. Tests will		
F 278	483.20(g) - (j) ASSESSMENT	F 278			

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F 278 SS=D	<p>Continued From page 5</p> <p>ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure assessments coded on the Minimum Data Set (MDS) accurately reflected the status for one (1) of thirty (30) sampled residents (Resident #6). Review of Resident #6's MDS assessments</p>	F 278	<p>be completed by 5/29/2015.</p> <p>4. A new hire checklist was implemented on 5/1/15 to include ensuring the reference checks are present in all new hire personnel file.</p> <p>The Special Projects Administrator, Administrator, Assistant Administrator, or Regional Vice President will review all new hires on a weekly basis to ensure the reference check is completed and present. This process was initiated on 5/1/15 and will continue for four(4) weeks and then be reviewed by the QAPI Committee to determine ongoing frequency and duration.</p> <p>The QAPI Director will review 20% of all new hires on a monthly basis to ensure the reference check is completed and present. This process will continue for three (3) months and then reviewed by the QAPI Committee to determine ongoing frequency and duration. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee include but are not limited to: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director.</p> <p>5. May 30, 2015</p> <p>F 278</p> <p>1. Residents #6 Quarterly Assessment dated 4/14/15 coded the use of a restraint. The Residents Quarterly MDS assessment dated 1/16/15 has been corrected on 5-13-15 to accurately reflect the use of a restraint.</p> <p>2. On 5/11/15 and 5/12/15 the Regional Clinical Reimbursement Specialist reviewed the most recent OBRA assessments on all residents to ensure assessment accurately reflect the resident's status with emphasis on section P. Any Concerns Identified were</p>	5/30/15

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F 278	<p>Continued From page 6</p> <p>revealed the assessment did not accurately reflect the resident's use of a lap belt restraint.</p> <p>The findings include:</p> <p>Interview with the Administrator on 04/20/15 at 1:39 PM, revealed the facility did not have a written policy related to accurately completing the MDS assessment. Continued interview with the Administrator revealed the facility followed the MDS 3.0 Manual for completing MDS assessments.</p> <p>Observation of Resident #8 on 04/14/15 at 3:10 PM, and on 04/15/15 at 8:40 AM, revealed the resident was up in his/her wheelchair with a lap belt restraint being utilized.</p> <p>Review of Resident #6's medical record revealed the facility admitted the resident on 11/13/13, with diagnoses that included Dementia, Insomnia, Delusions/Hallucinations, and Muscle Weakness. Further review of Resident #6's medical record revealed a Physician's Order dated 05/09/14, for the resident to utilize a self-release belt with a built-in alarm to promote safety while in a wheelchair.</p> <p>Review of Resident #6's Comprehensive Care Plan dated 05/09/14 revealed the resident required a physical restraint to protect him/her from harm. Review of the Quarterly MDS assessment dated 01/16/15 and the Annual MDS assessment dated 10/16/14 revealed the facility assessed Resident #8 to use no physical restraints. Review of the most recent Quarterly MDS dated 01/16/15 revealed the facility was unable to determine the Brief Interview for Mental Status (BIMS) score for Resident #8 because the</p>	F 278	<p>Immediately addressed.</p> <p>3.The Regional Clinical Reimbursement Specialist educated MDS and the Nurse Administrative Team on MDS Assessment accuracy with emphasis on section P on 5/11/15 and 5/12/15. The Licensed Nursing Staff will be educated on MDS accuracy by the Staff Development Coordinator, Director of Nursing, MDS Coordinators, Quality Assurance Nurse, or Assistant Director of Nursing to be completed by 5/29/15. The documentation by the Nursing Staff of any resident with a change of status will be reviewed daily in Am Clinical meeting Monday thru Friday to ensure documentation accurately reflects the resident's status.</p> <p>4.The Quality Assurance Nurse, Director of Nursing, Regional Nurse Consultant, or Regional Clinical Reimbursement Specialist will review 5 MDS assessments X 2 weeks then 3 assessments X 2 weeks then 10 assessments per quarter thereafter to ensure assessments accurately reflect the residents status beginning 5/11/15. The above audits will be brought to the monthly Quality Assurance Meeting in which analysis with the tracking and trending will be reviewed by the committee members in order to provide feedback, or evaluate for further need of education or intervention as well as need for further plans. The Team members consist of but not limited to The Administrator, Director of Nursing, Quality Assurance Nurse, Medical Director, Rehab Services Manager, Restorative Nurse Manager, Dietary Manager and Social Service Director.</p> <p>5. May 30, 2015</p>		

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F 278	Continued From page 7 resident could not be interviewed due to severe cognitive impairment. Interview with the Director of Nursing (DON) on 04/20/15 at 3:05 PM revealed the facility's MDS Coordinator attended the Quality Assurance Meeting every morning. Further interview with the DON revealed the MDS Coordinator should be notified of any changes related to a resident's care. Interview with the MDS Coordinator on 04/20/15 at 3:19 PM revealed she had not assessed Resident #6 to have a restraint on the Quarterly MDS assessment or on the Annual MDS assessment due to lack of evidence in the resident's medical record to indicate restraint use. However, continued interview with the MDS Coordinator revealed Resident #6 should have been assessed to have a restraint on the Quarterly and Annual MDS assessments.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	1.Residents #2 and #14 Comprehensive Care Plans and Nurse Aid care plans updated to address toenail care on 5/11/15 and 5/13/15. Resident #14 received toenail care on 4-14-15 by Nursing Staff. Resident #2 was evaluated and treated by the In house Podiatrist on 5-12-15. 2.All residents Comprehensive Care Plans were reviewed for updates and accuracy with emphasis on toenail care, by the Chief Nurse Executive, Regional Nurse Consultant, Director of Nursing, Quality Assurance Nurse, Medical Records Director, Unit Manager or Administrator on 4-20-15. Any concerns were addressed immediately. 3.The MDS Coordinator and Administrative Nurses were re-educated on Comprehensive Care Plan accuracy and updating by the Clinical Reimbursement	5/30/15	

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F 279	<p>Continued From page 8</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure a comprehensive plan of care was developed that addressed the care needs related to toenail care for two (2) of thirty (30) sampled residents (Resident #2 and Resident #14). The facility assessed Resident #14 and Resident #2 to require extensive assistance from staff members related to personal hygiene. However, review of Resident #2's and #14's Comprehensive Care Plans revealed toenail care was not addressed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Planning - Interdisciplinary Team," with a revision date of October 2013, revealed the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individual comprehensive care plan for each resident. Further review of the facility's policy revealed the care plan was based on the resident's comprehensive assessment and was developed by a Care Planning/Interdisciplinary Team.</p> <p>1. Observation of Resident #14 on 04/17/15 at 10:03 AM revealed the resident to have long, untrimmed toenails on both feet.</p>	F 279	<p>Specialist or Regional Nurse Consultant on 5-11-15 and 5-12-15. Nursing Staff were re-educated on accuracy and updating of Care Plans and Nurse Aid Care Plans by the Regional Nurse Consultant, Director of Nursing, Quality Assurance Nurse, Staff Development Nurse, Assistant Director of Nursing or MDS coordinator by May 29, 2015. Nurses will update care plans and nurse aid care plans daily with any changes. All changes of condition, physician orders, care plans and nurse aid care plans will be reviewed daily Monday thru Friday by but not limited to the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Staff Development Nurse, MDS coordinator or Unit Manager in AM Clinical meeting to ensure it reflects the Residents condition and care plans updated accurately. MDS coordinator completes/updates care plan/nurse aid care plans on any Quarterly, change of condition or comprehensive assessments. Quarterly, change of condition and comprehensive assessments will be reviewed during Interdisciplinary care plan meeting at least quarterly.</p> <p>4. An audit of 10% Comprehensive Care Plans and Nurse Aid care plans will be reviewed by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Unit Manager or Staff Development Nurse Monthly for 3 months. The Audits will be brought to the Monthly Quality Assurance meeting for review, in which analysis with the tracking and trending will be reviewed by the committee member in order to provide feedback, or evaluate for further need of education or intervention as well as need for further plans.</p> <p>5. May 30, 2015</p>		

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PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 279	<p>Continued From page 9</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 02/24/15 with diagnoses that included Multiple Sclerosis and Seizure Disorder. Review of Resident #14's Admission Minimum Data Set (MDS) assessment dated 03/03/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. Continued review of Resident #14's Admission MDS assessment revealed the facility assessed the resident to require extensive assistance with the support of at least two (2) staff persons related to personal hygiene.</p> <p>Review of Resident #14's Comprehensive Care plan dated 03/29/15 revealed the resident had an Activities of Daily Living (ADL) self-care deficit. However, toenail care was not addressed on the Comprehensive Care Plan. Review of Resident #14's Nurse Aide care plan dated March 2015 revealed toenail care was not addressed.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7 on 04/20/15 at 2:03 PM revealed resident nail care should be performed as needed. She stated Resident #14 had contractures of the feet and if toenails were not trimmed, they could "stab" him/her. SRNA #7 stated she had trimmed Resident #14's toenails on 04/15/15.</p> <p>Interview with Registered Nurse (RN) #1 on 04/20/15 at 2:10 PM revealed she was assigned to care for Resident #14 on 04/20/15. RN #1 stated that SRNAs were responsible for resident nail care unless the resident had a diagnosis of</p>	F 279			

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F 279	<p>Continued From page 10</p> <p>Diabetes. She stated nurses were to perform nail care on diabetic residents. Continued interview with RN #1 revealed she conducted walking rounds to ensure resident nail care had been performed. RN #1 stated even though she made daily walking rounds, she had not identified concerns with toenail care not being performed.</p> <p>2. Observation of Resident #2 during a skin assesment conducted with RN #4 and Kentucky Medication Aide (KMA) #1 on 04/15/15 at 9:50 AM, revealed the resident's toenails on both feet were long, thick, dark in color, and in need of trimming/grooming.</p> <p>Review of the medical record revealed the facility admitted Resident #2 on 01/05/15 with diagnoses that included Weakness, Cellulitis, and Diabetes Mellitus. Review of the Quarterly MDS assessment dated 04/15/15, revealed the facility assessed Resident #2 to require the extensive assistance of two (2) or more persons with personal hygiene and bathing. Review of the Comprehensive Care Plan dated 03/24/15, revealed the facility failed to develop a plan of care in self-care deficit that included keeping the resident's nails clean and groomed. According to the CNA's care plan (a guide used by the nursing assistants for providing resident care needs), the resident's nail care needs would be provided by the nurse(s).</p> <p>Interview conducted with RN #4 on 04/20/15, at 1:20 PM revealed the nurses did nail care on diabetic patients, as was noted on this resident's care plan.</p> <p>Interview with the Director of Nursing (DON) on 04/20/15 at 1:32 PM and 2:45 PM revealed</p>	F 279			

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F 279	Continued From page 11 resident nail care should be performed as needed for all residents and nail care should have been performed for Resident #14 and Resident #2. The DON stated that resident care plans were developed by the MDS Coordinator using the resident's MDS assessment and other documents in the resident's medical record. Interview with the MDS Coordinator on 04/20/15 at 3:54 PM revealed nail care should have been addressed on Resident #14's and Resident #2's Comprehensive Care Plans. Continued interview with the MDS Coordinator revealed when care plans were developed information was obtained from the resident's MDS assessments and reviewed for accuracy. The MDS Coordinator stated it was an oversight that Resident #14's care plan and Resident #2's care plan did not address nail care.	F 279		
F 282 SS=K	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to provide care and services in accordance with the written plan of care for four (4) of thirty (30) sampled residents (Residents #11, #15, #16, and #17) and one (1) unsampled resident (Resident A). Review of the plan of care for Resident #11 revealed the	F 282	F-282 1.The Physician and Power of Attorney (POA) for Residents #11, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurance (QA) Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all four (4) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All four (4) residents' medications were counted and a medication	5/30/15

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F 282	<p>Continued From page 12</p> <p>resident had interventions in place that included giving medications as ordered for the treatment of cardiovascular problems including atrial fibrillation (an irregular, rapid heart rate).</p> <p>Review of the plans of care for seizure activity or at risk for seizures for Residents #15, #16, and #17 revealed the residents had interventions in place that included administering medications as ordered. The facility documented on the residents' Medication Administration Records (MAR) that the residents' medications were administered according to Physician's Orders. However, observation of Resident #15's medication and review of Residents #11, #16, and #17's pharmacy medication dispensing records revealed the facility failed to administer the residents' medications as ordered by the residents' physicians. Resident #11's fourteen (14) day supply of Digoxin (medication to treat an abnormal heart beat) was not reordered for up to thirty-seven (37) days; Resident #17's thirty (30) day supply of Primidone (anti-seizure medication) went up to sixty-five (65) days between refills and up to forty-three (43) days between refills for a thirty (30) day supply of Depakote (medication to prevent seizures and treat some psychiatric disorders); and Resident #16's fifteen (15) day supply of Depakote went up to twenty-five (25) days between refills (refer to F333, F425, F490, and F514).</p> <p>Review of the plan of care for Resident A revealed interventions to provide wound care according to the Physician's Order. Resident A requested that a new dressing be applied to his/her foot on the morning of 04/18/15 at approximately 5:00 AM. However, nursing staff failed to provide the wound care and dressing</p>	F 282	<p>reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. Resident A was assessed and treatment was completed by the Wound Care Nurse at 2pm on 4-16-15. There was no decline in the Status of the wound. The allegation was immediately reported to the Director of Nursing on 4-16-15 and Licensed Practical Nurse #3 was immediately suspended pending investigation. Before Licensed Practical Nurse #3 was allowed to return to work she was counseled and reeducated by the Director of Nursing that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. In accordance with the comprehensive assessment and plan of care. Licensed Practical Nurse #3 was also re-educated on Signatures Policy and Procedure on Pressure Ulcers/Skin Breakdown-Clinical Protocol which includes immediately addressing any concern with a residents wound or treatment.</p> <p>2. All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container.</p>		

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F 282	<p>Continued From page 13 according to the plan of care.</p> <p>The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15.</p> <p>An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an "E" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Using the Care Plan," not dated, revealed the care plan shall be used in developing the resident's daily care routines and will be available for staff personnel who have responsibility for providing care or services to the resident. The policy further revealed the documentation must be consistent with the resident's care plan.</p>	F 282	<p>All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. Skin assessments were completed on all residents by 5/16/15 to ensure residents had the appropriate treatments in place as in accordance with the comprehensive assessment and plan of care.</p> <p>3. Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident</p>		

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F 282	<p>Continued From page 14</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13, with diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Review of Resident #11's actual/potential cardiovascular problems care plan, revised date 12/19/14, revealed the resident had an intervention in place to give medications as ordered.</p> <p>Review of Resident #11's April 2015 Physician's Orders revealed the resident had an order for staff to administer Digoxin (a medication used to slow the heart rate of patients with atrial fibrillation) 125 mcg (micrograms) per day. The medication was initially ordered on 08/17/14.</p> <p>Review of the Pharmacy Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's Digoxin was dispensed with fourteen (14) tablets per medication card and had been dispensed seven (7) times from 12/10/14 to 04/15/15 (dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and 04/15/15). During the timeframe reviewed (12/10/14 through 04/15/15) the pharmacy dispensed ninety-eight (98) Digoxin tablets; however, a total of one hundred twenty-eight (128) tablets were needed for staff to be able to administer the resident's Digoxin as it was ordered, per the Physician's Orders.</p> <p>Review of Resident #11's Digoxin laboratory level obtained on 01/05/15 and 04/03/15 revealed the resident's Digoxin level was subtherapeutic.</p> <p>2. Review of Resident #17's medical record</p>	F 282	<p>and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 05/29/15 all education was completed and any PRN or staff who had not completed the education received a certified letter and will not be allowed to return to work until the education has been completed and verified. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation.</p> <p>4. A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or</p>		

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F 282	<p>Continued From page 15</p> <p>revealed the facility admitted the resident on 10/23/98. The resident had diagnoses that included Seizure Disorder.</p> <p>Review of Resident #17's Seizure Activity/At Risk for Seizures care plan, revised 12/17/14, revealed the resident had an intervention to administer medications as ordered.</p> <p>Review of Resident #17's April 2015 Physician's Orders revealed the resident had an order for staff to administer Primidone (anti-seizure medication) 250 mg (milligrams) every morning (initially ordered 12/16/14) and two (2) capsules of Depakote 125 mg (generic name is Valproic Acid - anti-seizure medication) twice daily (initially ordered on 08/05/14).</p> <p>Review of the Pharmacy Medication Dispensing Records for Resident #17, dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed thirty (30) capsules of Primidone 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on 12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, for staff to be able to administer the resident's medications as physician ordered in order to follow the plan of care, one hundred seven (107) capsules were required. There was no explanation or documented evidence to account for the forty-seven (47) tablets that were needed in order for staff to administer the medication as physician ordered to follow the plan of care.</p> <p>Further review of the Pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of Depakote 125 mg, which was a thirty (30) day supply, on 02/20/15. However, the medication</p>	F 282	<p>Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. This was reviewed at the QAPI Meeting on 4/27/15 and facility continued with a medication pass observation for one random nurse per day, per shift. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed again on 5/4/15 at the QAPI Meeting and it was determined by the committee that the facility would reduce the medication pass observations to one random nurse per day. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed on 5/11/15 and the QAPI Committee determined to reduce the audits to medication pass observations on three random nurses per week for four (4) weeks. To be reviewed at the next QAPI Meeting to determine frequency and duration.</p> <p>b. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished.</p> <p>c. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant will audit five (5) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications are being given per the physician's orders and the plan of care Monday through Friday for four(4) weeks. The results of these audits will be carried through the QAPI Meeting at that time to determine ongoing monitoring frequency and duration.</p> <p>d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid</p>		

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F 282	<p>Continued From page 16</p> <p>was not dispensed to the facility again until 04/05/15, forty-four (44) days later. There was no explanation or documented evidence to account for the medication that was needed for administration for approximately fourteen (14) days to ensure the medication was given per the plan of care.</p> <p>The SSA's Pharmacist Consultant conducted a post survey review of the facility's pharmacy dispensing records. Review of Resident #17's medication orders dated 04/01/15, revealed the resident was ordered to receive Primidone 250 mg, one tablet each morning and evening, which had been in effect since 12/18/15; the dosage was verified via post survey phone interview with the Advanced Registered Nurse Practitioner on 05/01/15, as the physician was unavailable. In the initial citation narrative, the State Survey Agency's Surveyor stated the resident's Primidone was to be given only once daily (in the morning) when, in fact, the dosage was two (2) tablets per day. It was noted, based on the pharmacy's dispensing records, that Resident #17 had been provided two refills each of 30 tablets (on 12/18/14 again on 01/28/15) during the review period. It was noted that each 30 tablet quantity was a 30-day supply when, in fact, the refills were only fifteen (15)-day supplies. The surveyor further noted that, from 12/18/14 through 04/04/15, the resident would have required a total of one-hundred and seven (107) tablets to achieve the required dosage requirement for that time period. However, because the daily dosage called for two (2) tablets per day, the required number of tablets for that time period would have called for twice that amount, or up to two-hundred and fourteen (214) tablets. Since only sixty (60) tablets had been</p>	F 282	<p>medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p> <p>e. Reorder process below will continue:</p> <p>i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer.</p> <p>ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials.</p> <p>iii) The DON and/or ADONs ran the "Refill Reminder Report" from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring. This process will continue for four additional weeks and be reviewed during the QAPI Meeting to determine further monitoring duration and frequency.</p> <p>iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility Monday Through Friday.</p> <p>This process and monitoring was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring at this time. Current process will continue for an additional four weeks and then be reviewed by the QAPI Committee to determine ongoing monitoring and the frequency and duration.</p> <p>f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41601	
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F 282	<p>Continued From page 17</p> <p>dispensed to Resident #17 during that time period, there would have been a shortage of approximately one-hundred and fifty-six (156) tablets during that time period.</p> <p>3. Review of Resident #16's medical record revealed the facility admitted the resident on 09/05/14. The resident had diagnoses that included Seizure Disorder and Psychosis.</p> <p>Review of Resident #16's seizure activity/at risk for seizure activity care plan, revised 02/03/15, revealed the resident had an intervention in place to administer medications as ordered.</p> <p>Review of Resident #16's Physician's orders dated 09/05/14, revealed an order for Valproic Acid (brand name is Depakote, anti-seizure medication and used for some psychiatric disorders) 250 mg/5 ml (milliliters), 5 ml twice daily.</p> <p>Review of Pharmacy Medication Dispensing Records for Resident #16, dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed a 150-ml bottle (a 15-day supply) of Depakote on 01/24/15. However, the medication was not refilled again until 02/18/15, approximately twenty-six (26) days later. There was no documented evidence or explanation for the medication that was needed for the eleven (11) days to ensure the medication was given per the Physician's Order, per the plan of care.</p> <p>Review of the Valproic Acid laboratory values for Resident #16 revealed the Valproic Acid level was sub-therapeutic on 04/03/15.</p> <p>4. Review of Resident #15's medical record</p>	F 282	<p>medications other than by mouth (PO) or topical.</p> <p>All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15 and no changes were made to the monitoring. To be reviewed at the next weekly QAPI Meeting to determine ongoing frequency.</p> <p>The process was reviewed at the 5/4/15 QAPI Meeting and it was determined to make no changes to the monitoring at this time. Review in one week at the QAPI Meeting to determine ongoing frequency.</p> <p>This process was reviewed again at the 5/11/15 QAPI Meeting where the QAPI Committee determined it was appropriate to reduce the full medication reconciliation on all residents to once (1) weekly for one week. The QAPI Committee will review the findings at this time to determine the ongoing frequency of monitoring.</p> <p>Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation.</p>	

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F 282	<p>Continued From page 18</p> <p>revealed the facility admitted the resident on 10/18/13 and readmitted the resident on 03/20/15, after a hospital stay. The resident had a diagnosis of Seizure Disorder.</p> <p>Review of Resident #15's Seizure Activity/at risk for Seizures Care Plan, revision date of 02/22/15, revealed the resident had an intervention in place to administer medications as ordered.</p> <p>Review of Resident #15's April 2015 Physician's Orders revealed an order initially dated 03/19/15 for Keppra (anti-seizure medication) 100 mg/ml. Staff was to administer 5 ml of Keppra every morning and 7.5 ml of Keppra at bedtime.</p> <p>Review of the Pharmacy Medication Dispensing Records for Resident #15 revealed 473 ml of Keppra was dispensed to the facility on 03/20/15.</p> <p>Observation on 04/17/15 at 2:20 PM, of Resident #15's Keppra bottle from the facility's medication cart revealed the medication was dated as opened on 03/21/15, one day after the resident was readmitted to the facility. Observation revealed the Keppra bottle contained 150 ml of medication. According to the resident's Physician's Order, 342.5 ml of medication should have been administered to the resident, leaving 130.5 ml remaining in the bottle. However, review of Resident #15's MAR for 03/20/15 through 04/17/15 revealed staff documented they administered Keppra to Resident #15 as ordered by the resident's physician.</p> <p>Interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed no additional medication had been dispensed to the facility as they would not be able to reorder the medication</p>	F 282	<p>4. The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations twice weekly for four (4) weeks and reported findings during weekly QA for four (4) weeks, for recommendations and further follow-up as indicated.</p> <p>The QAPI Committee reviewed the above at the QAPI Meeting on 4/27/15, 5/4/15, 5/11/15 and no changes were made to the monitoring at this time. This will be reviewed again at the weekly QAPI Meeting to report any finding and determine ongoing frequency and duration of compliance audits.</p> <p>A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. QAPI Meetings were held on 4/27/15, 5/4/15, and 5/11/15 to discuss the findings of the audits and adjust the plan as necessary. QAPI Committee will review at the next Weekly QAPI Meeting to review any findings. Weekly QAPI Meetings will continue for an additional four weeks and to be reviewed at that time to determine ongoing frequency of Weekly QAPI Meeting. Once the weekly QAPI meetings frequency is discontinued, the QAPI Committee will review and evaluate the plan monthly during the normally scheduled Quality Assurance meeting.</p> <p>5.) May 30, 2015</p>		

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F 282	<p>Continued From page 19 until they were out of the medication, or on the last dose of medication.</p> <p>Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed that the resident's medications were administered per the Physician's Orders and the interventions on the resident's plan of care were followed.</p> <p>Interview on 04/14/15 at 6:07 PM with the Director of Nursing (DON) revealed facility staff should follow the plan of care for a resident. The interview further revealed residents' medications should be administered per Physician's Orders and per the care plan interventions.</p> <p>5. Review of the medical record for Resident A revealed the facility admitted the resident on 04/07/15, with diagnoses that included Guillain-Barre Syndrome, Coronary Artery Disease, Osteomyelitis, End Stage Renal Disease, Diabetes with Neuropathy, and Cerebrovascular Accident.</p> <p>Review of the "Weekly Skin Integrity Review" dated 04/08/15, revealed the resident had a diabetic ulcer to the right foot located near the last digit.</p> <p>Review of the "Interim Plan of Care" dated 04/15/15, revealed the resident had a disruption of skin surface not related to pressure with the wound type being an open lesion located on the right outer dorsal foot. Further review revealed the Plan of Care stated, "Wound care as ordered;</p>	F 282		

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F 282	<p>Continued From page 20</p> <p>see current treatment record and physician's orders; monitor effectiveness of/response to the treatment as ordered."</p> <p>Review of Resident A's Physician's Order, dated 04/15/15 at 6:30 PM, revealed wound care orders were to cleanse the right outer dorsal foot with one-quarter strength Dakin's solution, apply an Opticell Ag (type of wound dressing) cut to fit, and apply Sure-prep and border gauze every three (3) days and as needed (PRN).</p> <p>Review of the five-day final report of the facility's investigation, dated 04/16/15, revealed Resident A had requested on 04/16/15 at 5:00 AM for LPN #3 to replace the dressing that had fallen off during the night. Further review of the investigation revealed LPN #3 did not replace the dressing and had instructed the resident the dressing change would not be completed until the wound care nurses arrived at 8:00 AM.</p> <p>Interview with LPN #3 on 04/20/15 at 4:30 PM revealed the resident had requested the dressing be replaced; however, it was not done. The LPN stated she did not follow the resident's care plan. She stated she should have checked and followed the care plan.</p> <p>Interview with the DON on 04/20/15 at 2:37 PM revealed staff should follow the residents' care plans. She stated wound care should be done according to the care plan.</p> <p>Interview with the Administrator on 04/20/15 at 1:30 PM, revealed LPN #3 should have followed the resident's plan of care and replaced the resident's dressing.</p>	F 282		

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F 282	<p>Continued From page 21</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse</p>	F 282		

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F 282	Continued From page 22 reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators,	F 282			

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F 282	<p>Continued From page 23</p> <p>Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs.</p> <p>6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized.</p> <p>7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All</p>	F 282			

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F 282	Continued From page 24 clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows:	F 282			

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F 282	<p>Continued From page 25</p> <p>a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted.</p> <p>b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted.</p> <p>c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders and the plan of care. The process continued until immediacy was lifted.</p> <p>d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of</p>	F 282		

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F 282	<p>Continued From page 26</p> <p>twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p> <p>e. Reorder process below will continue until immediacy was lifted:</p> <p>i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer.</p> <p>ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials.</p> <p>iii) The DON and/or ADONs ran the "Refill Reminder Report" from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility.</p> <p>f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical.</p> <p>10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse</p>	F 282			

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F 282	<p>Continued From page 27</p> <p>Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15.</p> <p>12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation.</p> <p>13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly.</p> <p>14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>Consultant audited compliance of the above stated audits/observations daily until removal of Immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4) weeks, for recommendations and further follow-up as indicated.</p> <p>15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan.</p> <p>**The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The</p>	F 282			

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F 282	<p>Continued From page 29</p> <p>Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified.</p> <p>3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15.</p> <p>4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators,</p>	F 282			

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F 282	<p>Continued From page 30</p> <p>Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff.</p> <p>5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs.</p> <p>6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the</p>	F 282			

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F 282	<p>Continued From page 31</p> <p>Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records.</p> <p>7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the post-tests revealed staff (with the exception of staff who was on medical leave or who worked "as needed") had completed the post-test with a 100% score.</p> <p>8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and</p>	F 282			

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F 282	<p>Continued From page 32</p> <p>procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records.</p> <p>9) Review of the new process for medication reconciliation of residents' medications revealed the process was initiated on 04/22/15. The process was as follows:</p> <p>a. Review of the facility audits revealed one random nurse per day, per shift completed a medication pass observation with the DON, ADONs, SDC, Medical Record's Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate, and to ensure documentation was completed.</p> <p>b. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. The audits revealed the process was ongoing on 04/24/15.</p> <p>c. Review of the facility's in-services revealed the nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the</p>	F 282			

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F 282	<p>Continued From page 33</p> <p>discarded pill packets/bottles in the bottom drawer of the medication cart when the packet/bottle was finished. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited ten (10) discarded packets/bottles per unit daily and compared them to packets/bottles that were put into service to reconcile medications, confirm the reorder process and that the medications were being given per the physician's orders and the plan of care. Review of the facility's audits and an observation of the medication cart on 04/24/15, revealed the process was ongoing on 04/24/15.</p> <p>d. Observations of the medication carts on 04/24/15 revealed the nurses/KMAs had placed the date/time and their initials on the side of new medication packet/bottle. Further observations of the medication carts revealed liquid medications were dated 04/22/15.</p> <p>e. Review of the medication re-order process revealed the following process was in place</p> <p>i) Interviews, on 04/24/15, with nursing staff revealed a nurse reordered medications via the ezMAR alert system when three (3) to four (4) days of a medication was left to administer.</p> <p>ii) Observations on 04/24/15, and interviews with nursing staff, on 04/24/15, revealed a nurse placed the date of reorder and their initials on the current medication bubble package.</p> <p>iii) Interviews, on 04/24/15, with the DON and ADONs revealed the administrative staff ran the "Refill Reminder Report" from the ezMAR system,</p>	F 282			

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F 282	<p>Continued From page 34</p> <p>Monday -Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>iv) Interviews on 04/24/15, with the Facility Formulary Nurse, ADONs, SDC, QA Nurse, and Nursing Supervisors revealed the staff reconciled the Refill Reminder Report with the nightly medication manifest report and the actual medication packet on the cart or stored in overflow to ensure medications that were reordered had actually arrived at the facility.</p> <p>f. Review of the facility in-services revealed nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. Interviews, on 04/24/15, with nurses and KMAs revealed the staff had been trained on documentation practices and scope of practice for the KMA.</p> <p>10) Review of the facility's audits revealed all residents' medications were reconciled two (2) times weekly, starting on 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive. Interviews on 04/24/15 with the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant and Chief Nursing Executive revealed all residents' medications were reconciled two (2) times weekly with no issues identified.</p> <p>11) Review of the facility's in-services revealed education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON ADONs SDC, or the Regional</p>	F 282			

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F 282	Continued From page 35 Nurse Consultant regarding the above stated plan by 04/21/15. Interviews on 04/24/15 with the Administrator, DON, ADON, SDC, and the Regional Nurse Consultant revealed licensed nursing staff was provided education regarding all areas of the corrective plan. 12) Review of medication pass audits revealed the audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMA by 04/22/15. Interviews on 04/24/15 with the DON, ADON, SDC, Medical Records Nurse and Regional Nurse Consultant revealed a medication pass had been completed with all nurses and KMAs by 04/22/15. 13) Interviews on 04/24/15 with the Special Projects Administrator, the Regional Vice President of Operations, and the Chief Operating Officer revealed administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily. 14) Review of the audits and interviews on 04/24/15 with the Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant revealed the administrative staff audited the compliance of the above stated audits/observations daily. 15) Review of the Quality Assurance meeting minutes revealed a meeting was held on 04/17/15 and again on 04/20/15.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		5/30/15

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F 309	<p>Continued From page 36</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's investigation, and facility policy review it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being related to wound care for one (1) of two (2) unsampled residents (Resident A). Resident A had a Physician's Order and a care plan for wound care to be completed on the resident's right foot every three (3) days and as needed (PRN). Review of the facility's investigation, dated 04/16/15, revealed Resident A requested that Licensed Practical Nurse (LPN) #3 replace a wound dressing at approximately 5:00 AM on 04/16/15. However, the LPN failed to replace the dressing and instructed the resident to wait for the wound care nurses to arrive later in the day. Resident A's wound care was not completed until 04/16/15 at approximately 2:00 PM.</p> <p>The findings include: Review of the facility's policy, "Pressure Ulcers/Skin Breakdown-Clinical Protocol," revision date October 2013, revealed the</p>	F 309	<p>1) Resident A was assessed and treatment was completed by the Wound Care Nurse at 2pm on 4-16-15. There was no decline in the Status of the wound. The allegation was immediately reported to the Director of Nursing on 4-16-15 and Licensed Practical Nurse #3 was immediately suspended pending investigation. Before Licensed Practical Nurse #3 was allowed to return to work she was counseled and reeducated by the Director of Nursing that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Licensed Practical Nurse #3 was also re-educated on Signatures Policy and Procedure on Pressure Ulcers/Skin Breakdown-Clinical Protocol which includes immediately addressing any concern with a resident's wound or treatment.</p> <p>2) Skin assessments were completed on all residents by 5/15/15 to ensure residents had the appropriate treatments in place as in accordance with the comprehensive assessment and plan of care.</p> <p>3) Licensed Staff will be re-educated on Signatures Policy and Procedure on Pressure Ulcers/Skin Breakdown-Clinical Protocol, and providing care in accordance with the comprehensive assessment and plan of care by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Staff Development Coordinator, Regional Wound Certified Nurse, Regional Nurse Consultant or Unit Manager by May 29, 2015.</p> <p>4) A random 5 residents who receive wound care treatments will be observed to ensure the treatment is in place and in accordance with the comprehensive assessment and plan of care, by the Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator, Quality Assurance Nurse, Independent nurse consultant, or Regional Nurse Consultant weekly x4 weeks, then 3 residents</p>		

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F 309	<p>Continued From page 37</p> <p>physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressing (occlusive, absorptive, etc.), and application of topical agents if indicated for the type of skin alteration.</p> <p>Review of the medical record for Resident A revealed the facility admitted the resident on 04/07/15 with diagnoses that included Guillain-Barre Syndrome, Coronary Artery Disease, Osteomyelitis, End Stage Renal Disease, Diabetes with Neuropathy, and Cerebrovascular Accident. Further review of the medication record revealed the facility had not completed the Admission Minimum Data Set (MDS) assessment. Interview with the Administrator on 04/20/15 at 1:30 PM revealed Resident A made his/her needs known and was interviewable.</p> <p>Review of the "Weekly Skin Integrity Review" dated 04/08/15, revealed the resident had a diabetic ulcer to the right foot located near the last digit.</p> <p>Observation on 04/24/15 at 10:45 AM revealed the resident had a nickel-sized diabetic ulcer on the right dorsal side of his/her right foot.</p> <p>Review of Resident A's Physician's Order dated 04/15/15 at 6:30 PM, revealed wound care orders as follows: cleanse the right outer dorsal foot with one-quarter strength Dakin's solution, apply an Opticell Ag (wound dressing) cut to fit, and apply Sureprep (product to aid dressings to adhere to skin) and border gauze for protection every three (3) days and as needed (PRN).</p>	F 309	<p>weekly x4 weeks then 1 resident weekly x 4 weeks to ensure residents are receiving care and services for highest wellbeing. The above audits will be brought to the monthly quality assurance meeting in which tracking and trending will be reviewed by the committee members in order to provide feedback, or evaluate for further need of education or intervention as well as need for further plans.</p> <p>5) May 30, 2015</p>		

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PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41601		
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F 309	<p>Continued From page 38</p> <p>Review of the facility's investigation, dated 04/16/15, revealed Resident A reported on 04/16/15 at approximately 2:00 PM to the facility wound care nurses that he/she had requested for LPN #3 to replace the dressing on his/her foot on 04/16/15 at 5:00 AM. Further review of the investigation revealed LPN #3 had informed the resident the wound care would be completed when the Wound Care Nurse arrived at 8:00 AM.</p> <p>Interview with Resident A on 04/19/15 at 1:20 PM revealed he/she made LPN #3 aware the wound dressing had come off during the night and requested that the nurse replace the dressing. The resident stated the dressing was not replaced until the afternoon when the wound care nurses were called into the resident's room by the resident's spouse.</p> <p>Interview with LPN #3 on 04/20/15 at 4:30 PM revealed Resident A requested that his/her dressing be replaced on 04/16/15; however, LPN #3 did not change the dressing. The LPN stated that she did not check the Physician's Orders or pass the request on in report to the next shift. LPN #3 stated she assumed the dressing was off for a reason and she forgot to share the information in shift report. Further interview with the LPN revealed, "I guess I should have done something."</p> <p>Interview with Registered Nurse (RN) #3 on 04/17/15 at 3:55 PM revealed she was a wound care nurse in the facility. RN #3 stated she received new wound care orders for Resident A on the evening of 04/15/15. RN #3 stated Resident A's wound was cleaned and dressed according to the Physician's Order on 04/15/15 at approximately 6:00 PM. Further interview</p>	F 309			

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F 309	Continued From page 39 revealed she was not made aware of the need for Resident A's dressing to be replaced until the afternoon of 04/16/15. Interview with the Director of Nursing (DON) on 04/20/16 at 2:37 PM revealed when a "dressing comes off, becomes soiled, or needs to be replaced the nurse should change the dressing." The DON further stated that the facility had PRN (as needed) orders for that purpose. Interview with the Administrator on 04/20/15 at 1:30 PM, revealed the nurse should have met the resident's immediate need and replaced the dressing when the resident requested the dressing to be applied.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure necessary services were provided to maintain grooming and personal hygiene for two (2) of thirty (30) sampled residents (Resident #2 and Resident #14). The facility assessed Resident #2 and Resident #14 to require the extensive assistance from staff for care. However, the facility failed to ensure toenail care was provided for the residents. The	F 312	F 312 1.Residents #2 and #14 Comprehensive Care Plans and Nurse Aid care plans were updated to address toenail care on 5-11-15 and 5-13-15. Resident #14 received toenail care on 4-14-15 by Nursing Staff. Resident #2 was evaluated and treated by the in house Podiatrist on 5-12-15. 2.A 100% observation was completed on 5/7/15 by the DON, ADON, QA nurse, unit manager, facility formulary nurse, and weekend shift supervisor nurse to ensure all resident's fingernails and toenails were trimmed. Residents identified with needs that were not able to be met by the DON, ADON, unit manager, facility formulary nurse, or weekend shift supervisor nurse were communicated to the social services director and placed on the facility list for the Podiatrist to examine. All residents Comprehensive Care Plans were reviewed for updates and accuracy with emphasis on toenail care, by the Chief Nurse Executive, Regional Nurse Consultant, Director of Nursing,	5/30/15	

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F 312	<p>Continued From page 40</p> <p>residents were observed with long unkempt toenails.</p> <p>The findings include:</p> <p>Review of the facility's policy dated December 2010 and titled "Nail Care," revealed the nursing staff would provide observation and care of nails for all residents daily and as necessary and that nail care would be performed by a licensed nurse if the resident had a diagnosis of Diabetes or circulatory disease.</p> <p>1. Review of the medical record revealed the facility admitted Resident #2 on 01/05/15, with diagnoses that included Weakness, Cellulitis, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) assessment dated 04/15/15, revealed the facility assessed Resident #2 to require the extensive assistance of two (2) or more persons with personal hygiene and bathing.</p> <p>Review of the Comprehensive Care Plan for Resident #2 dated 03/24/15, revealed the facility failed to develop a plan of care related to self-care deficit that included personal hygiene and keeping the resident's nails clean and groomed. According to the CNA's care plan (a guide used by the nursing assistants for providing resident care needs), Resident #2's nail care would be provided by the nurse(s).</p> <p>Observations conducted during a skin assessment on 04/15/15 at 9:30 AM, with Registered Nurse (RN) #4 and Kentucky Medication Aide (KMA) #1 revealed Resident #2's toenails on both feet to be long, thick, dark in color, and in need of trimming/grooming.</p>	F 312	<p>Quality Assurance Nurse, Medical Records Director, Unit Manager or Administrator on 4-20-15.</p> <p>Any concerns were addressed immediately.</p> <p>3. Education on Signatures Policy and Procedures on fingernail care and Foot care (which includes toenail care) will be provided by the DON, ADON, SDC, QA nurse, unit manager, facility formulary nurse, or weekend shift supervisor for licensed nursing staff and certified nursing assistants to be completed by May 29 2015.</p> <p>The MDS Coordinator and Administrative Nurses were re-educated on Comprehensive Care Plan accuracy and updating by the Clinical Reimbursement Specialist or Regional Nurse Consultant on 5-11-15 and 5-12-15. Nursing Staff were re-educated on accuracy and updating of Care Plans and Nurse Aid Care Plans by the Regional Nurse Consultant, Director of Nursing, Quality Assurance Nurse, Staff Development Nurse, Assistant Director of Nursing or MDS coordinator by May 28, 2015. Nurses will update care plans and nurse aid care plans daily with any changes. All changes of condition, physician orders, care plans and nurse aid care plans will be reviewed daily Monday thru Friday by but not limited to the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Staff Development Nurse, MDS coordinator or Unit Manager in AM Clinical meeting to ensure it reflects the Residents condition and care plans updated accurately. MDS coordinator completes/updates care plan/nurse aid care plans on any Quarterly, change of condition or comprehensive assessments. Quarterly, change of condition and comprehensive assessments will be reviewed during Interdisciplinary care plan meeting at least quarterly.</p> <p>Certified nursing assistants and/or licensed nursing staff will provide nail care as needed to residents (excluding those who have a diagnosis of diabetes</p>		

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F 312	<p>Continued From page 41</p> <p>Interview with Certified Nurse Aide (CNA) #5 on 04/20/15 at 1:15 PM revealed she was responsible for the care of Resident #2. CNA #5 stated she had not seen the resident's toenails in a while because the resident was trying to groom himself/herself. She said she had previously noticed the resident's toenails were long; however, the nurses were responsible for grooming the resident's toenails because the resident was diabetic. The CNA stated she assumed the nurse was aware of the condition of Resident #2's toenails; however, she had not reported this to the nurse.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/20/15 at 1:27 PM, revealed she was the Charge Nurse on the North Hall and was responsible for ensuring nail care was provided by either the nurse or the CNA routinely by doing walking rounds. LPN #1 stated the CNAs should report any concerns related to nail care for the residents to the nurses. The LPN stated she had not observed Resident #2's toenails and was not aware the resident's toenails were long, thick, and discolored.</p> <p>Interview with RN #4 on 04/20/15, at 1:20 PM, revealed she was responsible for the nail care for the diabetic residents, but Resident #2's toenails were too thick to cut. RN #4 stated if nursing staff was unable to provide the care, they would tell Social Services, who then puts the names of the residents needing Podiatry care on a list. RN #4 stated she did not know if Resident #2's name was on the Podiatry List or not.</p> <p>Review of the Podiatry List revealed Resident #2 was listed for a podiatry consultation on the April</p>	F 312	<p>and/or circulatory disease) on their scheduled shower/bath days. Nail care performed will be documented on the resident's CNA Skin Care Alert (shower) form. Charge Nurses will review the Skin Care Alert sheets prior to the end of the Certified Nurse Assistants shift to ensure Residents nail care is being performed as needed.</p> <p>Residents who need or request the podiatrist for toenail care will be placed on the in house Podiatrist list as needed. If the Resident needs to be seen before the in house Podiatrist visit, the Resident will be scheduled for an outpatient visit to ensure the Residents needs are met The DON, ADON, SDC, QA nurse, unit manager, facility formulary nurse, or weekend shift supervisor will bring the completed CNA Skin Care Alert (shower) forms from the prior day(s) to the Clinical Meeting Monday-Friday for review by the Interdisciplinary Team. Nurses will inspect residents' nails during weekly skin assessments to ensure toenails are clean and trimmed. Identified concerns/issues will be addressed and documented at the time of the assessment.</p> <p>The weekly skin assessments will be brought to the am clinical meeting for review daily Monday thru Friday by the Interdisciplinary Team</p> <p>4. The DON, ADON, SDC, QA nurse, unit manager, facility formulary nurse, or weekend shift supervisor will perform a random audit of 5 residents' nail care weekly x 4 weeks, then 3 residents x 4 weeks, then 1 resident x4 weeks. An audit of 10% Comprehensive Care Plans and Nurse Aid care plans will be reviewed by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Unit Manager or Staff Development Nurse Monthly for 3 months. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for review, in which analysis with the tracking and trending will be reviewed by the committee members in order to provide feedback, or evaluate for further</p>	
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F 312	<p>Continued From page 42</p> <p>2015 list. However, there was no documented evidence Resident #2 was seen by the Podiatrist in April 2015.</p> <p>2. Observation of Resident #14 on 04/17/15 at 10:03 AM revealed the resident to have long, untrimmed toenails on both feet.</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 02/24/15 with diagnoses that included Multiple Sclerosis and Seizure Disorder. Review of Resident #14's Admission MDS assessment dated 03/03/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. Continued review of Resident #14's Admission MDS assessment revealed the facility assessed the resident to require extensive assistance, with the support of at least two (2) staff persons related to personal hygiene.</p> <p>Review of Resident #14's Comprehensive Care plan dated 03/29/15 revealed the resident had an Activities of Daily Living (ADL) self-care deficit. However, toenail care was not addressed on the Comprehensive Care Plan. Review of Resident #14's Nurse Aide care plan dated March 2015 revealed toenail care was not addressed.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7 on 04/20/15 at 2:03 PM revealed resident nail care should be performed as needed. SRNA #7 stated she had trimmed Resident #14's toenails on 04/15/15. Continued interview with SRNA #7 revealed Resident #14 had joint contractures and if his/her toenails were not trimmed, they could "stab" him/her.</p>	F 312	<p>need of education or intervention as well as need for further plans. Members of the Quality Assurance committee include but not limited to: the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Facility Formulary Nurse, Social Services Director, Food Services Director, Human Resources Director, Plant Operations Director, Quality of Life Director, Business Office Manager, Quality Assurance Nurse, Staff Development Coordinator, MDS Coordinator, Chaplain, Rehabilitation Services Manager, Medical Records Director, Central Supply Director, and Marketing/Admissions Director.</p> <p>5) May 30, 2015</p>		

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F 312	Continued From page 43 Interview with Registered Nurse (RN) #1 on 04/20/15 at 2:10 PM, revealed SRNAs were responsible for resident nail care unless the resident had a diagnosis of Diabetes. RN #1 stated nurses were to perform nail care on the diabetic residents. Continued interview with RN #1 revealed to ensure resident nail care had been performed she conducted daily walking rounds; however, she had not identified concerns with toenail care not being performed. Interview with LPN #1, the North Hall Unit Manager, on 04/20/15 at 1:27 PM revealed she was responsible to ensure nail care was provided by either the nurse or the SRNA. Further interview with LPN #1 revealed she routinely conducted walking rounds to ensure resident nail care was being performed. LPN #1 stated the CNAs should report any concerns related to nail care for the residents to the nurses. Continued interview with LPN #1 revealed she was not aware of Resident #14 having long, untrimmed toenails. Interview with the Director of Nursing (DON) on 04/20/15 at 2:45 PM, revealed resident nail care should be performed as needed for all residents and nail care should have been performed for Residents #2 and #14.	F 312			
F 333 SS=K	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	F333 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances(QA)Nurse, Nursing	5/30/15	

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F 333	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of medical records, pharmacy medication dispensing records, and the facility's policies, it was determined the facility failed to ensure five (5) of thirty (30) sampled residents (Residents #11, #13, #15, #16, and #17) were free of significant medication errors. Review of the residents' Medication Administration Records (MAR) revealed documentation that the residents' medications were administered according to Physician's Orders. However, observation of Resident #15's medication and review of Residents #11, #13, #16, and #17's pharmacy medication dispensing records revealed the facility failed to administer the residents' medications as ordered by the residents' physicians.</p> <p>Review of pharmacy dispensing records dated 12/01/14 thru 04/17/15 and review of Physician's Orders revealed the facility failed to administer Digoxin (a medication used to slow the heart rate of patients with atrial fibrillation) as ordered to Resident #11; failed to administer Primidone and Depakote (anti-seizure medications) as ordered to Resident #17; failed to administer Keppra (anti-seizure medication) as ordered to Resident #13; and failed to administer Valproic Acid (a medication used to prevent seizures) twice daily to Resident #16.</p> <p>In addition, observation on 04/17/15, revealed Resident #15's Keppra medication bottle contained 150 milliliters (ml) of liquid; however, since the resident was readmitted to the facility on 03/20/15, only 130.5 ml should have been</p>	F 333	<p>Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container.</p> <p>3) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication</p>	

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F 333	<p>Continued From page 45</p> <p>present if the medication had been administered per physician's order (Refer to F282, F425, F490, and F514).</p> <p>The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15.</p> <p>An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an "E" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Administration General Guidelines," dated December 2012, revealed medications were administered as prescribed in accordance with the manufacturer's specifications, good nursing principles and practices, and only by persons legally authorized to do so.</p>	F 333	<p>reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a posttest re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 05/29/15 all education was completed and any PRN or staff who had not completed the education received a certified letter and will not be allowed to return to work until the education has been completed and verified. Once education has been provided, each licensed nurse will</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 333	<p>Continued From page 46</p> <p>Review of the facility's policy titled "Medication Administration - Medication Discrepancies," dated December 2009, revealed medication discrepancies were documented and reported to the resident's attending physician, Director of Nursing, responsible party, and the Performance Improvement Committee. The policy defined a medication discrepancy as an omission of medication due to a prescribing, dispensing, or administering error. The policy further revealed when a medication discrepancy occurred immediate action should be taken to protect the patient's safety and welfare. Continued review of the policy revealed the attending physician was notified of the error or significant medication discrepancy and the patient was to be monitored closely for 24 to 72 hours or as directed by the physician. The policy stated a medication discrepancy/error/incident report was to be completed.</p> <p>Review of the facility's procedure for reordering medication, not dated, revealed staff should reorder medications when there was a three (3) day supply of medication remaining.</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13, with diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Review of Resident #11's April 2015 Physician's Orders revealed an order for staff to administer Digoxin 125 mcg (micrograms) per day. The medication was initially ordered 08/17/14.</p> <p>Record review and review of the facility's</p>	F 333	<p>complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows:</p> <p>a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. This was reviewed at the QAPI Meeting on 4/27/15 and facility continued with a medication pass observation for one random nurse per day, per shift. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed again on 5/4/15 at the QAPI Meeting and it was determined by the committee that the facility would reduce the medication pass observations to one random nurse per day. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed on 5/11/15 and the QAPI Committee determined to reduce the audits to medication pass observations on three random nurses per week for 4 weeks To be reviewed at the next QAPI Meeting to determine frequency and duration.</p> <p>b. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs,SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse,</p>		

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F 333	<p>Continued From page 47</p> <p>Investigation related to Resident #11, dated 04/07/15, revealed on 04/01/15, Resident #11's Digoxin medication card dated 03/24/15 (the date the medication card was received by the facility for use) revealed only four (4) tablets had been dispensed from the card leaving ten (10) tablets remaining on the medication card. The facility audited the medication card again on 04/03/15, prior to the morning medication pass (the medication was ordered to be administered every morning). At that time, Resident #11's Digoxin medication card still had ten (10) tablets remaining on the card. Review of the Medication Administration Record (MAR) revealed staff documented the medication had been administered on 04/02/15. There was no documented evidence the medication had not been held or refused the previous day.</p> <p>Review of the Pharmacy's Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's Digoxin was dispensed with fourteen (14) tablets per medication card. This medication was dispensed seven (7) times since 12/10/14 (dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and 04/15/15). During the timeframe reviewed (12/10/14 through 04/16/15), the pharmacy dispensed ninety-eight (98) Digoxin tablets; however, one hundred twenty-eight (128) tablets were required for the staff to be able to administer the resident's Digoxin per the Physician's Orders.</p> <p>Review of Resident #11's Digoxin laboratory level obtained on 01/05/15 revealed the level was not therapeutic at 0.80 ng/ml (nanograms/milliliter) (therapeutic range is 0.9 to 2.0 ng/ml). Further review of Resident #11's Digoxin level dated 04/03/15 revealed the resident's medication was</p>	F 333	<p>MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders and the plan of care.</p> <p>This was reviewed during the 4/27/15 QAPI Meeting and the QAPI Committee determined to reduce the audit to ten (10) discarded packets/bottles per side Monday through Friday. To be reviewed at the next QAPI Meeting.</p> <p>This was reviewed during the 5/4/15 QAPI Meeting and the QAPI Committee determined to reduce the audit to five (5) discarded packets/bottles per side Monday through Friday. To be reviewed at the next QAPI Meeting.</p> <p>This was reviewed again during the 5/11/15 QAPI Meeting and the QAPI Committee made no changes to the monitoring of five (5) discarded packets/bottles per side Monday through Friday. Will be ongoing for four (4) weeks and then to be reviewed at the next QAPI Meeting to determine ongoing monitoring frequency and duration.</p> <p>c. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p> <p>d. Reorder process below will continue:</p> <p>i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer.</p> <p>ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials.</p> <p>iii) The DON and/or ADONs ran the "Refill Reminder Report" from the ezMAR system,</p>		

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F 333	<p>Continued From page 48 also not therapeutic at 0.5 ng/ml.</p> <p>2. Review of Resident #17's medical record revealed the facility admitted the resident on 10/23/98. The resident had diagnoses that included Seizure Disorder.</p> <p>Review of Resident #17's April 2015 Physician's Orders revealed an order for staff to administer Primidone (anti-seizure medication) 250 mg every morning (initially ordered 12/16/14) and two (2) capsules of Depakote (anti-seizure medication) 125 mg twice daily (initially ordered on 08/05/14).</p> <p>Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed thirty (30) capsules of Primidone 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on 12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, one hundred seven (107) capsules were required for the staff to be able to administer the resident's Primidone, per the Physician's Orders.</p> <p>Further review of the Pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of Depakote 125 mg (a 30-day supply) on 02/20/15. However, the medication was not dispensed to the facility again until 04/05/15, approximately forty-four (44) days later.</p> <p>Review of Resident #17's MAR for 12/01/14 through 04/04/15 revealed staff omitted one (1) dose of Primidone for the resident on 01/05/15. Staff documented all other doses were administered per Physician's Orders. Further review revealed staff omitted one dose of</p>	F 333	<p>Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring. This process will continue for four additional weeks and be reviewed during the QAPI Meeting to determine further monitoring duration and frequency.</p> <p>iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility Monday Through Friday.</p> <p>This process and monitoring was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring at this time. Current process will continue for an additional four weeks and then be reviewed by the QAPI Committee to determine ongoing monitoring and the frequency and duration.</p> <p>All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15 and no changes were made to the monitoring. To be reviewed at the next weekly QAPI Meeting to determine ongoing frequency.</p>		

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F 333	<p>Continued From page 49</p> <p>Depakote on 04/04/15. Registered Nurse (RN) #1 documented that three (3) evening doses of Depakote were not administered to Resident #17 on 03/08/15, 03/18/15, and 03/23/15 because the resident's blood pressure or pulse was too low. On 03/17/15, RN #1 documented the resident refused the evening dose; and on 03/22/15 RN #1 documented Depakote was not administered because the resident had no insulin coverage.</p> <p>On 04/19/15 at 1:20 PM, after reviewing Resident #17's MAR, interview with RN #1 revealed she administered the resident's medications as ordered. She stated the resident did not refuse medications and the documentation on the resident's MAR was inaccurate because it was easy to enter the wrong code on the electronic MAR.</p> <p>Review of Resident #17's laboratory levels revealed on 04/03/15, the resident's Valproic Acid (Depakote) level was sub-therapeutic at less than 10 mcg/ml (therapeutic range is 50 - 100 mcg/ml). Further review of Resident #17's lab levels revealed on 03/16/15, the resident's Primidone level was sub-therapeutic at less than 2.5 mcg/ml (therapeutic range is 5-12 mcg/ml). On 03/19/15, the resident's Primidone level had increased to 9.1 mcg/ml.</p> <p>The SSA's Pharmacy Consultant conducted a post survey review. This review revealed Resident #17's Physician Orders for April 2015 had concurrent orders for the Primidone 250 mg; one order in which the resident was to be given one tablet (250 mg) each morning (initiated 09/19/14), and a second order in which the resident was also to be given one tablet (250 mg) each evening (initiated 12/16/14), for a total of</p>	F 333	<p>The process was reviewed at the 5/4/15 QAPI Meeting and it was determined to make no changes to the monitoring at this time. Review in one week at the QAPI Meeting to determine ongoing frequency. This process was reviewed again at the 5/11/15 QAPI Meeting where the QAPI Committee determined it was appropriate to reduce the full medication reconciliation on all residents to once (1) weekly for one week. The QAPI Committee will review the findings at this time to determine the ongoing frequency of monitoring. Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15.</p> <p>Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation.</p> <p>4) A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. QAPI Meetings were held on 4/27/15, 5/4/15, and 5/11/15 to discuss the findings of the audits and adjust the plan as necessary. QAPI Committee will review at the next Weekly QAPI Meeting to review any findings. Weekly QAPI Meetings will continue for an additional four weeks and to be reviewed at that time to determine ongoing frequency of Weekly QAPI Meeting. Once the weekly QAPI meetings frequency is discontinued, the QAPI Committee will review and</p>		

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F 333	<p>Continued From page 50</p> <p>two (2) tablets per day. During a post survey phone interview with the Advanced Registered Nurse Practitioner on 06/01/15, she acknowledged the resident was to receive 250 mg each morning and each evening. From 12/08/14 through 04/04/15, the resident would have needed a total of one-hundred and seven (107) tablets of Primidone 250 mg to meet the dosage required for the time period, if the order was for once a day. However, only sixty (60) tablets had been dispensed and delivered for the resident during that time period, as validated by the pharmacy's Delivery Manifest Record (aka, the pharmacy dispensing record). Record review revealed the resident was actually ordered to receive two (2) tablets per day of the Primidone during that time. The resident would have needed approximately twice that amount, between 210-214 tablets, to achieve the dosage that was ordered.</p> <p>3. Review of Resident #13's medical record revealed the facility admitted the resident on 06/10/13, and the resident had diagnoses that included Seizure Disorder.</p> <p>Review of Resident #13's Physician's Orders for April 2015 revealed an order for staff to administer Keppra (anti-seizure medication) 5 ml (100 mg/1 ml) twice daily.</p> <p>Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed 300 ml (a 30-day supply) of Keppra liquid medication three (3) times from 12/03/14 through 03/18/15, for a total of 900 ml. However, 1,050 ml of Keppra was required to administer the medication per Physician's Orders.</p>	F 333	<p>evaluate the plan monthly during the normally scheduled Quality Assurance meeting.</p> <p>5) May 30, 2015</p>	

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F 333	<p>Continued From page 51</p> <p>Review of Resident #13's MARs for January through March 2015 revealed staff documented the resident's Keppra medication was administered as ordered.</p> <p>Review of the Keppra medication laboratory results revealed on 12/01/15, the resident's Keppra level was 23 mcg/ml which was therapeutic (normal range is 5 - 63 mcg/ml). On 03/02/15, the resident's Keppra level was sub-therapeutic at 2.0 mcg/ml. Further review of Resident #13's laboratory results revealed on 04/03/15 the resident's Keppra level was also sub-therapeutic at 2.9 mcg/ml.</p> <p>The SSA's Pharmacy Consultant conducted a post survey review of the facility's pharmacy dispensing records. Review of Resident #13's MARs for January through April 2015 revealed no documented evidence (staff did not sign off as having been administered) staff administered the Keppra liquid medication as ordered; two (2) doses were omitted in January 2015, one (1) dose in February 2015, and two (2) doses in April 2015 for a total of five (5) doses (50 ml) missed.</p> <p>4. Review of Resident #16's medical record revealed the facility admitted the resident on 09/05/14. The resident had diagnoses that included Seizure Disorder and Psychosis.</p> <p>Review of Resident #16's Physician's Orders dated 09/05/14, revealed an order for Valproic Acid (250 mg/5 ml) 5 ml twice daily.</p> <p>Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, for Resident #16 revealed the pharmacy dispensed a</p>	F 333			

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F 333	<p>Continued From page 52</p> <p>150-ml bottle (a 15-day supply) of Depakote on 01/24/15. However, the medication was not refilled again until 02/18/15, twenty-six (26) days later.</p> <p>Review of Resident #16's MAR for 12/01/14 through 01/31/15 revealed staff omitted the resident's morning dose of Valproic Acid on 01/05/15. Staff documented the medication was administered as ordered for all other doses during these months.</p> <p>However, review of Resident #16's Valproic Acid laboratory level dated 04/03/15, revealed the resident's Valproic Acid level was sub-therapeutic at 20.6 mcg/ml (therapeutic range is 50 - 100 mcg/ml).</p> <p>5. Review of Resident #15's medical record revealed the facility admitted the resident on 10/18/13 and readmitted the resident on 03/20/15, after a hospital stay. The resident had a diagnosis of Seizure Disorder.</p> <p>Review of Resident #15's April 2015 Physician's Orders revealed an order initially dated 03/19/15 for staff to administer Keppra (anti-seizure medication) 5 ml every morning and 7.5 ml at bedtime.</p> <p>Review of the Pharmacy Medication Dispensing Records for Resident #15 revealed 473 ml of Keppra was dispensed to the facility on 03/20/15.</p> <p>Observation on 04/17/15 at 2:20 PM of Resident #15's Keppra bottle from the facility's medication cart revealed the medication was dated as opened on 03/21/15, one (1) day after the resident was readmitted to the facility.</p>	F 333			

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F 333	<p>Continued From page 53</p> <p>Observation revealed the Keppra bottle contained 150 ml of liquid medication. However, according to the resident's Physician's Order, 342.5 ml of medication should have been administered to the resident, leaving 130.5 ml remaining in the bottle. Review of Resident #15's MAR from 03/20/15 through 04/17/15 revealed staff documented they administered Keppra to Resident #15 as ordered by the resident's physician.</p> <p>Interview with the Pharmacy Director on 04/15/15 at 4:00 PM, revealed residents' medications were sent back to the pharmacy when the resident was out of the facility. The medications were re-dispensed when the resident returned to the facility.</p> <p>Review of Resident #15's laboratory results for Keppra revealed on 01/20/15, the resident's level was 8.0 mcg/ml (therapeutic range is 5 - 63 mcg/ml). However, on 04/03/15, the resident's level had decreased to 5.0 mcg/ml.</p> <p>Review of the facility's "Status Change" document that listed residents who had been admitted, transferred, or discharged from December 2014 through April 2015 revealed Residents #11, #13, #15, #16, and #17 had not been discharged or transferred from the facility during the times when there were discrepancies identified with their medications.</p> <p>Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed that if staff documented on the resident's MAR that their</p>	F 333			

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F 333	<p>Continued From page 54</p> <p>medication was administered, then the medication was administered per the physician's orders. The interviews further revealed the residents' medications had to be re-ordered by the nursing staff from the pharmacy when the resident's medication card had two (2) to seven (7) days remaining in the card. The nurses stated the facility did not have a system in place to determine when a medication card was placed in use after it was dispensed from the pharmacy.</p> <p>interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed the pharmacy sends a dispensing report to the facility that lists the quantity of the medication and the date the medication was sent to the facility. Continued interview revealed the facility notified the pharmacy when a resident was sent out to the hospital and the resident's medications were sent back to the pharmacy. The Pharmacy Director stated the facility notified the pharmacy of new admissions or readmissions. When the resident's orders were received by the pharmacy, the medications were sent to the facility. The interview revealed the facility's nurses reorder residents' medications when the supply gets low. Per interview, the pharmacy did not have a way to know if the facility was reordering medication when needed and administering the medication according to Physician's Orders.</p> <p>Interview on 04/14/15 at 6:07 PM, with the Director of Nursing (DON) revealed she did a random medication cart audit on 04/01/15 after the morning medication pass. She stated Resident #11's Digoxin raised a "red flag" because the medication card label was dated 03/24/15 and only four (4) tablets had been administered from the medication card leaving</p>	F 333		

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F 333	<p>Continued From page 55</p> <p>ten (10) tablets on the card. The DON stated she reviewed Resident #11's MAR and no doses (no documented evidence) had been held or refused. The DON revealed she immediately initiated an investigation, which included assessments of all residents on the hall where Resident #11 resided. The investigation included obtaining laboratory levels for all residents that lived on that hall, that were on medications that required therapeutic monitoring, and interviewing staff and alert and oriented residents. Continued interview revealed the assessments had not revealed any abnormal findings and the laboratory results had not revealed a pattern or a trend because some residents' laboratory levels were sub-therapeutic, some were normal, and some were elevated. The DON stated reviews of the pharmacy dispensing records were not evaluated as part of the investigation.</p> <p>Further interview with the DON revealed the administrative staff reviewed the investigation and did not feel there was enough concrete evidence to say Resident #11 did not receive his/her medications as ordered by the facility. She stated the only concrete information she had was a quantity of medication that was possibly more than she felt should have been in the resident's drawer; however, all the nurses interviewed revealed Resident #11's medications were administered as ordered. The DON further revealed the facility did not have a system to know how much of a particular medication the resident had in the medication cart at a given time.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the</p>	F 333			

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F 333	<p>Continued From page 56</p> <p>Immediate Jeopardy:</p> <p>1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA) Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified.</p> <p>3) All residents' medications were audited by the</p>	F 333			

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F 333	<p>Continued From page 57</p> <p>DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container.</p> <p>4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected:</p> <p>a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents</p> <p>5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse</p>	F 333			

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F 333	<p>Continued From page 58</p> <p>Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs.</p> <p>6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized.</p> <p>7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If</p>	F 333			

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F 333	<p>Continued From page 59</p> <p>100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant.</p> <p>8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation.</p> <p>9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows:</p> <p>a. One random nurse per day, per shift, will complete a medication pass observation with the</p>	F 333			

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F 333	<p>Continued From page 60</p> <p>DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted.</p> <p>b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted.</p> <p>c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant; DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders and the plan of care. The process continued until immediacy was lifted.</p> <p>d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p>	F 333			

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F 333	Continued From page 61 e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the "Refill Reminder Report" from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents	F 333		

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F 333	<p>Continued From page 62</p> <p>medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15.</p> <p>12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation.</p> <p>13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly.</p> <p>14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks</p>	F 333			

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F 333	<p>Continued From page 63 and reported findings during weekly QA for four (4) weeks, for recommendations and further follow-up as indicated.</p> <p>15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan.</p> <p>**The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was</p>	F 333		

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F 333	<p>Continued From page 64</p> <p>placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified.</p> <p>3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15.</p> <p>4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional</p>	F 333			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/24/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 333	<p>Continued From page 65</p> <p>Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff.</p> <p>5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs.</p> <p>6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director,</p>	F 333			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41801		
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F 333	<p>Continued From page 66</p> <p>SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records.</p> <p>7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the post-tests revealed staff (with the exception of staff who was on medical leave or who worked "as needed") had completed the post-test with a 100% score.</p> <p>8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information</p>	F 333			

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F 333	<p>Continued From page 67</p> <p>was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records.</p> <p>9) Review of the new process for medication reconciliation of residents' medications revealed the process was initiated on 04/22/15. The process was as follows:</p> <p>a. Review of the facility audits revealed one random nurse per day, per shift completed a medication pass observation with the DON, ADONs, SDC, Medical Record's Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate, and to ensure documentation was completed.</p> <p>b. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. The audits revealed the process was ongoing on 04/24/15.</p> <p>c. Review of the facility's in-services revealed the nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when the packet/bottle was finished. Review of the facility's</p>	F 333			

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F 333	<p>Continued From page 68</p> <p>audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited ten (10) discarded packets/bottles per unit daily and compared them to packets/bottles that were put into service to reconcile medications, confirm the reorder process and that the medications were being given per the physician's orders and the plan of care. Review of the facility's audits and an observation of the medication cart on 04/24/15, revealed the process was ongoing on 04/24/15.</p> <p>d. Observations of the medication carts on 04/24/15 revealed the nurses/KMAs had placed the date/time and their initials on the side of new medication packet/bottle. Further observations of the medication carts revealed liquid medications were dated 04/22/15.</p> <p>e. Review of the medication re-order process revealed the following process was in place</p> <p>i) Interviews, on 04/24/15, with nursing staff revealed a nurse reordered medications via the ezMAR alert system when three (3) to four (4) days of a medication was left to administer.</p> <p>ii) Observations on 04/24/15, and interviews with nursing staff, on 04/24/15, revealed a nurse placed the date of reorder and their initials on the current medication bubble package.</p> <p>iii) Interviews, on 04/24/15, with the DON and ADONs revealed the administrative staff ran the "Refill Reminder Report" from the ezMAR system, Monday -Friday, and validated that all medications due to be reordered, had actually been reordered.</p>	F 333		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41501
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F 333	<p>Continued From page 69</p> <p>iv) Interviews on 04/24/15, with the Facility Formulary Nurse, ADONs, SDC, QA Nurse, and Nursing Supervisors revealed the staff reconciled the Refill Reminder Report with the nightly medication manifest report and the actual medication packet on the cart or stored in overflow to ensure medications that were reordered had actually arrived at the facility.</p> <p>f. Review of the facility in-services revealed nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. Interviews, on 04/24/15, with nurses and KMAs revealed the staff had been trained on documentation practices and scope of practice for the KMA.</p> <p>10) Review of the facility's audits revealed all residents' medications were reconciled two (2) times weekly, starting on 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive. Interviews on 04/24/15 with the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant and Chief Nursing Executive revealed all residents' medications were reconciled two (2) times weekly with no issues identified.</p> <p>11) Review of the facility's in-services revealed education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON ADONs SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. Interviews on 04/24/15 with the Administrator, DON, ADON, SDC, and the</p>	F 333		
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F 333	Continued From page 70 Regional Nurse Consultant revealed licensed nursing staff was provided education regarding all areas of the corrective plan. 12) Review of medication pass audits revealed the audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMA by 04/22/15. Interviews on 04/24/15 with the DON, ADON, SDC, Medical Records Nurse and Regional Nurse Consultant revealed a medication pass had been completed with all nurses and KMAs by 04/22/15. 13) Interviews on 04/24/15 with the Special Projects Administrator, the Regional Vice President of Operations, and the Chief Operating Officer revealed administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily. 14) Review of the audits and interviews on 04/24/15 with the Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant revealed the administrative staff audited the compliance of the above stated audits/observations daily. 15) Review of the Quality Assurance meeting minutes revealed a meeting was held on 04/17/15 and again on 04/20/15.	F 333			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	F371 1.The one bottle of steak sauce, the jar of ranch dip, the jar of ham base, the two boxes of cream cheese, and bottle of white substance were immediately discarded upon identification on 4/14/15. The white pan was removed immediately and the surface was immediately sanitized upon identification on 4/14/15. 2)A kitchen sanitation audit was conducted by the Dietary Manager on 4/14/15 to identify any additional undated food items and sanitation issues. No other issues were identified. 3)All dietary staff was educated by the Kitchen Manager on April 28, 2015 regarding the purchasing, receiving, storing of food items using the FIFO (First In-First Out) Policy and Procedure, and the Sanitation Policy and Procedure Including to follow the daily cleaning schedules and weekly sanitation check list.	5/30/15	

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F 371	<p>Continued From page 71</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions for eighty-six (86) of ninety-six (96) residents who received a food tray. Observations on 04/14/15 revealed unlabeled and undated foods in a white storage pan with a tan liquid substance in the bottom of the pan sitting on a table with clean equipment. In addition, a dirty pan soiled with grease and food pieces was also observed to be sitting on the table with the clean equipment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Sanitation/Infection Control," undated, revealed the Dietary Manager was responsible for supervising all sanitation and housekeeping procedures within the Dietary Department. The policy stated all leftover foods would be labeled and dated prior to placing the items in the refrigerator. In addition, the policy stated the Dietary Manager was responsible for ensuring staff used proper sanitation procedures for storing, preparing, and serving foods.</p>	F 371	<p>The Kitchen Manager or lead cook will conduct a daily sanitation check. Findings related to checks on dates of food items and sanitation will be corrected immediately. These daily sanitation and date audits started on 4/28/15 and will continue through 5/28/15</p> <p>The Dietary Manager, Dietary Consultant, or Quality Assurance Coordinator will conduct a monthly audit of kitchen to identify any open and undated items and sanitation.</p> <p>4) The Dietary Manager will report to the QAPI Committee monthly the results and findings of the above audits related to open and undated items and sanitation for three months then quarterly thereafter. Any changes to the frequency of audits will be determined by the QAPI Committee. Members of the Quality Assurance Committee include but are not limited to: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director.</p> <p>5) May 30, 2015</p>		

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F 371	Continued From page 72 Observations on 04/14/15, at 1:10 PM, revealed one bottle of steak sauce, a jar of ranch dip, a jar of ham base, two boxes of cream cheese, and a bottle containing a white substance were opened, unlabeled, and undated. These food items were in a white storage pan with a tan liquid substance in the bottom of the pan. The white pan along with a pan observed to be soiled with grease and food pieces were placed on a table with clean silverware, a slicer, and two mixers. The white storage pan was observed to be placed on the table from the refrigerator by the Dietary Manager. Interview conducted with the Dietary Manager on 04/14/15, at 1:20 PM, revealed she was responsible for ensuring the kitchen was sanitary. The Dietary Manager stated all foods were required to be labeled and dated prior to being placed in the refrigerator. Further interview revealed she had not identified the unlabeled and undated foods, and had not identified the tan substance in the bottom of the white pan. She stated the pans should not have been placed on the table with the clean equipment. Interview conducted with the Registered Dietitian (RD) on 04/24/15, at 11:45 AM, revealed she was required to do a monthly audit of the kitchen, and she had not identified any concerns with sanitation. The RD stated the dirty pans should not have been placed on the table with the clean equipment and silverware. The RD also stated all foods should be labeled and dated when opened and should not have been in a dirty pan.	F 371			
F 425 SS=K	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425			

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F 425	<p>Continued From page 73</p> <p>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.</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's policy, it was determined the facility failed to provide pharmaceutical services to meet the needs of four (4) of thirty (30) sampled residents (Residents #11, #13, #16, and #17). The facility failed to have an effective system to reorder residents' medications timely to ensure the residents received their medications as physician ordered. Review of Pharmacy Medication Dispensing Records revealed Resident #11's Digoxin (medication to treat an abnormal heartbeat) was dispensed to the facility in a fourteen (14) day supply. However, this medication went up to thirty-seven (37) days</p>	F 425	<p>F 425</p> <p>1) The Physician and Power of Attorney (POA) for Residents #11, #13, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurance (QA) Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All four (4) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container</p>	5/30/15	

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F 425	<p>Continued From page 74</p> <p>between refills. Resident #17's Primidone (anti-seizure medication) went up to sixty-five (65) days between refills of a thirty (30) day supply and up to forty-three (43) days between refills for a thirty (30) day supply of Depakote (medication to prevent seizures and treat some psychiatric disorders). There was a forty-seven (47) day span between refills for a thirty (30) day supply of Resident #13's Keppra (medication to prevent seizures); and up to twenty-five (25) days between refills of a fifteen (15) day supply for Resident #16's Depakote. Laboratory tests revealed the residents' labs values for these medications that required monitoring were sub-therapeutic (refer to F282, F333, F490, and F514).</p> <p>The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15.</p> <p>An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an "E" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR</p>	F 425	<p>3) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation.</p> <p>Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 05/29/15</p>		

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F 425	<p>Continued From page 75</p> <p>483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Ordering and Receiving From the Pharmacy Provider (Ordering and Receiving Non-Controlled Medications)," dated September 2010, revealed medications and related products were received from the provider pharmacy on a timely basis. The policy stated that the facility maintained accurate records of medication order and receipt. A licensed nurse or appropriate personnel received medications delivered to the facility from the pharmacy and documented on the medication delivery receipt/manifest. The policy stated that facility staff re-ordered medications by writing the medication name and prescription number or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy.</p> <p>Interview with Registered Nurse (RN) #1 on 04/14/15 at 5:03 PM, Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 AM, RN #6 on 04/16/15 at 12:14 PM, Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and LPN #6 on 04/17/15 at 3:29 PM revealed medications could also be ordered on the computer from the resident's Electronic Medication Administration Record (e-MAR) by using the re-order tab on the screen.</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13. The resident had diagnoses that</p>	F 425	<p>all education was completed and any PRN or staff who had not completed the education received a certified letter and will not be allowed to return to work until the education has been completed and verified. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows:</p> <p>a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. This was reviewed at the QAPI Meeting on 4/27/15 and facility continued with a medication pass observation for one random nurse per day, per shift. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed again on 5/4/15 at the QAPI Meeting and it was determined by the committee that the facility would reduce the medication pass observations to one random nurse per day. To be reviewed at the next QAPI Meeting in one week.</p> <p>This was reviewed on 5/11/15 and the QAPI Committee determined to reduce the audits to medication pass observations on three random nurses</p>		

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PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 SOUTH MAYO TRAIL PIKEVILLE, KY 41601		
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F 425	<p>Continued From page 78</p> <p>Included Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Review of Resident #11's April 2015 Physician's Orders revealed an order (initially dated 08/17/14) for Digoxin 125 mcg (micrograms) per day.</p> <p>Review of the pharmacy's Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's Digoxin was dispensed with fourteen (14) tablets per medication card and was dispensed seven (7) times since 12/10/14. The medication was dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and on 04/15/15. During this timeframe (12/10/14 through 04/15/15), the pharmacy dispensed ninety-eight (98) Digoxin tablets. However, to ensure the resident received the medications as prescribed by the physician, one hundred twenty-eight (128) tablets were required for the staff to be able to administer the resident's Digoxin.</p> <p>2. Review of Resident #17's medical record revealed the facility admitted the resident on 10/23/98. The resident had diagnoses that included Seizure Disorder.</p> <p>Review of Resident #17's April 2015 Physician's Orders revealed an order for Primidone 250 mg (milligrams) every morning initially ordered 12/16/14 and two (2) capsules of Depakote 125 mg which was initially ordered on 08/05/14.</p> <p>Review of the Pharmacy's Medication Dispensing Records revealed the pharmacy dispensed thirty (30) capsules of Primidone 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on</p>	F 425	<p>per week for four (4) weeks. To be reviewed at the next QAPI Meeting to determine frequency and duration</p> <p>b. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders and the plan of care.</p> <p>This was reviewed during the 4/27/15 QAPI Meeting and the QAPI Committee determined to reduce the audit to ten(10) discarded packets/bottles per side Monday through Friday. To be reviewed at the next QAPI Meeting.</p> <p>This was reviewed during the 5/4/15 QAPI Meeting and the QAPI Committee determined to reduce the audit to five (5) discarded packets/bottles per side Monday through Friday. To be reviewed at the next QAPI Meeting.</p> <p>This was reviewed again during the 5/11/15 QAPI Meeting and the QAPI Committee made no changes to the monitoring of five (5) discarded packets/bottles per side Monday through Friday. This will continue for four (4) weeks and then to be reviewed at the next QAPI Meeting to determine ongoing monitoring frequency and duration.</p> <p>c. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p>		

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F 425	<p>Continued From page 77</p> <p>12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, one hundred seven (107) capsules were required for the staff to be able to administer the resident's Primidone per the Physician's Orders.</p> <p>Further review of the pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of Depakote 125 mg (a 30-day supply) on 02/20/15. However, the medication was not dispensed to the facility again until 04/05/15, forty-four (44) days later.</p> <p>The SSA's Pharmacy Consultant conducted post survey review of the facility's pharmacy's dispensing records. Review of the Physician Orders revealed Resident # 17 to have concurrent orders for Primidone; one order in which the resident was to be given 250 mg each morning (initiated on 09/18/14), and a second order in which the resident was to be given 250 mg each evening (initiated 12/16/14). Thus, the resident had been ordered two (2) tablets per day of the Primidone 150 mg since 12/18/14. The dosage of 250 mg twice daily was validated on 06/01/15 during a post survey phone interview with the Advanced Registered Nurse Practitioner. Resident #17 would have required a total of one-hundred and seven (107) tablets of Primidone to meet the dosage requirement from 12/08/14 through 04/04/15, if the order was for once a day. However, only sixty (60) tablets had been dispensed for the resident during that period. Based on the fact the resident was actually ordered to be receiving two (2) tablets daily of the Primidone during that period, the resident would have needed approximately twice that amount (between 204-214) tablets to achieve</p>	F 425	<p>d. Reorder process below will continue:</p> <p>i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer.</p> <p>ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials.</p> <p>iii) The DON and/or ADONs ran the "Refill Reminder Report" from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring. This process will continue for four additional weeks and be reviewed during the QAPI Meeting to determine further monitoring duration and frequency.</p> <p>iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility Monday Through Friday.</p> <p>This process and monitoring was reviewed at the QAPI Meeting on 4/27/15, 5/4/15, and 5/11/15 where no changes were made to the monitoring at this time. Current process will continue for an additional four weeks and then be reviewed by the QAPI Committee to determine ongoing monitoring and the frequency and duration.</p> <p>All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks</p>		

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F 425	<p>Continued From page 78 the dosage requirement as the physician had ordered.</p> <p>3. Review of Resident #13's medical record revealed the facility admitted the resident on 06/10/13 with diagnoses that included Seizure Disorder.</p> <p>Review of Resident #13's Physician's Orders for April 2015 revealed an order for Keppra 5 ml (milliliters) twice daily to be administered by staff.</p> <p>Review of the Pharmacy's Medication Dispensing Records for Resident #13 revealed the pharmacy dispensed 300 ml (a 30-day supply) of Keppra liquid medication three (3) times from 12/03/14 through 03/18/15 (there were 47 days between two of the refills), for a total of 900 ml. However, 1,050 ml of Keppra was required to administer the medication, per Physician's Orders.</p> <p>During the SSA's post survey review, the SSA's Consultant Pharmacist reviewed the pharmacy's Delivery Manifest Reports (aka, dispensing records) for 12/01/14 through 04/04/15. This review revealed Resident #13 received four (4) refills for a 30-day supply (300 ml) of Keppra Liquid (12/03/14, 01/08/15, 02/24/15, and 03/19/15).</p> <p>Further review revealed there was a twenty-three (23) day time span between two (2) of Resident #13's Keppra refills. Specifically, the resident received 300 ml (30 day supply) on 12/03/14, then received a subsequent refill of 300 ml on 01/08/15. The subsequent refill should have been received approximately thirty (30) days later, (from 12/03/14) or on/about 01/02/15. Thus, the refill was approximately six (6) days</p>	F 425	<p>and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>This was reviewed at the QAPI Meeting on 4/27/15 and no changes were made to the monitoring. To be reviewed at the next weekly QAPI Meeting to determine ongoing frequency.</p> <p>The process was reviewed at the 5/4/15 QAPI Meeting and it was determined to make no changes to the monitoring at this time. Review in one week at the QAPI Meeting to determine ongoing frequency. This process was reviewed again at the 5/11/15 QAPI Meeting where the QAPI Committee determined it was appropriate to reduce the full medication reconciliation on all residents to once (1) weekly for one week. The QAPI Committee will review the findings at this time to determine the ongoing frequency of monitoring. Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADCON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15</p> <p>4) A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. QAPI Meetings were held on 4/27/15, 5/4/15, and 5/11/15 to discuss the findings of the audits and adjust the plan as necessary. QAPI Committee will review at the next Weekly QAPI Meeting to review any findings. Weekly QAPI Meetings will continue for an additional four weeks and to be reviewed at that time to determine ongoing frequency of Weekly QAPI Meeting. Once the weekly QAPI meetings frequency is discontinued, the QAPI Committee will review and evaluate the plan monthly during the normally scheduled Quality Assurance meeting.</p> <p>5) May 30, 2015</p>	
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F 425	<p>Continued From page 79</p> <p>late. Further review revealed after receiving the refill on 01/08/15, the resident received the next subsequent refill of 300 ml forty-seven (47) days later on 02/25/15, or approximately seventeen (17) days late. That refill should have been received approximately thirty (30) days later, on/about 02/07/15.</p> <p>4. Review of Resident #16's medical record revealed the resident had diagnoses that included Seizure Disorder and Psychosis. Review of the medical record revealed a Physician's Order dated 09/05/14, for Valproic Acid.</p> <p>Review of Resident #16's 01/2015 MAR revealed the facility failed to administer the resident's morning dose of Valproic Acid on 01/05/15.</p> <p>Review of the Pharmacy's Medication Dispensing Records revealed the pharmacy dispensed a 150 ml (a 15-day supply) bottle of Depakote for Resident #16 on 01/24/15. However, the medication was not refilled again until 02/18/15, twenty-six (26) days later. Further review of the MARs revealed the facility documented that the resident's medication had been administered as ordered per the physician.</p> <p>Review of Resident #16's Valproic Acid laboratory level dated 04/03/15, revealed the resident's Valproic Acid level was sub-therapeutic at 20.6 mcg/ml (micrograms/milliliter)(normal range is 50 - 100 mcg/ml).</p> <p>Review of the facility's "Status Change" document that listed residents who had been admitted, transferred, or discharged from December 2014 through April 2015 revealed Residents #11, #13, #15, #16, and #17 had not been discharged or</p>	F 425			

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F 425	<p>Continued From page 80</p> <p>transferred from the facility during the times when there were discrepancies identified with their medications.</p> <p>Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #8 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #8 on 04/17/15 at 3:29 PM, revealed that if staff documented on the resident's MAR that their medication was administered, then the medication was administered per the Physician's Orders. The interviews further revealed the residents' medications had to be re-ordered by the nursing staff when the resident's medication card had two (2) to seven (7) days remaining in the card. The nurses stated the facility did not have a system in place to determine when a medication card was placed in use after it was dispensed from the pharmacy.</p> <p>Interview on 04/15/15 at 3:40 PM with the Facility's Pharmacist revealed all prescription medication labels contained a re-order date. The interview further revealed the pharmacy notified the facility if a medication was being re-ordered too early; however, the pharmacy did not notify the facility if a medication was not re-ordered when a refill was due.</p> <p>Interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed facility nursing staff reordered residents' medications when the supply was low. However, the pharmacy did not have a way to track if medications were not being reordered timely. He stated Pharmacy sent a dispensing report to the facility that listed the quantity of the medication and the date the</p>	F 425			

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F 425	<p>Continued From page 81 medication was sent to the facility.</p> <p>Interview with the Facility's Corporate Nurse Consultant on 04/17/15 at 2:45 PM revealed a report was available on the facility's computer system that listed all residents' medications that were pending reorder by the facility. The Nurse Consultant stated the Director of Nursing (DON) was required to compare the medications (that were pending re-order) to a report that was delivered with residents' medications to ensure the residents' medications were available. The Nurse Consultant stated the DON had identified no issues.</p> <p>Interview on 04/14/15 at 6:07 PM with the Director of Nursing revealed the facility did not have a system to know how much medication a resident had in stock at the facility at any given time. Further interview with the DON on 04/17/15 at 3:45 PM, revealed she had not identified any issues with medications not being re-ordered and administered per physician's orders.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16,</p>	F 425		

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F 425	<p>Continued From page 82</p> <p>and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified.</p> <p>3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on the medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of</p>	F 425			

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F 425	Continued From page 83 container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication	F 425		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	Continued From page 84 reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work "as needed" (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all	F 425			

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F 425	<p>Continued From page 85</p> <p>licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant.</p> <p>8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation.</p> <p>9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows:</p> <p>a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted.</p> <p>b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with</p>	F 425		

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F 425	<p>Continued From page 86 medication administration. This process was continued until immediacy was lifted.</p> <p>c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders and the plan of care. The process continued until immediacy was lifted.</p> <p>d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15.</p> <p>e. Reorder process below will continue until immediacy was lifted:</p> <p>i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer.</p> <p>ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials.</p> <p>iii) The DON and/or ADONs ran the "Refill</p>	F 425		
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F 425	<p>Continued From page 87</p> <p>Reminder Report" from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.</p> <p>lv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility.</p> <p>f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical.</p> <p>10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time.</p> <p>11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15.</p>	F 425			

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F 425	Continued From page 88 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4) weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan.	F 425			

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F 425	<p>Continued From page 89</p> <p>**The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/08/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant.</p> <p>2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on</p>	F 425			

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F 425	<p>Continued From page 90</p> <p>04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified.</p> <p>3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician Order Sheet, were present and the quantity of medication was counted, the quantity was placed on medication container along with the date/time completed and initialed by the Nurse Manager completing the validation/count process. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15.</p> <p>4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff.</p> <p>5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager,</p>	F 425			

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F 425	<p>Continued From page 91</p> <p>Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs.</p> <p>6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records.</p> <p>7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding</p>	F 425			

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F 425	<p>Continued From page 92</p> <p>the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the post-tests revealed staff (with the exception of staff who was on medical leave or who worked "as needed") had completed the post-test with a 100% score.</p> <p>8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records.</p> <p>9) Review of the new process for medication reconciliation of residents' medications revealed the process was initiated on 04/22/15. The process was as follows:</p>	F 425		
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