

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

PRINTED: 12/09/2013
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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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
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F 000 INITIAL COMMENTS

A Standard and Abbreviated Survey Investigating KY#00020995 was initiated on 11/19/13 and concluded on 11/21/13. KY #00020995 was substantiated with deficiencies cited. The highest Scope and Severity was a "E".

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D 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 observation, interview, record review and review of facility policy, it was determined the facility failed to ensure Physician's Orders were followed for two (2) of twenty-four (24) sampled residents (Residents #3 and #9).

Resident #3 received an abnormal Thyroid Stimulating Hormone (TSH) laboratory result on 10/10/13, and the Physician was notified. Verbal Physician's Orders were obtained on 10/10/13, to increase the Levothyroxine medication (a thyroid medication) dose from 125 micrograms (mcg's) to 150 mcg's a day and recheck the Thyroid Stimulating Hormone (TSH) level in six (6) weeks. The Physician's Order was not transcribed to the Physician's Telephone Order Sheet; however, the order was transcribed to the October 2013 Medication Administration Record (MAR). Resident #3 received the incorrect dosage of medication (125 mcg) from 10/11/13 to 11/21/13, although staff were signing the October MAR, from 10/11/13 which indicated they were administering a 150 mcg dose. In addition, the

F 000 Maintenance director will add to monthly preventative maintenance audit to ensure no further sprinkler piping concerns.

F 281 Maintenance Director will educate all contractors on appropriate installation and placement of any wiring in the ceilings.

Results of the audits will be reviewed and submitted to the monthly QA committee meeting for review and revision until the QA Committee has determined compliance is achieved.

The Administrator and Maintenance Director will be responsible for overall compliance.

The physician order for Resident #3 was clarified and written. The resident received the ordered dosage of levothyroxine on 11-21-2013. Resident #9 received the scheduled clonazepam and hydrocodone/APAP as ordered on 11-20-2013.

12-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

CANDACE THOMPSON

Administrator

12/18/13

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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lab order to re-check the TSH level was not input into the computer system and there was no TSH level drawn after 10/10/13.

Resident #9 did not receive the scheduled Clonazepam as ordered for the AM and PM dose on 11/06/13 and the PM dose for 11/12/13. In addition, Resident #9 did not receive the scheduled Hydrocodone/Apap dose for the 11/05/13 PM dose, the 11/06/13 AM and PM dose, and the 11/12/13 PM dose.

The findings include:

Review of the facility's policy titled, "Physicians' Medication Orders", revised date 12/21/10, revealed verbal orders were to be recorded immediately in the resident's chart by the person receiving the order. Continued review of the policy revealed drug orders were to be recorded on the Physician's Order Sheet in the resident's chart.

Review of the facility's policy, "Administering Medications" revised date 12/21/10, revealed medications should be administered in a safe and timely manner, and as prescribed. The policy revealed medications were to be administered in accordance with the orders and the person administering the medication was to check the label three (3) times to verify the right medication, right dosage, right time and right method before giving the medication. Continued review of the policy revealed if a dosage was believed to be inappropriate for a resident the person administering the medication should contact the resident's Attending Physician or the facility's Medical Director to discuss the concern. In addition, the policy noted after administering the

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Review of current residents physician orders and review of documentation of medication administration was completed by administrative nurses on 11/30/2013.

Nurses #1, 2, and 3 were re-educated by the Director of Nursing (DON) on 11/21/13 regarding transcribing and following physician orders. A medication administration competency and observation was completed for Nurses #1 and #2 by the SDC on 11-26-2013 and 11-30-2013.

Current nurses and Certified Medication Technicians (CMTs) received re-education by the SDC on 12/6/13 regarding writing/transcribing physician orders, notifying pharmacy of new orders, following the 5 rights of medication administration, administering medications as ordered and documentation of medication administration.

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medication the person was to initial the resident's Medication Administration Record (MAR) on the appropriate line.

Review of the facility's "Medlab" ordering system documentation, undated, for ordering lab tests, revealed the procedure indicated staff would select "new scheduled order" if there was no "existing" order; then select the Physician ordering the lab test; enter the test to be performed and enter the frequency the test was to be performed.

1. Review of Resident #3's medical record revealed the facility admitted the resident on 02/27/12, with diagnoses which included Parkinson's Disease and Hypothyroidism. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/28/13, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Score (BIMS) of six (6) which indicted the resident was severely cognitively impaired.

Review of Resident #3's monthly Physician orders for October and November 2013 revealed the resident was ordered Levothyroxine 125 micrograms (mcg), a thyroid medicine, daily.

Review of the October 2013 Medication Administration Record (MAR) revealed Resident #3 indicated Resident #3 received 125 mcg daily from 10/01/13 through 10/10/13; however, the MAR noted the Levothyroxine 125 mcg daily order was discontinued on 10/10/13. Continued review of the October MAR revealed the Levothyroxine dose had been changed to 150 mcg beginning on 10/11/13. Further review revealed medication administration staff had

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The SDC/designee will complete medication administration observations 3 x week x 1 week, 2x week x1 week, weekly x 2 weeks then monthly.

The QA nurse will complete audit of medications sign out sheets 3 times weekly for 1 week, 2 times weekly for 1 week, weekly for 1 week, then monthly.

The Unit Managers will review new physician orders to check for possible transcription errors 3 times weekly for 1 week, twice weekly for 1 week, weekly for 2 weeks, then monthly.

Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.

The Director of Nursing is responsible for overall compliance.

12-13-13

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signed off the new 150 mcg daily dose as given from 10/11/13 through 10/31/13.

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Review of the November 2013 MAR revealed Levothyroxine 150 mcg had been hand written on it; however, the 150 mcg had been lined through and 125 mcg written above it. Continued review of the November MAR revealed medication administration staff had initialed off the resident as receiving Levothyroxine 125 mcg daily, even though the October 2013 MAR had indicated the order had changed on 10/10/13 to 150 mcg.

Continued review of Resident #3's medical record revealed a lab report for a Thyroid-Stimulating Hormone (TSH) lab (a blood test used to detect problems affecting the thyroid gland) done 10/10/13 with an abnormal result of 8.700 (normal range 0.340 - 5.600 International Units per milliliters). Further review of the lab revealed the Physician noted a request for a dosage change to increase the Levothyroxine to 150 mcg and to repeat the TSH lab in six (6) weeks. However, review of the October 2013 Physician Verbal Order slips revealed no documented evidence of a verbal order written for the dosage change or for the repeat lab in six (6) weeks. Further review of the record revealed no documented evidence a TSH lab was performed as requested by the Physician after the abnormal results of the 10/10/13 lab.

Observation of Resident #3's Thyroid medications, on 11/20/13 at 4:03 PM, revealed Levothyroxine 125 mcg present; however, there was no evidence of Levothyroxine 150 mcg present in the patient's medications.

Interview, on 11/20/13 at 4:09 PM, with the

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PharMerica's Order Entry Technician revealed the current order for Resident #3's Levothyroxine was 125 mcg which had been ordered in August 2013 and last re-filled on 11/02/13. Continued interview with the technician revealed the pharmacy had received no order to increase Resident #3's Levothyroxine to 150 mcg in October.

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Interview, on 11/21/13 at 4:35 PM, with Licensed Practical Nurse (LPN) #3/House Supervisor revealed the TSH level was reported on 10/10/13 and she called the on-call Physician in regards to the lab. She stated the Physician gave a verbal order to change the Levothyroxine dose from 125 mcg to 150 mcg and wanted the TSH lab repeated in 6 weeks. The LPN stated the facility process, for taking verbal orders, was to write the order on the verbal order slip in the resident's record, then fax the order to the pharmacy. She indicated the order slip was then put in the Physician book for the Physician's signature. Additionally, LPN #3 stated the verbal order was transcribed onto the Medication Administration Record when appropriate. She stated she did not follow the verbal order process after calling the Physician with Resident #3's lab result on 10/10/13. LPN #3 stated therefore, the order was not written; the Pharmacy never received a copy of the order to change the dose; and the Physician's request for the repeat lab was not put into the system. She stated the Levothyroxine dose change from 125 mcg to 150 mcg was transcribed onto Resident #3's MAR. LPN #3 stated the dose change was transcribed to the MAR by the medication administration nurse after LPN #3 informed her of the change. The LPN further stated when nurses had administered the Levothyroxine dose, they should have looked at

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the medication to ensure the dose was correct.

Interview with LPN #4/Unit Coordinator Combs Unit on 11/20/13 at 2:44 PM, revealed staff had failed to write the verbal order given by the Physician after notification of the 10/10/13 TSH lab result for the dose increase and repeat lab. She stated the failure of staff to write the verbal order resulted in pharmacy not receiving a copy to change the Levothyroxine dose; and, the follow-up lab was not put into the system and performed as per Physician order. She indicated this placed Resident #3 at risk for possible further abnormal TSH level which could imply a Hypothyroid level and result in symptoms of Hypothyroidism. She stated however, no one had informed her the resident was having symptoms of this condition. Further interview with LPN #4 revealed the Levothyroxine dosage change to 150 mcg was transcribed onto the October MAR, starting October 11th. However, she stated pharmacy had not received an order to make the change and Resident #3's medication dose did not change. She stated the process for giving a medication was to check and ensure the right dose was administered. LPN #4 stated staff had not followed this process because staff signed off on the MAR the resident was getting Levothyroxine 150 mcg. She stated because pharmacy had not received the order, Resident #3 had just gotten Levothyroxine 125 mcg. She stated the reason for the November MAR having Levothyroxine 125 mcg transcribed was because there was never a verbal order written to change the dose to 150 mcg.

Interview, on 11/21/13 at 3:35 PM, with the Physician Assistant (PA) revealed when she gave an order she expected the facility to perform the

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F 281	<p>Continued From page 6</p> <p>order. She stated she gave the order to change the Levothyroxine dose based on the abnormal lab result. According to the PA, she reviewed lab slips and if the nurse wrote the verbal order on the lab slip she would not check to see if the actual order had been written. She stated she would expect facility staff to follow the orders given.</p> <p>Interview, on 11/21/13 at 4:55 PM, with the Director of Nursing (DON) revealed when a lab result was received staff notified the Physician and if indicated received orders. The DON stated the facility process was for nurses to write the verbal order on the telephone order sheet which was a three (3) part copy form. She stated the original copy of the telephone order sheet was faxed to the pharmacy and then put in the Physician book for signature. The DON stated the lab result was also placed in the Physician book. She stated the nurse, who took a lab order, was responsible for entering the lab request into the lab ordering system which went directly to the lab. She further stated the nurse making a verbal order was responsible for transcribing the order to the MAR. The DON stated in this situation the verbal order was received; however, the facility process was not followed and the verbal order was not transcribed to the telephone order sheet. According to the DON, therefore pharmacy did not get a copy of the verbal order to change the Levothyroxine dose to 150 mcg; and, there was no order for the Physician to sign. She indicated the dosage change had been put on the October MAR. In addition, the DON stated the verbal order to re-check the TSH level in six (6) weeks had not been put into the lab ordering system and as a result no re-check of the TSH was completed in</p>	F 281		
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six (6) weeks as per the Physician's request. She further stated they had a system to look at new Physician orders in the facility morning meeting; but not labs. The DON stated in this case no verbal order was ever written so it could not have been checked in morning meeting.

Continued interview, on 11/21/13 at 4:55 PM, with the DON revealed staff did not follow the medication process before administering the Levothyroxine medication in October. She stated they should have compared the dose being given to the order on the MAR. She further stated with the monthly MAR change over the nurse compared the new MAR to the orders written so, the November MAR reflected the current order of Levothyroxine 125 mcg.

2. Review of Resident #9's medical record revealed diagnoses which included Alzheimer's Disease, Parkinson's Disease, Manic Depression, Psychotic Disorder, and Osteoarthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/12/13, revealed the facility assessed the resident as having both short and long term memory loss.

Review of the Physician's Orders dated 11/30/13 revealed orders for clonazepam (an anti-anxiety medication) 0.5 milligrams (mg's) two (2) times daily for a diagnosis of Psychosis. Further review of the Physician's Orders additionally revealed orders for Hydrocodone-APAP (a pain medication) 5-325 mg two (2) times daily for Osteoarthritis.

Review of the Medication Administration Record (MARS) dated 11/01/13 through 11/30/13, revealed the medications were signed out as administered

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two (2) times a day. However, review of the Controlled Drug Record, revealed the Clonazepam 0.5 mg was not signed out for the 11/6/13 AM and PM dose or for the 11/12/13 PM dose. In addition, further review of the Controlled Drug Record, revealed the Hydrocodone APAP 5-325 mg was not signed out for the 11/05/13 PM dose, the 11/06/13 AM and PM dose or the 11/12/13 PM dose.

Interview with the Director of Nursing (DON) on 11/21/13 at 1:45 PM revealed Registered Nurse (RN) #9 was assigned to the resident on 11/5, 11/6 and 11/12 for the evening shift. She further stated Licensed Practical Nurse (LPN) #5 was assigned to the resident for the day shift on 11/6/13. Continued interview revealed her expectation was that narcotic medication would be administered as ordered. She stated however, no one "typically" checked the MARS against the Controlled Drug Record to ensure the narcotics were being administered as ordered.

Interview on 11/21/13 at 2:30 PM with RN #9, revealed her procedure for administration of narcotic medications was to unlock the narcotic drawer, check the narcotic label against the MAR, and then sign out the medication on the Controlled Drug Record and the MAR. She stated she could have inadvertently missed administering the Hydrocodone Apap on 11/5 and 11/6 for the PM doses and also the 11/12 PM dose and also the Clonazepam for the 11/6 and 11/12 PM dose. She indicated the medications should have been administered as ordered.

Phone interview on 11/21/13 at 5:00 PM with LPN #5 revealed if the Narcotic Count was correct at the end of her shift on 11/6/13, she must not have

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right dosage, right time, and right method before giving the medication. Continued policy review revealed if a dosage is believed to be inappropriate for a resident the person administering the medication should contact the resident's Attending Physician or the facility's Medical Director to discuss the concern.

Review of Resident #3's medical record revealed the facility admitted the resident on 02/27/12, with diagnoses which included Parkinson's Disease, Diabetes Type II, Debility, and Hypothyroidism. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/28/13, revealed the facility assessed the resident as severely cognitively impaired.

Review of Resident #3's monthly Physician orders for October and November 2013 revealed the resident was ordered Levothyroxine, a thyroid medication, 125 micrograms (mcg) daily. Review of the October 2013 Medication Administration Record (MAR) revealed the resident was receiving Levothyroxine 125 mcg as per the monthly order from 10/01 - 10/13. Continued review of the October 2013 MAR revealed the Levothyroxine 125 mcg was discontinued on 10/10/13 and the dose changed to 150 mcg beginning 10/11/13. Further review revealed the Levothyroxine 150 mcg dose was signed as being administered by medication administration staff from 10/11/13 through 10/31/13. Review of the November 2013 MAR revealed Levothyroxine 150 mcg had been hand written on it; however, the 150 mcg had been lined through and 125 mcg written above it. Continued review of the November MAR revealed medication administration staff had initialed off the resident as receiving Levothyroxine 125 mcg

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Current nurses and Certified Medication Technicians (CMTs) were re-educated by the SDC on 12/6/13 regarding writing and transcribing physician orders, notifying pharmacy of order changes, following the 5 rights of medication administration, administration of medication as ordered and documentation of medication administration.

The SDC/Designee will complete medication administration observations 3 times weekly for 1 week, 2 times weekly x 1 week, weekly for 2 weeks, and then monthly.

The QA Nurse will complete audits of Medication Administration Records (MARs) to identify compliance with MD orders 3 times weekly for 1 week, 2 times weekly for 1 week weekly for 2 weeks and then monthly.

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F 333	<p>Continued From page 11</p> <p>daily, even though the October 2013 MAR had indicated the order had changed on 10/10/13 to 150 mcg.</p> <p>Continued review of Resident #3's medical record revealed a Thyroid-Stimulating Hormone (TSH) lab, a blood test used to detect problems affecting the thyroid gland, done 10/10/13 with an abnormal result and a Physician requested dosage change for Resident #3's Levothyroxine from 125 mcg to 150 mcg. Review of the October 2013 Physician Verbal Order slips revealed no documented evidence of an order written for the dosage change.</p> <p>Observation of Resident #3's Thyroid medications, on 11/20/13 at 4:03 PM, revealed Levothyroxine 125 mcg; however, there was no evidence of Levothyroxine 150 mcg present.</p> <p>Interview, on 11/20/13 at 4:09 PM, with the Pharmacy's Order Entry Technician revealed the current order the pharmacy had for Resident #3 was Levothyroxine 125 mcg; which had been ordered in August 2013 and last re-filled on 11/02/13. Continued interview with the Technician revealed the pharmacy had not received an order to increase the Levothyroxine to 150 mcg in October.</p> <p>Interview, on 11/21/13 at 4:35 PM, with Licensed Practical Nurse (LPN) #3/House Supervisor revealed the TSH lab was received on 10/10/13, and the Physician gave a verbal order to change the dose to Levothyroxine 150 mcg. She stated the verbal order was not written therefore, the Pharmacy never received a copy of an order to change the dose to Levothyroxine 150 mcg. She</p>	F 333	<p>Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.</p> <p>The Director of Nursing is responsible for overall compliance.</p>	12-13-13	

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F 333 Continued From page 12

stated she informed the medication administration nurse to change the dose to Levothyroxine 150 mcg and the medication administration nurse transcribed the dose change onto Resident #3's October MAR. The LPN further stated when nurses administered the Levothyroxine dose, they should have looked at the medication to ensure the dose was correct.

Interview with LPN #4/Unit Coordinator Combs Unif, on 11/20/13 at 2:44 PM and on 11/21/13 at 2:53 PM, revealed the Levothyroxine dosage change to 150 mcg was transcribed onto the October MAR, starting October 11th. She stated pharmacy had not received a copy of an order to change the Levothyroxine dose to 150 mcg; therefore Levothyroxine 125 mcg continued to be sent and Resident #3 continued getting that dose. The LPN stated when an order to discontinue a medication was received, the medication was supposed to be pulled out of the medication cart supply. The LPN further stated it was a significant concern when this didn't happen and a resident received the wrong dose. She indicated the aspiration was for residents to receive the right medication and Physician orders to be followed. In addition, she stated Resident #3 had a TSH drawn on 11/21/13 and was still at a Hypothyroid TSH level (7.150) and this could have been the result of the dose not having been changed.

Interview, on 11/21/13 at 3:35 PM, with the Physician Assistant (PA) revealed when she gave an order she expected the facility to perform the order.

Interview, on 11/21/13 at 4:55 PM, with the Director of Nursing (DON) revealed a verbal order

F 333

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F 333	Continued From page 13 was received on 10/10/13, but not transcribed to the telephone order sheet. She stated therefore the pharmacy did not get a copy of an order to change the Levothyroxine dose to 150 mcg. According to the DON, this resulted in no verbal order form for the Physician to sign. She stated the dosage change for Levothyroxine 150 mcg was placed on the October MAR by the nurse administering the medication on 10/10/13. The DON revealed staff had not followed the facility's medication administration process prior to giving the Levothyroxine medication in October. The DON stated medication administration personnel should have compared the dose being given to the order written on the October MAR.	F 333		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 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 ensure the Pharmacist reported any irregularities from the monthly drug regimen review to the Physician and the Director of Nursing (DON) to ensure it was acted upon for	F 428	The pharmacist has reviewed the medication regimen for Resident #4. Recommendations were provided to the physician and Director of Nursing. The resident's thyroid stimulating hormone (TSH) was tested by lab on 11/22/02013 and an order was obtained for annual TSH testing. An audit of current resident's charts was completed by administrative nurses on 11/30/13 to identify medications requiring therapeutic drug monitoring. The Pharmacist was notified for any recommendations and the physician was notified of any irregularities with new physician orders implemented as needed.	

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F 428	<p>Continued From page 14</p> <p>one (1) of twenty-four (24) residents. Resident #4 was noted to be on Levothyroxine (Thyroid medicine) 100 mcg (micrograms) daily, however did not have a standing order for a TSH (Thyroid Stimulating Hormone) lab to monitor the resident's response to the treatment. The pharmacist failed to inform the Physician that Resident #4 had not had a TSH lab performed since 01/18/12.</p> <p>The findings include:</p> <p>Review of the facility's policy title, "Consultant Pharmacist Services Provider Requirements", dated October 2007, revealed the consultant Pharmacist, or designee, provided pharmaceutical care services, including the communication to the responsible Physician and the Director of Nursing (DON) of other findings related to medication therapy orders at least monthly. The policy stated this communication included recommendations for the monitoring of medication therapy.</p> <p>Review of Resident #4's medical record revealed the resident was admitted by the facility on 06/30/11 with diagnoses which included Alzheimer's, Seizure Disorder and Hypothyroidism. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/24/13, revealed the facility assessed the resident as severely cognitively impaired.</p> <p>Review of the monthly Physician Orders revealed the resident had an order dated 06/30/11, for Levothyroxine 100 mcg daily. Review of Resident #4's lab reports revealed the last TSH lab completed to monitor Resident #4's response to the Levothyroxine medication was dated</p>	F 428	<p>Pharmacy completed a monthly review of all current resident charts 12/11/2013 with recommendations for labs if indicated to the physician.</p> <p>The Director of Nursing re-educated the consultant pharmacist on 11/22/13 regarding F428 and expectations regarding therapeutic drug monitoring or any other medication irregularities.</p> <p>Nurses were re-educated by the SDC on (insert date) regarding requesting lab orders for those medications requiring therapeutic drug monitoring when new orders are received. The contract pharmacist will continue monthly chart reviews with recommendations per regulatory guidelines. Recommendations will be communicated to the Director of Nursing and physician with the physician deciding on whether further orders are to be implemented.</p>	

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F 428	Continued From page 15 11/18/12. Review of Resident #4's PharMerica Medication Regimen review, completed by the Pharmacist, revealed on the 08/17/12 review the Pharmacist had noted the resident's TSH as 0.5 IU/ml (International Units per milliliters), although no TSH lab had been performed that month. Further review of this Medication Regimen review revealed no recommendation by the Pharmacist to the Physician to have the TSH lab repeated. Interview, on 11/21/13 at 2:30 PM, with Licensed Practical Nurse (LPN) #1/Unit Coordinator revealed Resident #4 last TSH level was obtained 01/28/12 and was within normal limits. LPN #1 stated the Physician determined if a lab was to be performed routinely. She indicated at times the Pharmacist would recommend a lab needed to be done. She stated there were no Physician orders or recommendation from the Pharmacist to have the TSH lab obtained since the 01/28/12 lab. Interview, on 11/21/13 at 3:35 PM, with the Physician Assistant (PA) revealed when a resident was on Levothyroxine she did not always order standing (routine) orders to have the TSH drawn, it depended on the "clinical scenario" of the resident. The PA stated the routine time interval between checking the TSH level was six (6) to twelve (12) months since the last level was drawn. She stated the pharmacy also monitored for therapeutic levels and recommended when labs were to be drawn. The PA stated she thought pharmacy would have alerted her the TSH lab was needed when a resident was on Levothyroxine. Interview, on 11/21/13 at 12:35 PM and at 3:22	F 428	Pharmacy will provide a list of residents receiving medications that require therapeutic drug monitoring monthly. The QA nurse will cross reference monthly to order lab monitoring to ensure diagnostic orders in place. Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee. The Director of Nursing is responsible for overall compliance.	12-18-13	

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F 428	Continued From page 16 PM, with the Consultant Pharmacist revealed part of his pharmacological drug regimen review was to look to see if a therapeutic level was ordered when appropriate for the medication. He indicated he would check to see if the therapeutic level was within normal limits and if not see if the medication dose was changed and a re-check lab ordered. He stated when a resident was on Levothyroxine some Physicians did not always order a therapeutic level check and if one had not been done in six (6) months he would ask for one to be obtained. The Pharmacist stated he should have made the recommendation to check the TSH level as Resident #4's last TSH lab was 01/18/12. Interview, on 11/21/13 at 4:55 PM, with the DON revealed the facility did not have a process in place to ensure therapeutic levels for medications were checked. The DON stated they could only do what the MD ordered. She stated if medication related lab levels were needed pharmacy evaluated to see that levels were completed.	F 428			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	Combs and Amelia medication cart inspected with all medications separated per regulatory guidelines 11/22/2013. The identified medications and treatments were removed from the cart on 11/19/2013 and replaced with a new tube with a pharmacy label. The crash cart on Combs Unit was inspected and all supplies within usage dates 11/22/2013 by the QA nurse.		

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F 431	<p>Continued From page 17</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions.</p> <p>Observation of the medication cart on the Combs Unit and Amelia Unit revealed medication which was to be administered by different routes stored together in the same drawer and compartment. In addition, the treatment cart on the Combs unit contained a tube of Santyl (a debriding agent)</p>	F 431	<p>All medication and treatment carts were inspected on 11/22/13 by unit managers with separation of biologicals/drugs and removal of any multi-dose vials which did not reflect the date opened.</p> <p>All crash carts were inspected on 11/22/2013 by the QA nurse.</p>	

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F 431	<p>Continued From page 18</p> <p>Ointment with no pharmacy label; the medication refrigerator on the Combs Unit revealed a vial of Tuberculin Purified Protein Derivative (PPD) which had been opened with no opened date; and, the Crash Cart on the Combs Unit revealed two (2) bottles of expired Normal Saline.</p> <p>The findings include:</p> <p>Review of the facility "Storage of Medications" policy, revised 12/21/10, revealed drug containers with missing, incomplete, improper, or incorrect labels should be returned to pharmacy for proper labeling before storage. Further review revealed the facility was not to use discontinued, outdated, or deteriorated drugs or biologicals; and, drugs for external use were to be stored separately from other medications.</p> <p>1. Observation on the Combs Unit, on 11/19/13, at 12:40 PM, revealed the following:</p> <p>Treatment Cart 1, had a tube of Santyl Ointment with no evidence of a pharmacy label and no resident name or open date on it.</p> <p>Medication Cart 1 had a drawer containing promethazine (an anti-emetic medication) twenty-five (25) milligram's (mg's) vials for injection stored in the drawer with a pair of glasses, Jolly Rancher Candy, and a Milky Way Candy Bar. Another drawer had a bottle of Travaton 0.004% eye drops which had been opened with no open date noted. There was also a bag of Ipratropium/Albuterol Inhalation Solution vials in the same drawer and compartment with a bottle of Dairy Relief 3000 Unit caplets, and four (4) boxes of Tylenol 500 mg tablets.</p>	F 431	<p>On 12/5/13 the SDC re-educated nurses and Certified Medication Technicians (CMTs) regarding maintaining medication and treatment carts (including crash carts) and medication refrigerators to separate biologicals/drugs and labelling of biologicals/drugs. This re-education also monitoring for expiration dates of biologicals/drugs.</p> <p>Medication Carts/ Rooms will be audited 3 times weekly for 2 weeks, 2 times weekly for 2 weeks, weekly for 4 weeks and then monthly by Administrative nurses.</p> <p>Crash Cart contents will be audited monthly by the QA nurse for expiring products.</p>	

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F 431	<p>Continued From page 19</p> <p>In addition, the medication refrigerator in the Combs Medication Room contained a vial of Tuberculin Purified Protein Derivative (PPD) which was open with no opened date.</p> <p>Observation of the Crash Cart on the Combs Unit on 11/19/13 at 2:10 PM revealed two (2) Normal Saline 100 milliliter bottles which had an expiration date of 06/13.</p> <p>2. Observation on the Anielia Unit on 11/19/13 at 2:45 PM revealed Medication Cart 1 had a drawer which contained three (3) bottles of Polyethylene Glycol (a medication used to treat constipation) in the same compartment with two (2) Fleets Enemas and a box of Albuterol Inhalation Solution.</p> <p>Interview, on 11/21/13 at 1:45 PM, with the Director of Nursing (DON) revealed drugs were to be stored in a different drawer or with a divider depending on the type of administration of the drug. She further stated TB PPD vials should be dated when opened as should eye drops. Continued interview revealed nursing checked the crash cart lock daily; however, would not look for expired medications in the cart.</p> <p>Interview on 11/21/13 at 5:00 PM with the Consulting Pharmacist, revealed the pharmacy checked the medication carts every month and checked for expired medications, but they did not check the crash carts. He further stated there should be a divider between each route of medication.</p>	F 431	<p>Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.</p> <p>The Director of Nursing is responsible for overall compliance.</p> <p>Resident #3 and 2 un-sampled residents have had no adverse effects noted.</p> <p>All blood glucose machines have been disinfected prior to use 11/21/2013 by charge nurses.</p>	12-13-13	
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 20</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>Residents who receive blood glucose monitoring were monitored by administrative nurses on 11/21/2013 to ensure disinfection of the glucose monitoring meters.</p> <p>Re-education was provided on 11/21/13 by SDC/IC to Nurses #1 and 2 regarding glucometer disinfection.</p> <p>The manufacturer guidellines for the glucometer were reviewed with education of nurses and Certified Medication Technicians (CMTs) on 11/21/2013 by SDC/IC nurse.</p> <p>Re-education was provided on 11/22/13 by the SDC regarding disinfection and infection control standards.</p>	

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F 441	<p>Continued From page 21</p> <p>Based on observation, interview, review of Centers for Disease Control (CDC) and Prevention guidelines and the facility's policy and procedure, it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection for one (1) sampled resident (Resident #3) of twenty-four (24) sampled residents and two (2) unsampled residents (Unsampled Resident #B and C). The facility failed to ensure staff properly disinfected shared blood glucose monitors after each use. In addition, the facility failed to have a specific policy related to blood glucose monitor cleaning.</p> <p>On 11/20/13, observations revealed facility staff failed to disinfect the blood glucose monitor according to CDC guidelines between testing the blood sugar levels of Resident #3 and Unsampled Resident B on the Combs Unit, and after testing the blood sugar level of Unsampled C on the Breckinridge Unit.</p> <p>The findings include:</p> <p>Review of the Centers for Disease Control and Prevention guidelines revealed if blood glucose meters were shared, the device should be cleaned and disinfected after each use.</p> <p>Review of the facility policy titled, "Decontaminating and Labeling Equipment", revised 06/07/11, revealed reusable resident care equipment, instruments or devices were to be maintained and decontaminated according to manufacturer's instructions to prevent resident to resident transmission of infections. Interview with the Director of Nursing (DON) on 11/21/13 at 8:20</p>	F 441	<p>Audits will be completed by the Infection Control Nurse/Designee twice weekly for 2 weeks, weekly for 2 weeks and then monthly to monitor adherence to infection control standards and disinfection of blood glucose machines.</p> <p>Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.</p> <p>The Director of Nursing is responsible for overall compliance.</p>	12-18-13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515		
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F 441	<p>Continued From page 22</p> <p>AM revealed the facility had no specific policy related to cleaning blood glucose monitors.</p> <p>Review of the blood glucose monitor manufacturer's instructions revealed to clean the monitor's exterior it was to be wiped with a cloth moistened with tap water or a mild cleaning agent, then dried with a soft and dry cloth. Interview with the Director of Nursing (DON) on 11/21/13 at 8:20 AM revealed the manufacturer's instructions were for a home based kit; however, the facility used the CDC guidelines.</p> <p>1. Observation, on 11/20/13 at 4:00 PM on the Combs Unit, revealed Registered Nurse (RN) #8 entered Resident #3's room with a blood glucose monitor, alcohol preps, lancets, and test strips. RN #8 was observed to test Resident #3's blood sugar. Continued observation revealed after she completed the blood sugar testing, she did not clean or disinfect the blood glucose monitor; and, entered Unsampled Resident B's room with it. Observation revealed RN #8 placed the blood glucose monitor on the resident's bedside table and proceeded to insert a test strip into the monitor. However, RN #8 did not proceed with testing the resident's blood sugar due to surveyor intervention.</p> <p>Interview with RN #8 on 11/20/13 at 4:07 PM, revealed she had forgotten to clean the blood glucose monitor. She indicated the blood glucose monitor should be cleaned after each use. She stated she sometimes used alcohol pads to clean the machine; however, had an inservice related to the need to use Sanicloth (disinfectant) Wipes to clean the machine after each use. She indicated she checked the medication cart and could not find the Sanicloth Wipes on the cart.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515		
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F 441	Continued From page 23 2. Observation on 11/20/13 at 4:20 PM, of RN# 4 revealed she did not disinfect the blood glucose monitor after obtaining an blood glucose for Unsampled Resident C. Further observation revealed she placed the blood glucose monitor in the top drawer of the medication cart on the Breckinridge unit without cleaning or disinfecting the monitor. Interview, on 11/20/13 at 4:20 PM, with RN # 4 revealed third shift disinfected all the blood glucose monitors. She indicated she was not knowledgeable of a policy for disinfecting the blood glucose monitor. She stated if another resident on Unsampled Resident C's hall had required use of the blood glucose monitor there would have been an infection control issue as she had not cleaned or disinfected the monitor. RN #4 stated she should have disinfected the blood glucose monitor prior to placing it in the top drawer of the medication cart. Interview, on 11/21/13 at 2:50 PM, with the Unit Coordinator revealed RN #4 staff should have disinfected the blood glucose monitor with Sanicloth Wipes prior to placing the monitor in the medication cart. The Unit Coordinator indicated this was an infection control issue. The Unit Coordinator stated all staff had been educated during orientation and had obtained "hands-on" training on the floor on disinfecting the blood glucose monitor. Further interview, on 11/21/13, at 1:45 PM, with the DON revealed the blood glucose monitors were to be cleaned after each use with the Sanicloth Wipes. She stated the inservice related to cleaning the blood glucose monitors was done	F 441			

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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F 441	Continued From page 24 on hire. The DON stated there was also "on-the-spot" check-offs and annual check-offs to ensure staff were cleaning and disinfecting the blood glucose monitors correctly. She stated the training was performed by the Staff Development Nurse/Infection Control Nurse who observed medication pass. Interview, on 11/21/13 at 4:30 PM, with the Staff Development/Infection Control Nurse revealed she did training on blood glucose monitor cleaning in orientation and as a refresher if an issue came up. She stated, with the annual competency check-off she followed the nurses on the medication cart to observe medication pass; and, to observe the blood glucose monitor was cleaned and disinfected after each use with the Sanicloth Wipes. She stated she was unaware of any concerns related to the cleaning of the blood glucose monitors.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's lab ordering procedures, it was determined the facility failed to ensure laboratory services were provided in a timely manner to meet the needs of its residents for one (1) of twenty-four (24) sampled residents (Resident #3). Resident #3 had an abnormal TSH result on 10/10/13 and the physician requested a follow-up	F 502	Resident #3 had a TSH level checked by lab on 11/21/2013. The order to monitor TSH was clarified and written on 11/20/2013 by Unit Manager	

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NAME OF PROVIDER OR SUPPLIER NORTHPOINT/LEXINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 TRENT BOULEVARD LEXINGTON, KY 40515
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F 502 Continued From page 25
lab in six (6) weeks; however, the facility failed to ensure the follow-up lab was placed in the system for lab requests.

The findings include:

Review of the facility's "Medlab" ordering system documentation, undated, for ordering lab tests, revealed the procedure indicated staff would select "new scheduled order" if there was no "existing" order; then select the Physician ordering the lab test; enter the test to be performed and enter the frequency the test was to be performed.

Review of Resident #3's medical record revealed the facility admitted the resident on 02/27/12, with diagnoses which included Parkinson's Disease and Hypothyroidism. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/28/13, revealed the facility assessed the resident as being severely cognitively impaired.

Review of Resident #3's lab reports revealed a Thyroid-Stimulating Hormone (TSH) lab, a blood test used to detect problems affecting the thyroid gland, performed on 10/10/13. Continued review of this lab report revealed Resident #3 had an abnormal result of 8.700 IU/mL (International Units per milliliter) as the normal range was 0.340 to 5.600 IU/mL. Further review of the lab revealed a note indicating the Physician had requested the TSH lab be repeated in six (6) weeks. However, further review of Resident #3's lab reports revealed no documented evidence another TSH lab had been performed as per Physician request.

Interview, on 11/21/13 at 4:35 PM, with Licensed

F 502

Current residents had their orders reviewed by administrative nurses on 11/30/2013 to check that ordered labs had been completed.

Nurses were re-educated on 12/6/13 by the SDC regarding the procedure for ordering lab tests.

Unit Managers will audit lab orders have been implemented and receipt of lab results 5 times weekly for 2 weeks, 3 times weekly for 1 week, twice weekly for 1 week and then monthly.

Audit results will be reviewed monthly in the QA&A meeting with revision to the plan as deemed by the QA&A Committee.

The Director of Nursing is responsible for overall compliance.

12-13-13

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F 502	<p>Continued From page 26</p> <p>Practical Nurse (LPN) #3/House Supervisor revealed the TSH lab report was received on 10/10/13, and she called the on-call Physician regarding the lab results. She stated the Physician gave a verbal order to change Resident #3's dose of Levothyroxine from 125 mcg to 150 mcg and ordered the TSH lab to be repeated in six (6) weeks. She stated the facility process was for the person taking the lab order from the Physician to place the lab in the lab ordering system. LPN #3 stated she had not followed the facility process and placed the lab request into the lab ordering system.</p> <p>Interview with LPN #4/Unit Coordinator Combs Unit on 11/20/13 at 2:44 PM, revealed LPN #3 had failed to write the lab order requested by the Physician on 10/10/13. She stated as the order to repeat the lab had not been written, it was not placed in the lab ordering system and, therefore no lab would have been completed as ordered. The LPN stated new orders were reviewed at the facility's "morning meeting" and lab request slips were reviewed. She stated in this case as no order had been written, staff in the "morning meeting" would not have known requested lab work had not been completed as ordered. She stated the risk for Resident #3 not having the ordered TSH lab completed was the TSH level could still indicate a Hypothyroid level.</p> <p>Interview, on 11/21/13 at 4:55 PM, with the Director of Nursing (DON) revealed when a lab result was received staff notified the Physician and if indicated obtained orders. The DON stated the nurse who took a lab order was responsible for ensuring it was entered into the lab request system which was a direct system to the lab. She stated as no order had been written, there was no</p>	F 502		

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F 502	Continued From page 27 documentation in the system to perform the re-check of the TSH level. She further stated they had a system to look at new orders at the "morning meeting"; however, not labs. She indicated the order should have been written and the TSH lab obtained as ordered by the Physician.	F 502		