STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185338	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	124 WEST NASHVILLE ST PEMBROKE, KY 42266

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and review of the facility's policy and procedure, it was determined the facility failed to consult with the physician for eleven (11) of seventeen (17) sampled residents (Residents #1, #2, #3, #6, #10, #11, #12, #13, #14, #15 and #16). The facility failed to consult with the physicians when medications were not available for administration or when not administered for Residents #2, #3, #10, #11, #12, #13, #14, #15 and #16; and, when treatments were not provided for Resident #6. The physician was not notified when Resident #1 had an accident, which resulted in injury. The facility failed to notify the physician when Resident #10 did not receive a now dose of Potassium 40 milliequivalents (meq) which was ordered to be administered on [DATE], but was not given until [DATE]. Resident #11 did not receive Solu-[MEDICATION NAME] (steroid) 40 milligrams (mg) intramuscularly (IM) and [MEDICATION NAME] (antibiotic) 500 mg intravenously (IV) which was ordered stat (to be given immediately) on [DATE], but wasn't given until [DATE]. Resident #12, who had a [MEDICAL CONDITION] disorder, did not receive [MEDICATION NAME] [MEDICATION]) 500 mg by mouth twice daily from [DATE] through [DATE] for a total of six (6) doses and experienced a [MEDICAL CONDITION] and required hospitalization . Resident #14 did not receive a total of fourteen (14) doses of [MEDICATION NAME] (digestive enzyme) 5000 Units from [DATE] through [DATE]; Resident #15, who had a [DIAGNOSES REDACTED]. The resident presented with complaints of severe pain. Resident #16 did not receive [MEDICATION NAME] (diuretic) 30 mg daily, [MEDICATION NAME] (Gout) 50 mg daily, Aspirin (heart) 81 mg daily, [MEDICATION NAME] (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivalents three (3) times daily, [MEDICATION NAME] (antibiotic) 300 mg three (3) times daily for 10 days, [MEDICATION NAME] (antibiotic) one (1) Gram twice daily for seven (7) days and [MEDICATION NAME] ([MEDICATION NAME]) ,[DATE] mg every eight (8) hours routine on multiple occasions according to the resident's Medication Administration Record (MAR). Resident #3 did not receive seven (7) doses of [MEDICATION NAME] (blood pressure medication) 10 mg every day from [DATE] - [DATE]. Resident #2's [MEDICATION NAME] (antifungal) 100 milligrams (mg) by mouth every day for five (5) days for a yeast rash was not administered from ,[DATE]-,[DATE]; and, the facility failed to notify the physician when Resident #13 did not receive [MEDICATION NAME] (anti-anxiety) 5 mg per PEG tube twice daily routine from [DATE] at 9:00 PM through [DATE] at 9:00 AM for a total of six (6) doses. Additionally, the facility failed to notify the physician on [DATE], when Resident #1's legs became tangled in the metal pieces on the lift while being transferred with a lift. The State Registered Nurse Aide (SRNA) failed to notify the nurse to ensure the physician was notified of the incident. Resident #1 complained of pain to the right foot; an x-ray was completed on [DATE] which identified that Resident #1 had sustained right acute nondisplaced fractures of the distal tibia and fibula (leg). The facility's failure to consult with the physician when medications were not available for administration and when a resident had a incident with a lift that caused possible injury caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The findings include: Review of the facility policy titled, Medication Shortages /Unavailable Medications, last revised on [DATE], revealed if medication was not available for administration and if an emergency delivery of medication was unavailable, the facility nurse should have contacted the attending physician to obtain orders or directions. The facility should have collaborated with pharmacy and the physician/prescriber to determine a suitable therapeutic alternate. 1. Record review revealed the facility admitted Resident #10 on [DATE] with [DIAGNOSES REDACTED]. review of the resident's medical record revealed [REDACTED]. On [DATE] at 9:40 AM, Licensed Practical Nurse (LPN) #3 received an order from the Physician to medicate the resident with Potassium 40 meq by mouth (po) now meaning immediately. Review of the [DATE] MAR revealed the Potassium dose was not administered until [DATE] at 9:00 AM by LPN #4. Further review of Resident #10's medical record revealed no documented evidence the Physician was made aware that the dose of Potassium was not administered on [DATE], as ordered. Interview, on [DATE] at 3:00 PM with LPN #3, revealed she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. Review of a Laboratory Report, revealed a repeat potassium level was obtained on [DATE] at 1:45 PM and the result was 2.4 mmol/L (low). The result was phoned to the Physician's Assistant (PA) at 6:09 PM by the lab staff. Review of a Nurse's Note, revealed on [DATE] at 8:30 PM an order was received to send the resident to the emergency room for evaluation. Review of the Hospital History and Physical revealed the resident was evaluated in the Emergency Department on [DATE] at 8:59 PM and was subsequently admitted into the hospital with a [DIAGNOSES REDACTED]. Interview with Resident #10's Physician, on [DATE] at 2:30 PM, revealed he had not been made aware that the resident had not received his/her Potassium. He stated [DIAGNOSES REDACTED] was low Potassium and depending on how low, it could be life threatening. He stated he expected medications to be given as ordered. 2. Closed record review revealed the facility admitted Resident #11 on [DATE] with [DIAGNOSES REDACTED]. Review of Nursing Notes, dated [DATE] at 10:57 PM, revealed LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practitioner Registered Nurse (APRN) was notified on [DATE] at 11:30 PM and stat (indicating immediately) orders were received to medicate the resident with Solu-[MEDICATION NAME] (steroid) 40 mg intramuscularly (IM) and [MEDICATION NAME] 500 mg IV every 24 hours. Review of the [DATE] MAR and Nurse's Notes revealed the medication was not administered until [DATE] at 5:49 PM; however, further review of Resident #11's medical record revealed no documented evidence the Physician was notified the medication was not administered on [DATE] stat, as ordered. Review of the Nursing Notes, dated [DATE] at 6:24 PM, revealed the resident expired. 3. Record review revealed the facility admitted Resident #12 on [DATE] with [DIAGNOSES REDACTED]. Review of the Nursing Notes, dated [DATE] at 11:45 AM, revealed the resident experienced a [MEDICAL CONDITION] and was sent to the hospital and admitted . Review of Nurse's Notes, dated [DATE] at 5:38 PM, revealed Resident #12 was readmitted to the facility. Review of the admission orders [REDACTED]. Review of the [DATE] MAR revealed the first dose of [MEDICATION NAME] should have been administered on [DATE] at 9:00 PM, but there was no documented evidence the [MEDICATION NAME] was given after readmission to the facility on [DATE] through [DATE] (seven (7) doses) and there was no evidence the physician was notified the medication was not available for administration. Review of the Nurse's Notes revealed on [DATE], the resident experienced another [MEDICAL CONDITION] and was transported back to the emergency room and was admitted again. Interview with the Director of Nursing (DON), on [DATE] at 10:10 AM, revealed there was no way to verify the resident was administered the [MEDICATION NAME] as ordered from [DATE] through [DATE]. 4. Record review revealed the facility admitted Resident #15 on [DATE] with the [DIAGNOSES REDACTED].#15 as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) indicating the resident was interviewable. Review of the [DATE] Physician Orders revealed an order for [REDACTED]. Review of the [DATE] MAR revealed the resident did not receive his/her [MEDICATION NAME] on [DATE], [DATE] and [DATE] (a total of eight (8) days without a pain patch). However, further review of Resident #15's medical record revealed no documented evidence the Physician was notified the [MEDICATION NAME] was not available for

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 1)

administration. Interview with Resident #15, on [DATE] at 11:30 AM, revealed he/she was currently hurting bad. The Assistant Director of Nursing, at that time, was observed to assess the resident and verified there was no [MEDICATION NAME] in place. Interview with Licensed Practical Nurse (LPN) #3, on [DATE] at 3:00 PM, revealed she had called the Advanced Practical Registered Nurse (APRN) on [DATE] and was told the resident had been on [MEDICATION NAME] for some time and the APRN did not want to switch to [MEDICATION NAME] as the Pharmacy had recommended. LPN #3 stated she did not know if the physician had been notified when the [MEDICATION NAME] was not available to be administered on [DATE] and [DATE]. Interview with the APRN, on [DATE] at 1:30 PM, revealed she did not recall being made aware Resident #15 had not been administered his/her [MEDICATION NAME] three (3) different times in the month of May. The APRN stated there had been problems with Medicaid kicking me and the Physician out of the system but felt that was resolved. 5. Record review revealed the facility admitted Resident #13 on [DATE] with [DIAGNOSES REDACTED]. Review of a Physician's Order, dated [DATE], revealed an order for [REDACTED]. Review of the [DATE] MAR revealed staff initials were circled on the MAR for [DATE] through [DATE], indicating the mediation was not given, per the Director of Nursing. There was no entry for the 9:00 PM dose on [DATE]. The 9:00 AM dose on [DATE] had a circled initial on the MAR. Review of the back of the MAR revealed the pharmacy was called on [DATE] at 9:00 AM to inquire about the medication and was told it would be in that night. Review of the [DATE] MAR revealed the medication was given on [DATE] at 9:00 PM; however, further review of Resident #13's Medical Record revealed there was no documented evidence the physician had been notified that the medication was not available for administration. 6. Record review revealed the facility admitted Resident #14 on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated [DATE], revealed the facility assessed the resident as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable. Review of the Physician's Orders for [DATE], revealed [MEDICATION NAME] 5000 unit capsule at meals and before bedtime. Review of the [DATE] MAR revealed the resident did not receive a total of fourteen (14) doses of [MEDICATION NAME] (enzyme) 5000 units on [DATE], [DATE], [DATE] and [DATE]. However, there was no documented evidence the physician was notified the medication was not available for administration. Interview with Resident #14, on [DATE] at 2:25 PM, revealed the facility had not given him/her the medication and he/she did not understand why as he/she has been on it for years. The resident stated he/she was told that the medical card would not pay for it. Observation of the medication cart, on [DATE] at 2:55 PM revealed there was no [MEDICATION NAME] available to be administered. Interview with the Director of Nursing (DON), on [DATE] at 3:35 PM, revealed she was currently investigating the situation and that he/she had authorized the pharmacy to fill the medication and bill it to the facility. 7. Record review revealed the facility admitted Resident #16 on [DATE], with [DIAGNOSES REDACTED]. Review of a Quarterly MDS assessment, dated [DATE], revealed the facility assessed Resident #16 as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Review of [DATE] Physician Orders revealed orders for [MEDICATION NAME] (diuretic) 30 mg daily, [MEDICATION NAME] (Gout) 50 mg daily, Aspirin (heart) 81 mg daily, [MEDICATION NAME] (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivalents three (3) times daily, [MEDICATION NAME] (antibiotic) 300 mg three (3) times daily for 10 days (to end on [DATE]), [MEDICATION NAME] (antibiotic) one (1) Gram twice daily for seven (7) days (with last dose on [DATE]) and [MEDICATION NAME] ([MEDICATION NAME]) ,[DATE] mg every eight (8) hours routine. Review of the [DATE] MAR revealed the following omissions from the MAR: [MEDICATION NAME] 30 mg on [DATE], [DATE] and [DATE] (three doses): [MEDICATION NAME] 50 mg on [DATE] and [DATE] (two doses): Aspirin 81 mg on [DATE] and [DATE] (two doses); [MEDICATION NAME] 400 mg on [DATE] at 6:00 AM, [DATE] at 2:00 PM and [DATE] at 2:00 PM and 10:00 PM (four (4) doses); K-Dur 40 meq one dose on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], all three (3) doses on [DATE], one (1) dose on [DATE] and two (2) doses on [DATE] for a total of twelve (12) doses; [MEDICATION NAME] 300 mg on [DATE] and [DATE] at 5:00 PM (two (2) doses) ; [MEDICATION NAME] on [DATE] (one dose) and [MEDICATION NAME] on [DATE] at 6:00 AM, [DATE] at 2:00 PM and [DATE] at 2:00 PM and 10:00 PM (four (4) doses). However, review of Resident # 16's medical record revealed no documented evidence the Physician was notified these medications were not administered. Interview with Resident #16, on [DATE] at 2:23 PM, revealed the resident reported the presence of pain while not receiving his/her medications as ordered. 8. Record review revealed the facility admitted Resident #2 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated [DATE], revealed the facility assessed the resident as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Review of the Order Sheet, dated [DATE], revealed an order for [REDACTED]. Review of the [DATE] Medication Administration Record (MAR) revealed the medication was not given on [DATE]-[DATE]. Review of the Shipment Detail Report from the pharmacy revealed the medication was not delivered until [DATE] at 11:57 PM, three (3) days after the medication was ordered. Further review of Resident #2's medical record revealed no documented evidence the physician was made aware the medication was not available for administration, as ordered. Interview with Resident #2, on [DATE] at 4:00 PM, revealed he/she did not receive his/her medication. 9. Record review revealed the facility admitted Resident #3 on [DATE], with [DIAGNOSES REDACTED]. Review of a Physician's Order, dated [DATE], revealed an order to administer [MEDICATION NAME] (blood pressure medication) 10 milligrams (mg) every day. Review of the [DATE] MAR revealed this medication was initialed and circled from [DATE] through [DATE] (seven (7) doses) which indicated the medication was not given. However, further review of Resident #3's medical record revealed no documented evidence the Physician was notified the medication was not available for administration. 10. Record review revealed the facility admitted Resident #6 on [DATE] with [DIAGNOSES REDACTED]. Review of the [DATE] Treatment Administration Record (TAR) revealed there was no documented evidence the treatments were completed on the 6:00 AM-6:00 PM shift on [DATE] through [DATE]. Further record review revealed there was no documented evidence the physician was notified of the failure to provide these treatments. Interview with LPN #1, on [DATE] at 3:25 PM, revealed the order for the cleansing of the JP drain site was not on the original TAR and it wasn't done. Interview with the DON, on [DATE] at 1:10 PM, revealed medications could be ordered STAT and the pharmacy could send medications from the back up pharmacy as needed. The DON further reported if a medication or treatment wasn't documented, it wasn't done and the Physician should be notified. In further interview, the DON stated the Medical Director was made aware on [DATE], by the Administrator, of the concerns of medications not being available. Interview with the Administrator, on [DATE] at 3:20 PM, revealed when staff was unable to carry out a physician's order, he/she would expect the staff to report to the nurse in charge and/or to the Physician. 11. Review of the facility policy titled, Safe Handling and Movement Policy, last revised [DATE], revealed that injuries from patient handling and movement should be reported. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission MDS assessment, dated [DATE], revealed the facility assessed Resident #1 as cognitively intact with a BIMS score of fifteen (15), which indicated the resident was interviewable. Review of the facility's final report of the investigation revealed Resident #1 was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance on [DATE]. While being transferred, the resident's right foot became tangled, and due to the resident's [MEDICAL CONDITION], he/she was unable to feel pain to his/her leg. The SRNA did not report the incident to nursing staff to ensure the Physician was notified of the incident. Resident #1 had complaints of foot pain and an x-ray of the right foot was ordered on [DATE] and completed on [DATE] by the mobile x-ray service. Review of the Radiology Report, dated [DATE], revealed a reading of right acute nondisplaced fractures of the distal tibia and fibula. Interview with Licensed Practical Nurse (LPN) #7, on [DATE] at 3:51 PM, revealed she had been notified by the DON the resident was having leg pain. The LPN stated the physician was notified and an order was received for a radiograph (x-ray) of the right foot. The LPN stated the physician was not notified until the resident complained of pain to the foot because the SRNA had not notified anyone of the fall with the lift. Interview with the Assistant Director of Nurses (ADON), on [DATE] at 4:33 PM, revealed if medications weren't available from the pharmacy he/she would expect the staff to notify the DON, ADON and the Physician. Interview with the DON, on [DATE] at 1:10 PM, revealed if a medication or treatment wasn't documented, it wasn't done. Interview with the Administrator, on [DATE] at 1:10 PM and on [DATE] at 3:20 PM, revealed when staff was unable to carry out a physician's order, he/she would expect the staff to report to the nurse in charge and/or to the Physician. She stated on [DATE], nurses started doing administrative MAR and TAR reviews; and, a conference call Quality Assurance meeting was held with the Medical Director on [DATE] related to the medications not being available for administration or not administered. Further interview with the Administrator, on [DATE] at 4:30 PM, revealed she could not say the Physician was notified each time, about every resident who did not receive his/her medication as ordered. During the interview with the Medical Director, on [DATE] at 2:15 PM, he stated nurses should know their duties, know what they are doing and the supervisors should know what is going on. He stated, Can't wait twenty-four (24) hours to find out a medication was not given. *The facility implemented the following actions to remove the Immediate Jeopardy: On [DATE], the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17. On [DATE], the DON

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders. On [DATE], the RNC re-educated the DON on Medication Availability protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed. On [DATE], the DON began education with Licensed Nurses on Medication Availability and post test titled Medication Availability which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after [DATE] without having had this re-education and competency test. On [DATE], two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. Beginning the week of [DATE], the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance meeting (QAPI) was held on [DATE] to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made. The State Survey Agency validated the corrective actions taken by the facility as follows: On [DATE] at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a STAT order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to ,[DATE] days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON. On [DATE] at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on [DATE] regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago. On [DATE] at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse. On [DATE] at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN. On [DATE] at 11 :46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON. On [DATE] at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse. On [DATE] at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material. On [DATE] at 12:06 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved. On [DATE] at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified. On [DATE] at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed. On [DATE] at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training. On [DATE] at 2:40 PM, the DON verified through

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CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	**124 WEST NASHVILLE ST PEMBROKE, KY 42266**

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3)
F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep each resident's personal and medical records private and confidential.** Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure each resident's right to personal privacy and confidentiality of their clinical records for two (2) of seventeen (17) sampled residents (Resident #6 and #14). Resident #6 and #14's Medication Administration Record [REDACTED]. The findings include: Review of an undated policy, titled Medication Administration, revealed to provide privacy as appropriate. Review of a policy titled Quality of Life - Dignity, last revised October 2009, revealed staff shall maintain an environment in which confidential clinical information is protected. 1. Observation, on 05/28/14 at 10:47 AM, revealed a medication cart on Hall #2 with the MAR indicated [REDACTED]. Resident #6's MAR indicated [REDACTED]. Licensed Practical Nurse (LPN) #2 was passing medications and was in a resident's room with the door closed. Interview with LPN #2, on 05/28/14 at 10:50 AM, revealed she did not normally leave the resident's MARs open to view due to resident privacy. She stated, It was a fluke on my part, the MAR indicated [REDACTED]. 2. Observation, on 05/28/14 at 11:15 AM, revealed LPN #1 passing medications. LPN #1 prepared insulin for administration to Resident #14 and entered the resident's room leaving the resident's MAR indicated [REDACTED]. Interview with LPN#1, at the time, revealed resident information on MARs was not to be left in view and she should have closed the MAR book or covered the resident's MAR. Interview with the Assistant Director of Nursing (ADON), on 05/30/14 at 10:15 AM, revealed she expected the residents' MARs to be kept private and not left in full view of anyone passing by the cart.

F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, and review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, it was determined the facility failed to provide services, in accordance with acceptable standards of practice related to following physician's orders, for ten (10) of seventeen (17) sampled residents (Residents #2, #3, #6, #10, #11, #12, #13, #14, #15 and #16), and one (1) unsampled resident (Unsampled Resident A). Physician's orders had not been consistently followed related to medication administration and physician ordered treatments. It was determined the facility failed to ensure medications were administered as prescribed by their physician and according to acceptable standards of practice for nine (9) residents; and, the facility failed to provide a treatment as per the Physician's Order for a wound drain site for one resident. On [DATE], the physician ordered Resident #10 to receive a now dose of Potassium 40 milliequivalents (meq). However, the facility failed to administer the medication until [DATE]. The resident was sent to the hospital on [DATE] and diagnosed with [REDACTED]. On [DATE], the physician ordered Resident #11 to receive Solu-Medro (steroid) 40 milligrams (mg) intramuscular (IM) and [MEDICATION NAME] (antibiotic) 500 mg intravenously (IV) every 24 hours stat (immediately). However, the facility failed to administer the medication until [DATE]. The resident expired on [DATE]. On [DATE], Resident #12, who had a [MEDICAL CONDITION] disorder, was readmitted to the facility with a physician's order for [MEDICATION NAME] [MEDICATION]) 500 mg twice a day. However, the facility failed to administer the medication from [DATE] through [DATE] for a total of six (6) doses. The resident had another [MEDICAL CONDITION] on [DATE] and was hospitalized . The resident returned to the facility on [DATE], with a Physician's Order to change the milligrams from 500 mg to 1000 mg twice a day. The facility administered 500 mg (should have been 1000 mg) twice a day from [DATE] through [DATE] (total of thirty five doses). The physician ordered Resident #14 to receive [MEDICATION NAME] 5000 Units every meal and prior to bedtime. However, the facility failed to administer the medication on [DATE], [DATE], [DATE] and [DATE] for a total of fourteen (14) missed doses. Resident #15, who had a [DIAGNOSES REDACTED]. The facility failed to administer the patches on [DATE], [DATE] and [DATE] which resulted in the resident not having a pain patch in place for eight (8) days. The resident voiced complaints of severe pain. The physician ordered Resident #16 to receive [MEDICATION NAME] (diuretic) 30 mg daily, [MEDICATION NAME] (for Gout) 50 mg daily, Aspirin ([MEDICATION NAME]) 81 mg daily, [MEDICATION NAME] (anticonvulsant) 400 mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 meq three (3) times daily, [MEDICATION NAME] (antibiotic) 300 mg three (3) times daily for ten (10) days (to end on [DATE]), [MEDICATION NAME] (antibiotic) one (1) gram twice daily for seven (7) days (with last dose on [DATE]) and [MEDICATION NAME] ([MEDICATION NAME]) ,[DATE] mg every eight (8) hours routine. However, the facility failed to administer the medication consistently. On [DATE], Resident #2's physician ordered [MEDICATION NAME] 100 mg by mouth every day for five (5) days for a yeast rash. The facility failed to administer the medication from [DATE] through [DATE]. The physician ordered Resident #3 to receive [MEDICATION NAME] (blood pressure) 10 mg every day. The facility failed to administer the medication from [DATE] - [DATE] for a total of seven (7) missed doses. The physician ordered Resident #13 to receive [MEDICATION NAME] (antianxiety) 5 mg per PEG tube twice daily routine. The facility failed to administer the medication from [DATE] through [DATE], for a total six (6) missed doses. The Physician ordered Unsampled Resident A to receive [MEDICATION NAME] (blood pressure medication) 10 mg Tablet, give one tablet by mouth daily. However, observation of a medication pass on [DATE] revealed the medication was not available for administration and the physician order was not followed. On [DATE], the physician ordered Resident #6's wound drainage sites to be cleansed with normal saline/soap and pat dry every shift. The facility failed to provide the treatments [DATE] through ,[DATE] on the 6a-6p shift. The facility's failure to administer medication and provide treatment per professional standards of quality of care and per Physician's Orders has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The findings include: Interview with the Administrator, on [DATE] at 4:35 PM, revealed the facility based their standards of practice on the Kentucky Board of Nursing as well as the facility's policy, titled Medication Shortages/Unavailable Medications. Review of the facility policy and procedure titled, Medication Shortages/Unavailable Medications last revised [DATE], revealed actions to take upon discovery that the facility has an inadequate supply of medication to administer to a resident included staff taking immediate action to obtain the medication. If a medication shortage was discovered during normal Pharmacy hours, the nurse should call the pharmacy to determine the status of the order. If the medication has not been ordered, place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, obtain the medication from the Emergency Medication Supply to administer the dose. If the medication was not available in the Emergency Medication Supply, notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, staff should obtain the ordered medication from the Emergency Medication Supply and if it was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. The action may include emergency delivery or the use of an emergency (back-up) third party pharmacy. If an emergency delivery is unavailable, the nurse should contact the attending physician to obtain orders or directions. If the nurse was unable to obtain a response from the attending physician/prescriber in a timely manner, the nurse should notify the nursing supervisor and contact the facility's Medical Director for orders/direction while making sure to explain the circumstances of the medication shortage. When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the MAR or Treatment Administration Record (TAR) and in the Nurse's Notes per facility policy. Such documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken. Review of the Kentucky Board of Nursing Advisory Opinion Statement, AOS #14, last revised [DATE], revealed Registered Nursing Practice and Licensed Practical Nurse were expected to administer medication and treatment as prescribed by physician, physician assistant, dentist or advanced practice registered nurse. Components of medication administration include, but are not limited to: Preparing and giving medication in the prescribed dosage, route, and frequency, including dispensing medications. 1. Record review revealed the facility admitted Resident #10, on [DATE], with [DIAGNOSES REDACTED]. Review of routine laboratory test results, conducted on [DATE], revealed the resident's Potassium level was 3.2 millimoles/Liter (mmol/L) and the normal value was between 3XXX,[DATE].50 mmol/L. On [DATE], the resident was placed on intravenous fluids (IVFs) at 75 ml/hour to end on [DATE] and a now dose of Potassium 40 milliequivilant (meq) was administered. The Potassium level was rechecked on [DATE] with a result of 3.5 mmol/L. Review of a Physician's Order, dated [DATE] at 9:40 PM, revealed an order from the physician to medicate the resident with Potassium 40 meq now. Review of the [DATE] MAR revealed the Potassium dose was not administered on [DATE], according to the physician's order. Further review revealed the Potassium was not administered until [DATE] at 9:00 AM by

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F 0281

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 4)

LPN #4. Interview with Licensed Practical Nurse (LPN) #3, on [DATE] at 3:30 PM, revealed she was responsible to transcribe Physician's Orders onto the MAR and to administer medications per the Physician's Orders. She stated she should have placed the medication order on the MAR and administered the medication at that time because it was a now order but she forgot. Record review revealed a repeat potassium level was obtained on [DATE] at 1:45 PM and the result was 2.4 mmol/L (normal 3.5 to 5.0). The lab result was phoned to the Physician's Assistant (PA) at 6:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. The resident was evaluated in the Emergency Department on [DATE] at 8:59 PM and was subsequently admitted into the hospital with [DIAGNOSES REDACTED]. 2. Closed record review revealed the facility admitted Resident #11 on [DATE] with [DIAGNOSES REDACTED]. On [DATE] at 10:57 PM, per Nursing Notes,

LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practitioner Registered Nurse (APRN) was notified on [DATE] at 11:30 PM and stat orders were received to medicate the resident with Solu-[MEDICATION NAME] 40 mg intramuscularly (IM), and [MEDICATION NAME] 500 mg IV every 24 hours. Review of the [DATE] MAR

and Nursing Notes, revealed the medication was not administered stat on [DATE] as per the physician's order but was administered on [DATE] at 5:49 PM approximately seventeen (17) hours later. Further review of the Nurse's Notes, dated [DATE] at 6:24 PM, revealed the resident was noted to have a fixed facial expression. Cardiopulmonary resuscitation(CPR) was initiated and continued until Emergency Medical Services (EMS) arrived. Resuscitation was unsuccessful and the resident expired. Interview conducted with the Administrator, on [DATE] at 3:20 PM, revealed the oncoming licensed staff failed to obtain the stat Solu [MEDICATION NAME] which was in the EDK box and administer the medication. 3. Record review revealed the facility admitted Resident #12 on [DATE] with a [DIAGNOSES REDACTED]. According to a Nurse's Note, dated [DATE] at 7:27

PM, Resident #12 had a [MEDICAL CONDITION] at 11:45 AM (same date). Review of a Nurses Note, dated [DATE] at 6:53 AM, revealed a new order was received from the APRN to transport the resident to the emergency room for evaluation and treatment. The resident was transported by Emergency Medical Services (EMS) at 6:45 PM. Resident #12 was admitted to the hospital. Review of a Nurse's Note, dated [DATE] at 5:38 PM, revealed Resident #12 was readmitted to the facility with readmission orders [REDACTED]. Review of the [DATE] MAR revealed the order was handwritten on the MAR as [MEDICATION NAME]

(levetracetam) 500 mg by mouth twice daily and to receive the first dose at 9:00 PM on [DATE]. However, further review revealed there was no documentation on the MAR that the [MEDICATION NAME] was administered twice daily per the physicians order after the resident's readmission to the facility on [DATE] through [DATE] (a total of seven (7) doses) and no documentation as to why the medication was not administered according to the physician's order or if the pharmacy was notified. Further review of the Nurse's Notes revealed on [DATE], the resident experienced another [MEDICAL CONDITION] and was transported back to the emergency room and was admitted again. Interview with the Administrator, on [DATE] at 10:30 AM, revealed after reviewing the MAR that it appeared the [MEDICATION NAME] wasn't given. Review of the admission orders [REDACTED]. Interview with the Advanced Practical Registered Nurse (APRN), on [DATE] at 1:26 PM, revealed on [DATE] the discharge medications were written by the APRN for [MEDICATION NAME] 1000 mg PO twice a day. Interview with the Director of

Nursing, on [DATE] at 1:45 PM, revealed the [MEDICATION NAME] dosage given [DATE] through [DATE] was incorrect. The MAR was

printed to read [MEDICATION NAME] 500 mg by mouth twice a day instead of [MEDICATION NAME] 1000 mg by mouth twice daily. 4.

Record review revealed the facility admitted Resident #15 on [DATE] with a [DIAGNOSES REDACTED].#15's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) which indicated the resident was interviewable. Review of the [DATE] Physician Orders revealed an order for [REDACTED]. However, review of the [DATE] MAR revealed the resident did not receive his/her [MEDICATION NAME] every three (3) days as ordered on [DATE], [DATE] and [DATE] which resulted in the resident not having a pain patch in place to control his/her pain for a total of eight (8) days. Interview with Resident #15, on [DATE] at 11:30 AM, revealed he/she was currently hurting bad. Assessment at the time, by the Assistance Director of Nursing revealed there was no [MEDICATION NAME] in place. Resident #15 was unaware he/she did not have a patch in place. The resident stated the patch helped as he/she always had pain. Interview with LPN #3, on [DATE] at 3:00 PM, revealed Resident # 15 did not have the prescribed [MEDICATION NAME]es available in the medication cart drawer on [DATE] and another time at the beginning of the month. She stated she called the pharmacy and was told the [MEDICATION NAME] was not covered by the resident's insurance but [MEDICATION NAME] was covered. LPN #3 stated she

called the ARNP, who said the resident had been on the [MEDICATION NAME] for some time and she wanted him/her to have the [MEDICATION NAME]. LPN #3 stated Resident #15 had Hit me at the door complaining of pain and had never complained of pain like that before and that's how I knew it was missed. She stated, the pharmacy will not send a medication if it's not covered by insurance and the residents go a day or two without. 5. Record review revealed the facility admitted Resident #14 on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated [DATE], revealed the facility assessed Resident #14 as cognitively intact with a BIMS score of fourteen (14) which indicated the resident was interviewable. Review of the [DATE] Physician's Order, revealed an order for [REDACTED]. However, review of the [DATE] MAR revealed the resident did not receive a total of fourteen (14) doses of [MEDICATION NAME] (enzyme) 5000 units on [DATE], [DATE], [DATE] and [DATE] per the physician's orders. Interview with Resident #14, on [DATE] at 2:25 PM, revealed he/she had not received the medication and he/she did not know why as he/she had received this medication for years. The resident stated he/she was told that the medical card would not pay for it. Interview with the DON, on [DATE] at 3:35 PM revealed she was currently investigating the situation and he/she had authorized the pharmacy to fill the medication and bill it to the facility. 6. Record review revealed the facility admitted Resident #13 on [DATE] with [DIAGNOSES REDACTED]. Review of a Physician's Order, dated [DATE], revealed an order to administer [MEDICATION NAME] (antianxiety agent) 5 mg per PEG tube twice daily routine. Review of the [DATE] MAR revealed staff initials were circled on the MAR for [DATE] through [DATE] which indicated the medication was not given, with no entry for the 9:00 PM dose on [DATE]. The 9:00 AM dose on [DATE] had an initialed circle on the MAR. However, review of the back of the MAR with LPN #2, revealed the pharmacy was called on [DATE] at 9 AM to inquire about the medication and was told it would be in that night but there was no documentation indicating the pharmacy had been called prior to this or documentation as to why the medication was not given. Review of the [DATE] MAR revealed the medication was given on [DATE] at 9:00 PM. 7. Record review revealed the facility admitted Resident #16 on [DATE] with [DIAGNOSES REDACTED]. Review of a Quarterly MDS assessment, dated [DATE] revealed the facility

assessed Resident #16 as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Review of the [DATE] Physician's Orders revealed orders for [MEDICATION NAME] (diuretic) 30 mg daily, [MEDICATION NAME] (for Gout) 50 mg daily, Aspirin ([MEDICATION NAME]) 81 mg daily, [MEDICATION NAME] (anticonvulsant) 400

mg by mouth three (3) times daily, K-Dur (electrolyte supplement) 40 milliequivilant three (3) times daily, [MEDICATION NAME] (antibiotic) 300 mg three (3) times daily for 10 days (to end on [DATE]), [MEDICATION NAME] (antibiotic) one (1) Gram twice daily for seven (7) days (with last dose on [DATE]) and [MEDICATION NAME] ([MEDICATION NAME]) ,[DATE] mg every eight

(8) hours routine. Review of the [DATE] MAR revealed the boxes were blank and there was no documentation to indicate if the medication was given or not on the MAR for these medications on these dates: [MEDICATION NAME] 30 mg on [DATE], [DATE] and

[DATE], [MEDICATION NAME] 50 mg on [DATE] and [DATE], Aspirin 81 mg on [DATE] and [DATE], [MEDICATION NAME] 400 mg on

[DATE], [DATE] and [DATE], K-Dur 40 meq on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE],

[MEDICATION NAME] 300 mg on [DATE] and [DATE], [MEDICATION NAME] on [DATE] and [MEDICATION NAME] on [DATE], [DATE] and

[DATE]. Interview with Resident #16, on [DATE] at 2:23 PM, revealed the resident reported the presence of pain while not receiving his/her medications as ordered. Interview with the DON, on [DATE] at 1:10 PM, revealed if a medication or treatment wasn't documented, it wasn't done. 8. Observation of a medication pass performed by Licensed Practical Nurse (LPN) #3, on [DATE] at 8:40 AM, revealed [MEDICATION NAME] (blood pressure medication) 10 mg was not administered to Resident #18 as ordered because the medication was not available in the medication cart. Review of Resident #18's Physician's Orders, dated ,[DATE], revealed [MEDICATION NAME] 10 mg Tablet, give one tablet by mouth daily. Review of the [DATE] MAR revealed [MEDICATION NAME] 10 mg on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and

[DATE] (total of ten doses) was initial and circled. There was no documentation on the back of the MAR to indicate the rationale for the medication not being administered or if the pharmacy was notified. Additionally, Resident #18 did not receive Pantoprazole 20 mg eleven (11) times per the [DATE] MAR. The MAR revealed initials circled indicating not received on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. The back of the MAR revealed

six (6) days documentation for Pantoprazole not available on [DATE]th, 23rd, 24th, 25th, 26th and 27th. The five (5) remaining missed doses had no documentation to indicate the reason the medication was not administered. There was no documentation indicating if pharmacy was notified the medication was not available for administration. Interview conducted with LPN #3, on [DATE] at 9:30 AM and 10:25 AM, revealed she was not aware the resident was out of this medication until she was doing the medication pass. She stated she would check the Emergency Drug Kit (EDK) box to see if it would be in

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) there to give, then call the pharmacy to see what the issue was. LPN #3 revealed after checking with the Pharmacy she was informed the last time [MEDICATION NAME] was delivered was on [DATE]. 9. Record review revealed the facility admitted Resident #3 on [DATE] with a [DIAGNOSES REDACTED]. However, review of the [DATE] MAR revealed this medication was initialed and circled from [DATE] through [DATE] (seven (7) doses) which indicated the medication was not given and no documentation on the back of the MAR to indicate why it was not given and if the pharmacy had been notified. 10. Record review revealed the facility admitted Resident #2, on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of fifteen (15) indicating the resident was interviewable. Review of the Physician's Order, dated [DATE], revealed an order for [REDACTED]. However, a review of the [DATE] Medication Administration Record (MAR) revealed the medication was not initialed/documented as given on [DATE] through [DATE] and there was no documentation indicating the pharmacy was notified. Interview with Licensed Practical Nurse (LPN) #1, on [DATE] at 11:15 AM, verified the medication was not available for administration and that it was not available for administration the last time she passed medications a few days ago. Interview with Resident #2, on [DATE] at 4:00 PM, revealed he/she had not received the medication. 11. Record review revealed the facility admitted Resident #6 on [DATE] with [DIAGNOSES REDACTED]. However, review of the [DATE] Treatment Administration Record (TAR) revealed no documented evidence the treatments were performed on the 6a-6p shift on [DATE] through [DATE]. Interview with LPN #1, on [DATE] at 3:25 PM, revealed the order for the cleansing of the wound drainage site was not on the original TAR and she did not do it. He/she reported that the TAR was corrected the following Monday morning ([DATE]). Post Survey interview conducted on [DATE] at 3:35 PM with LPN #4 revealed nurses should follow the six (6) rights of medication administration related to right resident, right medication, right time, right dose, right route, and right to receive. The LPN stated when they identify a medication is getting low they have to peel off the sticker from the label and send it to the pharmacy. The LPN revealed the medication should come in that night's tote unless there were insurance or prescription issues and then the pharmacy would fax a paper stating the medication could not be delivered. The LPN stated if a medication was not available for administration the pharmacy would be called and the Unit Manager would be notified. She stated she would document by initialing the MAR and circling her initials and write the reason not given on the back of the MAR. The LPN stated the way she would find out if a medication was in the EDK box was by getting the list of medications that was in the box and see if it was on the list. Post Survey interview conducted on [DATE] at 3:45 PM with LPN #3 revealed nurses should follow the eight (8) rights of medication administration related to right resident, right medication, right time, right dose, right route, right documentation, right to refuse and right to receive. The LPN stated when they identify a medication is getting low, they remove the sticker on the box and place it on a fax sheet and fax to the pharmacy. The LPN revealed if a medication was not available to administer the pharmacy would be called and the Physician would be notified. She stated she would go on the computer and document in the Nurse's Notes which medication were not given and would initial and circle her initials on the MAR. The LPN stated she would look at the list kept in the EDK box to identify if a medication was in the box. Interview with the DON, on [DATE] at 1:10 PM, revealed if medications were not available for administration for a resident, the pharmacy should be called. She stated medications could be ordered STAT and the pharmacy could send them from the back up pharmacy as needed. The DON further reported that if a medication or treatment wasn't documented, it wasn't done. A Post Survey interview with the DON, on [DATE] at 9:20 AM, revealed the nurses should have initialed and circled the box on the MAR if the medication was not available for administration and should have documented on the back of the MAR why the medication was not given. In addition, she stated the nurses should have notified the pharmacy the medication was not available for administration and documented the pharmacy was notified on the back of the MAR. The DON stated some of the residents' medications were not available due to the physician's Medicaid number not being renewed but others were because the nurses had failed to order the medication. Interview with the Administrator, on [DATE] at 3:20 PM, revealed the facility had been having a problem with some of the resident's medications not being delivered from the pharmacy due to a Physician needing to update his provider number. She stated the protocol was for the pharmacy to continue to send the medications until the problem was resolved and the facility was currently working with the pharmacy on that. However, when staff was unable to carry out a physician's order, he/she would have expected the staff to report to the nurse in charge, and stated staff should have called the pharmacy and checked the EDK box to ensure medications were available for administration. A Post Survey interview with the Administrator, on [DATE] at 9:45 AM, revealed the staff should have documented on the MAR why a medication was not given and if the medication was not available for administration the staff should have documented this on the back of the MAR and also documented that pharmacy was made aware. *The facility implemented the following actions to remove the Immediate Jeopardy: On [DATE], the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's Order for Residents #3, #10, #11, #12, #13, #14, #15, #16 and #17. On [DATE], the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician Orders for the previous thirty (30) days to assure all orders were correct on the MAR. Any discrepancy was clarified with the physician and written correctly on the Physician Orders. On [DATE], the RNC re-educated the DON on Medication Availability protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed. On [DATE], the DON began education with Licensed Nurses on Medication Availability and post test titled Medication Availability which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after [DATE] without having had this re-education and competency test. On [DATE], two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. Beginning the week of [DATE], the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance meeting (QAPI) was held on [DATE] to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made. The State Survey Agency validated the corrective actions taken by the facility as follows: On [DATE] at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a STAT order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to ,[DATE] days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON. On [DATE] at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on [DATE] regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she

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	185338	A. BUILDING _____ B. WING _____	**06/13/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	**124 WEST NASHVILLE ST PEMBROKE, KY 42266**

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 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 6) has received education while in orientation rega

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Many

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, and review of the facility's policy and procedures, it was determined the facility failed to ensure care was provided in accordance with the plan of care for eight (8) of seventeen (17) sampled residents (Residents #1, #3, #10, #11, #13, #14, #15 and #16). Resident #1,who was a paraplegic, was care planned to be transferred by one staff manually; however, on 03/30/14, State Registered Nurse Aide (SRNA) #1 transferred Resident #1 with a lift. The resident was not assessed or care planned for the use of the lift. Resident #1's foot became caught between two steel pieces of the lift and the resident sustained [REDACTED]. Residents #3, #10, #11, #13, #14, #15, and #16 were care planned to receive medications as ordered; however, the facility failed to administer the medications. Resident #10 did not receive a now dose of Potassium on 05/29/14 and was hospitalized with a [DIAGNOSES REDACTED].#11 did not receive Solu-Medro (steroid) intramuscular (IM) and [MEDICATION NAME] (antibiotic) Intravenous (IV) until 05/22/14 although the order was received as a stat order on 05/21/14. Resident #13 did not receive a total of six (6) doses of [MEDICATION NAME] (antianxiety) 5 mg. Resident #14 did not receive a total of fourteen (14) doses of [MEDICATION NAME] (digestive enzyme) 5000 Units from 05/19/14 through 05/28/14. Resident #15, who had a [DIAGNOSES REDACTED]. Resident #16 did not consistently receive [MEDICATION NAME] (diuretic), [MEDICATION NAME] (gout), Aspirin (heart), [MEDICATION NAME] ([MEDICAL CONDITION]), K-Dur ([MEDICAL CONDITION]), [MEDICATION NAME] (antibiotic), [MEDICATION NAME] (antibiotic) and [MEDICATION NAME] (pain) according to the resident's Medication Administration Record (MAR). Resident #3 did not receive seven (7) doses of [MEDICATION NAME] (blood pressure medication). The facility's failure to provide care according to the resident's care plan has caused or is likely to cause serious harm, injury, impairment, or death to a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14.

The findings include: Review of an undated policy, titled Resident Comprehensive Care Plan, revealed the care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility and should always have realistic goals and approaches/interventions to address the residents' needs. 1. Record review revealed the facility admitted Resident #1 on 02/13/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) Assessment, dated 02/20/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) of fifteen (15) which indicated the resident was interviewable. The facility also assessed the resident as requiring the extensive assistance of two (2) staff for transfers. Review of the Comprehensive Care Plan for Activities of Daily Living, dated 04/24/14, revealed an intervention for one (1) person physical assist manually. Further review revealed there was no intervention to use a lift for transfers. Review of the facility's final report of the investigation, dated 04/10/14, revealed Resident #1 was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance. Further review of the investigation revealed while being transferred, the resident's right foot became tangled in the metal frame of the lift. Due to the resident's [MEDICAL CONDITION], he/she was unable to feel pain to the leg. The resident's family member, who was present to take the resident out for the day, witnessed and assisted the SRNA to untangle the resident's leg. The incident was not reported by the SRNA. Record review revealed an x-ray of the right foot was ordered on [DATE] and completed on 04/04/14 by the mobile x-ray service which revealed the resident had a right fractured tibia and fibula. Following the investigation, it was determined the SRNA did not follow the resident's plan of care and did not have assistance operating a mechanical lift. Review of a physician's orders [REDACTED]. An x-ray of the right lower leg on 04/04/14 at 10:30 PM, revealed a radiologist interpretation of diffuse severe osteopenia with oblique comminuted, minimally displaced fractures involving the distal tibia and fibula. Interview with Resident #1, on 05/21/14 at 9:00 AM, revealed while being transferred with the lift, his/her leg got caught. The resident reported he/she should have been transferred using two (2) assist. A telephone interview with a family member, on 05/22/14 at 10:22 AM, revealed on 03/30/04, he/she was at the facility to take the resident out for a while. Further interview revealed the staff person picked him/her up with the lift and caught the resident's leg between the two (2) steel pieces. He/she had to raise the lift to get the resident's foot out. She further stated the staff was working alone. Interview with the Administrator, on 05/21/14 at 11:10 AM, revealed the resident was not care planned for the use of a lift, according to the care plan the resident was to have the manual assistance of one person. 2. Record review revealed the facility admitted Resident #10 on 05/16/14 with [DIAGNOSES REDACTED]. Review of the Admission MDS assessment, dated 05/23/14, revealed the facility assessed the resident to have severe cognitive impairment. Review of the Comprehensive Care Plan for Alteration in Nutrition, dated 05/16/14, revealed Meds/labs as ordered. Review of a physician's orders [REDACTED].#3, to medicate the resident with Potassium 40 meq now (immediately) and recheck Potassium level four (4) to twenty-four (24) hours after administration. Review of the May 2014 Medication Administration Record (MAR) revealed the Potassium was not administered until 05/30/14 at 9:00 AM by another nurse, Licensed Practical Nurse (LPN) #4. Interview with Licensed Practical Nurse (LPN) #3, the nurse who received the order, on 05/31/14 at 3:30 PM, revealed she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. The missed potassium dose was not administered until 05/30/14 at 9:00 AM by LPN #4. Review of a Laboratory Report for a repeat Potassium level which was obtained on 05/30/14 at 1:45 PM revealed the result was 2.4 mmol/L (normal 3.5 to 5.0). The result was phoned to the Physician's Assistant (PA) at 6:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. Record review revealed the resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and subsequently admitted into the hospital with a [DIAGNOSES REDACTED]. 3. Record review revealed the facility admitted Resident #11 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan for Nutrition related to [MEDICAL CONDITION], dated 05/03/14, revealed an intervention to provide medication and treatment as ordered. Review of a Nurse's Note, dated 05/21/14 at 10:57 PM, revealed LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The Advanced Practice Registered Nurse (APRN) was notified on 05/21/14 at 11:30 PM and an order was received to medicate the resident with Solu-[MEDICATION NAME] 40 mg intramuscularly (IM), [MEDICATION NAME] 500 mg IV every 24 hours, [MEDICATION NAME] 40 mg by mouth times two (2) doses, [MEDICATION NAME] every 4 hours, check vital signs every 4 hours, a chest radiograph (x-ray) and a complete blood count (CBC) stat. However, review of the May 2014 MAR and Nurse's Notes revealed the resident did not receive the Solu-[MEDICATION NAME] 40 mg IM and the [MEDICATION NAME] 500 mg IV until 05/22/14 at 5:49 PM (next day) after it was taken from the emergency drug kit (EDK) by LPN #1. Review of the radiology report of the chest x-ray, dated 05/22/14, revealed defined infiltrative shadows in the left infrahilar and lower lobe suggestive of Pneumonia. 4. Record review revealed the facility admitted Resident #15 on 07/03/12 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan for Pain, dated 04/02/14, revealed an intervention to administer pain medications as ordered. Review of the May 2014 Physician order [REDACTED]. Review of the May 2014 MAR revealed the resident did not receive his/her [MEDICATION NAME] on 05/05/14, 05/14/14 and 05/26/14 which caused the resident to go without a patch in place for eight (8) days. 5. Record review revealed the facility admitted Resident #14 on 10/11/13 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment, dated 04/24/14, revealed the facility assessed Resident #14 as cognitively intact with a BIMS score of fourteen (14) indicating the resident was interviewable. Review of the Comprehensive Care Plan for Risk for Alteration in Nutrition, dated 04/24/14, revealed an intervention to receive medications as ordered. Review of the May 2014 physician's orders [REDACTED]. Review of the May 2014 MAR revealed the resident did not receive [MEDICATION NAME] on 05/19/14, 05/21/14, 05/22/14 and 05/28/14 for a total of fourteen (14) missed doses. Interview with Resident #14, on 05/28/14 at 2:25 PM, revealed he/she had been missing the medication but did not understand why as he/she has been on it for years. The resident stated he/she was told that the medical card would not pay for the medication. Interview with the Director of Nursing (DON), on 05/28/14 at 3:35 PM, revealed she was investigating the situation and that she had authorized the pharmacy to fill the medication and bill it to the facility. 6. Record review revealed the facility admitted Resident #13 on 07/01/14 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan related to Impulse Control, dated May 2014, revealed an intervention to give medications as ordered. Review of the physician's orders [REDACTED]. Review of the May 2014 MAR revealed the medication was not given 05/24/14 through 05/27/14 at 9:00 AM. Interview, on 06/02/14 at 2:38 PM, with the Pharmacy Account Representative, revealed the [MEDICATION NAME] order was received on 05/24/14 and if it was faxed before 3:30 PM, it would have been delivered that night. He stated after 3:30 PM, a call should have been placed as well as the fax to have the medication available. Further interview revealed for normal delivery, the medication would have been delivered on the night of 05/26/14. 7. Record review revealed the facility admitted Resident #3 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan for Hypertension, dated 04/10/14, revealed the resident should receive

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 7) medications as ordered. Review of the physician's orders [REDACTED]. Review of the May 2014 MAR revealed the [MEDICATION NAME] 10 mg. was initialed and circled from 05/23/14 through 05/29/14 (seven doses) which indicated the medication was not given. 8. Record review revealed the facility admitted Resident #16 on 09/19/13 with [DIAGNOSES REDACTED]. Review of a Quarterly MDS assessment, dated 05/01/14, revealed the facility assessed the resident as cognitively intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Review of the Comprehensive Care Plan for Alteration Of Comfort, last revised on 05/27/14, revealed an intervention for medications as ordered. Review of May 2014 physician's orders [REDACTED]./14) and [MEDICATION NAME] 10-325 mg every eight (8) hours routine. Review of the May 2014 MAR revealed the following omissions from the MAR: [MEDICATION NAME] 30 mg on 05/18/14, 05/25/14 and 05/31/14, [MEDICATION NAME] 50 mg on 05/14/14 and 05/26/14, Aspirin 81 mg on 05/11/14 and 05/20/14, [MEDICATION NAME] 400 mg on 05/17/14, 05/20/14 and 05/31/14, K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14, [MEDICATION NAME] 300 mg on 05/02/14 and 05/08/14, [MEDICATION NAME] on 05/20/14 and [MEDICATION NAME] on 05/18/14, 05/20/14 and 05/31/14. Interview with Resident #16, on 06/02/14 at 2:23 PM, revealed he/she reported the presence of pain while not receiving his/her medications as ordered. Interview with the Administrator and Director of Nursing (DON), on 06/02/14 at 4:30 PM, revealed the care plan interventions were developed from assessments and the DON was to ensure the care was provided per the plan of care and was monitored by the Administrator. A Post Survey interview with the DON, on 07/02/14 at 9:20 AM, revealed licensed staff conducted rounds to ensure care plans were being followed and if they identified any concerns it should be reported to her. A Post Survey interview with the Administrator, on 07/02/14 at 9:45 AM, revealed the licensed staff and Unit Managers on the floor observe to ensure staff are following the care plans and Administrative staff conduct clinical rounds to ensure staff are following the care plans. In addition, she stated the Administrative staff interview staff to ensure they have the supplies they need to provide the residents' care according to the care plan. No one had identified the medications were not available for administration during interviews. *The facility implemented the following actions to remove the Immediate Jeopardy: On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's orders [REDACTED].#10, #11, #12, #13, #14, #15, #16 and #17. On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician order [REDACTED]. Any discrepancy was clarified with the physician and written correctly on the Physician Orders. On 06/01/14, the RNC re-educated the DON on Medication Availability protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed. On 06/01/14, the DON began education with Licensed Nurses on Medication Availability and post test titled Medication Availability which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test. On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made. The State Survey Agency validated the corrective actions taken by the facility as follows: On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a STAT order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON. On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago. On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse. On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN. On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON. On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse. On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material. On 06/12/14 at 12:06 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved. On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified. On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed. On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training. On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test. On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified. On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care. On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14. On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of [MEDICATION NAME] and a 2:00 PM dose of [MEDICATION NAME] indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of [MEDICATION NAME] was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR. On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of [MEDICATION NAME] on 06/09/14 and 5:00 PM doses of [MEDICATION NAME] on 06/07/14 and 06/08/14. Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the [MEDICATION NAME] to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview. Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM [MEDICATION NAME] doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview. Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action. Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd, MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions. Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan. Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.
F 0323 **Level of harm -** 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 interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one (1) of seventeen (17) sampled residents (Resident #1) was provided adequate supervision to prevent accidents during a transfer with a mechanical lift. On 03/30/14, State Registered Nurse Aide (SRNA) transferred Resident #1 with a mechanical lift without assistance, as per facility policy and the resident's right foot became stuck between the (2) two metal bars on the lift. The SRNA failed to report the incident. On 04/03/14, the resident complained of pain to the right foot and an x-ray was ordered. The resident was diagnosed with [REDACTED]. The findings include: Review of the facility's policy titled Safe Handling and Movement Policy, last revised 10/31/13, revealed all patient transfers with mechanical lifts will be done with a minimum of two (2) persons or as specified in the patient's plan of care. Additionally, the policy revealed that injuries from patient handling and movement should be reported. Record review revealed the facility admitted Resident #1 on 02/13/14, with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 02/20/14, revealed the facility assessed Resident #1 as cognitively intact with a score of fifteen (15) which indicated the resident was interviewable. Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers. Further record review revealed no documented evidence of an assessment for the use of a mechanical lift for Resident #1. Review of the Comprehensive Care Plan for Activities of Daily Living (ADL), dated 04/24/14, revealed Resident #1's level of physical functioning required for transfers to be a one person assist and there was no intervention for staff to use a mechanical lift for transfers. Review of the facility's Final Report of the investigation, dated 04/10/14, revealed the resident was transferred by State Registered Nurse Assistant (SRNA) #1 using a mechanical lift without assistance. While being transferred, the resident's right foot became tangled and due to the resident's [DIAGNOSES REDACTED], the resident was unable to feel pain to his/her leg. The resident's family member was present and witnessed and assisted the SRNA to untangle the resident's leg. The incident was not reported by the

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	185338	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	124 WEST NASHVILLE ST PEMBROKE, KY 42266

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 9) SRNA. An x-ray of the resident's right foot was ordered on [DATE] and completed on 04/04/14 by the mobile x-ray service. Following the investigation, it was determined the SRNA did not follow the resident's plan of care and did not have assistance with operating a mechanical lift, as required by facility policy. The SRNA was terminated on 04/16/14. Review of the Radiology Report, dated 04/04/14, revealed the resident had nondisplaced fractures of the right distal tibia and fibula. The physician was notified of the result on 04/04/14 at 3:00 PM by Licensed Practical Nurse #7. Orders were received to make an orthopedic appointment which was scheduled for 04/10/14 at 1:00 PM. An order was received from the physician on 04/04/14 at 8:30 PM to send the resident to the emergency room for evaluation of the fractured tibia/fibula. An x-ray of the right lower leg done on 04/04/14 at 10:30 PM revealed a radiologist interpretation of diffuse severe osteopenia with oblique comminuted, minimally displaced fractures involving the distal tibia and fibula. Interview with Resident #1, on 05/21/14 at 9:00 AM, revealed he/she was transferred by a mechanical lift resulting in a leg fracture and deformity to the resident's leg. Further interview revealed the resident had no sensation so he/she could not feel any pain. He/she stated while being transferred, his/her leg got caught. The resident stated he/she should have been transferred using two (2) staff. A telephone interview with the family member, on 05/22/14 at 10:22 AM, revealed on Sunday, 03/30/14, he was at the facility to take the resident out for a while. He stated the staff person picked the resident up with the lift and caught the resident's leg between the two (2) steel pieces. He revealed the staff person had to raise the lift to get the resident's foot out. He stated the staff person was working alone and he was not sure if the staff normally used a lift with the resident. Further interview revealed there was no obvious injury and he didn't know the resident was hurt. He stated he was not sure if the staff person reported the incident. A telephone interview with Licensed Practical Nurse (LPN) #7, on 05/22/14 at 3:51 PM, revealed she was made aware the resident was reporting pain; however, record review revealed there was no documented evidence of the resident's complaints of pain. The physician was notified on 04/03/14 at 5:13 PM and an order received for an x-ray of the right foot. Interview with the Director of Nursing, on 05/23/14 at 10:46 AM, revealed the facility did conduct assessments of staff to ensure they were competent with the use of the lift. Further interview revealed the Interdisciplinary Team (IDT) determined which lift was to be used for which resident. Interview with the Administrator, on 05/21/14 at 11:10 AM, revealed Resident #1 sustained an injury to the right lower leg while being transferred by SRNA #1 using a mechanical lift. The Administrator revealed the resident was not care planned for the use of a lift.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of medication pass, interview, record review and review of the facility's policy and procedures, it was determined the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater. A total of thirty (30) opportunities were observed with two (2) errors observed resulting in an error rate of 6.7%. Licensed Practical Nurse (LPN) #1 was observed to draw up seven (7) units of [MEDICATION NAME] regular insulin (for Resident #17) instead of the five (5) units as per the physician's orders [REDACTED]. The LPN was about to administer the seven (7) units of insulin when LPN (#6), who was in orientation and shadowing LPN #1, pointed out the resident should only receive five (5) units. In addition, observation revealed Resident #10's [MEDICATION NAME] (blood pressure medication) 10 milligrams (mg) was not available for administration. The findings include: Review of a facility policy and procedure, titled General Dose Preparation and Medication Administration, last revised 01/01/13, revealed staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident. 1. Observation of a medication pass performed by Licensed Practical Nurse (LPN) #3, on 05/29/14 at 8:40 AM, revealed [MEDICATION NAME] (blood pressure medication)10 mg was not administered to Resident #18. Review of Resident #18's May 2014 physician's orders [REDACTED]. Interview conducted with Licensed Practical Nurse (LPN) #3, on 05/29/14 at 9:30 AM and 10:25 AM, revealed she was not aware the resident was out of this medication until she was doing the medication pass. She stated she would check the Emergency Drug Kit (EDK) box to see if the medication was available to administer, then call the pharmacy to see why the medication was not available. LPN #3 revealed after checking with the Pharmacy she was informed the last time [MEDICATION NAME] was delivered was on 04/06/14. Review of the May 2014 MAR revealed the resident had not received the medication for nine (9) days prior to this observation. 2. Observation of a second medication pass performed by LPN #1, on 05/29/14 at 11:00 AM, revealed LPN #1 obtained a 229 blood sugar reading for Resident #17 and drew up seven (7) units of Regular insulin and prepared to administer it to the resident. LPN #6, who was in orientation and shadowing LPN #1, informed LPN #1 that she thought the insulin amount should be five (5) units and not the seven (7) units LPN #1 had prepared. LPN #1 then re-checked the resident's MAR and determined the resident was to have five (5) and not seven (7) units of insulin. Review of Resident #17's May 2014 physician's orders [REDACTED]. Interview with LPN #1, on 05/29/14 at 11:00 AM, revealed she had another resident's sliding scale insulin orders and had drawn up and prepared to administer the wrong amount of insulin to Resident #17. She stated she would have to fill out a medication error report. Interview conducted with the Director of Nursing (DON), on 05/29/14 at 1:10 PM, revealed she expected nurses to go by the orders on the resident's Medication Administration Record and thought the nurse would have double checked.
F 0333 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy and procedures it was determined the facility failed to ensure one (1) of seven (7) sampled residents (Resident #15) was free of significant medication errors. Resident #15 did not receive two (2) doses of [MEDICATION NAME] (medication for nerve pain) and one (1) dose of Klonopin (medication for anxiety) as ordered by the physician due to the medication not being available for administration. The findings include: Review of the facility's policy and procedure titled, Medication Availability Protocol, not dated, revealed if staff were unable to provide the physician ordered medication, the physician should be notified and the notification should be documented. Additionally, when medications were not available to be administered, the time on the MAR indicated [REDACTED]. Any missed dose of medication except for medication refusals required an incident report to be completed, and the physician, resident's family should have been notified. Record review revealed the facility readmitted Resident #15 on 08/14/14 with [DIAGNOSES REDACTED]. Review of an Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #15's cognition as moderately impaired with a Brief Interview Mental Status (BIMS) score of ten (10), indicating he/she was interviewable. Review of a Readmission physician's orders [REDACTED]. Review of the August Medication Administration Record [REDACTED]. Further review revealed Klonopin 0.5 mg was not administered at 9:00 PM on 08/14/14. Review of the Medication Notes, dated 08/14/14 at 9:00 PM, revealed [MEDICATION NAME] 50 mg, and Klonopin 0.5 mg were unavailable, and the pharmacy and physician had been notified. Review of the Nursing Notes and physician's orders [REDACTED]. Additional review revealed on 08/15/14 at 9:00 AM, the [MEDICATION NAME] 50 mg was unavailable; however, there was no documentation that the physician or the pharmacy had been notified per the facility's policy and procedures. Interview with the Director of Nursing (DON), on 09/06/14 at 11:15 AM and at 4:15 PM, revealed an incident report was not completed for the medications that were not administered on 08/14/14 and 08/15/14. The DON stated when the nurse identified the [MEDICATION NAME] and Klonopin had not been received from the pharmacy an incident report should have been completed. In addition, the DON stated the Physician's directions related to the missed doses of medication should have been documented. The DON revealed the medication had not been sent by the pharmacy because the pharmacy had not received the original signed written script from the physician. Interview with the Administrator, on 09/06/14 at 4:30 PM, revealed the omitted doses of medication was a medication error and the facility's policy and procedure should have been followed for medication errors which included notifying the physician as well as completing an incident report. He stated this should have been completed and it was not done.
F 0425 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist**

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F 0425 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to provide pharmaceutical services to meet the needs of one (1) of seven (7) sampled residents (Resident #15); and, for one (1) unsampled resident (Resident F) related to the unavailability of medications for administration. Resident #15 was not administered two (2) doses of Lyrica (medication for nerve pain) and one (1) dose of Klonopin (medication for anxiety); and Unsampled Resident F had a physician's orders [REDACTED]. The findings include: Review of a facility protocol titled, Medication Availability Protocol not dated, revealed the physician's orders [REDACTED]. If at any time staff was unable to follow the physician's orders [REDACTED]. Further review revealed the policy for maintaining medications included obtaining the medication from the Emergency Drug Kit (EDK) or notifying the after-hours pharmacy and request for medications to be sent stat (immediately). Additionally, the protocol stated any missed dose of medication excluding refusals required an incident report for a medication error and the physician, family, and Director of Nursing (DON) should be notified. 1. Record review revealed the facility readmitted Resident #15 on 08/14/14 with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. However, review of the August 2014 Medication Administration Record (MAR), revealed Lyrica 50 mg was not administered on 08/14/14 at 9:00 PM and on 08/15/14 at 9:00 AM; and, Klonopin 0.5 mg was not administered on 08/14/14 at 9:00 PM. Review of the Medication Notes, dated 08/14/14 at 9:00 PM, revealed Lyrica 50 mg, and Klonopin 0.5 mg were unavailable, and the pharmacy and physician were notified. On 08/15/14 at 9:00 AM, it was documented Lyrica 50 mg was unavailable; however, there was no documentation that the physician or the pharmacy was notified per the facility's policy and procedures. Interview with the Director of Nursing, on 09/06/14 at 11:15 AM and at 4:15 PM, revealed Resident #15 had returned from a psychiatric hospitalization with new admission orders [REDACTED]. She further stated she was notified of the unavailable medications however, there was no documentation the staff followed protocol to obtain the unavailable medications. Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy could not fill an order for [REDACTED]. 2. Record review revealed the facility admitted Unsampled Resident F on 08/12/14. Review of the Admission physician's orders [REDACTED]. Observation during a MAR to medication cart audit, on 09/05/14 at 5:00 PM, revealed Unsampled Resident F's September 2014 MAR revealed an order for [REDACTED]. Further observation of the medication cart revealed the Norco was not available on the medication cart. Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy had received the new admission orders [REDACTED]. Further interview revealed the pharmacy faxed a request for the signed copy of the medication order on 08/12/14; however, they never received a response from the facility and therefore did not dispense the medication. Further interview revealed he was not aware of any system in place to follow up on the faxed request sent to the facility. Interview with the DON, on 09/06/14 at 4:15 PM, revealed she was not aware of the issue of not having the medication available. Interview with the Administrator, on 09/06/14 at 4:30 PM, revealed there were audits being performed by the pharmacy to ensure the medications were available for each resident according to their physician's orders [REDACTED]. He further stated, in addition to the pharmacy audits, audits were being performed by the Nursing Department to ensure accuracy of the MAR and physician's orders [REDACTED].
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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 interview, record review, and review of the Administrator Job Description, it was determined the facility failed to be 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 one (1) of seven (7) sampled residents (Resident #15) and one (1) unsampled residents (Resident F). The facility failed to have an effective system in place to ensure medications were available and/or administered according to the physician's orders [REDACTED]. Resident #15 did not receive two (2) doses of [MEDICATION NAME] (medication for nerve pain) on 08/14/14 and 08/15/14 and one (1) dose of Klonopin (medication for anxiety) on 08/14/14 as ordered by the physician due to the facility not providing the appropriate documentation to the pharmacy for administration. Unsampled Resident F had a physician's orders [REDACTED]. . The findings include: Review of the Job Description for the Administrator (no date) revealed the purpose was to direct the day to day functions of the facility in accordance with current Federal, State and Local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care can be provided to the residents at all times. Essential functions of the position included: Ensure excellent care for residents is maintained by overseeing and monitoring patient care services delivered. Review of the facility's Plan of Correction for the survey dated 06/13/14 with an alleged compliance date of 07/11/14, revealed the Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager would complete medication administration observations three (3) times per week to assure medications were administered correctly and to ensure medications were available. In addition, the Plan of Correction stated the Pharmacy would audit all current residents' Medication Administration Records (MARs) and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two (2) weeks for eight (8) weeks beginning on 06/09/14. Further review revealed the DON, Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Nurse or the Unit Managers would complete an audit of all MARs to ensure professional standards of practice for clinical record documentation were followed five (5) times per week for twelve (12) weeks. The results of the audits would be forwarded to the facility QAPI committee for review. 1. Review of Resident #15 's August 2014 MAR indicated [REDACTED]. Interview with the Director of Nursing, on 09/06/14 at 11:15 AM and at 4:15 PM, revealed Resident #15 had returned from a hospitalization with new admission orders [REDACTED]. 2. Record review revealed Unsampled Resident F had a physician's orders [REDACTED]. Interview with the Pharmacy Registered Nurse/Account Executive, on 09/06/14 at 2:55 PM, revealed the pharmacy had received the new admission orders [REDACTED]. Interview with the Administrator on 09/06/14 at 4:30 PM, revealed the facility had audits in place to identify when medications were not available for administration per physician's orders [REDACTED]. He further stated the facility's system had not been effective in identifying the issues; however, he was working to put new tools in place to monitor for the future.
F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined the facility failed to provide laboratory services to meet the needs of one (1) of seventeen (17) sampled residents (Resident #16) related to the failure to obtain a wound culture as ordered by the physician. The findings include: Interview on 06/02/14 at 4:30 PM, with the Administrator and Director of Nursing (DON) revealed the facility had no policy related to obtaining laboratory specimens and the facility did not have a log book to document the labs. Further interview revealed the Assistant Director of Nursing (ADON) was responsible for ensuring the laboratory specimens were obtained. Review of the Delegation of Duties listing, undated, revealed the ADON was responsible for labs daily. Record review revealed the facility admitted Resident #16 on 09/19/13 with [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 05/01/14, revealed the facility assessed Resident #16 as cognitively intact with a Brief Interview of Mental Status score of fifteen (15) indicating the resident was interviewable. Review of a physician's orders [REDACTED]. Review of Resident #16's medical record revealed no documented evidence of the results of a culture of the resident's stump. Interview with Resident #16, on 06/02/14 at 2:23

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CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	**124 WEST NASHVILLE ST PEMBROKE, KY 42266**

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F 0502 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 11) PM, revealed a wound culture was obtained from his/her stump and he/she was told by staff there were no results. The resident further stated staff had told him/her that the specimen had not been sent to the lab. Observation on 06/02/14 at 4:30 PM, revealed a culture tube was retrieved by the Director of Nursing (DON) from the specimen refrigerator. Further observation revealed the culture swab was labeled with Resident #16's name and dated 05/27/14. Interview with the DON, on 06/02/14 at 4:30 PM, revealed she was notified on 06/02/14 that the culture was not done on the resident. The DON stated she checked the specimen refrigerator and found the specimen container labeled with Resident #16's information and dated 05/27/14. She reported the facility did not currently have a specimen log book to monitor specimens for collection or results. The Assistant Director of Nursing, who was responsible for the labs, quit her employment at the facility and was unable to be contacted for an interview.

F 0514 **Level of harm -** Immediate jeopardy	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
Residents Affected - Many	Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to maintain clinical records that were complete and accurately documented for ten (10) of seventeen sampled residents (Residents #1, #2, #3, #10, #11, #12, #13, #14, #15, #16) and one (1) unsampled resident (Resident A), related to incomplete documentation of medication administration, treatments, and services provided. The facility failed to document in the clinical record when medications were not given, why and if the pharmacy was notified for Resident #2, #3, #10 #11, #12, #13, #14, #15, #16 and Resident A. The facility's failure to maintain clinical record that were complete and accurately documented caused or was likely to cause serious injury, harm, impairment or death of a resident. Immediate Jeopardy was identified on 06/02/14 and determined to exist on 05/05/14. The facility was notified of the Immediate Jeopardy on 06/02/14. The findings include: Review of the facility's policy and procedure titled, Medication Shortages/Unavailable Medications last revised 01/01/13, revealed actions to take upon discovery that the facility has an inadequate supply of medication to administer to a resident included staff taking immediate action to obtain the medication. When a missed dose is unavoidable, the nurse should document the missed dose and the explanation for such missed dose on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) and in the Nurse's Notes, per facility policy. Such documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy's response upon notification and the action(s) taken. 1. Record review revealed the facility admitted Resident #10 on 05/16/14 with [DIAGNOSES REDACTED]. On 05/29/14 at 9:40 AM, Licensed Practical Nurse (LPN) #3 received an order from the physician to medicate the resident with Potassium 40 meq now. Interview with LPN #3 on 05/31/14 at 3:00 PM, revealed that she forgot to put the medication order on the MAR and did not administer the Potassium as ordered. The missed Potassium dose was administered on 05/30/14 at 9:00 AM by LPN #4 after the ADON clarified the order. A repeat Potassium level was obtained on 05/30/14 at 1:45 PM and the result was 2.4 mmol/L. The result was phoned to the Physician's Assistant at 6:09 PM by the lab staff. An order was received at 8:30 PM to send the resident to the emergency room for evaluation. The resident was evaluated in the Emergency Department on 05/30/14 at 8:59 PM and subsequently admitted into the hospital with a [DIAGNOSES REDACTED]. The facility failed to ensure the clinical record was complete as the order for the resident's Potassium was not documented on the MAR. Interview conducted with LPN #3, on 05/31/14 at 3:00 PM, revealed on 05/29/14, she forgot to document the medication order on Resident #10's MAR and did not administer the Potassium as ordered. 2. Record review revealed the facility admitted Resident #1 on 02/13/14 with [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE], revealed the resident with a Brief Interview for Mental Status (BIMS) of fifteen (15) indicating the resident was interviewable. The Comprehensive Care Plan was not revised to include the transfer needs of the resident. The resident was transferred using a mechanical lift on 03/30/14 by one (1) staff member and received an injury resulting in a fractured right tibia and fibula. The resident was not care planned for the use of a mechanical lift during transfers. The facility failed to document the incident on 03/30/14, or the subsequent event details in the medical record. 3. Record review revealed the facility admitted Resident #2 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS dated [DATE], revealed the resident to have a BIMS score of fifteen (15). On 05/16/14, the Advanced Practice Registered Nurse (APRN) ordered [MEDICATION NAME] 100 mg by mouth every day for five (5) days for a yeast rash. The shipment detail from the pharmacy revealed the medication was delivered on 05/19/14 at 11:57 PM. An interview with the resident revealed she did not receive the medication. Review of the May 2014 MAR revealed the [MEDICATION NAME] was to be administered at 7:00 AM on 05/17/14 through 05/22/14. Further review of the MAR revealed initials with circles on those dates indicating the medication was not given. The facility failed to ensure the medical record was complete and accurate as there was no documentation on the back of the MAR to indicate the reason the medication was not administered, that pharmacy was notification and their response, as per the policy. 4. Record review revealed the facility admitted Resident #3 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the MAR revealed the resident did not receive [MEDICATION NAME] (blood pressure medication) 10 mg daily from 05/23/14 through 05/29/14. The facility failed to ensure the medical record was complete and accurate as there was no documented evidence in the medical record stating the medication was not administered or why it wasn't given. 5. Record review revealed the facility admitted Resident #11 on 07/01/12 with [DIAGNOSES REDACTED]. On 05/21/14 at 10:57 PM, LPN #5 assessed the resident and noted the resident was experiencing labored breathing. The APRN was notified on 05/21/14 at 11:30 PM and orders received to medicate the resident with Solu-[MEDICATION NAME] 40 mg intramuscularly (IM), [MEDICATION NAME] 500 mg IV every 24 hours, [MEDICATION NAME] 40 mg by mouth times two (2) doses, [MEDICATION NAME] every 4 hours, check vital signs every 4 hours, a chest radiograph (x-ray) and a complete blood count (CBC) stat. The resident received the Solu-[MEDICATION NAME] 40 mg IM on 05/22/14 at 5:49 PM (the next day) after taken from the emergency drug kit (EDK) by LPN #1. The facility failed to ensure the medical record was complete and accurate as they failed to document on the resident's MAR that the medications were not given. LPN #5 failed to document on the back of the resident's MAR, as per the policy, the reason the medications were not administered and response of the pharmacy when notified. 6. Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was admitted to the hospital on [DATE] at 11:45 AM, after experiencing [MEDICAL CONDITION] activity. On 05/05/14 Resident #12 returned to the facility with a continued order for [MEDICATION NAME] (anti-convulsant) 500 mg twice daily. Review of the May 2014 MAR revealed no documented evidence the medication was administered or not administered from the time of readmission on 05/05/14 until 05/08/14 (six doses). 7. Record review revealed the facility admitted Resident #13 on 07/01/14 with [DIAGNOSES REDACTED]. The Annual MDS assessment dated [DATE], revealed the resident to have a BIMS score of six (6). The Comprehensive Care Plan, May 2014, related to impulse control lists as an intervention to give medications as ordered. On 05/24/14 an order was received from the APRN for [MEDICATION NAME] 5 mg per PEG tube twice daily routine. The medication was unavailable for administration until 05/27/14 at 9:00 PM. There was no evidence the facility policy was followed related to documenting why a medication was not administered. 8. Record review revealed the facility admitted Resident #14 on 10/11/13, with [DIAGNOSES REDACTED]. Review of the May 2014 MAR revealed the resident did not receive a total of fourteen (14) doses of [MEDICATION NAME] 5000 units on 05/19/14, 05/21/14, 05/22/14 and 05/28/14. The medication was ordered to be taken at meals and before bedtime. An interview with the resident on 05/28/14 at 2:25 PM revealed he/she has been missing the medication but doesn't understand why as he/she has been on it for years. Review of the MAR revealed no documented evidence why the medication was not given, as ordered on [DATE], 05/23/14 and 05/28/14 or if pharmacy was notified or their response, as per the facility policy. 9. Record review revealed the facility admitted Resident #15 on 07/03/12, with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, revealed no care plan for chronic pain. A review of the May 2014 Physician orders [REDACTED]. A review of the May 2014 MAR revealed the resident did not receive his/her [MEDICATION NAME] on 05/5/14, 05/14/14 and 05/26/14. The facility failed to ensure the medical record was complete and accurate as there was no documentation on the back of the MAR to indicate why the medication was not given, if the pharmacy had been notified and their response. 10. Record review revealed the facility admitted Resident #16 on 09/19/13, with [DIAGNOSES REDACTED]. Review of May 2014 physician's orders [REDACTED]./14) and [MEDICATION NAME] 10-325 mg every eight (8) hours routine. Review of the May 2014 MAR revealed there was no documentation the medications were given or not give on the MAR for these medications on these dates: [MEDICATION NAME] 30 mg on 05/18/14, 05/25/14 and 05/31/14; [MEDICATION NAME] 50 mg on 05/14/14 and 05/26/14; Aspirin 81 mg on 05/11/14 and 05/20/14; [MEDICATION NAME] 400 mg on

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	185338	A. BUILDING _____ B. WING _____	**06/13/2014**

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CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	**124 WEST NASHVILLE ST PEMBROKE, KY 42266**

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 12) 05/17/14, 05/20/14 and 05/31/14; K-Dur 40 meq on 05/01/14, 05/06/14, 05/08/14, 05/09/14, 05/13/14, 05/19/14, 05/20/14, 05/27/14 and 05/31/14; [MEDICATION NAME] 300 mg on 05/02/14 and 05/08/14; [MEDICATION NAME] on 05/20/14; and, [MEDICATION NAME] on 05/18/14, 05/20/14 and 05/31/14. 11. Observation during a medication pass, on 05/29/14 at 9:20 AM, revealed Resident A did not receive [MEDICATION NAME] 10 mg as ordered, as it was not available. Review of the May 2014 MAR revealed the resident did not receive [MEDICATION NAME] 10 mg on 05/15/14, 05/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14, 05/28/14, and 05/29/14 (total of ten doses). There was no documentation on the back of the MAR to indicate the rationale for the medication not being administered. Additionally, Resident #18 did not receive Pantoprazole 20 mg eleven (11) times according to the May 2014 MAR. The MAR revealed initials circled indicating not received on 05/12/14, 05/13/14, 05/15/14, 05/16/14, 05/19/14, 05/23/14, 05/24/14, 05/25/14, 05/26/14, 05/27/14, and 05/28/14. The back of the MAR revealed six (6) days documentation for Pantoprazole unavailable on May 13th, 23rd, 24th, 25th, 26th, and 27th. The five (5) remaining missed doses had no documentation to indicate the reason the medication was not administered. Interview with the Assistant Director of Nurses (ADON), on 05/30/14 at 10:15 AM, revealed if a medication was not administered, a circled initial was to be placed on the MAR indicating it was not given and the reason also documented. Interview with the Director of Nursing (DON) and the Administrator, on 05/29/14 at 1:10 PM, revealed if medications were not available for administration for a resident, the pharmacy should be called. The nurse should circle the initial and document on the back of the MAR or Nurse's Notes the reason why the medication was not given and would not be accurate if not correctly documented. *The facility implemented the following actions to remove the Immediate Jeopardy: On 06/04/14, the physician was notified by the Director of Nursing (DON) of medications not administered according to physician's orders [REDACTED].#10, #11, #12, #13, #14, #15, #16 and #17. On 05/31/14, the DON and a consulting DON and the Regional Nurse Consultant (RNC) audited Physician order [REDACTED]. Any discrepancy was clarified with the physician and written correctly on the Physician Orders. On 06/01/14, the RNC re-educated the DON on Medication Availability protocol, which states the procedure to follow for physician notification when medications are not available to be administered as per the physicians order, and post test completed. On 06/01/14, the DON began education with Licensed Nurses on Medication Availability and post test titled Medication Availability which states the procedure to follow for physician notification when medications are not available to be administered per physician order. This training will be completed with all licensed nurses by the DON. The DON will educate and validate competency with the Assistant Director of Nursing (ADON), MDS Nurse or Unit Manager and the licensed nurses. No licensed nurse will work after 06/04/14 without having had this re-education and competency test. On 06/02/14, two representatives from the Pharmacy completed a Medication Administration Record (MAR) to medication cart audit for all current residents to ensure all medications were available for administration per physician order. Any medication identified as not available and not in the emergency drug kit was sent stat to the pharmacy for immediate delivery. Beginning the week of 06/09/14, the Pharmacy will audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two weeks for eight (8) weeks to assure all medications are available. Any deficiency identified will be corrected immediately. The results of this audit will be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review and recommendation weekly until the Jeopardy is removed and then monthly for at least three (3) months. If at any time concerns are identified, the QAPI Committee will convene to review and make further recommendations as needed. The QAPI Committee will consist of at a minimum; the Administrator, DON, ADON, Social Services Director, Dietary Services Manager and Business Office Manager with the Medical Director attending at least quarterly. An Ad-Hoc Quality Assurance meeting (QAPI) was held on 06/03/14 to review the alleged deficient practice and plan of removal with the Medical Director, Administrator, Director of Nursing, MDS Nurse, Social Service Director, Housekeeping Supervisor, Director of Rehabilitation, Dietary Manager, Maintenance Director, and Admissions Coordinator with no further recommendations made. The State Survey Agency validated the corrective actions taken by the facility as follows: On 06/12/14 at 10:40 AM, LPN #4 verified through interview he/she had received recent inservice training on medication availability. If a medication is not in the medication cart drawer, the emergency drug kit (EDK) should be checked to see if the medication is available there. If unavailable, the pharmacy should be called and the medication will be delivered anywhere from one-four hours for a STAT order. When there are new medication orders for a resident, the medications are entered in the computer and then a copy of the order is faxed to the pharmacy as well as a follow-up phone call to the pharmacy. If a medication is unavailable the physician is notified. Normal pharmacy delivery is made on the night shift. The MAR checks are done at the end of shift for the opposite hallway. The DON has also been completing MAR checks to make sure that medications are not missed. For medication STAT orders, staff are to look in the EDK, STAT from the pharmacy or if an urgent need the resident would be sent out to the hospital. The LPN stated medications have been available recently for administration. When a medication supply for a resident gets down to 3-5 days, the sticker is pulled and a fax is sent to the pharmacy. If there is an insurance issue, the pharmacy will send medication for the resident then will work to resolve the issue. LPN #4 verified he/she was provided recent education regarding Care Plans. If staff is unable to follow the resident's care plan, the physician should be notified as well as the DON. On 06/12/14 at 10:54 AM, RN #2 verified through interview he/she has been educated regarding medication administration and availability. If a medication is not available on the medication cart, the EDK should be checked, the pharmacy should be called and the physician notified of any issues. RN #2 revealed through interview he/she was still in orientation and was to receive education on 06/12/14 regarding medication orders for a newly admitted resident. She verified there was a list of medications available in the EDK box for staff reference. RN #2 verified through interview that he/she has received education while in orientation regarding Care Plans. A computer based education program was provided in reference to care plans and the Accunurse system. Further interview revealed care plans were changed by the RN for new orders or changes in care. The DON and Charge Nurse are notified of any changes in the care plan. RN #2 verified no problems with medication availability since he/she started working at the facility two (2) days ago. On 06/12/14 at 11:02 AM, LPN #9 (MDS Nurse) verified through interview that she had received inservice training regarding medication availability. If a medication is not available, the EDK should be checked and the pharmacy should be called. The physician should be notified if a medication cannot be given at the ordered time. She stated she was unaware of any recent issues with medication availability. The process to reorder medications is to pull the sticker and fax it to the pharmacy to get the medication delivered. An order has to be received at the pharmacy by 5:30 PM in order to receive the medication on the routine evening delivery. Medication orders for new residents should be faxed to the pharmacy to assure medication delivery. LPN #9 verified through interview he/she has received inservice training regarding care plans to include that care plans are to be followed and if the care plan cannot be followed the DON and the physician should be notified. It was reported that nurses update care plans and if a change is made with the MDS assessment, revisions are made at that time by the MDS nurse. On 06/12/14 at 11:15 AM, LPN #3 verified through interview that he/she had received recent education regarding medication availability and care plans. If there is a new resident admission, the pharmacy should be called to get the medications. The EDK should be checked to see if the medication is available in the box. If there is a problem getting a medication, the physician should be notified. LPN #3 denied any recent problems with medication availability. To reorder medications, the sticker should be pulled and faxed to the pharmacy. As a routine, staff should be checking to make sure that medications are available. LPN #3 reported that staff need to take the initiative to get medications before the resident runs out. The LPN stated the pharmacy is good about getting STAT medications to the facility. Staff should make sure that they notify the physician for any new orders or changes related to medications. LPN #3 verified that he/she has received education regarding care plans. He/she reports that staff need to go by the care plan and if something is unavailable, the Charge Nurse should be made aware. If there is an intervention on the care plan that cannot be followed, staff need to call the DON and the physician. LPN #3 revealed that care plan revisions were completed by the RN. On 06/12/14 at 11:46 AM, SRNA #2 verified through interview that he/she has received recent education regarding Care Plans. Staff are to access the Accunurse system to check care plans and any updates. He/she also reports the receipt of daily written care plans for the residents. If a problem with a care plan is identified or cannot be carried out, the SRNA would notify the charge nurse. The SRNA care plan is updated by the DON. On 06/12/14 at 12:00 PM, SRNA #3 verified through interview that he/she has received recent education regarding Care Plans. Inservice training was also provided regarding the Accunurse system and how to retrieve the plan of care for a resident. He/she revealed the Accunurse system alerts staff when a resident's plan of care has changed. The DON updates the care plan as needed. Staff was required to complete a quiz regarding education material. If staff is unable to follow a plan of care, the SRNA should notify the Charge Nurse. On 06/12/14 at 12:03 PM, SRNA #4 verified through interview that he/she has received recent education regarding Care Plans. If a care plan changes in the Accunurse system, staff will be alerted regarding the change. Staff also received a copy of the

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 13) resident's plan of care. If the SRNA is unsure about the plan of care, he/she should notify the Charge Nurse. If the care plan cannot be followed, the SRNA should contact the Charge Nurse. SRNA was required to complete a post test on the covered inservice material. On 06/12/14 at 12:06 PM, SRNA #5 verified through interview that he/she had received recent education regarding care plans and completed a post test. Further interview revealed the education provided covered the Accunurse System and how to review the care plan. Staff were to notify the Charge Nurse if the plan of care could not be followed. Staff should follow the chain of command for reporting if the issue was not resolved. On 06/12/14 at 12:09 PM, SRNA #6 verified through interview that he/she had received recent education regarding care plans. Staff were to check the Accunurse system headset for any change in the plan of care for the resident. Staff are also alerted of changes to the plan of care through the headset. It is reported that staff also receive a written copy of the care plan. If staff is unable to provide resident care as outlined in the plan of care, the Charge Nurse should be notified. On 06/12/14 at 12:30 PM, SRNA #7 verified through interview that he/she had received recent education regarding care plans and the Accunurse system. Staff should use the Accunurse system to review required care needs for a resident. If there was a concern providing care for the resident, the Charge Nurse should be notified. Staff received a copy of interventions for each resident daily. A post test was completed. On 06/12/14 at 1:37 PM, SRNA #8 verified through interview that he/she received recent education regarding care plans. If staff is unable to follow the plan of care, the Charge Nurse should be notified immediately. Access to the resident's plan of care is through the Accunurse system and staff received printed information. The Accunurse system will alert staff to any changes in a resident's plan of care. SRNA #8 also verified that he/she completed a post test after inservice training. On 06/12/14 at 2:40 PM, the DON verified through interview that she began education with licensed staff on 06/01/14 regarding medication administration and availability. The staff was required to complete a post test. On 06/12/14 at 2:50 PM, RN #3 verified through interview that he/she had received recent training on medication availability and administration. Reports that medication availability was covered to include checking the EDK box, calling the pharmacy and if unable to obtain the medication in a timely manner, the physician should be notified. RN #3 stated that medication availability was 100% better. If a medication supply is getting low, the sticker should be pulled and faxed to pharmacy. Medications were usually reordered when a three (3) day supply is left. Staff is to notify the physician if there are problems obtaining a medication or if the resident refuses a medication. RN #3 also verified the receipt of education regarding care plans. Staff should always follow the care plan and if unable should notify the physician as well as the DON. Care plans were updated by a RN; and, SRNA's care plans were updated by the RN or the DON. SRNAs use the Accunurse system to access information regarding a resident's plan of care. If a SRNA is unable to follow the care plan for a resident, the Charge Nurse or administration should be notified. On 06/12/14 at 3:08 PM, LPN #5 verified through interview that he/she had received recent education on medication availability and administration. A post test was completed after receiving inservice training. If a medication is not available, the EDK box should be checked and if the medication is not available there, the pharmacy should be called to get the medication STAT and the physician should be called for additional orders. Reordering resident medications should be done when there is a three (3) day supply of the medication left. The sticker should be pulled, placed on the reorder form and faxed to the pharmacy. LPN #5 revealed that medication availability has improved. The LPN verified that he/she has received recent education regarding care plans. If staff is unable to follow the plan of care for a resident, the Charge Nurse should be notified and will alert the DON and the physician. The computer or the Accunurse system can be utilized to view the resident's plan of care. On 06/12/14 at 3:34 PM, the pharmacy representative verified through interview that he and Certified Pharmacy Technicians completed a MAR to medication cart audits for all residents on 06/02/14 and 06/09/14. On 06/12/14 at 4:20 PM, an interview with the DON and the Administrator, revealed omissions on the June 2014 MAR for Resident #15 on 06/05/14 at 3:00 PM of a dose of [MEDICATION NAME] and a 2:00 PM dose of [MEDICATION NAME] indicated the medications were not administered by LPN #1. It was revealed that LPN #1 was terminated related to the medication errors. On 06/11/14 at 5:00 AM, a dose of [MEDICATION NAME] was not documented as given by RN #4 and disciplinary action was pending related to the omission on the MAR. On 06/12/14 at 4:52 PM, the DON and the Administrator were interviewed regarding omissions on the June 2014 MAR for Resident #18. Review of the June 2014 MAR revealed no documentation for a 7:00 AM dose of [MEDICATION NAME] on 06/09/14 and 5:00 PM doses of [MEDICATION NAME] on 06/07/14 and 06/08/14. Interview on 06/12/14 at 5:15 PM with LPN #3 revealed that he/she had given the [MEDICATION NAME] to Resident #18 on 06/09/14 but failed to document it on the MAR. The LPN stated she had signed a disciplinary action five (5) minutes prior to the interview. Interview on 06/12/14 at 5:24 PM with LPN #4 revealed that he/she had given the 5:00 PM [MEDICATION NAME] doses to Resident #18 on 06/07/14 and 06/08/14 but failed to document the administration on the MAR. Further interview revealed the LPN received disciplinary action thirty (30) minutes prior to the interview. Interview with the DON on 06/12/14 at 5:48 PM, revealed that training and education were provided to staff as a part of a disciplinary action. Interview with the Administrator, on 06/12/14 at 5:50 PM, revealed that an additional, 3rd MAR check was added on 06/12/14 to include staff at shift change checking MARs for omissions. Interview with the Administrator, on 06/13/14 at 9:15 AM, revealed that an additional, 3rd MAR check was initiated on 06/12/14. The Medical Director was notified and participated in a QA meeting/conference call regarding the plan. Interview with the Administrator, on 06/13/14 at 10:28 AM, revealed that LPN #4 had not worked and had been out of town and that disciplinary action was provided upon the first day of her return to work. Interview with the Administrator, DON and Regional RN, on 06/13/14 at 10:50 AM, revealed the medications for Resident #18 were available on the cart for administration. Staff interviews reveal that the medications were administered and available on 06/07/14, 06/08/14 and 06/09/14 and disciplinary action was administered according to the AOC. The number of pills available on the medication cart on 06/13/14 appeared to be adequate based on the date of delivery.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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 Quality Assurance Policy, it was determined the facility failed to monitor its plans of action to correct identified quality deficiencies. The facility failed to identify, during their audits, that medications were not available for one (1) of seven sampled residents (Resident #15) and for one (1) unsampled resident (Resident F). The findings include: Review of the facility's policy and procedure titled, Quality Assurance Policy, last revised 01/11, revealed the Administrator's purpose was to ensure an interdisciplinary approach to all residents' needs and to provide the highest level of care possible all the while keeping the Interdisciplinary Team (IDT), physician and responsible party informed of their condition changes and interventions implemented as they occur and when necessary. The Interdisciplinary Team will meet at least weekly and consist of at minimum the Administrator, Director of Nursing or Nursing Representative, Social Services, Therapy, Dietary and Activities. Review of the facility's Plan of Correction for the survey dated 06/13/14 with an alleged compliance date of 07/11/14, revealed medication administration observations would be conducted three (3) times per week to assure medications were administered correctly were available. The results of these audits would be forwarded to the facility's Quality Assurance Performance Improvement (QAPI) Committee for review at least monthly for three (3) months. In addition, the Plan of Correction stated the Pharmacy would audit all current residents' MARs and compare to the medication available in the medication cart for each resident one (1) time per week for four (4) weeks then every two (2) weeks for eight (8) weeks beginning on 06/09/14. Further review revealed the DON, ADON, Minimum Data Set (MDS) Nurse or the Unit Managers will complete an audit of all MARs to ensure professional standards of practice for clinical record documentation were followed five (5) times per week for twelve (12) weeks. The results of the audits would be forwarded to the facility QAPI committee for review. 1. Record review revealed Resident #15 did not receive two (2) doses of [MEDICATION NAME] (nerve medication) on 08/14/14 and 08/15/14 and one (1) dose of Klonopin (nerve medication) on 08/14/14 as ordered by the physician due to the failure of the facility to send the appropriate documentation to the pharmacy to ensure medication was available for administration. 2. Record review revealed Usampled Resident F had a physician's orders [REDACTED]. However, the facility failed to send the appropriate documentation to the pharmacy to ensure the medication was available for administration. Interview with the Director of Nursing (DON), on

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 14) 09/06/14 at 4:15 PM, revealed the audits were completed by the pharmacy to compare the MAR indicated [REDACTED]. In addition she stated that she and other staff completed the audits of medication administration observations to ensure medications were administered correctly and ordered medications were available which was done three (3) times per week; however, they failed to identify the medication was not available. Interview with the Administrator, on 09/06/14 at 4:30 PM, revealed the audits were in place and the facility should have identified the errors.