

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

PRINTED: 11/25/2013
FORM APPROVED
OMB NO. 0938-0391

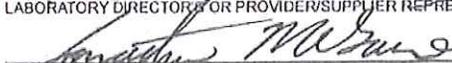


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2013
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NAME OF PROVIDER OR SUPPLIER GREENWOOD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY20926 was conducted on 11/06/13 through 11/08/13 to determine the facility's compliance with Federal requirements. KY20926 was substantiated with deficiencies cited.	F 000	Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy and procedure review it was determined the facility failed to ensure the services provided met professional standards of quality for one (1) of three (3) residents (Resident #1). The Licensed Nurse administered "Norco" (narcotic pain medication) after the physician had discontinued the medication. The findings include: Review of the facility's Medication Administration policy and procedure, (not dated), revealed any deviation from the following principles shall be considered a medication error: 1. To the right resident 2. Administration of the right medication 3. In the right dose 4. By the right route 5. By the right method 6. At the right time Record review revealed the facility admitted	F 281	Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding. Resident number one no longer resides at the facility.	

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/5/13
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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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F 281	<p>Continued From page 1</p> <p>Resident #1 on 09/10/13 with diagnosis which included Displacement Lumbar Intervertebral Disc with Myelopathy, Difficulty in Walking, Unspecified Backache, Unspecified Mononeuritis of Lower Limb, and Unspecified Neuralgia Neuritis and Radiculitis.</p> <p>Review of physician orders, dated 09/10/13-09/30/13 revealed staff should administer Hydrocodone 5 milligrams(mg.)Acetaminophen 325 mg. (Norco) every four (4) hours related to pain. However, review of a physician's order, dated 09/30/13 at 7:45 AM, revealed the physician discontinued the order for the Norco due to the resident exhibiting symptoms of delirium.</p> <p>Review of the October 2013 Medication Administration Record (MAR) revealed the order for Norco was marked through with a large "X".</p> <p>Review of Resident #1's Pain Management Log revealed the resident was administered Norco for pain on 10/01/13 on the 11:00 PM to 7:00 AM.</p> <p>Interview with Registered Nurse (RN) #1, on 11/07/13 at 8:25 PM, revealed she was assigned to work with Resident #1 on 10/01/13. The RN stated Resident #1 requested pain medication and she administered Norco to the resident. RN #1 revealed she went by the medication sheet that was in the narcotic book and doesn't recall looking at the MAR's. The RN stated she usually compares both the MAR, the narcotic book and the orders to see what is ordered but doesn't recall doing that on 10/01/13. She stated "she gave Norco twice that night and both times looked at the narcotic book" and doesn't recall looking at the MAR and was not aware the Norco</p>	F 281	<p>Resident that resident on the unit of the occurrence was reviewed on 10/1/13 by the unit manager to ensure that no other discontinued medications had been administered. All medication carts were inspected on 11/8/13 by unit manager and no other discontinued medications were found on the medication carts. Licensed nurses were in-service on 10/10/13 in a written in-service completed by the staff development coordinator (SDC) regarding the facility policy of medication administration and the five rights. The in-service also included a new expectation and procedure to remove discontinued medications from the medication cart.</p> <p>The removal of discontinued medications from the medication cart is now a written facility practice.</p> <p>Licensed nurses and certified medication administration aides (C.M.A.) will be in-serviced on 12/5/13 and 12/6/13 regarding the new facility practice by the staff development coordinator.</p> <p>The unit managers, QA nurse and / or DON will monitor for the proper discontinuation of medications to include the removal of discontinued medications from the medication carts weekly for four weeks, then bi-monthly for two times and then monthly for three months utilizing a QI tool. Upon identification of any potential concerns, the unit manager, QA nurse or DON will take follow up action as necessary.</p>		

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F 281	Continued From page 2 had been discontinued. Interview with the Director of Nursing (DON), on 11/07/13 at 5:15 PM, revealed when the facility checked the narcotic sheets they found where the night shift nurse (RN #1) had made a medication error and gave Resident #1 a medication that had been discontinued. The DON stated RN #1 failed to check the MAR and thought Resident #1 still had the medication because the medication was still in the drawer. Interview the Administrator and the DON, on 11/08/13 at 2:25 PM, revealed the facility implemented a new process for when medications were discontinued. Discontinued medications would be taken off of the medication cart to decrease potential for error. The Administrator and DON stated the facility implemented the facility's process to pull discontinued medications off the medication cart and the information was provided to staff in a newsletter dated 10/10/13. The staff were not inserviced nor were there any steps taken to ensure all licensed staff were aware of the new process. The Administrator and DON stated they would have prevented a medication error if this had been their practice. They revealed the policy to pull the medication from the medication cart was implemented but was not written.	F 281	The results of the audits will be forwarded to the Executive QA committee monthly for 3 months for review, identification of trends, for follow up action as deemed appropriate and to determine the need for an/or frequency of continued monitoring. Completion Date: - 12/11/13	12/11/13
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		

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F 333	<p>Continued From page 3</p> <p>by: Based on record review and staff interview it was determined the facility failed to ensure one (1) of three (3) residents (Resident #1) was free from a significant medication error. Resident #1 was administered Norco (narcotic pain medication) two times after the physician discontinued the medication due to the resident having symptoms of delirium.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 09/10/13 with diagnosis which included Displacement Lumbar Intervertebral Disc with Myelopathy, Difficulty in Walking, Unspecified Backache, Unspecified Mononeuritis of Lower Limb, and Unspecified Neuralgia Neuritis and Radiculitis.</p> <p>Review of physician orders, dated 09/10/13-09/30/13 revealed staff should administer Hydrocodone 5 milligrams(mg.)/Acetaminophen 325 mg. (Norco) every four (4) hours related to pain.</p> <p>Review of the physician notes, dated 09/30/13, revealed he was asked urgently by the nurses to assess Resident #1 due the the resident having a mental status change since around 5:00 AM. The resident had been writing on the bed, writing on the pillow and needed to be helped. The resident stated the staff was trying to hurt her/him and they were from the devil.</p> <p>Review of a physician's order, dated 09/30/13 at 7:45 AM, revealed the physician discontinued the order for the Norco due to the resident exhibiting symptoms of delirium.</p>	F 333	<p>Resident number one no longer resides at the facility.</p> <p>Resident that resident on the unit of the occurrence was reviewed on 10/1/13 by the unit manager to ensure that no other discontinued medications had been administered. All medication carts were inspected on 11/8/13 by unit manager and no other discontinued medications were found on the medication carts. Licensed nurses were in-service on 10/10/13 in a written in-service completed by the staff development coordinator (SDC) regarding the facility policy of medication administration and the five rights. The in-service also included a new expectation and procedure to remove discontinued medications from the medication cart.</p> <p>The removal of discontinued medications from the medication cart is now a written facility practice.</p> <p>Licensed nurses and certified medication administration aides (C.M.A.) will be in-serviced on 12/5/13 and 12/6/13 regarding the new facility practice by the staff development coordinator.</p>		

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F 333	<p>Continued From page 4</p> <p>Review of the October 2013 Medication Administration Record (MAR) revealed the order for Norco was marked through with a large "X"; however, review of Resident #1's Pain Management Log revealed the resident was administered Norco for pain two times on 10/01/13 on the 11:00 PM to 7:00 AM.</p> <p>Interview with Registered Nurse (RN) #1, on 11/07/13 at 8:25 PM, revealed she was assigned to work with Resident #1 on 10/01/13. The RN stated Resident #1 requested pain medication and she administered Norco to the resident. RN #1 revealed she went by the medication sheet that was in the narcotic book and doesn't recall looking at the MAR's. She stated "she gave Norco twice that night and both times looked at the narcotic book", doesn't recall looking at the MAR and was not aware the Norco had been discontinued.</p> <p>Interview with the Director of Nursing (DON), on 11/07/13 at 5:15 PM, revealed when the facility checked the narcotic sheets they found where the night shift nurse (RN #1) had made a medication error and gave Resident #1 a medication that had been discontinued. The DON stated RN #1 failed to check the MAR and thought Resident #1 still had the medication because the medication was still in the drawer.</p> <p>Interview the Administrator and the DON, on 11/08/13 at 2:25 PM, revealed the facility implemented a new process for when medications were discontinued. Discontinued medications would be taken off of the medication cart to decrease potential for error. The Administrator and DON stated the facility</p>	F 333	<p>The unit managers, QA nurse and / or DON will monitor for the proper discontinuation of medications to include the removal of discontinued medications from the medication carts weekly for four weeks, then bi-monthly for two times and then monthly for three months utilizing a QI tool. Upon identification of any potential concerns, the unit manager, QA nurse or DON will take follow up action as necessary.</p> <p>The results of the audits will be forwarded to the Executive QA committee monthly for 3 months for review, identification of trends, for follow up action as deemed appropriate and to determine the need for an/or frequency of continued monitoring.</p> <p>Completion Date: - 12/11/13</p>	12/11/13	

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F 333	Continued From page 5 implemented the facility's process to pull discontinued medications off the medication cart and the information was provided to staff in a newsletter dated 10/10/13. The staff were not inserviced nor were there any steps taken to ensure all licensed staff were aware of the new process. The Administrator and DON stated they would have prevented a medication error if this had been their practice. They revealed the policy to pull the medication from the medication cart was implemented but was not written.	F 333			