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	185311	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE AT ROCKFORD REHAB & WELLNESS	4700 QUINN DRIVE LOUISVILLE, KY 40216

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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 07/27/2020, and concluded on 07/31/2020 to investigate Complaint #KY00032073. The Division of Healthcare substantiated the allegation with deficiencies cited. In addition, a COVID-19 Focused Infection Control Survey was conducted and found no deficiencies related to 42 CFR 483.80.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

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

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resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, it was determined the facility failed to notify the Power of Attorney (POA) for one (1) of six (6) sampled residents, Resident #1, with laboratory reports, and a need to alter treatment.

The findings include:

Review of the facility policy and procedure titled, "Change of Condition", and dated 11/06/19, revealed Guideline: 7. Notify the resident's representative, consistent with his or her authority, of change and follow through completed by the facility, and document in the

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Electronic Medical Record (EMR).

Review of the Quarterly Minimum Data Set (MDS), dated and signed on 06/25/2020, revealed the facility re-admitted Resident #1 on 03/11/2020 with the following diagnoses: Cancer, Anemia, and Coronary Artery Disease (CAD). Continued review revealed other diagnoses including Hypertension (HTN), Diabetes, Cerebrovascular Accident (CVA), Seizure Disorder, Dysphagia, Anxiety Disorder, and Depression. Further review of the MDS revealed the facility assessed Resident #1 with a Brief Interview for Mental Status exam score of fourteen (14), and determined the resident was interviewable.

Observation of Resident #1, on 07/27/2020 at 1:15 PM, revealed the resident in the process of transferring self from the wheelchair into the bed. The resident appeared alert, and was dressed appropriately for the season.

Telephonic interview with Resident #1 on 07/28/2020 at 9:00 AM revealed he/she expected the facility to notify his/her POA anytime changes were made in his/her delivery of care.

Telephonic interview with Resident #1's POA, on 07/27/2020 at 10:20 AM, revealed on 07/14/2020 Resident #1 made her aware of recent blood work, and new medications. She stated the facility did not notify her of the medication changes, or the need for lab work.

Review of the Medication Administration History, dated 07/01/2020 through 07/27/2020, revealed a provider order for Lasix, forty (40) milligrams (MG) daily for two (2) days, start 07/14/2020, and

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end 07/15/2020.

Review of the progress notes, dated 07/13/2020 at 9:40 AM, and signed by the Assistant Director of Nurses (ADON) #1, revealed labs reviewed from 07/10/2020, new order for Lasix forty 40 MG for two (2) days, and repeat labs on 07/13/2020. Resident is aware.

Telephonic interview with ADON #1, on 07/31/2020 at 1:22 PM, revealed she did not contact Resident #1's POA regarding the new order for Lasix, or the new order for labs. She stated the resident was pretty alert and the resident said he/she would tell the POA. The ADON revealed that normally staff notified the POA of new orders.

Review of the Care Plan Conference Summary, dated 01/07/2020 and signed by Resident #1, and the POA as well as Social Services, the Director of Nursing, the Advanced Registered Nurse Practitioner #1, Unit Manager #1, and the Ombudsman, revealed the POA requested to be first and only point of contact. The summary continued the facility explained person centered care but facility would communicate changes with the POA, and Resident #1 at the same time and Responsible Party (RP) and resident in agreement.

Telephonic interview with the Director of Nursing 07/28/2020 at 11:40 AM revealed staff should notify Resident #1's POA with any changes in the resident's treatment plan.

Telephonic interview with the Administrator, on 07/31/2020 at 12:28 PM, revealed during the previous Care Plan Conference in January 2020,

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F 580	Continued From page 4 both the resident and the POA concurred the facility would notify both with any changes in the resident's care. She stated her expectation was Resident #1 was to be notified first of changes, and ask the resident if it was okay to also notify the POA. She stated the facility had not done audits related to notification of changes.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		

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F 656	Continued From page 5 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement the individualized plan of care for two (2) of five sampled residents, (Resident #1, and Resident #3) related to medication administration. The findings include: Review of the policy titled, "Comprehensive Care Plans", revised on 07/19/2020, revealed the care plan included how the facility assisted the resident to meet their needs, goals, and preference. The resident had the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made...in the case of a resident refusal or declination of care or treatment poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or	F 656		

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treatment being declined, the risk the declination poses to the resident, and the efforts made by the Interdisciplinary Team to educate the resident and representative as appropriate. The attempts to find alternative means to address the identified need/risk shall be documented in the care plan.

1. Review of the Quarterly Minimum Data Set (MDS), dated and signed on 06/25/2020, revealed the facility re-admitted Resident #1 on 03/11/2020 with the following diagnoses: Cancer, Anemia, Coronary Artery Disease (CAD), and Hypertension (HTN). Other diagnoses included Diabetes, Cerebrovascular Accident (CVA), Seizure Disorder, Dysphagia, Anxiety Disorder, and Depression. Continued review of the MDS revealed the facility assessed the resident with a Brief Interview for Mental Status exam score of fourteen (14), and determined the resident was interviewable.

Observation of Resident #1, on 07/27/2020 at 1:15 PM, revealed the resident in the process of transferring self from the wheelchair into the bed. The resident appeared alert, and dressed appropriately for the season.

Record review of Resident #1's Medication Administration Record (MAR) dated 07/01/2020 through 07/27/2020, revealed the following medications were not administered per provider orders: Amlodipine two (2) point five (5) milligrams (MG) orally (PO) once a day (QD). Staff did not document administration of the medication to Resident #1 on 07/04/2020, 07/05/2020, 07/08/2020, 07/14/2020, and 07/21/2020. Review of the Reasons/Comment documentation stated, Not Administered/Item Unavailable.

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Review of Resident #1's MAR revealed a provider order for Aspirin eighty-one (81) MG Chewable Tablet QD. There was no documentation staff administered Resident #1 the medication on July 8th, and July 14th. Review of the document titled "House Stock Drug Kit" revealed the medication was available to staff, however, it was not administered per providers order.

Review of Resident #1's care plan revealed, dated 06/13/2019, the problem, Resident has potential for cardiovascular complications related to diagnoses of Hypertension, Hyperlipidemia, Coronary Artery Disease, history of Myocardial Infarction (MI) with stents, Cerebrovascular Accident (CVA) and Arteriosclerotic Heart Disease (ASHD). The goal, with target date 10/18/2020, was Resident will remain free of complications related to multiple cardiac diagnoses through next review, and the Approach, dated 08/07/2020, was administer medications as ordered.

2. The facility admitted Resident #3 on 10/29/2019. Current diagnoses include: Anemia, Hypertension, Non-Alzheimer's Dementia. Other diagnoses included Anxiety, and Chronic Atrial Fibrillation.

Review of the MDS, signed and dated on 05/11/2020, revealed the facility assessed Resident #3 with BIMS exam score of 00, and determined the resident was not interviewable.

Record review of Resident #3's MAR, dated 07/01/2020 revealed an order for Ativan zero point five (0.5) MG twice a day. Continued review revealed the resident did not receive the

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medication per provider order on 07/19/2020 (morning dose), 07/20/2020, 07/21/2020 (morning dose), 07/22/2020, 07/23/2020, 07/25/2020, 07/26/2020, 07/27/2020, 07/28/2020, and 07/29/2020 (morning dose). The reasons/comments for each missed administration of the medication stated "Not Administered: Drug/Item Unavailable."

Review of the care plan, dated 11/04/2019, revealed the problem the Resident has a memory/recall problem related to BIMS assessment and diagnosis of Dementia. Resident has impaired long-term memory as evidenced by (AEB) being unable to recall correct year, month, and day of week, and impaired short term memory AEB not recalling words given to remember. The Long Term Goal was the Resident will not sustain serious injury due to memory/recall deficit, and the approach, dated 07/14/2020, was administer antianxiety medication as ordered.

Continued review of Resident #3's MAR revealed an order for Xarelto (rivaroxaban) twenty (20) MG once a day. There was no documentation the medication was administered to the resident on 07/21/2020, 07/22/2020, or 07/23/2020. The reason/comments revealed the "Drug/Item was Unavailable".

Review of Resident #3's care plan, dated 10/30/2019, revealed the problem the Resident has a diagnosis of Atrial Fibrillation with a Long Term Goal, 08/11/2020, the Resident's heart rate/rhythm will remain/return to within normal limits AEB decreased complaints of palpitations, decreased nausea and vomiting, decreased light-headedness, weakness, and decreased

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F 656	Continued From page 9 tachycardia. The approach, dated 10/30/2019, was medications as ordered. Telephonic interview with Unit Manager (UM) #1, on 07/29/2020 at 9:27 AM, revealed an individualized care plan was developed for each resident so staff could deliver the appropriate care. Telephonic interview with Registered Nurse (RN)#2, on 07/31/2020 at 10:15 AM, revealed the purpose of the care plan was to guide staff on how to care for each individual resident. She stated the care plan should be followed by staff to avoid a negative outcome to a resident. Telephonic interview with the Director of Nursing (DON), on 07/29/2020 at 2:21 PM, revealed the care plan was an outline of care provided based on a resident's needs, and staff should follow the care plan. Telephonic interview with the Administrator, on 07/31/2020 at 12:28 PM, revealed the plan of care was developed based on resident choices, and needs. She stated she expected staff to review, and follow the care plan in order to provide the best care possible to each resident.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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F 684	Continued From page 10 practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, it was determined the facility failed to ensure three (3) of five (5) sampled residents (Resident #1, #2, #3), received treatment and care in accordance with provider orders. Record review and inteview revealed staff failed to follow physician orders.

The findings include:

Review of the policy titled, "Medication Administration General Guidelines, dated 09/2018 revealed medications were administered as prescribed in accordance with manufacturers' specifications, and good nursing practices. Review of the section Medication Administration revealed medications were administered in accordance with written orders of the prescriber; and, if two (2) consecutive doses of a vital medication were withheld or refused, the physician was notified.

1. Review of the Quarterly Minimum Data Set (MDS), dated and signed on 06/25/2020, revealed the facility re-admitted Resident #1 on 03/11/2020 with the following diagnoses: Cancer, Anemia, and Coronary Artery Disease (CAD).

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Other diagnoses included Hypertension (HTN), Diabetes, Cerebrovascular Accident (CVA), Seizure Disorder, Dysphagia, Anxiety Disorder, and Depression. Continued review of the MDS revealed the facility assessed the resident with a Brief Interview for Mental Status exam score of fourteen (14) and determined the resident was interviewable.

Observation of Resident #1, on 07/27/2020 at 1:15 PM, revealed the resident in the process of transferring self from the wheelchair into the bed. The resident appeared alert, and was dressed appropriately for the season.

Record review of Resident #1's Medication Administration Record (MAR), dated 07/01/2020 through 07/27/2020, revealed the following medications were not administered per provider orders: Amlodipine two (2) point five (5) milligrams (MG) orally (PO) once a day (QD). Resident #1 did not receive the medication on 07/04/2020, 07/05/2020, 07/08/2020, 07/14/2020, and 07/21/2020. Review of the Reasons/Comment documentation stated, Not Administered/Item Unavailable. Diagnosis-Essential Primary Hypertension.

Continued review of Resident #1's MAR revealed a provider order for Aspirin eighty-one (81) MG Chewable Tablet QD. Further review revealed staff did not administer the medication to Resident #1 on July 8th, and July 14th. Review of the document titled "House Stock Drug Kit" revealed the medication was available to staff, however, it was not administered per providers order.

Review of Resident #1's care plan dated 06/13/19

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revealed Problem the resident has potential for cardiovascular complications related to diagnoses of Hypertension, Hyperlipidemia, Coronary Artery Disease, history of Myocardial Infarction (MI) with stents, Cerebrovascular Accident (CVA) and Arteriosclerotic Heart Disease (ASHD), Goal, target date 10/18/2020. Resident will remain free of complications related to multiple cardiac diagnoses through next review, and Approach, dated 08/07/2020, administer medications as ordered.

Review of the MAR revealed a provider order for Cefuroxime axetil two-hundred and fifty (250) MG, one (1) tablet twice a day (BID) for three (3) days. Start 07/20/2020 and end 07/22/2020. Continued review revealed no administration of the medication on 07/20/2020, nor the morning dosage on 07/21/2020. The resident only received three (3) of the six (6) ordered dosages. Documentation on the MAR revealed the medication was not given as ordered because Drug/Item Unavailable. Review of the House Stock Drug Kit revealed the medication as available to staff, however, it was not administered per order.

2. The facility admitted Resident #2 on 02/19/2020 with the following diagnoses: Anemia, Coronary Artery Disease (CAD), and Hypertension. Other diagnoses included Neurogenic Bladder, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Hemiplegia, Anxiety Disorder, Bipolar Disorder, and Hydronephrosis.

Review of the Quarterly MDS revealed the facility assessed the resident with a BIMS of ten (10) and determined the resident was moderately

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SIGNATURE HEALTHCARE AT ROCKFORD REHAB & WELLNESS	4700 QUINN DRIVE LOUISVILLE, KY 40216

(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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cognitively impaired.

Record review of the MAR dated 07/01/2020 through 07/29/2020 revealed the following medications were not administered to Resident #2 per provider orders: Aspirin eighty-one (81) MG orally QD not administered on 07/04/2020, 07/06/2020, 07/12/2020, 07/17/2020 and 07/26/2020. Continued review of the House Stock Drug Kit document revealed Aspirin eighty-one (81) MG was available for staff to access however, the medication was not administered.

Continued review of the MAR for Resident #2 revealed an order for Ativan, zero point five (0.5) MG twice a day (BID). However, the resident did not receive the medication on 07/01/2020, 07/04/2020 (evening dose), or 07/13/2020 (evening dose). Further review of the MAR revealed documentation, which stated, Not Administered/Drug/Item Unavailable.

Continued review of Resident #2's MAR revealed an order - docusate sodium (OTC) one-hundred (100) MG orally twice a day (BID). Further review revealed the medication was not administered on 07/07/2020 (evening dose), 07/09/2020, 07/10/2020 (evening dose), 07/12/2020 (morning dose), 07/14/2020 (evening dose), 07/17/2020, 07/20/2020 (morning dose), 07/23/2020 (evening dose), 07/24/2020 (evening dose), 07/25/2020 (evening dose), and 07/28/2020 (morning dose) due to,Drug/Item Unavailable. Review of the document "House Stock Drug Kit" revealed docusate sodium 100 MG was available to staff to administer, however, the resident did not receive the medication as prescribed by the provider.

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3. The facility admitted Resident #3 on 10/29/2019 and diagnoses included Anemia, Hypertension, Non-Alzheimer's Dementia, Anxiety, and Chronic Atrial Fibrillation.

Review of the MDS, signed and dated on 05/11/2020, revealed the facility assessed Resident #3 with a BIMS exam score of 00, and determined the resident was not interviewable.

Record review of Resident #3's MAR, dated 07/01/2020 revealed an order fir Ativan zero point five (0.5) MG twice a day. Continued review revealed the resident did not receive the medication per provider order on 07/19/2020 (morning dose), 07/20/2020, 07/21/2020 (morning dose), 07/22/2020, 07/23/2020, 07/25/2020, 07/26/2020, 07/27/2020, 07/28/2020, and 07/29/2020 (morning dose). The reasons/comments for each missed administration of the medication stated "Not Administered: Drug/Item Unavailable."

Review of the care plan, dated 11/04/2019, revealed the problem the Resident has a memory/recall problem related to BIMS assessment and diagnosis of Dementia. Resident has impaired long term memory as evidenced by (AEB) being unable to recall correct year, month, and day of week, and impaired short term memory AEB not recalling words given to remember. Long Term Goal- Resident will not sustain serious injury due to memory/recall deficit. Approach, dated 07/14/2020, administer antianxiety medication as ordered.

Continued review of the MAR revealed Depakote (divalproex tablet delayed release (DR/EC) two-hundred and fifty (250) MG twice a day.

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Continued review revealed the medication was refused by the resident on 07/09/2020 (refused both doses).

Review of Resident #3's MAR revealed an order for meloxicam tablet seven point five (7.5) MG oral twice a day with meals. The resident refused both doses of the medication on 07/09/2020.

Continued review of the MAR revealed an order for potassium chloride twenty (20) milliequivalents (MEQ) orally twice a day. Resident #3 refused both the morning and evening dose on 07/09/2020.

Review of the MAR revealed an order for Vitamin C (ascorbic acid) five-hundred (500) MG twice a day. Resident #3 refused the medication on 07/09/2020 for a total of two (2) missed doses.

Continued review of Resident #3's MAR revealed an order for Xarelto (rivaroxaban) twenty (20) MG once a day. The medication was not administered to the resident on 07/21/2020, 07/22/2020, or 07/23/2020. The reason/comments revealed the "Drug/Item was Unavailable".

Review of Resident #3's care plan, dated 10/30/2019, stated, Problem- Resident has a diagnosis of Atrial Fibrillation Long Term Goal, 08/11/2020 was Resident's heart rate/rhythm will remain/return to within normal limits AEB decreased complaints of palpitations, decreased nausea and vomiting, decreased light-headedness, weakness, and decreased tachycardia. Approach, dated 10/30/2019, was medications as ordered.

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Telephonic interview with Registered Nurse #1 on 07/29/2020 at 8:37 AM revealed any time staff did not administer a medication to a resident as ordered by the provider, the staff should notify the Advanced Registered Nurse Practitioner (ARNP). Staff should inform the ARNP either the resident refused the medication, the medication was not available in the facility to administer, or a prescription was needed to obtain the medication. He revealed any interventions put into place to obtain medications, as well as notification of the ARNP should be documented in the clinical record. He stated the facility did have an emergency cart from which staff could pull medications and that he has pulled medications from the cart before.

Telephonic interview with Certified Medication Technician (CMT) #1, on 07/29/2020 at 9:22 AM revealed anytime a resident refused a medication, or a medication was not available, she notified the resident's nurse. She revealed she was not aware of a House Stock Drug Kit, or what medications were available in the kit.

Telephonic interview with Unit Manager (UM) #1, on 07/28/2020 at 9:27 AM, revealed she was unaware Cefuroxime axetil (Resident #1) was stored in the House Stock Drug Kit because the drug ordered was Cefuroxime axetil, and the House Stock Drug Kit referred to the medication as Cefuroxime only. She stated she should have researched the drugs name more, or contacted the physician for a possible alternative treatment. She stated the resident was to receive the medication for a Urinary Tract Infection (UTI) and this was an important medication that Resident #1 should have not missed.

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Telephonic interview with CMT #2, on 07/29/2020 at 11:25 AM, revealed she never looked in the House Stock Drug Kit to replace missing medications because it never crossed her mind.

Telephonic interview with Licensed Practical Nurse # 1 on 07/29/2020 at 12:20 PM revealed anytime a resident does not get their medications as ordered, the doctor, or the ARNP should be notified immediately because they may give alternative treatment orders.

Telephonic interview with the Pharmacy Consultant, on 07/29/2020 at 12:27 PM, revealed she reviewed resident medications once a month for antibiotic use. She revealed she reviewed resident MARs on 07/23/2020 but did not observe that Resident #1 had not received Cefuroxime axetil as ordered on 07/20/2020 and 07/21/2020. She stated when medications are not administered as ordered, she will email the Director of Nursing as soon as possible so she could address the issue.

Telephonic interview with Registered Nurse #2 on 07/31/2020 at 10:15 AM revealed whenever a medication was not available to administer to a resident, staff should call pharmacy, and ask for a re-supply of the medication. She stated staff could also access the House Stock Drug Kit as well. She revealed if a medication had been completely omitted then the doctor or the ARNP should be notified, and an alternative treatment might be ordered. She continued to state if a prescription was needed, the ARNP would fax it within thirty (30) minutes to both the facility and the pharmacy. She stated staff should chart anything relevant to a missed dosage of medication as well as provider notification in the

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progress notes.

Telephonic interview with the ARNP, on 07/29/2020 at 1:00 PM, revealed her expectation was notification from the staff whenever an ordered medication was going to be administered late, or was not available for administration, and the plan of course for treatment might be changed. She revealed she was not aware of Resident #1, Resident #2, or Resident #3's missed medications.

Telephonic interview with the DON, on 07/28/2020 at 11:40 AM, revealed whenever medication administration times had to be altered, or a medication was omitted, the nurse should notify the pharmacy, and call the doctor for a possible replacement order. She stated if the medication was in the Emergency Kit staff should go ahead and pull it for administration. She stated the pharmacy delivered medications to the facility twice a day. The DON stated the nurses should document all notifications made to the pharmacy, and the doctor in the event medication times were altered, or a medication was omitted. She revealed the nurses should follow up on any missing or omitted medications, and chart the findings. She stated the facility ran a medication omission report daily for review in the morning meeting. However, she stated the facility did not compare omitted medications with the availability of the medication in the Emergency Kit (eKit).

Telephonic interview with the Administrator, on 07/31/2020 at 12:28 PM, revealed her expectation of staff, as the Administrator, was any missing medications be re-ordered through the electronic system, and a call be made to the

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F 684	Continued From page 19 Pharmacy. If the medication was available in the eKit, staff should pull and give the medication to the resident. She revealed staff were informed and were aware of the eKit and to utilize the kit, as needed. She stated the Provider should be notified of any missed medications, and her expectation was for staff to document the notification. She revealed omitted and missed medications were reviewed in the Clinical Meeting, however, the facility had not performed audits related to missed medications.	F 684		

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E 000	Initial Comments An Abbreviated Survey investigating KY#00032073 and a COVID-19 Focused Infection Control Survey was initiated on 07/27/2020 and concluded on 07/31/2020. Complaint KY#00032073 was substantiated with deficiencies cited. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 95.	E 000		

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

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.

Office of Inspector General

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N 000	Initial Comments A Complaint Survey initiate on 07/27/2020, and concluded on 07/31/2020 to investigate Complaint #KY00032073. The Division of Healthcare substantiated the allegation with deficiencies cited. In addition, a Focused Infection Control Survey was conducted and found no deficiencies.	N 000		

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