STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALYERSVILLE NURSING AND REHABILITATION CENTER	571 PARKWAY DRIVE SALYERSVILLE, KY 41465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, and review of the facility's investigation, it was determined the facility failed to ensure an allegation of misappropriation of resident property was reported to state agencies as required by state law and the facility's policy for three (3) of three (3) unsampled residents (Residents C, D, and E). On 04/30/14, Resident C reported to Registered Nurse (RN) #2 that Licensed Practical Nurse (LPN) #10 attempted to administer an unknown white pill to the resident instead of a narcotic pain medication. In addition, staff reported that LPN #10 did not administer Residents D and E's narcotic pain medication on 04/30/14. The facility initiated an investigation and suspended LPN #10. However, the facility failed to report the allegation to state agencies. The findings include: Review of the facility's policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, which was undated, revealed the facility would report all alleged violations and substantiated incidents to the State Agencies as required, and take all corrective actions depending on the results of the investigation. The policy also revealed the facility was required to report the results of their investigation to the State Survey Agency within five calendar days. Review of the facility's policy titled, Medication Administration, undated, revealed the licensed nurse or medication assistant was required to check the following prior to administering a resident's medication: the right medication, the right dosage, the right dosage form, the right route, the right resident, and the right time. Review of the medical record revealed on 04/28/14, Resident C's physician prescribed [MEDICATION NAME] (a narcotic pain medication that contains 7.5 of [MEDICATION NAME] and 325 milligrams of [MEDICATION NAME]), orally for Resident C every six hours, as needed for pain. The facility assessed Resident C on 04/22/14, to have a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident's cognition was moderately impaired. Interview conducted on 07/17/14, at 4:40 PM, with Resident C revealed LPN #10 attempted to give the resident a white pill after the resident requested a pain pill. Resident C stated he/she knew the pill the LPN gave the resident was not his/her pain pill and questioned LPN #10. The LPN threw the white pill in the trash and brought the resident the correct medication. Resident C stated he/she got the white pill out of the trash, gave the pill to RN #2, and told the RN that LPN #10 attempted to give the resident the pill instead of his/her pain pill. Review of an investigation completed by the Director of Nursing (DON) revealed on 04/30/14, at approximately 5:00 AM, Resident C requested something for pain and LPN #10 attempted to administer 10 milliequivalents of Potassium Chloride (the white pill was identified as Potassium Chloride, used to treat low potassium levels) to Resident C instead of the [MEDICATION NAME] that was prescribed by the resident's physician. The investigation revealed Resident C told LPN #10 that the medication the LPN handed to the resident was not his/her pain pill. The LPN threw the pill into the resident's trash, left the resident's room, and administered the pain medication that was prescribed by the physician to the resident. Continued review of the investigation revealed Resident C retrieved the medication LPN #10 had disposed of from the trash and gave the pill to Registered Nurse (RN) #2. RN #2 reported the allegation to the DON, and an investigation was initiated. According to the facility's investigation, Residents D and E stated that LPN #10 administered their narcotic pain medication and had no concerns. Based on review of documentation, the DON immediately suspended LPN #10 pending the outcome of the facility's investigation. However, the facility failed to report the allegations regarding LPN #10 on 04/30/14 to the appropriate State Agencies until 07/15/14 (76 days after the allegation was made), after the State Survey Agency initiated an abbreviated survey. LPN #10's employment at the facility was terminated on 05/13/14 due to appearing to be under the influence of drugs and she could not be contacted for interview. The DON acknowledged in interview on 07/18/14, at 10:00 AM, that she had been notified of the allegations on 04/30/14 regarding LPN #10. The DON stated based on the facility's investigation of the allegations, the allegations did not need to be reported to the State Agency because she had not considered them to be allegations of abuse, neglect, or misappropriation of resident property. However, the DON stated looking back on it she should have reported the allegations to the State Survey Agency. Interview conducted with the Administrator on 07/18/14, at 6:35 PM, revealed she was notified by the DON of the allegation related to Resident C and LPN #10. The Administrator stated the DON completed an investigation of the allegations related to LPN #10. According to the Administrator, the DON was responsible for ensuring reports were reported to State Agencies. She stated the facility should have reported the allegations to the State Survey Agency.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation, interview, and review of facility policy it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observations revealed bedside fall mats with carpeted top surfaces in four (4) of seventy-six (76) resident rooms (resident room numbers 118, 215, 308, and 315) that had stains, food crumbs, and lint on the carpeted areas and needed to be cleaned. Resident room 215 had two bedside mats that were in need of cleaning. The findings include: A request was made on 07/17/14 at 10:19 AM for the facility's housekeeping policy. The facility provided a document entitled Housekeeping In-Service with a date of 01/01/2000 located at the bottom of the page. Interview with the facility's Housekeeping Supervisor on 07/17/14 at 9:44 AM revealed the facility did not have a policy related to maintaining cleanliness of carpeted surfaces, including the bedside fall mats. Interview with the facility's Administrator on 07/17/14 at 10:19 AM, also revealed the facility did not have a written policy to address proper cleaning/sanitizing of carpeted surfaces in resident rooms. Observations of resident room 118 on 07/15/14 at 4:34 PM, and on 07/17/14 at 9:18 AM revealed one carpeted bedside fall mat that was stained, had food crumbs and lint on it, and was in need of cleaning. Observation conducted on 07/17/14 at 9:35 AM of resident rooms 308 and 315 also revealed each room had a carpeted bedside mat that was stained, had food crumbs and lint on them, and that were in need of cleaning. Continued observation conducted on 07/17/14 at 9:35 PM revealed resident room 215 had two carpeted bedside fall mats that were stained, had food crumbs on them, and were in need of cleaning. Interview with the Housekeeper on 07/17/14 at 9:24 AM revealed the fall mats in resident rooms should be vacuumed and/or cleaned only when dirty and stated the facility did not have a set time to vacuum and/or clean the mats. The Housekeeper stated that she did not know when the fall mats had been vacuumed or cleaned. Interview with the Housekeeping Supervisor on 07/17/14 at 9:44 AM revealed housekeeping staff was to clean resident rooms on a daily basis. According to the Housekeeping Supervisor, housekeeping staff was to clean and/or vacuum rugs, including the carpeted bedside fall mats, every time housekeeping staff cleaned a resident room. The Housekeeping Supervisor stated she had instructed housekeeping staff to use disinfectant spray on the

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

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) carpeted bedside fall mats for spot cleaning. Further interview with the Housekeeping Supervisor revealed that she had attempted to contact the manufacturer of the carpeted bedside fall mats to determine what the manufacturer's recommendations were for cleaning/sanitizing the fall mats but she had been unsuccessful. The Supervisor stated she was not aware staff had failed to vacuum and/or clean the carpeted bedside fall mats. Continued interview with the Housekeeping Supervisor on 07/17/14 at 4:08 PM revealed facility staff had never deep cleaned the carpeted bedside fall mats and stated she was not aware that the mats could be deep cleaned. Interview on 07/17/14 at 3:30 PM with a representative of the company that provided the carpeted bedside mats to the facility revealed the carpeted beside mats should be vacuumed daily and spot cleaned as necessary. Further interview with the representative revealed the mats may be deep cleaned using any method that would normally be used to clean any other carpet. Interview with the Administrator of the facility on 07/17/14 at 10:19 AM revealed that housekeeping staff was required to clean everything in the resident rooms on a daily basis. Continued interview with the Administrator on 07/17/14 at 6:40 PM revealed staff had never deep cleaned the carpeted bedside fall mats and stated she was not aware that they could be deep cleaned. The Administrator also stated the Housekeeping Supervisor had informed staff to clean each resident room on a daily basis, including carpeted surfaces, and she was not aware that housekeeping staff had not vacuumed the carpeted bedside fall mats on a daily basis as instructed.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's laboratory contract, and review of the facility's policy entitled, Using The Care Plan, it was determined the facility failed to ensure services were provided in accordance with a written plan of care for one (1) of thirty-four (34) sampled residents (Resident #8). Review of the plan of care for Resident #8 dated [DATE], and revised [DATE], revealed facility staff had developed a plan of care related to the resident's [DIAGNOSES REDACTED]. The care plan included an intervention to obtain a [MEDICATION NAME] Time (PT) with an International Normalized Ratio (INR) as ordered (a test to check for bleeding time). Review of the physician's orders [REDACTED]. Record review revealed facility staff had administered the medications as ordered. However, the facility failed to ensure the laboratory test had been conducted as ordered and as required by the resident's plan of care. Further review revealed a PT with INR had been obtained on [DATE]; however, the next PT with INR was not conducted until [DATE], a timeframe of seven weeks after the previous test, at which time the PT was 85.1 seconds (reference range 9.5 to 11.6 seconds), and the INR was 7.0 (reference range 0.9 to 1.1). Documentation on the laboratory report revealed the PT and INR levels were critical. Review of the Nurse's Notes on [DATE] revealed the resident's physician was notified of the abnormal PT and INR levels and the resident was transferred to the hospital. Review of the hospital medical record revealed Resident #8 had been admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. The facility's failure to ensure residents received services in accordance with the resident's written plan of care caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on [DATE] at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. Prior to exit on [DATE], the State Survey Agency determined the Immediate Jeopardy was removed on [DATE] as alleged by the facility, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Using the Care Plan, with a revision date of [DATE], revealed the care plan would be used in developing the resident's daily care routines and would be available to staff personnel who had the responsibility to provide care or services to the resident. Review of the facility's contract with the laboratory, dated [DATE], revealed chart audit reviews of physician-ordered laboratory testing would be conducted on a monthly basis. The contract did not specify a timeframe for when a physician's orders [REDACTED]. However, interview on [DATE], at 2:00 PM with the laboratory's Corporate Manager revealed all routine standing laboratory orders expired 400 days after the initial receipt of the order. According to the Corporate Manager, the standing orders would need to be updated in the laboratory's computer system prior to the expiration date of the laboratory orders. Record review revealed the facility admitted Resident #8 on [DATE] with [DIAGNOSES REDACTED]. Further review of Resident #8's medical record revealed on [DATE] the resident's physician ordered a PT with INR Q (every) week. Review of the [DATE] physician's orders [REDACTED]. Continued review of physician's orders [REDACTED].#8 every night. On [DATE], the physician gave a verbal order to staff to reduce the resident's [MEDICATION NAME] to 5 milligrams every night. On [DATE], the physician gave a verbal order to discontinue the 5 milligrams of [MEDICATION NAME] and to administer 6 milligrams of [MEDICATION NAME] every night. Review of the Comprehensive Plan of Care, dated [DATE], revealed staff had developed a plan of care to address Resident #8's [DIAGNOSES REDACTED]. According to the plan of care, the resident was at risk for bleeding related to the use of [MEDICATION NAME] and the interventions included to obtain a PT/INR as ordered and to notify the physician of the PT/INR results. Review of Resident #8's laboratory records revealed on [DATE], the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds) and his/her INR level was 2.2 (reference range 0.9 to 1.1). However, continued review of Resident #8's medical record revealed staff failed to ensure the PT with INR laboratory tests were obtained on a weekly basis as ordered by the physician and in accordance with the plan of care. Record review revealed the next PT with an INR for Resident #8 was not completed until [DATE] (seven weeks after the previous test) at which time the resident's PT was 85.1 seconds (73.5 seconds above reference range) and the INR was 7.0 (5.9 above the reference range). Review of the laboratory report revealed both levels were Critical. The resident's physician was notified of the abnormal lab results. On [DATE], the facility transferred Resident #8 to a hospital for further assessment and treatment in accordance with physician's orders [REDACTED]. Review of the hospital record for Resident #8 revealed the resident was admitted to the hospital on [DATE], placed on telemetry, and was diagnosed with [REDACTED]. Interview with Unit Manager #1 on [DATE] at 9:05 AM, revealed staff was to review the plan of care on a monthly basis to ensure care was provided in accordance with the plan of care. According to the Unit Manager, she became aware that a PT and INR had not been obtained on a weekly basis for Resident #8 when she was in the process of transcribing the monthly Physician order [REDACTED]. included monitoring laboratory tests to ensure the tests were completed as ordered. The Unit Manager also stated after the incident with Resident #8, she learned the company that obtained laboratory tests discontinued the orders for routine laboratory tests 400 days after the tests were initially ordered and required a new physician's orders [REDACTED]. According to the Unit Manager, the initial order for the PT with INR for Resident #8 had been ordered by the physician on [DATE] and staff had transcribed the laboratory tests to the resident's physician's orders [REDACTED].#8's PT and INR laboratory test 400 days from the time the test had been initially ordered, which would have been on [DATE], three days after the PT and INR had been obtained on [DATE]. An interview on [DATE], at 2:00 PM, conducted with the laboratory's Corporate Manager, revealed the laboratory sent an auditor once a month to verify the facility's laboratory orders. The Corporate Manager stated the auditor updated orders at that time and left reports of any identified concerns for the facility to follow up on. According to the Corporate Manager, ultimately it was the facility's responsibility to monitor to ensure laboratory orders were updated and the laboratory process had not changed. The Corporate Manager revealed the auditor had been to the facility on [DATE], and had updated the order for Resident #8's PT with INR to be collected on a weekly basis. However, the Corporate Manager stated the auditor had entered a start date of [DATE], instead of [DATE], for the PT and INR, which caused the laboratory orders to be missed from [DATE] until [DATE]. Interview conducted with the Laboratory Auditor on [DATE], at 3:15 PM, revealed she had been responsible for updating Resident #8's PT with INR orders in the computer system and had inadvertently placed the wrong start date in the computer. The Laboratory Auditor stated she had placed [DATE], as the start date for the PT with INRs and should have put [DATE], as the start date. The Laboratory Auditor stated she reviewed physician's orders [REDACTED]. The Laboratory Auditor stated she then provided a report to the DON of any discrepancies. Interview with the Director of Nursing on [DATE] at 1:15 PM revealed Unit Managers were responsible for monitoring to ensure residents' laboratory orders had been completed as ordered by the physician and that care had been provided in accordance with the resident's comprehensive plan of care. The DON stated she forwarded any reports left by the Laboratory Auditor to the Unit Managers to follow through. The DON stated she made rounds several times throughout the day to ensure care was being provided as directed in the plan of care, reviewed the residents' plans of care at random, and had not identified any problems related to laboratory tests not conducted as ordered by the physician. The

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Administrator acknowledged in interview conducted on [DATE], at 2:30 PM that she became aware that staff had failed to ensure the PT and INR laboratory tests had not been conducted as ordered by the physician. The Administrator stated the facility had not taken any action after the incident to ensure care was provided as planned in each resident's plan of care and in accordance with physician's orders [REDACTED]. **The facility provided an acceptable Allegation of Compliance (AOC) on [DATE]. The facility implemented the following actions to remove the Immediate Jeopardy: -Resident #8 had a physician's orders [REDACTED]. Resident #8 had a PT with INR drawn on [DATE]. On [DATE], the lab noted that the PT with INR for Resident #8 was going to expire on [DATE] so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to [DATE] through [DATE], which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from [DATE] until [DATE]. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on [DATE]. The physician was notified by the Unit Manager and a clarification order was obtained 0n [DATE] to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was [DATE]. The PT with INR was drawn on Resident #8 on [DATE]. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from [DATE] to [DATE]. -All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on [DATE], prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner. -The Administrator drafted a letter to the manager of the laboratory on [DATE], stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from [DATE] is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely. -A lab policy and protocol was developed by the Quality Assurance team on [DATE] to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness. -The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on [DATE], before they in-serviced the licensed nursing staff. -All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by [DATE], by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work. -Administrative Nursing Staff completed a 100 percent audit of all labs on [DATE] to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order [REDACTED]. -The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday. -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on [DATE] by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any stat laboratory tests were ordered on the weekend. If stat laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of [DATE]. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of [DATE]. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on [DATE]. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on [DATE] and completed on [DATE]. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on [DATE] to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented [DATE] and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective [DATE]. If any weekend stat laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results. -Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until [DATE]; then one (1) time weekly until [DATE] or as needed; then monthly thereafter or as needed sooner. -Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol. -The Pharmacy Consultant reviewed Resident #8's medical record on [DATE] and on [DATE]. The pharmacist noted on the [DATE] review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders [REDACTED]. During the audit, the pharmacist failed to review all [MEDICATION NAME] or other blood thinning laboratory tests, which placed all residents with this type of medication at risk. -The DON spoke with the current Pharmacy Consultant on [DATE], who had conducted the pharmacy review for Resident #8 in May and [DATE], and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August. -The Administrator drafted a letter to the General Manager of the pharmacy on [DATE], stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for [REDACTED]. -On [DATE], the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports. -The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education. -The Administrator and DON now have access to the pharmacy computer system effective [DATE], so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the

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Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received. -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from [DATE] to [DATE]. -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff. -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by [DATE]. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work. -One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on [DATE]. -One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on [DATE] by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services. -The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders. -The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly. **The surveyors validated the Immediate Jeopardy was removed as follows: -Review of the laboratory reports for Resident #8 revealed a PT with INR dated [DATE] with the results being 85.1 for the PT and the INR results being 7.0. -Review of the Nurse's Notes for Resident #8 dated [DATE], at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital. -Interview conducted with Registered Nurse (RN) #2 on [DATE] at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the [DATE] physician orders. The RN stated on [DATE] she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on [DATE], the resident's physician was notified of the results, and the resident was sent to a hospital. -Interview with the laboratory Corporate Manager on [DATE], at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on [DATE], and had inadvertently set the new start date for [DATE], instead of [DATE]. -Review of the Laboratory Policy and Protocol developed by the facility on [DATE], revealed a posttest had been completed by all facility nurses. -Review of an in-service roster dated [DATE], revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans. -Interview conducted with the DON and the SDN on [DATE], at 4:40 PM, revealed they had attended an in-service on [DATE], by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff. -Interview conducted on [DATE], at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on [DATE], related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff. -Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required. -Review of the letter sent to the laboratory dated [DATE], revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire. -Interview conducted with the Administrator on [DATE], at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on [DATE], of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on [DATE], of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary. -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit. -Observations of the laboratory calendars were conducted on [DATE], on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed. -Interview conducted with the Administrator on [DATE], at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician. -Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call. -Review of an in-service by the Administrator dated [DATE], and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning [DATE]. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on [DATE]. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on [DATE]. -Interview conducted with the Administrator on [DATE], at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on [DATE]. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, [DATE]. The Administrator stated she would be reviewing the audits every Monday in the morning meeting
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's Incidents and Accidents policy, it was

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) determined the facility failed to ensure one (1) of thirty-four (34) sampled residents (Resident #12) received adequate assistive devices to prevent accidents. A review of Resident #12's care plan revealed the resident's wheelchair required anti-rollback devices and bilateral leg rests because the resident was at risk for injury from falling. Observations of Resident #12 sitting in his/her wheelchair on 07/21/14, 07/22/14, and 07/23/14 revealed there were no anti-rollback devices or leg rests attached to the wheelchair. The findings include: Review of the facility's Incidents and Accidents Policy, with a revision date of 10/16/12, revealed the policy did not address the prevention of accidents. Interview with the Administrator on 07/24/14 at 1:30 PM, revealed the facility did not have a policy related to assistive devices. Record review revealed the facility admitted Resident #12 on 09/25/13 with [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severely impaired cognition. Review of the Comprehensive Plan of Care with a revision date of 06/24/14, revealed the facility developed a care plan intervention for anti-rollback devices (device to prevent the wheelchair from rolling back when the resident attempts to stand) and bilateral leg rests (attachment placed on the wheelchair to allow the resident's legs to rest on and aid in mobility) to be on Resident #12's wheelchair to prevent falls. Observations of Resident #12 on 07/21/14 at 4:50 PM, on 07/22/14 at 11:28 AM, and on 07/23/14 at 9:36 AM revealed the resident was sitting in a wheelchair in the dining room. The resident's wheelchair revealed staff failed to ensure the anti-rollback devices and bilateral leg rests were in place on the wheelchair. Interview conducted with State Registered Nurse Aide (SRNA) #10 on 07/23/14 at 10:16 AM revealed she was responsible for the care of Resident #12 on 07/23/14. Further interview revealed she was to review the resident's care plan daily. However, the SRNA stated she was unaware what anti-rollback to the wheelchair meant, or if Resident #12's wheelchair had anti-rollbacks or leg rests. Interview conducted with SRNA #11 on 07/23/14 at 10:19 AM revealed she was also responsible for the care of Resident #12 on 07/23/14. She stated she was required to review the care plan of the residents that she provided care for each day, as the care plan would include information about the resident's care needs. However, SRNA #11 also stated she was unaware if Resident #12 had anti-rollbacks and leg rests to the resident's wheelchair. Registered Nurse (RN) #1 acknowledged in an interview conducted on 07/23/14 at 10:27 AM that Resident #12 did not have anti-rollbacks or leg rests on the resident's wheelchair. The RN stated therapy staff was responsible for placing attachments onto wheelchairs. Interview conducted with the Physical Therapist (PT) on 07/23/14, at 1:31 PM, revealed the Therapy Department was responsible for placing attachments on wheelchairs. The PT stated she was unsure why the attachments were not on Resident #12's wheelchair or if the attachments had ever been placed on the wheelchair. The PT stated nursing staff monitored the care of residents to ensure care was provided. Further interview with RN #1 on 07/23/14 at 2:22 PM revealed she was the Unit Manager for the Green Wing and Resident #12 resided on her unit. RN #1 stated she made rounds frequently throughout the unit to monitor to ensure residents were being provided the care they required. However, the RN stated she had not identified that the anti-rollbacks or the bilateral leg rests were not on the resident's wheelchair. Interview with the Director of Nursing (DON) on 07/25/14 at 1:17 PM revealed the facility monitored residents to ensure they were provided with adequate supervision to prevent accidents when they conducted resident care rounds randomly throughout the facility. The DON stated Therapy staff was required to place attachments on wheelchairs, but nursing staff was responsible to ensure the attachments were in place or to notify the Therapy Department to place them on the wheelchairs.
F 0329 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's policies entitled Lab and Diagnostic Test Results-Clinical Protocol and Medication Administration, and a review of the facility's contract for Laboratory Services, it was determined the facility failed to ensure nursing staff effectively monitored medications and laboratory results for one (1) of thirty-four (34) sampled residents (Resident #8). Review of physician's orders [REDACTED].#8 at night, and for a [MEDICATION NAME] Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check bleeding time) to be completed weekly. A review of Resident #8's medical record revealed the facility administered [MEDICATION NAME] on a daily basis at night and a PT and INR was obtained on [DATE] and on [DATE]. The PT/INR that was obtained on [DATE] revealed the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds), and the resident's INR was 2.2 (reference range 0.9 to 1.1). Documentation revealed facility staff continued to administer 6 mg of [MEDICATION NAME] to Resident #8 at night; however, staff failed to ensure the PT and INR was collected on a weekly basis as ordered by the resident's physician. review of the resident's medical record revealed [REDACTED].#8 again until [DATE] (seven weeks after the previous test on [DATE]) at which time the resident's PT was 85.1 seconds (73.5 seconds above reference range), the INR was 7.0 seconds (5.9 above the reference range), and was identified by the laboratory to be at a Critical level. Review of the Nurse's Notes dated [DATE], revealed Resident #8's physician was notified of the abnormal lab results and the resident was transported and admitted to a hospital where he/she was placed on telemetry (heart monitoring) and diagnosed with [REDACTED]. The facility's failure to ensure facility staff provided adequate monitoring of drugs and laboratory testing and failure to ensure residents were free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on [DATE] at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AOC) was received on [DATE], which alleged removal of the Immediate Jeopardy on [DATE]. Prior to exit on [DATE], the State Survey Agency determined the Immediate Jeopardy was removed on [DATE] as alleged by the facility, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Lab and Diagnostic Test Results-Clinical Protocol, with a revision date of [DATE], revealed the physician would identify and order diagnostic and laboratory testing based on diagnostic and monitoring needs. The policy stated nursing staff would process the test requisition and arrange for the tests to be completed by the laboratory. Review of the facility's policy titled, Medication Administration, which was undated, revealed nursing staff would evaluate if the medication was implicated in an adverse consequence and had achieved the therapeutic goal. However, the policy failed to address monitoring medication/medication errors. Review of the facility's contract titled, Laboratory Contract Addendum, dated [DATE], revealed the laboratory will provide chart audit services for facility on a monthly basis. However, the contract did not address a specific amount of time in which a laboratory test order would expire/stop being collected. Review of the facility's contract titled, Pharmacy Consultant Agreement, dated [DATE], revealed the Pharmacist (RPh) would review the drug regimen of each resident in the facility and would report in writing any irregularity to the facility's Administrator, Medical Director, the resident's physician, and the DON. Record review revealed the facility initially admitted Resident #8 to the facility on [DATE] following a hospitalization , and was readmitted on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of Resident #8's [DATE] physician's orders [REDACTED].#8's medical record revealed facility staff administered 6 mg of [MEDICATION NAME] to the resident nightly; however, staff failed to ensure the PT/INR was collected on a weekly basis from [DATE] through [DATE] (a timeframe of seven weeks). A PT and INR laboratory test was conducted on [DATE], which revealed Resident #8's PT was 85.1 seconds (73.5 seconds above the reference range), his/her INR was 7.0 seconds (5.9 above the reference range), and the laboratory results revealed the levels were Critical. Review of the Nurse's Notes dated [DATE], revealed Resident #8's physician was notified of the Critical lab results and the resident was transported to a hospital. Review of the Hospital record revealed Resident #8 was admitted to the hospital, placed on telemetry, and diagnosed with [REDACTED]. (According to the Occupational Safety and Health Administration (n.d.), the signs and symptoms of [MEDICATION NAME] toxicity include bloody nose; bleeding gums; muscle and joint pain; hematomas of the arms, legs, buttocks, and/or joints; frank blood in the urine and feces; anorexia, nausea, vomiting, diarrhea or abdominal pain; pallor and fatigue caused by [MEDICAL CONDITION]; paralysis caused by [MEDICAL CONDITION]; blurry vision, eye pain, and [MEDICAL CONDITION]; [MEDICAL CONDITION] and petechiae, necrosis, or gangrene). A review of the resident's facility and hospital medical records and interviews with

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F 0329 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) staff revealed Resident #8 did not exhibit any outward signs or symptoms of [MEDICATION NAME] Toxicity. Interview with Unit Manager #1, on [DATE] at 9:05 AM, revealed she was responsible to ensure laboratory orders were completed. However, according to the Unit Manager, on [DATE] she discovered the PT with INR had not been collected for Resident #8 since [DATE]. The Unit Manager stated she contacted the laboratory on [DATE], and was told the order for Resident #8's PT with an INR had expired. According to the Unit Manager, the Corporate Manager for the laboratory informed her standing orders for laboratory tests expired after 400 days. The Unit Manager stated she was not aware of the date the laboratory request had expired. Interview on [DATE] at 1:20 PM with Resident #8's physician revealed the failure to ensure Resident #8's PT and INR levels were obtained and reported weekly could have caused the resident harm. The physician stated he assessed the resident on [DATE], and had documented Resident #8's PT with INRs were being monitored weekly in his Progress Notes, but stated he had just reviewed the laboratory reports that were on the resident's medical record and had not identified the PT with INRs had not been completed weekly for Resident #8 as he had ordered. Interview conducted on [DATE], at 2:00 PM with the Corporate Manager for the laboratory utilized by the facility revealed the laboratory sent an Auditor to the facility on ce a month to verify laboratory orders. The Corporate Manager stated the Auditor would update an order at that time, but it was ultimately the facility's responsibility to ensure laboratory orders were updated and the process had not changed. The Corporate Manager stated when the Auditor verified Physician order [REDACTED]. laboratory tests of [DATE], instead of [DATE], and that had caused the laboratory orders to be missed from [DATE] until [DATE]. Interview with the Director of Nursing (DON) on [DATE] at 1:15 PM revealed the Laboratory the facility utilized to perform laboratory testing maintained standing orders for laboratory tests for a timeframe of 400 days, and then discontinued the order unless it was reordered by the physician. According to the DON, the Laboratory had conducted the PT and INR for Resident #1 in accordance with the physician's initial order, but had discontinued the test the first day after the standing order expired (the 400th day). The DON stated facility staff was required to update standing orders for the Laboratory to continue to conduct laboratory tests. The DON stated until the incident with Resident #8, neither she nor the facility had been aware of the expiration of a laboratory order after 400 days, nor was it specified in the contract between the facility and the laboratory. The DON stated the facility had not put any monitors in place other than the Laboratory Auditor until after Resident #8's PT with INRs had been missed. Interview with the Administrator on [DATE], at 2:30 PM, revealed she was informed of the facility's failure to obtain PT and INR laboratory tests for Resident #8 on [DATE]. The Administrator stated the facility had not taken any action after the incident to ensure care was provided in accordance with physician's orders [REDACTED]. **The facility provided an acceptable Allegation of Compliance (AOC) on [DATE]. The facility implemented the following actions to remove the Immediate Jeopardy: -Resident #8 had a physician's orders [REDACTED]. Resident #8 had a PT with INR drawn on [DATE]. On [DATE], the lab noted that the PT with INR for Resident #8 was going to expire on [DATE] so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to [DATE] through [DATE], which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from [DATE] until [DATE]. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on [DATE]. The physician was notified by the Unit Manager and a clarification order was obtained 0n [DATE] to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was [DATE]. The PT with INR was drawn on Resident #8 on [DATE]. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from [DATE] to [DATE]. -All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on [DATE], prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner. -The Administrator drafted a letter to the manager of the laboratory on [DATE], stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from [DATE] is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely. -A lab policy and protocol was developed by the Quality Assurance team on [DATE] to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness. -The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on [DATE], before they in-serviced the licensed nursing staff. -All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by [DATE], by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work. -Administrative Nursing Staff completed a 100 percent audit of all labs on [DATE] to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order [REDACTED]. -The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday. -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on [DATE] by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any stat laboratory tests were ordered on the weekend. If stat laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of [DATE]. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of [DATE]. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on [DATE]. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on [DATE] and completed on [DATE]. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on [DATE] to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented [DATE] and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective [DATE]. If any weekend stat laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure

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F 0329 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results. -Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until [DATE]; then one (1) time weekly until [DATE] or as needed; then monthly thereafter or as needed sooner. -Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol. -The Pharmacy Consultant reviewed Resident #8's medical record on [DATE] and on [DATE]. The pharmacist noted on the [DATE] review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders [REDACTED]. During the audit, the pharmacist failed to review all [MEDICATION NAME] or other blood thinning laboratory tests, which placed all residents with this type of medication at risk. -The DON spoke with the current Pharmacy Consultant on [DATE], who had conducted the pharmacy review for Resident #8 in May and [DATE], and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August. -The Administrator drafted a letter to the General Manager of the pharmacy on [DATE], stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for [REDACTED]. -On [DATE], the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports. -The Administrator and/or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education. -The Administrator and DON now have access to the pharmacy computer system effective [DATE], so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received. -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from [DATE] to [DATE]. -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff. -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by [DATE]. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work. -One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on [DATE]. -One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on [DATE] by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services. -The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders. -The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly. **The surveyors validated the Immediate Jeopardy was removed as follows: -Review of the laboratory reports for Resident #8 revealed a PT with INR dated [DATE] with the results being 85.1 for the PT and the INR results being 7.0. -Review of the Nurse's Notes for Resident #8 dated [DATE], at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital. -Interview conducted with Registered Nurse (RN) #2 on [DATE] at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the [DATE] physician orders. The RN stated on [DATE] she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on [DATE], the resident's physician was notified of the results, and the resident was sent to a hospital. -Interview with the laboratory Corporate Manager on [DATE], at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on [DATE], and had inadvertently set the new start date for [DATE], instead of [DATE]. -Review of the Laboratory Policy and Protocol developed by the facility on [DATE], revealed a posttest had been completed by all facility nurses. -Review of an in-service roster dated [DATE], revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans. -Interview conducted with the DON and the SDN on [DATE], at 4:40 PM, revealed they had attended an in-service on [DATE], by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff. -Interview conducted on [DATE], at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on [DATE], related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff. -Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required. -Review of the letter sent to the laboratory dated [DATE], revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire. -Interview conducted with the Administrator on [DATE], at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on [DATE], of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on [DATE], of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary. -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit. -Observations of the laboratory calendars were conducted on [DATE], on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed. -Interview conducted with the Administrator on [DATE], at 4:30 PM, and the DON

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F 0329 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 7) at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician. -Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call. -Review of an in-service by the Administrator dated [DATE], and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning [DATE]. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on [DATE]. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on [DATE]. -Interview conducted with the Administrator on [DATE], at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on [DATE]. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, [DATE]. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program. -An in-service roster dated [DATE], regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service. -Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation. -Interviews conducted on [DATE], with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest. -Interview conducted with the SDN on [DATE], at 12:55 PM, revealed she had prov
F 0428 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN [BRACKETS] HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's contract with the pharmacy, it was determined the facility failed to ensure the pharmacist reported irregularities to the attending physician and to the Director of Nursing (DON) in order for the reports to be acted upon for one (1) of thirty-four (34) sampled residents (Resident #8). Resident #8 had physician's orders [REDACTED]. Review of Resident #8's May 2014 monthly Physician order [REDACTED]. Record review revealed a PT and INR was obtained on 05/12/14 and revealed the resident's PT was 24.6 seconds (reference range 9.5 to 11.6 seconds), and the INR was 2.2 (reference range 0.9 to 1.1). However, the next PT with an INR for Resident #8 was not completed until 07/02/14 (seven weeks after the previous PT/INR had been obtained on 05/12/14) and the resident's PT was 85.1 seconds (73.5 seconds above reference) and the INR was 7.0 (5.9 above the reference range). Review of the Laboratory report revealed the resident's PT and INR at that time was Critical. Resident #8 was admitted to the hospital on [DATE], was placed on telemetry, and diagnosed with [REDACTED].#8's medical record on 05/19/14 and 06/26/14. However, there was no evidence the pharmacist had notified the physician or the DON that the resident's PT and INR had not been obtained as ordered by the physician. The facility's failure to ensure residents received adequate drug monitoring and was free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520 at a scope and severity of J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14. An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. On 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14, as alleged, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's contract with the pharmacy entitled, Pharmacy Consultant Agreement, dated 02/01/99, revealed the Pharmacist (RPh) would review the drug regimen of each resident in the facility and would report in writing any irregularity to the facility's Administrator, Medical Director, the resident's physician, and the DON. Record review revealed the facility admitted Resident #8 on 09/07/12 with a [DIAGNOSES REDACTED]. Further review of Resident #8's medical record revealed physician's orders [REDACTED].#8 was to receive 6 milligrams of Coumadin (anticoagulant) every night, and a Prothrombin Time (PT) with an International Normalized Ratio (INR) (laboratory tests to check for bleeding time) every week. Review of Physician order [REDACTED]. In addition, the physician gave a verbal order dated 05/12/14 for the resident's Coumadin to be increased to 6 milligrams every night. Review of Resident #8's laboratory records dated 05/12/14 revealed the PT was 24.6 seconds with the normal range being 9.5 to 11.6 seconds. The INR was 2.2 with the normal range being 0.9 to 1.1 seconds. Further review of laboratory results for Resident #8 revealed the laboratory testing had not been completed on a weekly basis as ordered. Review of laboratory reports revealed a PT and INR was conducted on 07/02/14, seven weeks after the most recent tests on 05/12/14, and the resident's PT was 85.1 seconds (73.5 seconds above the reference range) and the INR was 7.0 (5.9 above the reference range). The laboratory report indicated both levels were Critical. A hand written note on the laboratory report revealed a Registered Nurse (RN) notified the resident's physician of the abnormal lab results and Resident #8 was transported to a hospital. Review of the hospital record for Resident #8 revealed the resident was admitted to the hospital on [DATE], placed on telemetry, and was diagnosed with [REDACTED]. Review of the Medication Regimen Review revealed the RPh had reviewed the medication regimen for Resident #8 on 05/19/14 and 06/26/14. However, there was no documented evidence the RPh had identified and/or notified the Administrator, DON, Medical Director, or the resident's physician that the weekly PT and INR laboratory tests had not been conducted as prescribed for Resident #8. Interview conducted with the RPh on 07/18/14, at 1:40 PM, revealed he conducted monthly medication regimen reviews, and reviewed laboratory reports of those residents that received Coumadin (anticoagulant). The RPh stated he had not recorded Resident #8's PT with INR on 06/26/14, and that he had missed the fact that the resident had not had a PT with INR completed since 05/12/14. Interview with the Director of Nursing on 07/18/14 at 1:15 PM revealed she had not received any communication from the RPh that the weekly PT and INR that had been ordered by Resident #'8s physician had not been done. The DON stated she would have expected the pharmacist to notify her. Interview on 07/18/14 at 1:20 PM with the Medical Director revealed he was also Resident #8's physician. According to the Medical Director, he expected the pharmacist that conducted the monthly drug regimen reviews at the facility to notify him of any drug irregularities and that the weekly PT and INRs that he had ordered for Resident #8 had not been completed as ordered. Interview conducted with the Administrator on 07/18/14, at 2:30 PM, revealed the pharmacist conducted drug regimen on a monthly basis and the pharmacist was to notify her of any drug irregularities as the result of his monthly drug regimen review. The Administrator stated the pharmacist had conducted a monthly drug regimen review for Resident #8 on 05/19/14 and 06/26/14. However, according to the Administrator, the pharmacist had not notified her of any drug irregularities or that the laboratory tests used to monitor Resident #8's Coumadin use had not been conducted as ordered by the physician. **The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy: -Resident #8 had a physician's orders [REDACTED]. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained 0n 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14. -All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse

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F 0428 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner. -The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely. -A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness. -The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff. -All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work. -Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order [REDACTED]. -The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday. -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any stat laboratory tests were ordered on the weekend. If stat laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend stat laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results. -Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner. -Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol. -The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders [REDACTED]. During the audit, the pharmacist failed to review all Coumadin or other blood thinning laboratory tests, which placed all residents with this type of medication at risk. -The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August. -The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for [REDACTED]. -On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports. -The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education. -The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received. -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14. -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff. -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation

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F 0428 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work. -One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14. -One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services. -The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders. -The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly. **The surveyors validated the Immediate Jeopardy was removed as follows: -Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0. -Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital. -Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital. -Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14. -Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses. -Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans. -Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff. -Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff. -Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required. -Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary. -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit. -Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician. -Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call. -Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program. -An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service. -Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest. -Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans. -Review of a list of Quality Assurance Team Committee members was conducted. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools. -Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted. -Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified. -Review of Resident

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	185221	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALYERSVILLE NURSING AND REHABILITATION CENTER	571 PARKWAY DRIVE SALYERSVILLE, KY 41465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0428 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician. -Review of Care Plan Protocol staff were informed where care plans were located at each nursing station, and staff were required to follow the plans of care for each resident, and directed that care plans would be updated with any change in condition that would impact a resident's care. -Review of an in-service roster dated 07/21/14, regarding the Care Plan Protocol attended by licensed nursing staff revealed the nurses were provided education on the Care Plan Protocol as well as required to take a posttest. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, a
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility policies entitled Medication Administration and Lab and Diagnostic test results-Clinical Protocol, and the Administrator's position description, it was determined the facility's Administration failed to ensure its resources were used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (1) of thirty-four (34) sampled residents (Resident #8). The facility admitted Resident #8 on 09/07/12 with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED].#8's physician's orders [REDACTED].#8 as ordered. Review of laboratory reports revealed a PT with INR had been conducted on 05/12/14; however, the next PT with INR had not been conducted until 07/02/14, a timeframe of seven weeks. Review of the laboratory report for the PT and INR conducted on 07/02/14 revealed Resident #8's PT and INR levels were Critical, and the resident was transferred and admitted to a hospital, placed on telemetry, and diagnosed with [REDACTED]. Interview conducted with the Administrator revealed the Director of Nursing (DON) informed her on 07/01/14 that the routine laboratory tests used to monitor Resident #8's [MEDICATION NAME] use had not been conducted as ordered by the physician since 05/12/14, even though it had been ordered to be conducted on a weekly basis. The Administrator stated the Unit Managers and DON were present on 07/01/14, when the incident was discussed. According to the Administrator, because the Unit Managers were required to monitor laboratory tests to ensure the tests were done and were present when the DON was notified of the incident, the facility had not conducted staff in-services related to the incident and had not monitored any other resident records, including physician orders [REDACTED]. [REDACTED]. The facility's failure to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for its residents caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.60 Pharmacy Services (F428), 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14. An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. On 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14, as alleged, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the Administrator's Position Description dated and signed by the Administrator on 02/12/13, revealed the Administrator was responsible for directing the day to day functions of the facility in accordance with current federal, state, and local guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times. The position description also revealed it was the Administrator's responsibility to ensure excellent care was maintained for residents by overseeing and monitoring patient care services delivered. Review of an undated facility policy titled, Medication Administration, revealed the nursing staff would evaluate medications to determine if a resident had an adverse consequence such as an abnormal laboratory test result, or had achieved the therapeutic drug level (within the desired level), or a level that was too high or too low. Review of the facility's policy titled, Lab and Diagnostic test results-Clinical Protocol, with a revision date of October 2010, revealed the physician would identify and order diagnostic and laboratory testing based on diagnostic and monitoring needs. The policy revealed nursing staff would process the test requisitions and arrange for the tests to be completed by the laboratory. Review of the contract between the laboratory and the facility dated 10/02/06, revealed the contract did not specify an amount of time at which a physician's routine laboratory order would expire. The contract revealed the laboratory would furnish to the facility the results of all routine tests as outlined in the physician's orders [REDACTED]. Medical record review revealed the facility initially admitted Resident #8 on 09/07/12, with a [DIAGNOSES REDACTED]. Review of the monthly May 2014 physician's orders [REDACTED].#8's laboratory results revealed a PT with INR had been conducted on 05/12/14; however, no further PT with INR had been conducted until 07/02/14, at which time the resident's PT was 85.1 seconds (73.5 seconds above the reference range of 9.5 to 11.6 seconds) and his/her INR was 7.0 (5.9 above the reference range of 0.9 to 1.1). According to the laboratory report, both levels were Critical. Documentation in the Nursing Notes revealed on 07/02/14, at 5:41 PM, facility staff notified the resident's physician of the elevated PT and INR laboratory results and the resident was transported to a hospital for further evaluation and treatment. Documentation in the resident's hospital record revealed Resident #8 was admitted to the hospital on [DATE], placed on telemetry to monitor his/her vital signs, and the physician at the hospital diagnosed Resident #8 to have [MEDICATION NAME] Toxicity. Interview conducted with the Administrator on 07/18/14, at 2:30 PM, revealed the Director of Nursing (DON) had informed her on 07/01/14 that the routine laboratory tests used to monitor Resident #8's [MEDICATION NAME] use had not been conducted as ordered by the physician since 05/12/14 even though it had been ordered to be conducted on a weekly basis. The Administrator stated the pharmacist and nursing staff failed to identify and/or report that the routine laboratory tests for Resident #8 had not been conducted as ordered by the physician. The Administrator stated a Unit Manager had learned on 06/30/14 that the laboratory tests had not been conducted as ordered by the physician for Resident #8 and contacted the resident's physician. According to the Administrator, the Unit Manager that learned the laboratory tests had not been conducted notified the DON on 07/01/14 in the presence of the facility's Unit Managers, who were responsible to monitor the laboratory requests to ensure they had been completed. According to the Administrator, because the Unit Managers were present when the DON was notified of the omission of the laboratory tests for Resident #8, the Administrator had not taken any action to educate staff of the facility's policies related to the incident and had not monitored any other resident records, including physician orders [REDACTED]. In addition, the Administrator stated that prior to 07/01/14 she was not aware laboratory orders would expire in the computer system after 400 days nor was that information in the contract between the facility and the laboratory. However, when the Administrator became aware on 07/01/14, no action was taken to ensure laboratory testing orders did not expire and laboratory tests were obtained as ordered by residents' physicians. **The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy: -Resident #8 had a physician's orders [REDACTED]. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained 0n 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14. -All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner. -The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be

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	185221	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALYERSVILLE NURSING AND REHABILITATION CENTER	571 PARKWAY DRIVE SALYERSVILLE, KY 41465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely. -A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness. -The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff. -All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work. -Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order [REDACTED]. -The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday. -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any stat laboratory tests were ordered on the weekend. If stat laboratory tests have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend stat laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results. -Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner. -Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol. -The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders [REDACTED]. During the audit, the pharmacist failed to review all [MEDICATION NAME] or other blood thinning laboratory tests, which placed all residents with this type of medication at risk. -The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August. -The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for [REDACTED]. -On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports. -The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education. -The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received. -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14. -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff. -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work. -One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14. -One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services. -The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders. -The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate

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	185221	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALYERSVILLE NURSING AND REHABILITATION CENTER	571 PARKWAY DRIVE SALYERSVILLE, KY 41465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 12) jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly. **The surveyors validated the Immediate Jeopardy was removed as follows: -Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0. -Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital. -Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital. -Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14. -Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses. -Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans. -Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff. -Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff. -Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care plans. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required. -Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary. -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit. -Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician. -Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call. -Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program. -An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service. -Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest. -Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans. -Review of a list of Quality Assurance Team Committee members was conducted. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools. -Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy entitled, Quality Assessment and Assurance Plan, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies for one (1) of thirty-four (34) sampled residents (Resident #8). Review of the May 2014 Physician order [REDACTED]. time, to be completed on a weekly basis. On 05/05/14, the physician gave staff a verbal order to decrease Resident #8's [MEDICATION NAME] dosage from 6 milligrams daily to 5 milligrams a day. Review of laboratory results dated [DATE], revealed the resident's PT was 24.6 seconds with a reference range of 9.5 to 11.6 seconds. The INR was 2.2 seconds with a reference

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) range of 0.9 to 1.1 seconds. Further review of the laboratory results for Resident #8 revealed after 05/12/14, the facility failed to obtain a PT and INR for Resident #8 until 07/02/14 (a timeframe of seven weeks after the previous PT and INR had been obtained), at which time the resident's PT was 85.1 seconds (73.5 seconds above the normal range of 9.5 to 11.6 seconds) and his/her INR level was 7.0 (5.9 above the normal range of 0.9 to 1.1). Review of the laboratory report revealed the PT and INR levels obtained on 07/02/14 were Critical. Review of the Nurse's Notes revealed Resident #8's physician was notified of the abnormal lab results on 07/02/14 and the resident was taken to a hospital where he/she was placed on telemetry and diagnosed with [REDACTED]. Interview revealed the facility failed to identify that a PT and INR had not been conducted on a weekly basis (for a timeframe of seven weeks) as ordered by Resident #8's physician and, as a result, failed to develop and implement appropriate plans of action through a Quality Assurance Program to correct the identified deficiency to prevent medication and laboratory monitoring errors, the pharmacist's failure to identify and report drug irregularities to the physician and the Director of Nursing, and the facility's failure to be administered in a manner to ensure each resident maintained the highest practicable physical, mental, and psychosocial wellbeing of each resident. (Refer to F282, F329, F428, and F490.) The facility's failure to ensure residents received adequate drug monitoring and was free from significant medication errors caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was determined to exist on 05/19/14 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F329). The facility was notified of the Immediate Jeopardy on 07/18/14. An acceptable Allegation of Compliance (AOC) was received on 07/24/14, which alleged removal of the Immediate Jeopardy on 07/24/14. Prior to exit on 07/25/14, the State Survey Agency determined the Immediate Jeopardy was removed on 07/24/14 as alleged, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F329), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F490 and F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, Quality Assessment and Assurance Plan, with a revision date of December 2009, revealed the facility would develop, implement, and maintain an ongoing, facilitywide Quality Assessment and Assurance Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems. The policy revealed the Administrator was responsible for ensuring the facility's Quality Assessment and Assurance Program complied with federal, state, and local regulatory agency requirements. Record review revealed the facility admitted Resident #8 on 09/07/12, with a [DIAGNOSES REDACTED]. Review of Resident #8's May 2014 monthly physician's orders [REDACTED]. Review of Resident #8's physician's orders [REDACTED]. to 6 milligrams every night. Review of Resident #8's PT with INR results, which were dated 05/12/14, revealed the resident's PT was 24.6 seconds, with a reference range of 9.5 to 11.6 seconds and the resident's INR level was 2.2, with a reference range of 0.9 to 1.1. Continued review of the laboratory results for Resident #8 revealed no documented evidence the weekly lab testing had been completed as ordered by the physician until 07/02/14 (a timeframe of seven weeks), at which time the resident's PT level was 85.1 seconds (73.5 seconds above the reference range of 9.5 to 11.6 seconds) and the INR was 7.0 (5.9 above the reference range of 0.9 to 1.1 seconds). According to the lab report dated 07/02/14, the resident's PT and INR levels were Critical. Review of Resident #8's Nurse's Notes revealed the resident's physician was notified of the abnormal lab results and Resident #8 was transported to a local hospital. Review of Resident #8's hospital record revealed the resident was admitted to on 07/02/14, placed on telemetry, and was diagnosed to have [MEDICATION NAME] Toxicity. Interview conducted with the Director of Nursing (DON) on 07/17/14, at 6:30 PM, revealed she was responsible for the Quality Assurance Program for the facility. The DON stated even though she became aware on 07/01/14 that Resident #8's laboratory tests (PT and INR) had not been conducted as ordered, no additional education in-services or monitors had been put into place. The DON stated the Unit Managers, who were responsible for monitoring to ensure all residents laboratory testing had been completed as it was ordered by the physician, had been present when she learned of the omission of Resident #8's laboratory tests. According to the DON, she and the Unit Managers discussed the situation and the DON determined they had been sufficiently educated on the omission of laboratory tests. The Administrator stated in interview conducted on 07/18/14, at 2:30 PM that the pharmacist had not notified her that the laboratory tests used to monitor Resident #8's [MEDICATION NAME] use had not been conducted as ordered by the physician. The Administrator stated nursing staff had also failed to identify that the routine laboratory tests had not been conducted as ordered by the physician until 06/30/14. The Administrator stated the Unit Manager notified the DON of the incident on 07/01/14 in the presence of the facility's Unit Managers. According to the Administrator, because the Unit Managers were present when the DON was notified of the omission of the laboratory tests for Resident #8, the facility had not conducted staff in-services related to the incident and had not monitored any other resident records, including physician orders [REDACTED]. **The facility provided an acceptable Allegation of Compliance (AOC) on 07/24/14. The facility implemented the following actions to remove the Immediate Jeopardy: -Resident #8 had a physician's orders [REDACTED]. Resident #8 had a PT with INR drawn on 5/12/14. On 06/12/14, the lab noted that the PT with INR for Resident #8 was going to expire on 07/31/14 so she went in to renew the lab in the Medlab System. She mistakenly changed the start date to 07/31/14 through 07/31/14, which deleted the order out of the system until that date; therefore, there would be no PT with INR order in the system for Resident #8 from 05/12/14 until 07/01/14. The Unit Manager discovered that a PT with 1NR was not being drawn during changeover on 6/30/14. The physician was notified by the Unit Manager and a clarification order was obtained 0n 06/30/14 to obtained a PT with INR weekly. The Unit Manager put the PT with INR in the Medlab computer system to be drawn on the next lab day, which was 7/1/14. The PT with INR was drawn on Resident #8 on 7/2/14. The PT was 85.1 seconds and the INR was 7.0. The physician was notified by the LPN and new orders were received to transfer Resident #8 to the hospital for direct admission. Resident #8 was admitted to the hospital from 07/02/14 to 07/04/14. -All residents who were to have routine labs ordered by the physician are at risk. The Regional Nurse Consultant provided an in-service for the DON and Staff Development Nurse on the lab policy on 07/19/14, prior to providing an in-service to Licensed Nursing Staff and Unit Managers. All of the nurses, as well as the Unit Managers, will be in-serviced by the DON, Staff Development Nurse or designee on the new laboratory policy and protocol. New protocol has been developed to ensure that laboratory tests are drawn as ordered by the physician and that the results are received in a timely manner. -The Administrator drafted a letter to the manager of the laboratory on 07/22/14, stating that the minimum expectation is that for any changes in renewing a lab order or any other changes to the laboratory system they must notify the Administrator and DON as well as provide education on those changes. Also stated in the letter from 07/22/14 is the expectation that no laboratory auditor will renew any labs at all, the facility will be responsible for that. The laboratory was also expected during their monthly audits to provide the Administrator and DON with a list of names for those orders expiring in the upcoming month so that they could renew the lab orders in the laboratory system timely. -A lab policy and protocol was developed by the Quality Assurance team on 07/19/14 to be used for all laboratory tests. This new policy and protocol includes the steps to take starting from receiving a laboratory order all the way to getting the results and monitoring for timeliness. -The Regional Nurse Consultant in-serviced the DON and the Staff Development Nurse on the lab policy and protocol on 07/19/14, before they in-serviced the licensed nursing staff. -All licensed nursing staff as well as the unit managers will be educated on the new lab policy and protocol by 7/20/14, by the DON, Staff Development Nurse or designee. All new nursing hires will be educated on the lab policy and protocol during orientation. No licensed nursing staff will be permitted to work prior to receiving this education. Six (6) licensed nursing staff had not received the in-service because of vacation and sick leave; however, the facility will provide in-service to the six employees before they return to work. -Administrative Nursing Staff completed a 100 percent audit of all labs on 07/22/14 to ensure labs were drawn per physicians order; any issues identified were addressed and taken through QA. Based on the information provided, Quality Assurance follow-up included completion of documentation, Physician order [REDACTED]. -The Unit Managers will have a laboratory calendar, which has all routine laboratory tests scheduled to be drawn for the rest of the year on it. They will compare the laboratory calendar to the laboratory tests in the laboratory book prior to the morning meetings Monday through Friday to ensure that they match and to ensure that they are drawn timely as ordered and results are received as well as family and physician notification as needed. The Administrator and/or DON or designee will monitor use of the laboratory book five (5) days a week, Monday through Friday, in the morning meeting to ensure that laboratory tests have been drawn as ordered and results have been returned to the facility and have been addressed. Routine laboratory tests are performed Monday through Thursday. -The Nurse on the rotating call schedule was in-serviced on the weekend lab-monitoring log on 07/22/14 by the Administrator. The Weekend Nurse on Call will call the facility on Saturday and Sunday at 9 AM, 5 PM, and 9 PM to see if any stat laboratory tests were ordered on the weekend. If stat laboratory tests

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) have been ordered they will verbally verify that the results have been received and the physician and the family have been notified and if any new orders have been received. They will write this down on the weekend lab monitoring log beginning this upcoming weekend. -All staff has been in-serviced on abuse, the definition of abuse, and reporting abuse. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency is used at the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -All staff will be in-serviced on Resident Rights. Education will be conducted by DON, Staff Development Nurse or designee with a completion date of 07/20/14. No agency staff are used the facility. All new hires will be educated during general orientation by the Staff Development Nurse. -The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Unit Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director. -The Quality Assurance Committee members reviewed the education material on 07/19/14. The education materials created were reviewed by Quality Assurance and have been taught to staff by the DON and Staff Development Nurse, who were in-serviced by the Regional Nurse Consultant before they in-serviced the Licensed Nursing Staff. Records of the in-service include signatures of attendance, signature of in-services received, and copy of testing for efficacy of the training. Staff in-service education was provided on 07/19/14 and completed on 07/20/14. Staff retained copies of all in-service materials for their use. -Members of the Quality Assurance Committee developed a policy on 07/19/14 to validate that Laboratory tests were obtained as ordered by the physician and results were received and followed up on timely per policy protocol. This was implemented 07/19/14 and is ongoing. The Unit Managers will compare the laboratory calendar to the laboratory tests listed on the laboratory-tracking sheet before morning meetings to verify they match. The Unit Manager will then follow up prior to the morning meeting to ensure that laboratory tests were drawn as listed, results have been received, and they have been followed up on timely. During the morning meetings, Monday through Friday, the Administrator, DON, or designee will check the Laboratory book as well as the laboratory calendar to ensure that laboratory tests have been drawn as physician ordered and results have been received. Any issues identified will be corrected immediately. This practice became effective 07/19/14. If any weekend stat laboratory tests ordered, the Nurse on Call will call the Administrator or DON and will audit any laboratory tests ordered and received. -Quality Assurance Meetings will be held with two (2) or more team members in attendance daily, five (5) days a week and PRN for review of data to ensure compliance including: any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results. -Quality Assurance Committee members will review data (any findings of laboratory tests not completed per physician order, any abnormal lab results found without physician notification, or any critical lab results) minimally five (5) days a week and PRN for thirty (30) days or additionally as necessary until 08/15/14; then one (1) time weekly until 09/12/14 or as needed; then monthly thereafter or as needed sooner. -Regional Nurse Consultant or the Regional Direct of Operations will review, comment, recommend, and/or approve Quality Assurance meetings as per the monitoring protocol. -The Pharmacy Consultant reviewed Resident #8's medical record on 05/19/14 and on 06/26/14. The pharmacist noted on the 06/26/14 review in Omniview (the pharmacy's computerized system) that Resident #8 hadn't been having their PT with INR drawn weekly per physician's orders [REDACTED]. During the audit, the pharmacist failed to review all [MEDICATION NAME] or other blood thinning laboratory tests, which placed all residents with this type of medication at risk. -The DON spoke with the current Pharmacy Consultant on 07/18/14, who had conducted the pharmacy review for Resident #8 in May and June 2014, and the Pharmacy Consultant stated that he was resigning and someone else would be doing the pharmacy consulting for the facility starting in August. -The Administrator drafted a letter to the General Manager of the pharmacy on 07/23/14, stating that during the pharmacist's monthly review, the minimum expectation is that all residents with an order for [REDACTED]. -On 07/21/14, the Administrator called and spoke with the General Manager of the pharmacy and explained to him that the pharmacy consultant must exit with the Administrator and/or DON and go over their consultant reports when reports are ready and provide the facility with a hard copy of the consultant reports. -The Administrator and/ or DON will educate the Pharmacy Consultant before their next regular review to ensure they assess the following areas: monitoring labs for critical levels, drug-to-drug interactions, and recommended drug alternatives. The education will also include that the Pharmacy Consultant must exit with the Administrator and/or DON upon completion of their review to go over the consultant reports and provide the facility with a hard copy of the consultant reports. The Pharmacy Consultant will be required to sign verification of education. -The Administrator and DON now have access to the pharmacy computer system effective 07/23/14, so they can go in and look at the consultant reports as well as any notes that had been made. The Administrator and DON will review the reports in the pharmacy computer system when they become available after the Pharmacy Consultant has completed his exit. The Administrator and DON will check the computer system daily after the pharmacy consultant has exited to see if the reports are on the computer. When the reports are available on the computer the Administrator and DON will compare the computer to the hard copy pharmacy reports to ensure that they match. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -The Administrator and DON will review the Pharmacy Consultant's report monthly to see what recommendations have been made, and to identify any issues found. Any issues found will be addressed through quality assurance and taken to quality assurance meetings for follow-up. -If any weekend stat labs are ordered, the Nurse on Call will call the Administrator or DON and will document any labs on the audit tool for the weekend lab tests ordered and received. -Resident #8 has a care plan for anticoagulants, which stated to obtain a PT/INR as ordered, at least monthly. However, the PT with INR laboratory tests for Resident #8 were not drawn weekly as ordered by the physician or as care planned from 05/12/14 to 07/02/14. -Based on the fact that the Care Plan was not followed for anticoagulant therapy the root cause has been determined to be lack of use of the care plan as a communication tool to licensed nursing staff. -Licensed Nursing staff will be in-serviced on the comprehensive care plan use in directing resident care by 7/21/14. In-services will be conducted by the Staff Development Nurse, DON or designee. In-services will include documentation required for the use of interventions on the care plans. All new hires will be educated during general orientation by the Staff Development Nurse. Six (6) licensed staff members have not been in-serviced due to vacation, or sick leave and they will be educated before they are allowed to return to work. -One hundred percent (100%) of all anti-coagulant care plans were reviewed and/or updated by the Regional Nurse Consultant as necessary on 07/20/14. -One hundred percent (100%) of the care plans have been reviewed and/or updated for labs on 07/21/14 by members of the care planning team including the DON, MDS, Unit managers, Dietary Manager, Social Services. -The Administrator did not have sufficient lab protocols in place to assure that Resident #8 had received labs per physician orders. -The Regional Director of Operations or the Clinical Nurse Consultant will be in the building daily until the facility has abated the immediate jeopardy to provide facility oversight. After the facility has abated the immediate jeopardy, they will be in the facility to provide management oversight throughout the survey process at least weekly. **The surveyors validated the Immediate Jeopardy was removed as follows: -Review of the laboratory reports for Resident #8 revealed a PT with INR dated 07/02/14 with the results being 85.1 for the PT and the INR results being 7.0. -Review of the Nurse's Notes for Resident #8 dated 07/02/14, at 5:41 PM, revealed Resident #8's physician was notified regarding the results of the resident's PT with INR, and the resident was sent to the hospital. -Interview conducted with Registered Nurse (RN) #2 on 07/18/14 at 9:05 AM, revealed Resident #8 had not received his/her PT with INRs weekly as was ordered by the physician in the May 2014 physician orders. The RN stated on 06/30/14 she notified Resident #8's physician that the resident had not received a PT with INR laboratory test as ordered and received an order to obtain weekly PT with INR. A PT with INR was completed on 07/02/14, the resident's physician was notified of the results, and the resident was sent to a hospital. -Interview with the laboratory Corporate Manager on 07/22/14, at 2:00 PM, revealed during her monthly review of laboratory orders, the Laboratory Auditor had updated Resident #8's PT with INR order in the computer, which was set to expire on 07/31/14, and had inadvertently set the new start date for 07/01/14, instead of 05/19/14. -Review of the Laboratory Policy and Protocol developed by the facility on 07/19/14, revealed a posttest had been completed by all facility nurses. -Review of an in-service roster dated 07/19/14, revealed the DON and Staff Development Nurse (SDN) attended an in-service by the Regional Nurse Consultant on the lab policy, neglect, resident rights, and care plans. -Interview conducted with the DON and the SDN on 07/25/14, at 4:40 PM, revealed they had attended an in-service on 07/19/14, by the Regional Corporate Nurse on the lab policy and protocol, abuse, resident rights, and care plans. The DON and SDN stated they had then provided the in-service to the nursing staff. -Interview conducted on 07/25/14, at 4:15 PM, with the Regional Nurse Consultant revealed she had been responsible for providing an in-service to both the DON and the SDN on 07/19/14, related to the lab policy and protocol, abuse, resident rights, and care plans prior to them providing an in-service to the nursing staff. -Review of the in-service roster revealed 43 facility nurses attended the in-service provided by the DON and SDN on the lab policy and protocol and care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALYERSVILLE NURSING AND REHABILITATION CENTER	571 PARKWAY DRIVE SALYERSVILLE, KY 41465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 15) plans. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM all revealed they had attended an in-service on abuse, and resident rights. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, and LPN #6 at 2:02 PM revealed they had attended an in-service related to the lab policy and protocol regarding how to put a laboratory order into the computer, the tracking process, and documentation required. -Review of the letter sent to the laboratory dated 07/22/14, revealed the laboratory service was not to renew any laboratory orders that were near expiration, and that the facility would do all renewals. The laboratory was required to immediately notify the Administrator and the DON of any changes or any laboratory orders that were about to expire. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed the Administrator had notified the laboratory's General Manager by phone and then by letter and had instructed them that they were to no longer update any laboratory orders in the computer, that the facility would do all laboratory updates, and that the facility expected the Laboratory Auditor to give the Administrator and the DON a list of all residents whose laboratory orders were nearing expiration. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, of all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician revealed all had been completed. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, and the DON at 4:40 PM, revealed they had all assisted in completing an audit on 07/22/14, of all residents' laboratory orders to ensure the orders had been completed as ordered by the physician and the reports had been placed on the resident's medical record and the results reported to the physician as necessary. -Review of the laboratory calendars for each nursing station revealed all Unit Managers had documented all laboratory orders and the date the laboratory test was due for the residents on their unit. -Observations of the laboratory calendars were conducted on 07/25/14, on the Blue Wing at 2:40 PM, Peach Wing at 2:45 PM, and the Green Wing at 2:50 PM. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, and RN #9 at 2:38 PM, revealed they used the calendars to monitor laboratory orders to ensure the laboratory test were completed. The RNs also revealed they were required to check laboratory orders daily prior to attending the morning Quality Assurance meeting and were required to report any concerns with laboratory orders not being completed. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, and the DON at 4:40 PM, revealed they reviewed the laboratory calendars every morning in the Quality Assurance morning meeting to ensure laboratory orders had been completed as ordered by the physician. -Review of the Nurse on Call schedule revealed a nurse was scheduled every weekend to take Administrative call. -Review of an in-service by the Administrator dated 07/22/14, and attended by the DON, RN #2, and RN #9 revealed the weekend On-Call Nurse was required to call the facility on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been conducted. If any were ordered, the RN was then required to verbally verify if the results had been received by the facility. The weekend Nurse on Call was required to document the information on the weekend log beginning 07/26/14. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, and the DON at 4:40 PM, all revealed they had attended an in-service by the Administrator on 07/22/14. The interviews revealed they were required to call the facility when on call on Saturday and Sunday at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM, to ensure any stat laboratory orders had been ordered, and the results returned. The interview revealed they were also required to document the information on a weekend lab-monitoring tool as part of the Quality Assurance program, which began on 07/26/14. -Interview conducted with the Administrator on 07/25/14, at 4:30 PM, revealed she had conducted an in-service for nurses who would be taking administrative call on weekends on 07/22/14. The Administrator stated the on-call nurses were required to call the facility at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM to ensure all stat laboratory orders had been completed and the results were on the resident's medical record. The Administrator stated the process would begin on Saturday, 07/26/14. The Administrator stated she would be reviewing the audits every Monday in the morning meeting, which was a part of the Quality Assurance program. -An in-service roster dated 07/20/14, regarding Abuse and Resident Rights with a posttest, revealed all employees had attended the in-service. -Review of a new hire in-service syllabus was reviewed and the laboratory policy in-service was added to the new hire orientation. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #9 at 2:38 PM, Licensed Practical Nurse (LPN) #3 at 2:46 PM, LPN #5 at 2:56 PM, LPN #6 at 2:02 PM, State Registered Nurse Aide (SRNA) #8 at 2:24 PM, SRNA #10 at 2:00 PM, SRNA #14 at 2:11 PM, SRNA #15 at 2:15 PM, and SRNA #16 at 2:28 PM revealed they had attended an in-service on abuse and resident rights and had also completed a posttest. -Interview conducted with the SDN on 07/24/14, at 12:55 PM, revealed she had provided in-service for staff on the lab policy and protocol, abuse, resident rights, and the required usage of the care plans. -Review of a list of Quality Assurance Team Committee members was conducted. -Review of an audit completed by the DON, RN #2, RN #8, RN #9, and RN #10 on 07/22/14, revealed the facility had reviewed all residents' laboratory orders to ensure laboratory orders had been completed as ordered by the physician. -Interviews conducted on 07/25/14, with RN #2 at 4:43 PM, RN #8 at 2:30 PM, RN #9 at 2:38 PM, DON at 4:40 PM, and the Administrator at 4:30 PM, revealed they were all part of the Quality Assurance Committee and attended meetings daily Monday through Friday during the morning meeting which was part of the Quality Assurance program. The staff revealed they developed and reviewed education in-services and policies for the lab policy and protocol, care plans, and the abuse and resident rights in-service, as well as the audit tools that will be used. The staff stated they would also be reviewing the audit tools. -Review of Quality Assurance morning meeting minutes dated 07/19/14, 07/20/14, 07/21/14, 07/22/14, 07/23/14, 07/24/14, and 07/25/14, which had all been reviewed and signed by the Regional Nurse Consultant or the Regional Director of Operations, was conducted. -Interviews conducted on 07/25/14, at 4:45 PM, with the Regional Corporate Nurse Consultant and the Regional Director of Operations, revealed they had reviewed and signed all daily Quality Assurance minutes beginning on 07/19/14 through 07/25/14. The Regional Corporate Nurse Consultant stated she had been in the facility every day since immediate jeopardy had been identified. -Review of Resident #8's Comprehensive Plan of Care regarding anticoagulant therapy revealed the resident had a care plan intervention to obtain a PT with INR as ordered by the physician. -Review of Care Plan Protocol staff were informed where care plans were located at e