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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	185446		C 05/26/2012

JAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUEGRASS CARE & REHABILITATION CENTER	3576 PIMLICO PARKWAY LEXINGTON, KY 40517

(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 000	INITIAL COMMENTS	F 000	F 514	
	An Abbreviated Survey investigating KY#00018403 was initiated on 05/24/12 and concluded on 05/26/12. KY#00018403 was substantiated with deficiencies cited. The highest Scope and Severity (S/S) cited was a "D".		**Immediate Corrective Action For Residents Found To Be Affected**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	♦ A review of the medication for resident #1 revealed the resident was medicated per physician's orders. A medication record review revealed resident #1's medication administration record was not completed per policy.	
	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.			
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.		**Identification of Other Residents With The Potential to be Affected**	
	This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for one (1) of three (3) sampled residents (Resident #1). The facility failed to document on the Medication Administration Record (MAR) several doses of Oxycodone (pain medication) that was administered to Resident #1 during May 2012. Also the MAR did not reflect a dose of Levaquin		♦ An audit of 100% of the resident population's MAR (Medication Administration Record) and TAR (Treatment Administration Record) were completed from May 26 through May 31, 2012 by DON (Director of Nursing), ADON (Assistant Director of Nursing), SDC (Staff Development Coordinator), RNM (Restorative Nurse Manager), NNM (Night Nurse Manager) or MDSN (Minimum Data Set Nurse) with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/20/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 514	Continued From page 1 (an antibiotic used to treat infection), the resident received on 04/02/12 and one (1) dose of acetaminophen (pain medication), the resident received on 05/09/12. In addition, the facility failed to accurately document on the the May 2012 Treatment Administration Record (TAR), the treatment of facial application of Hydrocortisone 2.5% cream (steroid cream). The findings include: Review of the facility's policy titled, "Medication Administration-Administering Medications (Licensed Staff)", dated 12/2010, revealed in the procedural steps, after administration of the medication, to record the medication given on the medication record. Review of the medical record revealed the facility admitted Resident #1 on 10/11/11 with diagnoses which included Cerebral Palsy, Neurogenic Bladder, Paraplegia and Chronic Pain. Record review of the April 2012 MAR revealed no documented evidence the resident received a dose of Levaquin 500 mg at 4:00 PM on 04/02/12 for a urinary tract infection as ordered. The nurses notes did reflect "ATB [antibiotic] for UTI [urinary tract infection]" however, the facility policy for documentation on the medication record was not followed. Review of Resident #1's May MAR revealed incomplete documentation for the administration of oxycodone IR (pain medication) ten milligrams (10 mg), orally, every four (4) hours as needed and Acetaminophen (Tylenol) Five Hundred milligrams (500 mg) every four (4) hours as	F 514	resident(s) identified via a missing documentation. Those residents identified were assessed by the DON, ADON, SDC, RNM, NNM or MDSN with no negative outcomes identified. **Measures Taken To Assure There Will Not Be a Recurrence** Licensed staff will be educated by the SDC, DON, ADON, RNM, NNM or MDSN from May 25 through June 19, 2012, as well as during on-boarding for new staff beginning May 29, 2012 regarding the facility policy of medication and treatment administration and documentation of provision thereof. ♦ The licensed staff has the responsibility to monitor the medication and treatment administration records prior to the end of their scheduled shift and accurately document per the facility policy. Any missed medication or treatment documentation will be reviewed by the licensed nurse and	

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F 514	Continued From page 2 needed for pain. The Pain Flow Sheet revealed the resident received oxycodone on 05/02/12, 05/09/12 and 05/20/12, however, the MAR did not reflect the resident received the medication on those dates. Documentation on the Pain Flow Sheet, dated 05/09/12, also revealed the resident received acetaminophen which was not recorded on the MAR. Interview on 05/25/12 at 11:05 AM, with Registered Nurse (RN) #2, revealed the facility policy is to always document administration of medications on the MAR in addition to other locations as appropriate in the medical record. Interview with Licensed Practical Nurse (LPN) #3, on 05/26/12 at 3:50 PM, revealed she failed to document the administration of the medications on the MAR. She further stated although the medications are noted in the medical record as administered to Resident #1, she acknowledged it is the facility policy to document on the MAR. Record review of May's Treatment Administration Record (TAR) revealed no documented evidence the treatment related to facial application of Hydrocortisone 2.5% cream (steroid cream) was administered as ordered. Interview on 05/25/12 at 11:05 AM, with Registered Nurse (RN) #2, revealed she had completed the treatment as ordered when assigned to care for Resident #1, but did not know why she did not sign the TAR other than she had just overlooked the area for the required documentation. Interview with LPN #2, on 05/25/12 at 4:45 PM,	F 514	appropriate documentation will be completed prior to the end of the scheduled shift. ♦ The on-coming and the off-going shift licensed staff will review the medication and treatment administration records for completion. The on-coming shift licensed staff will not receive the medication cart until the documentation is complete for the off-going shift. **Monitoring Changes To Assure Continuing Compliance** ♦ The medical records director will perform medication and treatment administration record audits, five times per week, for completion of documentation of medication and treatments. Results of the audits will be forwarded to the DON/ADON for review and follow up as deemed appropriate relative to staff and resident outcomes. ♦ The DON/ADON will report the daily and weekly medication and	

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F 514	Continued From page 3 revealed she had applied the Hydrocortisone facial cream per Resident #1's orders. She further stated she just overlooked the designated location to chart the treatment on the TAR. Interview with LPN #3, on 05/26/12 at 3:50 PM, revealed the dates in May she was assigned to care for Resident #1 he did receive the treatment to his face. She further stated she just failed to document the treatment on the TAR. Further interview revealed when reviewing the TAR she failed notice she had not signed the TAR with the absence of signatures for all dates in May for that specific treatment.	F 514	treatment administration audits to the administrator monthly for follow up and review. ♦ Reports of the monthly audits will be presented to the quarterly Quality Assurance Committee. for review and follow up with the medical director until at such time consistent substantial compliance has been achieved as determined by the committee. **Date of Completion:**	06-29-12