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

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185201	A. BUILDING _____ B. WING _____	C 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANBARK HEALTH CARE CENTER	1121 TANBARK ROAD LEXINGTON, KY 40515

(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 A Recertification, Relicensure, and Abbreviated Survey was initiated on 07/09/12 and concluded on 07/12/12. ARO #KY00018692 was unsubstantiated with no related deficiencies cited. The Recertification and Relicensure Survey had deficiencies with the highest scope and severity being an "F."	F 000	Resident #11 was said to affected by the deficient practice. The resident had no negative outcome related to the fact she did not get doses that would exceed what was ordered or over the daily recommended amount. The MAR was corrected removing the error off of the PRN MAR leaving the order on the routine MAR. On 7/11/12 the doctor was notified of the error and the PRN dose was d/c on 7/12/12 related to lack of use and pending d/c home on 7/25/12. No other resident was identified as being affected by the deficient practice as evidence by an audit completed by the Administrator on 7/11/12 & by a licensed pharmacist on 7/18/12 with no other errors of medications being listed on the incorrect MAR were found. As well as no medication orders that placed residents at risk for over dose.	8-20-12
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 observation, interviews, record review and review of facility policy, it was determined the facility failed to meet professional standards of quality for one (1) of eleven (11) sampled residents when a License Practical Nurse administered Per Requested or Needed (PRN) medication to Resident #11, without a Physician's Order. The findings include: Review of the facility's policy entitled 'Timing of Medication Pass', not dated, revealed it was the policy of the facility to provide medications to all residents in following the state and federal regulations. Further review of the policy revealed unless otherwise ordered by the physician, all medications would be given in accordance with the manufacturing guidelines. Observation during Medication Pass, on 07/11/12	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Conferra Collins Admin. 8/24/12

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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 observation, interviews, record review and review of facility policy, it was determined the facility failed to meet professional standards of quality for one (1) of eleven (11) sampled residents when a License Practical Nurse administered Per Requested or Needed (PRN) medication to Resident #11, without a Physician's Order. The findings include: Review of the facility's policy entitled 'Timing of Medication Pass', not dated, revealed it was the policy of the facility to provide medications to all residents in following the state and federal regulations. Further review of the policy revealed unless otherwise ordered by the physician, all medications would be given in accordance with the manufacturing guidelines. Observation during Medication Pass, on 07/11/12	F 281	No other resident was identified as being affected by the deficient practice as evidence by an audit completed by the Administrator on 7/11/12 & by a licensed pharmacist on 7/18/12 with no other errors of medications being listed on the incorrect MAR were found. As well as no medication orders that placed residents at risk for over dose.	

RECEIVED
AUG 24 2012
BY:

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F 281	Continued From page 1 at 03:00 PM, revealed Licensed Practical Nurse (LPN) #1 administered a PRN dose of two (2) 500 milligrams (mg) Tylenol tablets (total of 1000 mg) to Resident #11. Review of the medical record revealed the facility admitted Resident #11, on 05/30/12, with diagnoses which included Bowel Obstruction, Internal Hernia, Urinary Tract Infection, Diarrhea with Negative Clostridium Difficile, and Anemia. Review of the current active Physician's Orders revealed orders for Tylenol, 1000 milligrams (mg) twice daily, and 650 mg. every six hours PRN. Review of the Medication Administration Record (MAR) revealed Resident #11 was to receive Tylenol, 1000 mg. twice daily as a routine order. Continued review revealed the resident could be given 650 mg. every six hours PRN (as needed). In addition, on a separate line, the MAR indicated the resident could be given 1000 mg. every six hours PRN. Review of facility form, Medication Error Report, dated 07/11/12, revealed during the end of month review of MAR by nursing staff at facility, nursing staff failed to notice an order for 1000 mg Tylenol listed under PRN orders and should have been listed under Routine Orders. Further review of the error report revealed nursing staff gave PRN order of Tylenol 1000 mg instead of Tylenol 650 mg per oral route (PO). Interview with LPN #3, on 07/11/12 at 06:10 PM, revealed she had handwritten the routine dose of Tylenol 1000 mg BID but did not see the routine dose of Tylenol listed under PRN orders. LPN #3 stated she must have "overlooked it."	F 281	A new system was put in place. During admission a nurse, who is not completing the actual admission will review MARS to insure that medications are listed on the correct MAR. At month end change over a primary nurse caring for that resident will complete MAR audits to insure that medications are listed on the correct MAR. Beginning on 8/3/12 and on-going until 8/11/12 nurses were in-serviced on this process as well as in all new nurse hire orientation. On 7/13/12 the owner of PCA pharmacy in-serviced the data entry clerks on the correct process of entering medications on the correct MAR. The facility will monitor compliance through an audit being performed within the first 72 hours of admission by a nurse manager on all MARS and physician orders to insure compliance. The last night of the month a nurse will compare the upcoming month's MARS with the current MARS auditing to insure compliance.	

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F 281	Continued From page 2	F 281		
	Interview with LPN #1, on 07/11/12 at 06:30 PM, revealed she noted two (2) PRN Tylenol orders on the MAR, and made the decision to give the higher dose (1000 mg.) because she felt it would be more effective.			
	Interview with Director of Nursing (DON), on 07/11/12 at 04:20 PM, revealed the current MAR should be compared to the new MAR and necessary corrections made. She stated a review of Resident #11's June MAR revealed a handwritten order for Tylenol 1000 mg BID under routine orders and only Tylenol 325/ 2(two) tabs under PRN orders. Further interview with the DON revealed LPN #3 was responsible for reconciling the MARs and should have caught the error.			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		
	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions		No resident was said to be affected by the deficient practice. All residents had the potential to be affected by deficient practice. Although no negative outcome occurred with any resident based on a 3 day audit of the 24 hour nursing report beginning 7/10/12- 7/12/12.	8-20-12
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies titled Meal Service and Environmental Sanitation it was determined the facility failed to prepare, distribute and serve food			

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F 371	Continued From page 3 under sanitary conditions. During the meal observation on 07/10/12 a shrimp salad plates temperature was taken prior to the beginning of assembling the resident trays and was noted to be fifty-seven (57) degrees Farenheit and was served to residents and Cook #1 was observed to use poor hand sanitation by changing tasks with out washing hands and changing gloves. The findings include: Review of the facility's policy titled Meal Service, dated 2006, revealed cold foods are refrigerated at less than or equal to forty-one (41) degrees Farenheit. It further stated perishable and potentially hazardous foods do not remain at room temperature for more than thirty (30) minutes. Review of the facility's policy titled Environmental Sanitation/Infection Control, dated 2010, revealed hands are to be properly washed before and/or after the following activities, when entering a food preparation area and before putting on clean, single-use gloves for working with food and between glove changes. Observation, on 07/10/12 at 11:05 AM, revealed the temperature of the shrimp salad to be fifty seven (57) degrees Farenheit. Interview with Cook #1, on 07/10/12 at 11:15 AM, revealed the shrimp salad is too warm and should be below forty (40) degrees Farenheit. During tray line observation, on 07/10/12 between 11:18 AM and 11:25 AM, revealed eight (8) residents were served shrimp salad on their tray.	F 371	Dietary Manager in-serviced all dietary staff on 7/10/12 being completed by 8/10/12 & with all new hire orientation on required temperatures for hot/cold foods. Prior to a meal, no food ready to serve for that meal will be stored in the reach –in. All food for that meal will be stored in the walk in. All dietary staff was in-serviced on hand washing beginning on 7/10/12 being completed by 8/10/12 & with all new hire orientation by the Dietary Manager. The facility will monitor compliance through daily rounds by the Dietary Manger or designee x30 days and random audits thereafter. Dietary staff will be observed to insure proper hand washing is occurring. Temperatures will be taken prior to each meal and documented . The Dietary Manager or designee will monitor compliance of this every day x30 days and 2 xs per week thereafter.	

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F 371	Continued From page 4 Observation on, 07/10/12 at 11:26 AM, revealed Cook #1 left the resident tray line to prepare a grilled cheese sandwich. He opened the storage cabinet to obtain bread with gloved hands and then opened refrigerator door to obtain cheese. Cook #1 was observed to change gloves without washing hands. He placed the sandwich on the grill, removed his gloves and while throwing the gloves away touched the lid of the trash can while throwing away gloves. Further observation revealed he did not wash his hands and continued to cook grilled cheese. At 11:30 AM, Cook #1 was observed to walk towards the dish room and noted to scratch his head and changed his gloves as he re-entered the kitchen without washing his hands. He then used his gloved hands to hold the grilled cheese as he cut it in half. Interview with Cook #1, on 07/10/12 at 12:35 PM, revealed he should have washed his hands and changed his gloves between each new task and he was unaware he had failed to wash his hands and change his gloves. Interview with the Food Service Supervisor, on 07/10/12 at 12:38 PM, revealed the shrimp salad should have been held between 32 and 42 degrees Farenheit and should have been between these two (2) temperatures when checked prior to serving.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425	Resident #11 was said to be affected by the deficient practice. Review of the record revealed that resident had a current order for 1000 mg	8-20-12

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F 425	Continued From page 5 §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. 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. 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. 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 provide pharmaceutical services including procedures that assure the accurate dispensing, and administering of drugs for one (1) of eleven (11) sampled residents. Observation during Medication Pass, on 07/11/12 at 03:00 PM, revealed Licensed Practical Nurse (LPN) #1 administered a PRN dose of two (2) 500 mg Tylenol tablets (total of 1000 mg) to Resident #11 as indicated on the Medication Administration Record (MAR) even though the Physician's Order was written to give 650 mg. every six hours PRN. The findings include:	F 425	Tylenol BID routine. The order was placed on the PRN MAR and the routine MAR. On 7/11/12 the resident's physician was notified of the resident getting 1000mg instead of 650 mg PRN at 3:00 PM. The incorrect order of 1000mg PRN was removed from MAR leaving 1000 BID on the correct routine MAR. On 7/12/12 the physician discontinued the Tylenol 650 mg every 6 hours PRN related to lack of use and resident's pending discharge home on 7/25/12. Resident #11 had no negative outcome as they did not receive more than the daily recommended dosage of Tylenol.	

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F 425	Continued From page 6 Review of the facility's policy entitled 'Timing of Medication Pass', not dated, revealed it was the policy of the facility to provide medications to all residents in following the state and federal regulations. Further review of the policy revealed unless otherwise ordered by the physician, all medications would be given in accordance with the manufacturing guidelines. Observation during Medication Pass, on 07/11/12 at 03:00 PM, revealed Licensed Practical Nurse (LPN) #1 administered a PRN dose of two (2) 500 milligrams (mg) Tylenol tablets (total of 1000 mg) to Resident #11. Review of the medical record revealed the facility admitted Resident #11, on 05/30/12, with diagnoses which included Bowel Obstruction, Internal Hernia, Urinary Tract Infection, Diarrhea with Negative Clostridium Difficile, and Anemia. Review of the current active Physician's Orders revealed orders for Tylenol, 1000 milligrams (mg) twice daily, and 650 mg. every six hours PRN. Review of the Medication Administration Record (MAR), from 05/30/12 through 07/11/12, revealed Resident #11 was to receive Tylenol, 1000 mg. twice daily as a routine order. Continued review revealed the resident could be given 650 mg. every six hours PRN (as needed). In addition, on a separate line, the MAR indicated the resident could be given 1000 mg. every six hours Interview with LPN #1, on 07/11/12 at 06:30 PM, revealed she noted two (2) PRN Tylenol orders on the MAR, and made the decision to give the higher dose (1000 mg.) because she felt it would	F 425	All residents had the potential to be affected by the deficient practice. 7/11/12 Administrator audited all MARS and physician orders & on 7/16/12 a licensed pharmacist audited all MARS and physician orders to insure no medications were listed incorrectly. No residents were found to be affected. A new system was put in place. During admission a nurse, who is not completing the actual admission will review MARS to insure that medications are listed on the correct MAR. At month end change over a primary nurse caring for that resident will complete MAR audits comparing current month MARS with upcoming	

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F 425	Continued From page 7 be more effective. Interview with LPN #3, on 07/11/12 at 06:10 PM, revealed she had handwritten the routine dose of Tylenol 1000 mg BID but did not see the routine dose of Tylenol listed under PRN orders. LPN #3 stated she must have "overlooked it." Interview with Director of Nursing (DON), on 07/11/12 at 04:20 PM, revealed the current MAR should be compared to the new MAR and necessary corrections made. She stated a review of Resident #11's June MAR revealed a handwritten order for Tylenol 1000 mg BID under routine orders and only Tylenol 325/ 2(two) tabs under PRN orders. Further interview with the DON revealed LPN #3 was responsible for reconciling the MARs and should have caught the error. Interview with the facility's Consultant Pharmacist from Professional Comprehensive Accurate (PCA) Pharmacy, via telephone, on 07/11/12 at 05 50 PM, revealed the order for Tylenol 500 mg, 2 tabs, was in the PCA computer system as a scheduled medication. The Consultant Pharmacist further stated PCA printed the July MAR for the facility. When asked why scheduled medication was printed under PRN medication, the Pharmacist responded it was an error in the coding of the medication in the Medical Records area of PCA which prepared the MARs.	F 425	MARS to insure medications are listed on the correct MAR. On 7/13/12 the pharmacy owner in-serviced the data entry clerks on the process of entering medications correctly. Beginning on 8/3/12 and on-going until 8/11/12 & with new hire orientation Administrator in-serviced nurses on this process. The facility will monitor performance during admission by having another nurse besides the admitting nurse verify medications are listed on the correct MAR indicating PRN or routine. The last night of the month a nurse will compare current month's MARS with upcoming month's MARS auditing to insure compliance.	

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) Building: 01 Plan Approval: 05/11/88 Survey: 2000 Existing Facility Type: Skilled Nursing Facility (SNF) Type of Structure: Type III (211) one (1) story with Full basement Smoke Compartments: 2 Fire Alarm: Complete fire alarm. Sprinkler System: Complete (wet) sprinkler system A standard Life Safety Code survey was conducted on 07/10/12. Tanbark Health Care Center was found to be in compliance with the requirements for participation in Medicare and Medicaid.	K 000		

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