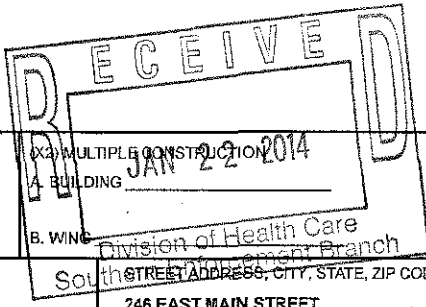


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/25/2013
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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311
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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
F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>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 services provided by the facility met professional standards of quality for one of four sampled residents (Resident #3). A review of the medical record for Resident #3 revealed a physician's order dated 10/29/13 for the resident to receive Cefepime (an antibiotic medication) intramuscularly (IM) twice a day for seven days for treatment of an abdominal wound. However, the facility failed to initiate the administration of the medication to Resident #3 until 11/07/13, eight days after the medication was ordered by the physician.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Medication Administration," effective 12/02/10, revealed all medications would be administered as ordered by the physician. The policy also revealed any failure to administer the medication, regardless of the reason, would be documented on the Medication Administration Record (MAR) and/or</p>	F 281	<p>Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan Bush</i>	TITLE <i>NHA</i>	(X6) DATE <i>12/16/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>in the nursing notes of the resident's medical record. Review of the facility's procedure titled "Physicians Orders at a Glance," undated, revealed the nurse that received the order for a medication was responsible to complete the order documentation and to communicate the order to the pharmacy.</p> <p>Review of documentation in the medical record revealed the facility admitted Resident #3 on 10/18/13, with diagnoses that included an Open Abdominal Wound, Diabetes Mellitus, and Obesity.</p> <p>Review of Resident #3's medical record revealed facility staff arranged for the resident to be transferred to the hospital on 10/23/13 due to having sustained a fall in the facility. The facility readmitted Resident #3 to the facility on 10/28/13, with physician's orders which included for staff to administer 1 gram of Cefepime, intramuscularly (IM), to Resident #3 twice a day for seven days. However, review of Resident #3's nurse's notes dated 10/28/13, revealed the pharmacy had called the facility and alerted staff that administering Cefepime to Resident #3 could potentially cause an adverse reaction due to the resident's known allergy to Penicillin, and the medication would not be delivered to the facility until a clarification order was obtained from Resident #3's physician. A review of a physician's order dated 10/29/13 for Resident #3 revealed the Cefepime order was clarified and was to be administered as previously ordered on 10/28/13. In addition, the physician requested staff to monitor the resident for any signs/symptoms of an allergic reaction/adverse effects.</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> An order clarification was obtained for residents #3 to receive Cefepime twice daily intramuscular, (IM) and sent to the pharmacy the medication was administered resident did not experience any negative outcome. MD and family were notified of delay in following Physician orders. Medication administration records were reviewed by the Director of Nursing, ADON, and Unit Managers on 11/25/2013 for Resident #3 to ensure the completion of the ordered antibiotics. Resident #3 did not experience any negative outcome. The Medication Administration Records for all resident with orders for antibiotics will be reviewed by the Unit Manager, ADON, SDC and Director of Nursing to ensure completion for the last 60 days as ordered by December 1, 2013. Licensed Nursing staff will receive education by December 20, 2013 Provided by Staff Development Coordinator, ADON, Unit Manager or DON regarding following all physician orders to include all medications, diagnostic tests, consults, referrals, and treatments with emphasis on completion of antibiotics. 	

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F 281	<p>Continued From page 2</p> <p>Review of the MARs for Resident #3 dated October 2013 and November 2013 revealed the Cefepime order received on 10/29/13 had been transcribed to the resident's October 2013 and November 2013 MARs. Based on documentation on the MARs, staff was to administer the Cefepime to Resident #3 at 9:00 AM and 9:00 PM beginning on 10/30/13, and continuing until 11/05/13. However, documentation on Resident #3's MARs from 10/30/13 through 11/05/13 revealed the medication had not been administered to Resident #3 as ordered and contained no documentation as to why the medication was not administered.</p> <p>Interview on 11/25/13, at 4:40 PM with a Pharmacy Technician from the pharmacy utilized by the facility confirmed the pharmacy had notified the facility on 10/28/13, that the Cefepime was contraindicated for Resident #3. The Pharmacy Technician stated the pharmacy had not reviewed a clarification order or any communication from the facility on 10/29/13 regarding the Cefepime for Resident #3. The Pharmacy Technician stated the facility had not provided any form of communication and/or clarification related to the Cefepime for Resident #3 until 11/06/13, at which time a clarification from the physician was received and the medication was processed and delivered to the facility.</p> <p>An interview conducted with Registered Nurse (RN) #3 on 11/25/13, at 5:15 PM revealed on 10/29/13 she had received the physician's order that provided clarification related to the administration of the Cefepime to Resident #3 as previously ordered on 10/28/13. RN #3 stated she would have been responsible to ensure the</p>	F 281	<p>A system to ensure appropriate documentation of all Physician orders with emphasize on antibiotics orders has been initiated. All orders including antibiotics will be brought to clinical meeting (Monday-Friday). All antibiotics will be placed on a clinical white board to ensure the order is carried out per physician order. Physician orders will be reviewed by Unit Manager, ADON, or DON daily (Monday-Friday) in the clinical meeting.</p> <p>Antibiotics will be reviewed in the daily (Monday-Friday) clinical meeting, to ensure appropriate doses of antibiotics have been received by the resident per Physician Order by the ADON,SDC, Unit Manager or DON.</p> <p>The ADON, SDC, Unit Manager, or DON will complete an audit daily (Monday-Friday) x4 weeks, then monthly x 3 months for residents requiring antibiotics to ensure appropriate doses, start and end dates of antibiotic per physician orders and has been documented on the (MAR), Medication Administration Record as ordered.</p> <p>Any concerns identified will be addressed upon identification and reported to the DON or Administrator.</p> <p>4. Findings of the above stated audit will be discussed in the quality assurance meeting monthly for three months for recommendations and further follow-up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing,</p>	

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F 281	<p>Continued From page 3</p> <p>physician's order was faxed or communicated to the pharmacy, but could not recall the specifics about the day or the physician's order. RN #3 stated she had not provided direct care to Resident #3 again until 11/06/13, at which time she realized the Cefepime had not been administered to Resident #3. RN #3 stated she contacted the pharmacy and Resident #3's physician about the medication error and obtained another order from the physician for staff to administer the Cefepime, beginning on 11/07/13, two times a day for seven days.</p> <p>Interview with RN #1 on 11/25/13, at 5:37 PM revealed she had administered medications on 10/30/13 and 10/31/13 and would have administered the Cefepime to Resident #3; however, RN #1 stated the Cefepime was not available at the facility for administration to Resident #3. Therefore, RN #3 stated she circled the area on Resident #3's MAR to indicate the medication had not been administered, but failed to document the reason for not administering the medication as required in the facility's medication administration procedure. RN #1 stated she had seen documentation that the pharmacy had alerted the facility that the Cefepime prescribed by the physician for Resident #3 was contraindicated and "assumed" that was why the medication was not available. However, RN #1 stated she had failed to contact the pharmacy or Resident #3's physician to clarify the Cefepime order for Resident #3.</p> <p>Interview with RN #2 on 11/25/13, at 5:00 PM revealed she administered medications on 11/01/13 and would have administered the Cefepime to Resident #3. However, after a review of Resident #3's MAR, RN #2 stated it</p>	F 281	<p>Assistant Director of Nursing, Unit Manager, Social Services Director, Dietary Manager, and Quality of Life Director.</p> <p>5. Date of Compliance 12-30-2013</p>	

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F 281	<p>Continued From page 4</p> <p>appeared as though she had not administered the medication (Cefepime) to Resident #3 as ordered and had failed to document why the medication had not been administered.</p> <p>Staff was observed on 11/25/13, at 10:15 AM as they provided wound care to Resident #3's abdominal wound. The observation revealed the resident's wound was closed with the exception of an approximate 4-centimeter area in the middle of the incisional area that was open. The wound bed was pink and no odor was detected from the wound. Due to the resident's impaired cognition, an interview was not conducted.</p> <p>Interview with the Director of Nursing (DON) on 11/25/13, at 4:58 PM revealed that each nurse that administered medications from 10/30/13 through 11/05/13 should have contacted the pharmacy to determine why Resident #3's medication (Cefepime) was not available for administration. The DON acknowledged staff failed to clarify the medication order and failed to document. The DON stated she was unaware that Resident #3 had not received the Cefepime from 10/29/13 through 11/05/13 until it was discovered on 11/06/13, eight days after the physician had prescribed the medication for Resident #3.</p>	F 281		