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

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 05/11/2012
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229	

(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 An abbreviated survey investigating KY18205, KY18276 and KY18337 was initiated on 05/09/12 and concluded on 05/11/12. The Division of Health Care substantiated KY18276 and a regulatory violation was cited. KY18205 and KY18337 were unsubstantiated and no further regulatory violations were identified.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review it was determined the facility failed to ensure medication was administered as ordered on one (1) of five (5) sampled residents. The facility failed to administer Resident #4's Dilantin as ordered by physician. The findings include: Review of the facility's policy regarding Administration of Medication, revealed omitted medications should be documented on the Medication Administration Record along with reasons for omission and the physician notified. Review of Resident #4's clinical record revealed	F 309	**Plan of Correction** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. **POC F309** 1. The physician was called and a new order was obtained for Resident #4. The new order was written for 200mg of Dilantin to be administered in the am and 300mg of Dilantin to be administered at pm. The employee that failed to follow the physician's initial order is no longer employed with our facility. 2 The facility will review physician orders for all residents to ensure that they are being administered as ordered. 3 The DNS and/or Staff Development nurse will in-service/instruct staff monthly for six months, then quarterly on the proper policy and procedure that should be used when following medication orders. Instruction will include proper administration of medication as policy states, proper documentation of medication as policy states, what constitutes a medication error, as well as how to properly document a medication error.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Beverly M. Edwards — TITLE: X Administrator — (X6) DATE: 5/31/12

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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	185268	A. BUILDING B. WING	C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229

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F 309	Continued From page 1 the facility admitted Resident #4 on 03/31/12 with a diagnosis of Breakthrough Seizures. The resident had an order written for Dilantin 300 mg twice a day. The order was modified on 04/23/12 at 5:30 PM to hold for twenty four hours. A new order was written on 04/26/12 to administer Dilantin 300 mg at bedtime. On 04/27/12 RN #1 held the Dilantin dose and did not indicate a reason why on the medication administration record. Interview with RN #1, on 05/10/12 at 10:12 AM, revealed she did not give the Dilantin on 04/27/12 because of confusion in the way the order had been written. When asked if she tried to clarify the Dilantin order she stated no, she was very busy that night and did not have a chance to go back and review the physician's order nor did she notify the physician of the omission. Interview with the Director of Nursing (DON), on 05/10/12 at 4:00 PM, revealed if a nurse sees an order that might be confusing, especially if it was a medication order, the expectation was to call the physician for clarification.	F 309	The DNS and/or Staff Development nurse will in-service/instruct staff monthly for six months, then quarterly on the proper policy and procedure that should be used when discontinuing a medication order. The DNS will develop a uniform standard of practice that details how to handle physician orders which call for temporary "holding" of medications by 6/1/2012. The DNS and/or Staff Development nurse will in-service/instruct staff monthly for six months, then quarterly on the proper policy and procedure that should be used when following a physician order to "HOLD" medications temporarily. The DNS and/or Staff Development nurse will in-service/instruct staff monthly for six months, then quarterly on the importance of contacting the physician for clarification anytime confusion or vagueness surround a medication order. It should be clear to each nurse that if at anytime a medication order is confusing or unclear the next step will always be to contact the physician for a clarification of the order. It should be clear to each nurse that once clarification is obtained a new order should be written given the clarified details obtained during the phone call/conversation with the physician. 4 The DON, Unit Manager, HIM Director will complete a random audit of 25% of resident physician orders to ensure that they are being followed as ordered bi weekly x 3 months and 100% of all physician orders monthly x 9 thereafter to ensure that all physician orders are followed as ordered. The results of the audits will be reported to QA for further review and recommendations. 5 All corrective measure will be completed by 6/22/2012.	

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