STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	04/24/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, record review, and facility policy review, it was determined the facility failed to notify the family member for one (1) of thirty (30) sampled residents (Resident #18) when the resident had a significant change in condition. Review of the medical record for Resident #18 revealed the resident was sent to the hospital on [DATE], at 5:25 AM with Cardiopulmonary Resuscitation (CPR) in progress. However, there was no evidence the family was notified that Resident #18 required CPR prior to leaving the facility. The findings include: Review of the facility's policy titled Change in a Resident's Condition or Status, with a revision date of [DATE], revealed the facility would notify a resident's representative promptly with any changes in the resident's medical or mental condition. Review of the medical record for Resident #18 revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of the Nurse's Notes for Resident #18 dated [DATE], at 4:30 AM, revealed the resident's oxygen saturation level was documented as being eighty-six percent (86%) with a normal range being ninety-five (95) to one hundred (100) percent. The Nurse's Notes stated the resident agreed for the facility to send him/her to the acute care hospital. According to the medical record, the resident's son was listed as the resident's responsible party. Review of a Nurse's Note dated [DATE], at 5:00 AM, revealed the nurse notified the resident's physician and the family of the change in the resident's condition that occurred at that time. The Nurse's Notes revealed on [DATE], at 5:25 AM, the nurse was called to Resident #18's room where the resident was unresponsive, CPR was initiated immediately, the ambulance service arrived, and the resident was sent to the acute care hospital. However, there was no documented evidence the family was notified of this further change in condition that required CPR prior to the resident being transferred to the hospital. Interview with Resident #18's family member on [DATE], at 9:45 AM, revealed he had not been notified that CPR had been initiated on Resident #18 at the facility. Further interview revealed the acute care hospital notified the resident's family member, after the resident expired at approximately 7:00 AM, that CPR had been initiated at the nursing facility. Several unsuccessful attempts were made to contact the nurse, Licensed Practical Nurse (LPN) #2, who was assigned to care for Resident #18 on [DATE]. Calls were made on [DATE] at 11:00 AM, [DATE] at 2:30 PM, and on [DATE] at 4:30 PM. Interview with the Director of Nursing (DON) on [DATE], at 2:35 PM, revealed staff was required to notify a resident's family with any change in the resident's condition. The DON stated Resident #18's family should have been notified regarding CPR being performed at the facility immediately following the resident leaving the facility.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, personnel record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure the past employment work history or reference checks were completed upon hire for one (1) of five (5) personnel records reviewed (Registered Nurse #2). The findings include: Review of the facility's policy, Abuse, Neglect, and Misappropriation, revised March 2013, revealed interviews and reference checks would be conducted on all employees and volunteers. Review of the personnel record on 04/15/15 at 3:00 PM for RN #2 revealed the employee's hire date was 08/26/14. However, the facility failed to check the past employment work history or personal reference checks to ensure the employee did not have a history of abuse, neglect, or mistreatment of [REDACTED]. Interview with the Administrator on 04/15/15 at 3:30 PM, revealed all new hires should have reference checks completed. Further interview revealed the Human Resources Director was responsible for completing reference checks; however, this person was no longer employed by the facility.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 it was determined the facility failed to provide care and services in accordance with the written plan of care for four (4) of thirty (30) sampled residents (Residents #11, #15, #16, and #17) and one (1) unsampled resident (Resident A). Review of the plan of care for Resident #11 revealed the resident had interventions in place that included giving medications as ordered for the treatment of [REDACTED]. Review of the plans of care for [MEDICAL CONDITION] activity or at risk for [MEDICAL CONDITION] for Residents #15, #16, and #17 revealed the residents had interventions in place that included administering medications as ordered. The facility documented on the residents' Medication Administration Records (MAR) that the residents' medications were administered according to physician's orders [REDACTED].#15's medication and review of Residents #11, #16, and #17's pharmacy medication dispensing records revealed the facility failed to administer the residents' medications as ordered by the residents' physicians. Resident #11's fourteen (14) day supply of [MEDICATION NAME] (medication to treat an abnormal heart beat) was not reordered for up to thirty-seven (37) days; Resident #17's thirty (30) day supply of [MEDICATION NAME] [MEDICATION]) went up to sixty-five (65) days between refills and up to forty-three (43) days between refills for a thirty (30) day supply of [MEDICATION NAME] (medication to prevent [MEDICAL CONDITION] and treat some psychiatric disorders); and Resident #16's fifteen (15) day supply of [MEDICATION NAME] went up to twenty-five (25) days between refills (refer to F333, F425, F490, and F514). Review of the plan of care for Resident A revealed interventions to provide wound care according to the physician's orders [REDACTED]. However, nursing staff failed to provide the wound care and dressing according to the plan of care. The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0282

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)
(F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15. An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an E at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.

The findings include:

Review of the facility's policy, titled Using the Care Plan, not dated, revealed the care plan shall be used in developing the resident's daily care routines and will be available for staff personnel who have responsibility for providing care or services to the resident. The policy further revealed the documentation must be consistent with the resident's care plan.

1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13, with [DIAGNOSES REDACTED].

Review of Resident #11's actual/potential cardiovascular problems care plan, revised date 12/19/14, revealed the resident had an intervention in place to give medications as ordered.

Review of Resident #11's April 2015 physician's orders [REDACTED].

Review of the Pharmacy Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's [MEDICATION NAME] was dispensed with fourteen (14) tablets per medication card and had been dispensed seven (7) times from 12/10/14 to 04/15/15 (dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and 04/15/15). During the timeframe reviewed (12/10/14 through 04/15/15) the pharmacy dispensed ninety-eight (98) [MEDICATION NAME] tablets; however, a total of one hundred twenty-eight (128) tablets were needed for staff to be able to administer the resident's [MEDICATION NAME] as it was ordered, per the physician's orders [REDACTED].

Review of Resident #11's [MEDICATION NAME] laboratory level obtained on 01/05/15 and 04/03/15 revealed the resident's [MEDICATION NAME] level was subtherapeutic.

2. Review of Resident #17's medical record revealed the facility admitted the resident on 10/23/98. The resident had [DIAGNOSES REDACTED].

Review of Resident #17's [MEDICAL CONDITION] Activity/At Risk for [MEDICAL CONDITION] care plan, revised 12/17/14, revealed the resident had an intervention to administer medications as ordered.

Review of Resident #17's April 2015 physician's orders [REDACTED].

Review of the Pharmacy Medication Dispensing Records for Resident #17, dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed thirty (30) capsules of [MEDICATION NAME] 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on 12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, for staff to be able to administer the resident's medications as physician ordered in order to follow the plan of care, one hundred seven (107) capsules were required. There was no explanation or documented evidence to account for the forty-seven (47) tablets that were needed in order for staff to administer the medication as physician ordered to follow the plan of care.

Further review of the Pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of [MEDICATION NAME] 125 mg, which was a thirty (30) day supply, on 02/20/15. However, the medication was not dispensed to the facility again until 04/05/15, forty-four (44) days later. There was no explanation or documented evidence to account for the medication that was needed for administration for approximately fourteen (14) days to ensure the medication was given per the plan of care.

The SSA's Pharmacist Consultant conducted a post survey review of the facility's pharmacy dispensing records. Review of Resident #17's medication orders dated 04/01/15, revealed the resident was ordered to receive [MEDICATION NAME] 250 mg, one tablet each morning and evening, which had been in effect since 12/16/15; the dosage was verified via post survey phone interview with the Advanced Registered Nurse Practitioner on 05/01/15, as the physician was unavailable. In the initial citation narrative, the State Survey Agency's Surveyor stated the resident's [MEDICATION NAME] was to be given only once daily (in the morning) when, in fact, the dosage was two (2) tablets per day. It was noted, based on the pharmacy's dispensing records, that Resident #17 had been provided two refills each of 30 tablets (on 12/18/14 again on 01/28/15) during the review period. It was noted that each 30 tablet quantity was a 30-day supply when, in fact, the refills were only fifteen (15)-day supplies. The surveyor further noted that, from 12/18/14 through 04/04/15, the resident would have required a total of one-hundred and seven (107) tablets to achieve the required dosage requirement for that time period. However, because the daily dosage called for two (2) tablets per day, the required number of tablets for that time period would have called for twice that amount, or up to two-hundred and fourteen (214) tablets. Since only sixty (60) tablets had been dispensed to Resident #17 during that time period, there would have been a shortage of approximately one-hundred and fifty-six (156) tablets during that time period.

3. Review of Resident #16's medical record revealed the facility admitted the resident on 09/05/14. The resident had [DIAGNOSES REDACTED].

Review of Resident #16's [MEDICAL CONDITION] activity/at risk for [MEDICAL CONDITION] activity care plan, revised 02/03/15, revealed the resident had an intervention in place to administer medications as ordered.

Review of Resident #16's physician's orders [REDACTED].

Review of Pharmacy Medication Dispensing Records for Resident #16, dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed a 150-ml bottle (a 15-day supply) of [MEDICATION NAME] on 01/24/15. However, the medication was not refilled again until 02/18/15, approximately twenty-six (26) days later. There was no documented evidence or explanation for the medication that was needed for the eleven (11) days to ensure the medication was given per the physician's orders [REDACTED].

Review of the [MEDICATION NAME] Acid laboratory values for Resident #16 revealed the [MEDICATION NAME] Acid level was sub-therapeutic on 04/03/15.

4. Review of Resident #15's medical record revealed the facility admitted the resident on 10/18/13 and readmitted the resident on 03/20/15, after a hospital stay. The resident had a [DIAGNOSES REDACTED].

Review of Resident #15's [MEDICAL CONDITION] Activity/at risk for [MEDICAL CONDITION] Care Plan, revision date of 02/22/15, revealed the resident had an intervention in place to administer medications as ordered.

Review of Resident #15's April 2015 physician's orders [REDACTED]. Staff was to administer 5 ml of [MEDICATION NAME] every morning and 7.5 ml of [MEDICATION NAME] at bedtime.

Review of the Pharmacy Medication Dispensing Records for Resident #15 revealed 473 ml of [MEDICATION NAME] was dispensed to the facility on [DATE].

Observation on 04/17/15 at 2:20 PM, of Resident #15's [MEDICATION NAME] bottle from the facility's medication cart revealed the medication was dated as opened on 03/21/15, one day after the resident was readmitted to the facility. Observation revealed the [MEDICATION NAME] bottle contained 150 ml of medication. According to the resident's physician's orders [REDACTED]. However, review of Resident #15's MAR for 03/20/15 through 04/17/15 revealed staff documented they administered [MEDICATION NAME] to Resident #15 as ordered by the resident's physician.

Interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed no additional medication had been dispensed to the facility as they would not be able to reorder the medication until they were out of the medication, or on the last dose of medication.

Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed that the resident's medications were administered per the physician's orders [REDACTED].

Interview on 04/14/15 at 6:07 PM with the Director of Nursing (DON) revealed facility staff should follow the plan of care for a resident. The interview further revealed residents' medications should be administered per physician's orders [REDACTED].

5. Review of the medical record for Resident A revealed the facility admitted the resident on 04/07/15, with [DIAGNOSES REDACTED].

Review of the Weekly Skin Integrity Review dated 04/08/15, revealed the resident had a diabetic ulcer to the right foot located near the last digit.

Review of the Interim Plan of Care dated 04/15/15, revealed the resident had a disruption of skin surface not related to pressure with the wound type being an open lesion located on the right outer dorsal foot. Further review revealed the Plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) of Care stated, Wound care as ordered; see current treatment record and physician's orders [REDACTED]. Review of Resident A's physician's orders [REDACTED]. Review of the five-day final report of the facility's investigation, dated 04/16/15, revealed Resident A had requested on 04/16/15 at 5:00 AM for LPN #3 to replace the dressing that had fallen off during the night. Further review of the investigation revealed LPN #3 did not replace the dressing and had instructed the resident the dressing change would not be completed until the wound care nurses arrived at 8:00 AM. Interview with LPN #3 on 04/20/15 at 4:30 PM revealed the resident had requested the dressing be replaced; however, it was not done. The LPN stated she did not follow the resident's care plan. She stated she should have checked and followed the care plan. Interview with the DON on 04/20/15 at 2:37 PM revealed staff should follow the residents' care plans. She stated wound care should be done according to the care plan. Interview with the Administrator on 04/20/15 at 1:30 PM, revealed LPN #3 should have followed the resident's plan of care and replaced the resident's dressing. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician order [REDACTED]. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work as needed (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted. c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders [REDACTED]. The process continued until immediacy was lifted. d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15. e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the Refill Reminder Report from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time. 11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4)weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. **The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician order [REDACTED]. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15. 4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff. 5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs. 6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records. 7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the POS [REDACTED]as needed) had completed the post-test with a 100% score. 8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records. 9) Review of the new process for medication reconcili
F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of medical records, pharmacy medication dispensing records, and the facility's policies, it was determined the facility failed to ensure five (5) of thirty (30) sampled residents (Residents #11, #13, #15, #16, and #17) were free of significant medication errors. Review of the residents' Medication Administration Records (MAR) revealed documentation that the residents' medications were administered according to physician's orders [REDACTED].#15's medication and review of Residents #11, #13, #16, and #17's pharmacy medication dispensing records revealed the facility failed to administer the residents' medications as ordered by the residents' physicians. Review of pharmacy dispensing records dated 12/01/14 thru 04/17/15 and review of physician's orders [REDACTED].#11; failed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0333

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 4)
to administer [MEDICATION NAME] and [MEDICATION NAME] [MEDICATION]s) as ordered to Resident #17; failed to administer
[MEDICATION NAME] [MEDICATION]) as ordered to Resident #13; and failed to administer [MEDICATION NAME] Acid (a medication
used to prevent [MEDICAL CONDITION]) twice daily to Resident #16.
In addition, observation on 04/17/15, revealed Resident #15's [MEDICATION NAME] medication bottle contained 150 milliliters (ml) of liquid; however, since the resident was readmitted to the facility on [DATE], only 130.5 ml should have been present if the medication had been administered per physician's orders [REDACTED].
The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15.
An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an E at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.
The findings include:
Review of the facility's policy titled Medication Administration General Guidelines, dated December 2012, revealed medications were administered as prescribed in accordance with the manufacturer's specifications, good nursing principles and practices, and only by persons legally authorized to do so.
Review of the facility's policy titled Medication Administration - Medication Discrepancies, dated December 2009, revealed medication discrepancies were documented and reported to the resident's attending physician, Director of Nursing, responsible party, and the Performance Improvement Committee. The policy defined a medication discrepancy as an omission of medication due to a prescribing, dispensing, or administering error. The policy further revealed when a medication discrepancy occurred immediate action should be taken to protect the patient's safety and welfare. Continued review of the policy revealed the attending physician was notified of the error or significant medication discrepancy and the patient was to be monitored closely for 24 to 72 hours or as directed by the physician. The policy stated a medication discrepancy/error/incident report was to be completed.
Review of the facility's procedure for reordering medication, not dated, revealed staff should reorder medications when there was a three (3) day supply of medication remaining.
1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13, with [DIAGNOSES REDACTED].
Review of Resident #11's April 2015 physician's orders [REDACTED]. The medication was initially ordered 08/17/14.
Record review and review of the facility's investigation related to Resident #11, dated 04/07/15, revealed on 04/01/15, Resident #11's [MEDICATION NAME] medication card dated 03/24/15 (the date the medication card was received by the facility for use) revealed only four (4) tablets had been dispensed from the card leaving ten (10) tablets remaining on the medication card. The facility audited the medication card again on 04/03/15, prior to the morning medication pass (the medication was ordered to be administered every morning). At that time, Resident #11's [MEDICATION NAME] medication card still had ten (10) tablets remaining on the card. Review of the Medication Administration Record (MAR) revealed staff documented the medication had been administered on 04/02/15. There was no documented evidence the medication had not been held or refused the previous day.
Review of the Pharmacy's Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's [MEDICATION
NAME] was dispensed with fourteen (14) tablets per medication card. This medication was dispensed seven (7) times since 12/10/14 (dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and 04/15/15). During the timeframe reviewed (12/10/14 through 04/16/15), the pharmacy dispensed ninety-eight (98) [MEDICATION NAME] tablets; however, one hundred twenty-eight (128) tablets were required for the staff to be able to administer the resident's [MEDICATION NAME] per the physician's orders [REDACTED].
Review of Resident #11's [MEDICATION NAME] laboratory level obtained on 01/05/15 revealed the level was not therapeutic at 0.80 ng/ml (nanograms/milliliter) (therapeutic range is 0.9 to 2.0 ng/ml). Further review of Resident #11's [MEDICATION NAME] level dated 04/03/15 revealed the resident's medication was also not therapeutic at 0.5 ng/ml.
2. Review of Resident #17's medical record revealed the facility admitted the resident on 10/23/98. The resident had [DIAGNOSES REDACTED].
Review of Resident #17's April 2015 physician's orders [REDACTED].
Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed thirty (30) capsules of [MEDICATION NAME] 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on 12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, one hundred seven (107) capsules were required for the staff to be able to administer the resident's [MEDICATION NAME], per the physician's orders [REDACTED].
Further review of the Pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of [MEDICATION NAME] 125 mg (a 30-day supply) on 02/20/15. However, the medication was not dispensed to the facility again until 04/05/15, approximately forty-four (44) days later.
Review of Resident #17's MAR for 12/01/14 through 04/04/15 revealed staff omitted one (1) dose of [MEDICATION NAME] for the resident on 01/05/15. Staff documented all other doses were administered per physician's orders [REDACTED]. Registered Nurse (RN) #1 documented that three (3) evening doses of [MEDICATION NAME] were not administered to Resident #17 on 03/08/15, 03/18/15, and 03/23/15 because the resident's blood pressure or pulse was too low. On 03/17/15, RN #1 documented the resident refused the evening dose; and on 03/22/15 RN #1 documented [MEDICATION NAME] was not administered because the
resident had no insulin coverage.
On 04/19/15 at 1:20 PM, after reviewing Resident #17's MAR, interview with RN #1 revealed she administered the resident's medications as ordered. She stated the resident did not refuse medications and the documentation on the resident's MAR was inaccurate because it was easy to enter the wrong code on the electronic MAR.
Review of Resident #17's laboratory levels revealed on 04/03/15, the resident's [MEDICATION NAME] Acid ([MEDICATION NAME])
level was sub-therapeutic at less than 10 mcg/ml (therapeutic range is 50 - 100 mcg/ml). Further review of Resident #17's lab levels revealed on 03/16/15, the resident's [MEDICATION NAME] level was sub-therapeutic at less than 2.5 mcg/ml (therapeutic range is 5-12 mcg/ml). On 03/19/15, the resident's [MEDICATION NAME] level had increased to 9.1 mcg/ml.
The SSA's Pharmacy Consultant conducted a post survey review. This review revealed Resident #17's Physician order [REDACTED]. During a post survey phone interview with the Advanced Registered Nurse Practitioner on 06/01/15, she acknowledged the resident was to receive 250 mg each morning and each evening. From 12/08/14 through 04/04/15, the resident would have needed a total of one-hundred and seven (107) tablets of [MEDICATION NAME] 250 mg to meet the dosage required for the time period, if the order was for once a day. However, only sixty (60) tablets had been dispensed and delivered for the resident during that time period, as validated by the pharmacy's Delivery Manifest Record (aka, the pharmacy dispensing record). Record review revealed the resident was actually ordered to receive two (2) tablets per day of the [MEDICATION NAME] during that time. The resident would have needed approximately twice that amount, between 210-214 tablets, to achieve the dosage that was ordered.
3. Review of Resident #13's medical record revealed the facility admitted the resident on 06/10/13, and the resident had [DIAGNOSES REDACTED].
Review of Resident #13's physician's orders [REDACTED].
Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed 300 ml (a 30-day supply) of [MEDICATION NAME] liquid medication three (3) times from 12/03/14 through 03/18/15, for a total of 900 ml. However, 1,050 ml of [MEDICATION NAME] was required to administer the medication per physician's orders [REDACTED].
Review of Resident #13's MARs for January through March 2015 revealed staff documented the resident's [MEDICATION NAME] medication was administered as ordered.
Review of the [MEDICATION NAME] medication laboratory results revealed on 12/01/15, the resident's [MEDICATION NAME] level
was 23 mcg/ml which was therapeutic (normal range is 5 - 63 mcg/ml). On 03/02/15, the resident's [MEDICATION NAME] level was sub-therapeutic at 2.0 mcg/ml. Further review of Resident #13's laboratory results revealed on 04/03/15 the resident's [MEDICATION NAME] level was also sub-therapeutic at 2.9 mcg/ml.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) The SSA's Pharmacy Consultant conducted a post survey review of the facility's pharmacy dispensing records. Review of Resident #13's MARs for January through April 2015 revealed no documented evidence (staff did not sign off as having been administered) staff administered the [MEDICATION NAME] liquid medication as ordered; two (2) doses were omitted in January 2015, one (1) dose in February 2015, and two (2) doses in April 2015 for a total of five (5) doses (50 ml) missed. 4. Review of Resident #16's medical record revealed the facility admitted the resident on 09/05/14. The resident had [DIAGNOSES REDACTED]. Review of Resident #16's physician's orders [REDACTED]. Review of the Pharmacy Medication Dispensing Records dated 12/01/14 through 04/17/15, for Resident #16 revealed the pharmacy dispensed a 150-ml bottle (a 15-day supply) of [MEDICATION NAME] on 01/24/15. However, the medication was not refilled again until 02/18/15, twenty-six (26) days later. Review of Resident #16's MAR for 12/01/14 through 01/31/15 revealed staff omitted the resident's morning dose of [MEDICATION NAME] Acid on 01/05/15. Staff documented the medication was administered as ordered for all other doses during these months. However, review of Resident #16's [MEDICATION NAME] Acid laboratory level dated 04/03/15, revealed the resident's [MEDICATION NAME] Acid level was sub-therapeutic at 20.6 mcg/ml (therapeutic range is 50 - 100 mcg/ml). 5. Review of Resident #15's medical record revealed the facility admitted the resident on 10/18/13 and readmitted the resident on 03/20/15, after a hospital stay. The resident had a [DIAGNOSES REDACTED]. Review of Resident #15's April 2015 physician's orders [REDACTED]. Review of the Pharmacy Medication Dispensing Records for Resident #15 revealed 473 ml of [MEDICATION NAME] was dispensed to the facility on [DATE]. Observation on 04/17/15 at 2:20 PM of Resident #15's [MEDICATION NAME] bottle from the facility's medication cart revealed the medication was dated as opened on 03/21/15, one (1) day after the resident was readmitted to the facility. Observation revealed the [MEDICATION NAME] bottle contained 150 ml of liquid medication. However, according to the resident's physician's orders [REDACTED]. Review of Resident #15's MAR from 03/20/15 through 04/17/15 revealed staff documented they administered [MEDICATION NAME] to Resident #15 as ordered by the resident's physician. Interview with the Pharmacy Director on 04/15/15 at 4:00 PM, revealed residents' medications were sent back to the pharmacy when the resident was out of the facility. The medications were re-dispensed when the resident returned to the facility. Review of Resident #15's laboratory results for [MEDICATION NAME] revealed on 01/20/15, the resident's level was 8.0 mcg/ml (therapeutic range is 5 - 63 mcg/ml). However, on 04/03/15, the resident's level had decreased to 5.0 mcg/ml. Review of the facility's Status Change document that listed residents who had been admitted , transferred, or discharged from December 2014 through April 2015 revealed Residents #11, #13, #15, #16, and #17 had not been discharged or transferred from the facility during the times when there were discrepancies identified with their medications. Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed that if staff documented on the resident's MAR that their medication was administered, then the medication was administered per the physician's orders [REDACTED]. card had two (2) to seven (7) days remaining in the card. The nurses stated the facility did not have a system in place to determine when a medication card was placed in use after it was dispensed from the pharmacy. Interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed the pharmacy sends a dispensing report to the facility that lists the quantity of the medication and the date the medication was sent to the facility. Continued interview revealed the facility notified the pharmacy when a resident was sent out to the hospital and the resident's medications were sent back to the pharmacy. The Pharmacy Director stated the facility notified the pharmacy of new admissions or readmissions. When the resident's orders were received by the pharmacy, the medications were sent to the facility. The interview revealed the facility's nurses reorder residents' medications when the supply gets low. Per interview, the pharmacy did not have a way to know if the facility was reordering medication when needed and administering the medication according to physician's orders [REDACTED]. Interview on 04/14/15 at 6:07 PM, with the Director of Nursing (DON) revealed she did a random medication cart audit on 04/01/15 after the morning medication pass. She stated Resident #11's [MEDICATION NAME] raised a red flag because the medication card label was dated 03/24/15 and only four (4) tablets had been administered from the medication card leaving ten (10) tablets on the card. The DON stated she reviewed Resident #11's MAR and no doses (no documented evidence) had been held or refused. The DON revealed she immediately initiated an investigation, which included assessments of all residents on the hall where Resident #11 resided. The investigation included obtaining laboratory levels for all residents that lived on that hall, that were on medications that required therapeutic monitoring, and interviewing staff and alert and oriented residents. Continued interview revealed the assessments had not revealed any abnormal findings and the laboratory results had not revealed a pattern or a trend because some residents' laboratory levels were sub-therapeutic, some were normal, and some were elevated. The DON stated reviews of the pharmacy dispensing records were not evaluated as part of the investigation. Further interview with the DON revealed the administrative staff reviewed the investigation and did not feel there was enough concrete evidence to say Resident #11 did not receive his/her medications as ordered by the facility. She stated the only concrete information she had was a quantity of medication that was possibly more than she felt should have been in the resident's drawer; however, all the nurses interviewed revealed Resident #11's medications were administered as ordered. The DON further revealed the facility did not have a system to know how much of a particular medication the resident had in the medication cart at a given time. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician order [REDACTED]. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work as needed (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted. c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders [REDACTED]. The process continued until immediacy was lifted. d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15. e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the Refill Reminder Report from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time. 11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4)weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. **The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	04/24/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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 0333 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 7) symptoms of adverse reactions, with no issues identified. 3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician order [REDACTED].
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions for eighty-six (86) of ninety-six (96) residents who received a food tray. Observations on 04/14/15 revealed unlabeled and undated foods in a white storage pan with a tan liquid substance in the bottom of the pan sitting on a table with clean equipment. In addition, a dirty pan soiled with grease and food pieces was also observed to be sitting on the table with the clean equipment. The findings include: Review of the facility's policy titled Sanitation/Infection Control, undated, revealed the Dietary Manager was responsible for supervising all sanitation and housekeeping procedures within the Dietary Department. The policy stated all leftover foods would be labeled and dated prior to placing the items in the refrigerator. In addition, the policy stated the Dietary Manager was responsible for ensuring staff used proper sanitation procedures for storing, preparing, and serving foods. Observations on 04/14/15, at 1:10 PM, revealed one bottle of steak sauce, a jar of ranch dip, a jar of ham base, two boxes of cream cheese, and a bottle containing a white substance were opened, unlabeled, and undated. These food items were in a white storage pan with a tan liquid substance in the bottom of the pan. The white pan along with a pan observed to be soiled with grease and food pieces were placed on a table with clean silverware, a slicer, and two mixers. The white storage pan was observed to be placed on the table from the refrigerator by the Dietary Manager. Interview conducted with the Dietary Manager on 04/14/15, at 1:20 PM, revealed she was responsible for ensuring the kitchen was sanitary. The Dietary Manager stated all foods were required to be labeled and dated prior to being placed in the refrigerator. Further interview revealed she had not identified the unlabeled and undated foods, and had not identified the tan substance in the bottom of the white pan. She stated the pans should not have been placed on the table with the clean equipment. Interview conducted with the Registered Dietitian (RD) on 04/24/15, at 11:45 AM, revealed she was required to do a monthly audit of the kitchen, and she had not identified any concerns with sanitation. The RD stated the dirty pans should not have been placed on the table with the clean equipment and silverware. The RD also stated all foods should be labeled and dated when opened and should not have been in a dirty pan.
F 0425 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide pharmaceutical services to meet the needs of four (4) of thirty (30) sampled residents (Residents #11, #13, #16, and #17). The facility failed to have an effective system to reorder residents' medications timely to ensure the residents received their medications as physician ordered. Review of Pharmacy Medication Dispensing Records revealed Resident #11's Digoxin (medication to treat an abnormal heartbeat) was dispensed to the facility in a fourteen (14) day supply. However, this medication went up to thirty-seven (37) days between refills. Resident #17's Primidone (anti-seizure medication) went up to sixty-five (65) days between refills of a thirty (30) day supply and up to forty-three (43) days between refills for a thirty (30) day supply of Depakote (medication to prevent seizures and treat some psychiatric disorders). There was a forty-seven (47) day span between refills for a thirty (30) day supply of Resident #13's Keppra (medication to prevent seizures); and up to twenty-five (25) days between refills of a fifteen (15) day supply for Resident #16's Depakote. Laboratory tests revealed the residents' labs values for these medications that required monitoring were sub-therapeutic (refer to F282, F333, F490, and F514). The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15. An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an E at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled Medication Ordering and Receiving From the Pharmacy Provider (Ordering and Receiving Non-Controlled Medications), dated September 2010, revealed medications and related products were received from the provider pharmacy on a timely basis. The policy stated that the facility maintained accurate records of medication order and receipt. A licensed nurse or appropriate personnel received medications delivered to the facility from the pharmacy and documented on the medication delivery receipt/manifest. The policy stated that facility staff re-ordered medications by writing the medication name and prescription number or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Interview with Registered Nurse (RN) #1 on 04/14/15 at 5:03 PM, Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 AM, RN #6 on 04/16/15 at 12:14 PM, Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and LPN #6 on 04/17/15 at 3:29 PM revealed medications could also be ordered on the computer from the resident's Electronic Medication Administration Record [REDACTED]. 1. Review of Resident #11's medical record revealed the facility admitted the resident on 10/04/13. The resident had [DIAGNOSES REDACTED]. Review of Resident #11's April 2015 physician's orders [REDACTED]. Review of the pharmacy's Medication Dispensing Records, dated 12/01/14 through 04/17/15, revealed Resident #11's Digoxin was dispensed with fourteen (14) tablets per medication card and was dispensed seven (7) times since 12/10/14. The medication was dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and on 04/15/15. During this timeframe (12/10/14 through 04/15/15), the pharmacy dispensed ninety-eight (98) Digoxin tablets. However, to ensure the resident received the medications as prescribed by the physician, one hundred twenty-eight (128) tablets were required for the staff to be able to administer the resident's Digoxin. 2. Review of Resident #17's medical record revealed the facility admitted the resident on 10/23/98. The resident had [DIAGNOSES REDACTED]. Review of Resident #17's April 2015 physician's orders [REDACTED]. Review of the Pharmacy's Medication Dispensing Records revealed the pharmacy dispensed thirty (30) capsules of Primidone 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (on 12/18/14 and 01/28/15), for a total of sixty (60) capsules. However, one hundred seven (107) capsules were required for the staff to be able to administer the resident's Primidone per the physician's orders [REDACTED]. Further review of the pharmacy Medication Dispensing Records revealed the pharmacy dispensed one hundred twenty (120) capsules of Depakote 125 mg (a 30-day supply) on 02/20/15. However, the medication was not dispensed to the facility again until 04/05/15, forty-four (44) days later. The SSA's Pharmacy Consultant conducted post survey review of the facility's pharmacy's dispensing records. Review of the Physician order [REDACTED]. Thus, the resident had been ordered two (2) tablets per day of the Primidone 150 mg since 12/16/14. The dosage of 250 mg twice daily was validated on 06/01/15 during a post survey phone interview with the Advanced Registered Nurse Practitioner. Resident #17 would have required a total of one-hundred and seven (107) tablets of Primidone to meet the dosage requirement from 12/08/14 through 04/04/15, if the order was for once a day. However, only sixty (60) tablets had been dispensed for the resident during that period. Based on the fact the resident was actually ordered to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0425 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) receiving two (2) tablets daily of the Primidone during that period, the resident would have needed approximately twice that amount (between 204-214) tablets to achieve the dosage requirement as the physician had ordered. 3. Review of Resident #13's medical record revealed the facility admitted the resident on 06/10/13 with [DIAGNOSES REDACTED]. Review of Resident #13's physician's orders [REDACTED]. Review of the Pharmacy's Medication Dispensing Records for Resident #13 revealed the pharmacy dispensed 300 ml (a 30-day supply) of Keppra liquid medication three (3) times from 12/03/14 through 03/18/15 (there were 47 days between two of the refills), for a total of 900 ml. However, 1,050 ml of Keppra was required to administer the medication, per physician's orders [REDACTED]. During the SSA's post survey review, the SSA's Consultant Pharmacist reviewed the pharmacy's Delivery Manifest Reports (aka, dispensing records) for 12/01/14 through 04/04/15. This review revealed Resident #13 received four (4) refills for a 30-day supply (300 ml) of Keppra Liquid (12/03/14, 01/08/15, 02/24/15, and 03/19/15). Further review revealed there was a twenty-three (23) day time span between two (2)of Resident #13's Keppra refills. Specifically, the resident received 300 ml (30 day supply) on 12/03/14, then received a subsequent refill of 300 ml on 01/08/15. The subsequent refill should have been received approximately thirty (30) days later, (from 12/03/14) or on/about 01/02/15. Thus, the refill was approximately six (6) days late. Further review revealed after receiving the refill on 01/08/15, the resident received the next subsequent refill of 300 ml forty-seven (47) days later on 02/25/15, or approximately seventeen (17) days late. That refill should have been received approximately thirty (30) days later, on/about 02/07/15. 4. Review of Resident #16's medical record revealed the resident had [DIAGNOSES REDACTED]. Review of the medical record revealed a physician's orders [REDACTED]. Review of Resident #16's 01/2015 MAR indicated [REDACTED]. Review of the Pharmacy's Medication Dispensing Records revealed the pharmacy dispensed a 150 ml (a 15-day supply) bottle of Depakote for Resident #16 on 01/24/15. However, the medication was not refilled again until 02/18/15, twenty-six (26) days later. Further review of the MARs revealed the facility documented that the resident's medication had been administered as ordered per the physician. Review of Resident #16's Valproic Acid laboratory level dated 04/03/15, revealed the resident's Valproic Acid level was sub-therapeutic at 20.6 mcg/ml (micrograms/milliliter)(normal range is 50 - 100 mcg/ml). Review of the facility's Status Change document that listed residents who had been admitted , transferred, or discharged from December 2014 through April 2015 revealed Residents #11, #13, #15, #16, and #17 had not been discharged or transferred from the facility during the times when there were discrepancies identified with their medications. Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed that if staff documented on the resident's MAR indicated [REDACTED]. The interviews further revealed the residents' medications had to be re-ordered by the nursing staff when the resident's medication card had two (2) to seven (7) days remaining in the card. The nurses stated the facility did not have a system in place to determine when a medication card was placed in use after it was dispensed from the pharmacy. Interview on 04/15/15 at 3:40 PM with the Facility's Pharmacist revealed all prescription medication labels contained a re-order date. The interview further revealed the pharmacy notified the facility if a medication was being re-ordered too early; however, the pharmacy did not notify the facility if a medication was not re-ordered when a refill was due. Interview on 04/15/15 at 4:00 PM with the Pharmacy Director revealed facility nursing staff reordered residents' medications when the supply was low. However, the pharmacy did not have a way to track if medications were not being reordered timely. He stated Pharmacy sent a dispensing report to the facility that listed the quantity of the medication and the date the medication was sent to the facility. Interview with the Facility's Corporate Nurse Consultant on 04/17/15 at 2:45 PM revealed a report was available on the facility's computer system that listed all residents' medications that were pending reorder by the facility. The Nurse Consultant stated the Director of Nursing (DON) was required to compare the medications (that were pending re-order) to a report that was delivered with residents' medications to ensure the residents' medications were available. The Nurse Consultant stated the DON had identified no issues. Interview on 04/14/15 at 6:07 PM with the Director of Nursing revealed the facility did not have a system to know how much medication a resident had in stock at the facility at any given time. Further interview with the DON on 04/17/15 at 3:45 PM, revealed she had not identified any issues with medications not being re-ordered and administered per physician's orders [REDACTED]. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician order [REDACTED]. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0425 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work as needed (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted. c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders [REDACTED]. The process continued until immediacy was lifted. d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15. e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the Refill Reminder Report from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time. 11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4)weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. **The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician order [REDACTED]. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15. 4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0425 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) were corrected by the facility staff. 5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs. 6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records. 7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the POS [REDACTED]as needed) had completed the post-test with a 100% score. 8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records. 9) Review of the new process for medication reconciliation of residents' medications revealed the process was initiated on 04/22/15. The process was as follows: a. Review of the facility audits revealed one random nurse per day, per shift completed a medication pass observation with the DON, ADONs, SDC, Medical Record's Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate, and to ensure documentation was completed. b. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. The audits revealed the process was ongoing on 04/24/15. c. Review of the facility's in-services revealed the nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when the packet/bottle was finished. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited ten (10) discarded packets/bottles per unit daily and compared them to packets/bottles that were put into service to reconcile medications, confirm the reorder process and that the medications were being given per the physician's orders [REDACTED]. Review of the facility's audits and an observation of the medication cart on 04/24/15, revealed the process was ongoing on 04/24/15. d. Observations of the medication carts on 04/24/15 revealed the nurses/KMAs had placed the date/time and their initials on the side of new med
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of pharmacy medication dispensing records, review of the facility's investigation, and review of facility policy, it was determined the facility's Administration failed to ensure its resources were used effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being of each resident. On 04/03/15, the facility initiated an investigation of an allegation of neglect related to Resident #11's [MEDICATION NAME] (a medication used to slow the heart rate of patients with [MEDICAL CONDITION]). Review of the facility's investigation revealed the facility determined on 04/01/15 that Resident #11 had ten (10) [MEDICATION NAME] tablets in the medication cart, and on 04/03/15 ten (10) [MEDICATION NAME] tablets remained in the cart. The facility obtained a laboratory level for the resident's medication [MEDICATION NAME] on 04/03/15, which revealed the resident's medication level was sub-therapeutic. In addition, six (6) of nine (9) other residents had sub-therapeutic medication levels when tests were obtained on 04/03/15. The Administrator took no further action to conduct additional investigations or to address the medication concerns (refer to F282, F333, F425, and F514). The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15. An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an E at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled Medication Administration - Medication Discrepancies, dated December 2009, revealed medication discrepancies were documented and reported to the resident's attending physician, Director of Nursing, responsible party, and the Performance Improvement Committee. The policy defined a medication discrepancy as an omission of medication due to a prescribing, dispensing, or administration error. The policy further revealed when a medication discrepancy occurred immediate action should be taken to protect the patient's safety and welfare. The policy revealed a medication discrepancy/error/incident report was to be completed. Review of the facility's Administrator Job Description, dated December 2011, revealed the Administrator would lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Review of Resident #11's April 2015 physician's orders [REDACTED]. The medication was initially ordered 08/17/14. Review of the facility's investigation related to Resident #11, dated 04/07/15, revealed on 04/01/15, Resident #11's [MEDICATION NAME] medication card dated 03/24/15 (the date the medication card was received from the pharmacy), revealed only four (4) tablets had been dispensed from the card leaving ten (10) tablets remaining on the medication card. The facility audited the medication card again on 04/03/15, prior to the morning dose of [MEDICATION NAME] being administered, and Resident #11's [MEDICATION NAME] medication card still had ten (10) tablets remaining on the card. Even though the pill count remained the same, review of the Medication Administration Record (MAR) revealed staff documented the medication was administered on 04/02/15; and that the medication had not been held or refused the previous day. The facility initiated an investigation on 04/03/15, which included obtaining laboratory results for nine (9) residents who received medications that must maintain a therapeutic level. Review of the laboratory tests revealed six (6) of the nine (9) residents tested had sub-therapeutic laboratory levels. Further review of the facility's investigation revealed the facility unsubstantiated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) allegation. Review of the Pharmacy's Medication Dispensing records, dated 12/01/14 through 04/17/15, revealed medications that required monitoring were not being dispensed by the pharmacy in the amount required to ensure they were available to be administered per physician's orders [REDACTED]. Further review of the Dispending Records revealed Resident #11's [MEDICATION NAME] went up to thirty-seven (37) days between refills; Resident #17 went up to sixty-five (65) days for his/her [MEDICATION NAME] [MEDICATION]) and up to forty-three (43) days to get the [MEDICATION NAME] (anti- [MEDICAL CONDITION] medication) refilled. Further review revealed there were up to forty-seven (47) days between refills of Resident #13's [MEDICATION NAME] (anti-[MEDICAL CONDITION]); and up to twenty-five (25) days between refills of Resident #16's [MEDICATION NAME]. Further review revealed 473 ml of [MEDICATION NAME] (a 30-day supply) was dispensed to the facility on [DATE] for Resident #15 and dated as opened on 03/21/15; the [MEDICATION NAME] bottle contained 150 ml of liquid medication and by the documentation on the MAR there should have only been 130.5 ml remaining in the bottle. The SSA's Consultant Pharmacist's post survey review revealed there was a delay of approximately twenty-three (23) days between receipt of two of Resident #13's refills of [MEDICATION NAME] Liquid (30-day supply). Interview on 04/14/15 at 6:07 PM with the Director of Nursing (DON) revealed she conducted a random medication cart audit on 04/01/15 after the morning medication pass. She stated Resident #11's [MEDICATION NAME] raised a red flag because the medication card label was dated 03/24/15 and only four (4) tablets had been administered from the medication card leaving ten (10) tablets on the card. The DON stated she reviewed Resident #11's MAR and no doses had been held or refused. Further interview revealed she immediately initiated an investigation which included assessments of all residents on the hall where Resident #11 resided. Laboratory levels for all residents on that hall that were ordered medications that require therapeutic monitoring were obtained. However, the DON stated review of the Pharmacy Dispensing Records was not conducted as part of the investigation. She stated the administrative staff reviewed the investigation and did not feel there was enough concrete evidence to say Resident #11 did not receive his/her medications as ordered by the physician. Although six (6) residents were identified to have sub-therapeutic laboratory levels, interview with the Director of Nursing revealed no pattern or trend was identified and no further action was taken. Interview on 04/20/15 at 1:30 PM with the Administrator revealed the allegation was discussed by the Interdisciplinary Treatment Team and it was determined there had been a thorough investigation of the discrepancy. Even though the Administrator was aware that Resident #11's medication had the same number of pills for two (2) days (04/01/15-04/03/15), and other residents had sub-therapeutic levels of medications, he stated he did not feel the allegation could be substantiated without proof that the medication was not administered to Resident #11 per the physician's orders [REDACTED]. According to the facility's policy, when a medication discrepancy occurred immediate action should be taken to protect the patient's safety and welfare. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician order [REDACTED]. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work as needed (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) administration, the resident's care plan was being followed and accurate along with completed documentation was noted. b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted. c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders [REDACTED]. The process continued until immediacy was lifted. d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15. e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the Refill Reminder Report from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time. 11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4)weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. **The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician order [REDACTED]. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15. 4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff. 5) Review of the facility's audits on 04/24/15, revealed all residents care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all residents' care plans reflected the current resident care needs. 6) Review of the facility's in-services revealed education was provided to the Administrator, HR, Medical Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant. The education provided included the medication administration policy and procedure to include medication reconciliation, care plan policy, and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. Interviews conducted on 04/24/15, with the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors revealed the staff was educated on 04/20/15 on care plans, the medication administration policy and procedure and accurate medical records. 7) Review of the facility's in-services revealed education was initiated for licensed staff, KMAs and SRNAs on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the medication administration policy and procedure to include medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) accurately documented, readily accessible and systematically organized. Interviews on 04/24/15 with licensed staff, KMAs, and SRNAs revealed the facility provided staff education that included information on the medication administration policy, medical record documentation, care planning and following the care plan and medication reconciliation. Review of the post-tests revealed staff (with the exception of staff who was on medical leave or who worked as needed) had completed the post-test with a 100% score. 8) Review of new employee orientation revealed newly hired staff would receive education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records and that the information was added to the new hire orientation. Interviews on 04/24/15, with newly hired staff revealed the staff had been provided information on medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records. 9) Review of the new process for medication reconciliation of residents' medications revealed the process was initiated on 04/22/15. The process was as follows: a. Review of the facility audits revealed one random nurse per day, per shift completed a medication pass observation with the DON, ADONs, SDC, Medical Record's Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate, and to ensure documentation was completed. b. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. The audits revealed the process was ongoing on 04/24/15. c. Review of the facility's in-services revealed the nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when the packet/bottle was finished. Review of the facility's audits revealed the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited ten (10) discarded packets/bottles per unit daily and compared them to packets/bottles that were put into service to reconcile medications, confirm the reorder process and that the medications were being given per the physician's orders [REDACTED]. Review of the facility's audits and an observation of the medication cart on 04/24/15, revealed the process was ongoing on 04/24/15. d. Observations of the medication carts on 04/24/15 revealed the nurses/KMAs had placed the date/time and their initials on the side of new medication packet/bottle. Further observations of the medication carts revealed liquid medications were dated 04/22/15. e. Review of the medication re-order process revealed the following process was in place i) Interviews, on 04/24/15, with nursing staff revealed a nurse reordered medications via the ezMAR alert system when three (3) to four (4) days of a medication was left to administer. ii) Observations on 04/24/15, and interviews with nursing staff, on 04/24/15, revealed a nurse placed the date of reorder and their initials on the current medication bubble package. iii) Interviews, on 04/24/15, with the DON and ADONs revealed the administrative staff ran the Refill Reminder Report from the ezMAR system, Monday -Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Interviews on 04/24/15, with the Facility Formulary Nurse, ADONs, SDC, QA Nurse, and Nursing Supervisors revealed the staff reconciled the Refill Reminder Report with the nightly medication manifest report and the actual medication packet on the cart or stored in overflow to ensure medications that were reordered had actually arrived at the facility. f. Review of the facility in-services revealed nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. Interviews, on 04/24/15, with nurses and KMAs revealed the staff had been trained on documentation practices and scope of practice for the KMA. 10) Review of the facility's audits revealed all residents' medications were reconciled two (2) times weekly, starting on 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive. Interviews on 04/24/15 with the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant and Chief Nursing Executive revealed all residents' medications were reconciled two (2) times weekly with no issues identified. 11) Review of the facility's in-services revealed education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON ADONs SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. Interviews on 04/24/15 with the Administrator, DON, ADON, SDC, and the Regional Nurse Consultant revealed licensed nursing staff was provided education regarding all areas of the corrective plan. 12) Review of medication pass audits revealed the audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMA by 04/22/15. Interviews on 04/24/15 with the DON, ADON, SDC, Medical Records Nurse and Regional Nurse Consultant revealed a medication pass had been completed with all nurses and KMAs by 04/22/15. 13) Interviews on 04/24/15 with the Special Projects Administrator, the Regional Vice President of Operations, and the Chief Operating Officer revealed administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily. 14) Review of the audits and interviews on 04/24/15 with the Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant revealed the administrative staff audited the compliance of the above stated audits/observations daily. 15) Review of the Quality Assurance meeting minutes revealed a meeting was held on 04/17/15 and again on 04/20/15.
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policies, pharmacy medication dispensing records, and review of Kentucky Board of Nursing Advisory Opinion Statement #15 it was determined the facility failed to maintain accurately documented Medication Administration Records (MARs) for five (5) of thirty (30) sampled residents (Residents #11, #13, #15, #16 and #17). Review of the residents' MARs and interviews with staff revealed from December 2014 through 04/17/15, staff documented they administered residents' medications per physician's orders [REDACTED].#11, #13, #16, and #17, and observation of Resident #15's medication, revealed the following medications were not administered as ordered by the residents' physicians: Resident #11's [MEDICATION NAME] (medication to treat an abnormal heartbeat); Resident #17's [MEDICATION NAME] [MEDICATION]) and [MEDICATION NAME] (anti-[MEDICAL CONDITION] and treat some psychiatric disorders); Resident #13's [MEDICATION NAME] (anti-[MEDICAL CONDITION]); Resident #16's [MEDICATION NAME]; and Resident #15's [MEDICATION NAME]. On 04/03/15, the facility obtained physician's orders [REDACTED].#17's [MEDICATION NAME]. The lab results revealed Residents #11, #17, #13, and #16's medication levels were subtherapeutic (less than the amount required to treat or cure the disease process) (refer to F282, F333, F425, and F490). Additional review of Medication Administration Records (MARs) revealed a medication aide, who is not authorized in the state of Kentucky to administer medications via a resident's gastrostomy tube (a gastrostomy tube, or [DEVICE], is a tube inserted through the abdomen that delivers nutrition directly to the stomach), documented she administered medications via Residents #11, #15, #16, and #17's gastrostomy tubes, when the medications were administered by licensed staff. The facility's failure to have an effective system in place to ensure care and services were provided as per the resident's plan of care was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 04/02/15 at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and 42 CFR 483.75 Administration (F490 and F514). The facility was notified of the Immediate Jeopardy on 04/20/15. An acceptable Allegation of Compliance was received on 04/23/15, which alleged removal of the Immediate Jeopardy on 04/23/15. An extended survey was conducted on 04/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 04/23/15, which lowered the Scope and Severity to an E at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F425), and, 42 CFR 483.75 Administration (F490 and F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	04/24/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) The findings include: Review of the facility's policy titled Medication Administration General Guidelines, dated December 2012, revealed medications were administered as prescribed in accordance with the manufacturer's specifications, good nursing principles and practices, and only by persons legally authorized to do so. The policy further stated medications were administered in accordance with written orders of the prescriber. The individual who administered the medication dose was required to record the administration on the resident's MAR immediately following the medication being given. If a dose of regularly scheduled medication was withheld, refused, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration was initialed and circled. Review of the facility's policy titled Medication Administration - Medication Discrepancies, dated December 2009, revealed medication discrepancies were documented and reported to the resident's attending physician, Director of Nursing, responsible party, and the Performance Improvement Committee. The policy defined a medication discrepancy as an omission of medication due to a prescribing, dispensing, or administering error. The policy further revealed when a medication discrepancy occurred immediate action should be taken to protect the patient's safety and welfare. Continued review of the policy revealed the attending physician was notified of the error or significant medication discrepancy and the patient was to be monitored closely for 24 to 72 hours or as directed by the physician. The policy revealed a medication discrepancy/error/incident report was to be completed. 1. Review of Resident #11's medical record revealed the resident had [DIAGNOSES REDACTED]. Further review revealed physician's orders [REDACTED]. Review of Resident #11's MARs for December 2014 through 04/17/15 staff documented one (1) dose of [MEDICATION NAME] was omitted on 01/05/15. Staff documented all other doses of [MEDICATION NAME] were administered per the physician's orders [REDACTED].>However, review of the facility's investigation related to Resident #11, dated 04/07/15, revealed on 04/01/15, Resident #11's [MEDICATION NAME] medication card dated 03/24/15 (the date the medication card was received by the facility for use) revealed ten (10) of fourteen (14) tablets were remaining on the medication card. The facility audited the medication card again on 04/03/15 (two days later), prior to the morning dose of [MEDICATION NAME], and Resident #11's [MEDICATION NAME] medication card still had ten (10) tablets remaining on the card. Review of the Medication Administration Record (MAR) revealed staff documented the medication was administered on 04/02/15 and the medication had not been held or refused the previous day. Review of the pharmacy's medication dispensing records, dated 12/01/14 through 04/17/15, revealed fourteen (14) [MEDICATION NAME] tablets were dispensed for Resident #11 seven (7) times since 12/10/14 (dispensed on 12/10/14, 12/21/14, 01/28/15, 02/11/15, 02/25/15, 03/25/15, and 04/15/15). During the timeframe reviewed (12/10/14 through 04/16/15) the pharmacy dispensed ninety-eight (98) [MEDICATION NAME] tablets; however, the resident required one hundred twenty-eight (128) tablets for the staff to be able to administer the resident's [MEDICATION NAME] per the physician's orders [REDACTED]. Review of Resident #11's [MEDICATION NAME] laboratory levels dated 01/05/15 and 04/03/15 revealed the resident's medication was at a sub-therapeutic level. 2. Review of Resident #17's medical record revealed the resident had a [DIAGNOSES REDACTED].#17's physician's orders [REDACTED]. Review of Resident #17's MARs for 12/01/14 through 04/04/15 revealed staff omitted one dose of [MEDICATION NAME] for the resident on 01/05/15. Staff documented all other doses had been administered. Further review revealed staff omitted one dose of [MEDICATION NAME] on 04/04/15 and documented that the medication was not administered on five (5) other occasions (03/08/15, 03/17/15, 03/18/15, 03/22/15, and 03/23/15). All other doses were administered, according to the MARs. Review of the pharmacy medication dispensing records dated 12/01/14 through 04/17/15, revealed the pharmacy dispensed thirty (30) capsules of [MEDICATION NAME] 250 mg (a 30-day supply) twice from 12/18/14 through 04/04/15 (12/18/14 and 1/28/15), for a total of sixty (60) capsules. However, one hundred seven (107) capsules were required for the staff to be able to administer the resident's [MEDICATION NAME] per the physician's orders [REDACTED]. Further review of the pharmacy medication dispensing records revealed the pharmacy dispensed one hundred twenty (120) capsules of [MEDICATION NAME] 125 mg (a 30-day supply) on 02/20/15; however, the medication was not refilled again until 04/05/15, forty-four (44) days later. Review of Resident #17's laboratory results revealed on 04/03/15, the resident's [MEDICATION NAME] Acid ([MEDICATION NAME]) level was not therapeutic. Further review of Resident #17's lab levels revealed on 03/16/15, the resident's [MEDICATION NAME] level was sub-therapeutic at less than 2.5 mcg/ml (micrograms/milliliter) (therapeutic range is 5 - 12 mcg/ml), but had increased to 9.1 mcg/ml on 03/19/15. As a result of post-survey review by the SSA 's pharmacist consultant, it was determined Resident #17's had Physician order [REDACTED]. 3. Review of Resident #13's medical record revealed the resident had [DIAGNOSES REDACTED]. Review of April 2015 physician's orders [REDACTED]. Review of Resident #13's MARs for January through March 2015, revealed staff documented the resident's [MEDICATION NAME] medication was administered as ordered. Review of the pharmacy medication dispensing records for Resident #13 revealed the pharmacy dispensed 300 ml (a 30-day supply) of [MEDICATION NAME] liquid medication four (4) times from 12/03/14 through 03/18/15, for a total of 900 ml. There were forty-seven (47) days between refills from 01/08/15 through 02/24/15. However, 1,050 ml of [MEDICATION NAME] was required to administer the medication per physician's orders [REDACTED]. Review of Resident #13's laboratory results revealed on 12/01/15, the resident's [MEDICATION NAME] level was therapeutic at 23 mcg/ml (normal range is 5 - 63 mcg/ml). However, on 03/02/15 and 04/03/15, the resident's [MEDICATION NAME] level was sub-therapeutic (2.0 mcg/ml and 2.9 mcg/ml, respectively). During the SSA's post-survey review by the State Agency Pharmacist Consultant, it was determined through review of the pharmacy's Delivery Manifest Report from 12/01/14 through 04/04/15 revealed Resident # 13's [MEDICATION NAME] Liquid refills were supplied as 30-day increments of 300 ml each. The review also revealed the resident received four (4) refills (12/03/14, 01/08/15, 02/24/15, and 03/19/15) of [MEDICATION NAME] Liquid during that time. Thus, the subsequent refill was approximately six (6) days late. Likewise, after receiving the 300 ml refill on 01/08/15, the resident received a subsequent refill of 300 ml forty-seven (47) days later on 02/25/15, or approximately seventeen (17) days late, as the subsequent refill should have been received approximately 30 days later, on/about 02/07/15. Post Survey review of the January through April 2015 revealed staff did not administer the [MEDICATION NAME] liquid medication as ordered; two (2) doses were omitted in January 2015, one (1) dose in February 2015, and two (2) doses in April 2015 for a total of five (5) doses (50 ml). 4. Review of Resident #16's medical record revealed the resident had [DIAGNOSES REDACTED]. Further review revealed a physician's orders [REDACTED]. Review of Resident #16's MARs for 12/01/14 through 04/17/15 revealed staff omitted the resident's morning dose of [MEDICATION NAME] Acid on 01/05/15; however, staff documented the resident's [MEDICATION NAME] Acid was administered as ordered for all other doses during these months. However, review of the pharmacy medication dispensing records revealed the pharmacy dispensed a 150-ml bottle (a 15-day supply) of [MEDICATION NAME] for Resident #16 on 01/24/15. However, the medication was not refilled again until 02/18/15, twenty-six (26) days later. Review of Resident #16's [MEDICATION NAME] Acid laboratory level dated 04/03/15 revealed the resident's [MEDICATION NAME] Acid level was sub-therapeutic at 20.6 mcg/ml (therapeutic range is 50 - 100 mcg/ml). 5. Review of Resident #15's medical record revealed the facility readmitted the resident on 03/20/15, after a hospital stay. Further review revealed the resident had a [DIAGNOSES REDACTED]. However, review of Resident #15's MARs for 03/20/15 through 04/17/15 revealed staff documented they administered [MEDICATION NAME] to Resident #15 as ordered by the resident's physician. Review of the pharmacy's medication dispensing records for Resident #15 revealed 473 ml of [MEDICATION NAME] was dispensed to the facility on [DATE]. Observation on 04/17/15 at 2:20 PM of Resident #15's [MEDICATION NAME] medication bottle, that was available for use in the medication cart, revealed the medication was dated as opened on 03/21/15, one day after the resident was readmitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) facility. The bottle contained 150 ml. However, according to the resident's physician's orders [REDACTED]. Review of Resident #15's laboratory results revealed on 01/20/15, the resident's level was 8.0 mcg/ml (normal range is 5 - 63 mcg/ml). However, on 04/03/15, the resident's level had decreased to a sub-therapeutic level of 5.0 mcg/ml. Review of the facility's Status Change document that listed residents who had been admitted , transferred, or discharged from December 2014 through April 2015 revealed Residents #11, #13, #15, #16, and #17 had not been absent from the facility, during the times the discrepancies were identified with their medication. Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, with Kentucky Medication Aide (KMA) #1 on 04/17/15 at 1:27 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed staff denied any resident's medication was not administered per physician's orders [REDACTED]. [REDACTED]. Interview on 04/14/15 at 6:07 PM with the Director of Nursing (DON) revealed the DON only reviewed MARs for omissions and discrepancies daily and had not identified any concerns. The DON further stated administrative staff observed random medication passes with the nursing staff and had not identified any concerns. 6. Review of Kentucky Board of Nursing Advisory Opinion Statement #15 revealed unlicensed personnel known as medication aides may function by administering oral and topical medications in long-term care facilities only through delegation by and under the supervision of a registered nurse or licensed practical nurse. Review of the Kentucky Medication Aide (KMA) course curriculum revealed medication aides DO NOT: . administer medications via tubes inserted into any body cavity. Review of Residents #11, #15, #16, and #17's physician's orders [REDACTED]. Review of Resident #11 and #17's MARs for January 2015 through April 2015 revealed KMA #1 documented that she administered [DEVICE] medications to the residents on four (4) days in January 2015, three (3) days in February 2015, one day in March 2015, and four (4) days in April 2015. Review of Resident #15's MARs for January 2015 through April 2015 revealed KMA #1 documented she administered Resident #15's [DEVICE] medications on four (4) days in January 2015, three (3) days in February 2015, and three (3) days in April 2015. Review of Resident #16's MARs for January 2015 through April 2015 revealed KMA #1 documented she administered the resident's [DEVICE] medications on four (4) days in January 2015, three (3) days in February 2015, one (1) day in March 2015, and three (3) days in April 2015. Interview with KMA #1 on 04/17/15 at 1:27 PM revealed she did not administer medications via residents' [DEVICE]s. She stated the residents' MARs had her name on them because she was signed into the electronic Medication Administration Record (eMAR) when the licensed nurses administered the medications. KMA #1 stated nursing staff failed to sign into the electronic MAR under their own names when they administered [DEVICE] medications. The KMA further stated she only administered oral medications. Interview with RN #1 on 04/14/15 at 5:03 PM, with Licensed Practical Nurse (LPN) #5 on 04/16/15 at 11:55 PM, with RN #6 on 04/16/15 at 12:14 PM, and with LPN #6 on 04/17/15 at 3:29 PM, revealed they always administered medications for residents with [DEVICE]s. They stated they were required to have the KMA sign out of the resident's electronic MAR and they should sign in before administering [DEVICE] medications or they should document a note in the electronic MAR; however, the staff could provide no evidence this practice occurred. Interview with the facility's Corporate Nurse Consultant on 04/17/15 at 2:45 PM and the DON on 04/17/15 at 3:45 PM revealed they were not aware nursing staff was not signing in or documenting when they administered [DEVICE] medications when the KMA was signed/logged into the electronic MAR system. Interview on 04/14/15 at 6:07 PM with the DON revealed she reviewed MARs for omissions and discrepancies daily and administrative staff randomly observed medication administration. She further stated no concerns had been identified related to KMAs documenting administration of [DEVICE] medications. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/23/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) The Physician and Power of Attorney (POA) for Residents #11, #13, #14, #15, #16, and #17 were notified immediately upon identification of potential medication errors by the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADONs), Staff Development Coordinator (SDC), Quality Assurances (QA)Nurse, Nursing Supervisor, Medical Records Nurse or Regional Nurse Consultant on 04/20/15. Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or QA Nurse on 04/20/15 for any signs and symptoms of adverse reactions, with no issues identified. Laboratory levels were drawn on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated, as needed. All six (6) residents' medications were counted and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) The physician and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) All residents' medications were audited by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, to ensure that the current medications, compared to the current Physician order [REDACTED]. A new bottle of medications were requested and placed into service on 04/22/15 for the liquid medications that could not be counted, due to opacity of container. 4) All residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The following issues were identified and corrected: a. Social Services Quarterly Notes were not within compliance- for three (3) residents b. Activity Quarterly Notes not within compliance-three (3) residents c. Care plan updates-two (2) residents d. Behavior Management care plan updates-two (2) residents 5) All residents' care plans were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director, Quality of life, Dietary Manager, Chaplain, Medical Records or Regional Nurse Consultant by 04/22/15 to ensure all resident care plans reflected the current resident care needs. 6) Education was provided to the Administrator, HR, Med Record's Nurse, BOM, Quality of Life, Admissions, Assistant Administrator, Plant Ops, Food Service Director, SSD, Central Supply, Housekeeping Supervisor, DON, ADONs, SDC, MDS Coordinators, and Nursing Supervisors on 04/20/15 by the Regional Nurse Consultant regarding the facility's medication administration policy and procedure which included medication reconciliation. The care plan policy and the procedure included following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. 7) Education was initiated for licensed staff, Kentucky Medication Aides (KMAs) and State Registered Nurse Aides (SRNAs) on 04/20/15 by the Administrator, Assistant Administrator, Regional Nurse Consultant, DON, ADONs or the SDC regarding the Medication Administration Policy and Procedure which included medication reconciliation, care plan policy and the procedure to include following the care plan, administering care to ensure highest practical physical, mental, and psychosocial well-being of each resident, and maintain clinical records in acceptable professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. All clinical staff completed or will complete a post-test and score 100% to ensure understanding of education/training provided. If 100% is not obtained then the staff member will be re-educated and a post-test re-administered until the staff member obtains 100% score to ensure understanding of the material covered. Clinical staff was not allowed to work prior to receiving the above stated education. Those clinical staff members that were on Family Medical Leave Act (FMLA), leave or work as needed (PRN) were sent a certified letter and were not allowed to work until the education had been received and a post-test completed with 100% score obtained. As of 04/23/15, 60% of all licensed staff and clinical staff had been educated with post-test completed and 100% score obtained; 15% have been contacted by phone, provided education and notified that they cannot work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	**04/24/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF PIKEVILLE	**260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501**

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 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) until 1:1 education with post-test was completed, and, 100% score obtained. The remaining 25% were in the process of being contacted and will not be allowed to work until education with post-test has been completed and 100% score obtained. Once education has been provided, each licensed nurse will complete a medication administration observation pass with the DON, ADONs, SDC, Nursing Supervisor, or Regional Nurse Consultant. 8) Education regarding medication administration policy and procedure, care plan policy and procedure, administrative oversight, and complete and accurate clinical records were included in the new hire orientation. 9) A new process was initiated on 04/22/15 for medication reconciliation of residents' medications. The process is as follows: a. One random nurse per day, per shift, will complete a medication pass observation with the DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant to ensure compliance with medication administration, the resident's care plan was being followed and accurate along with completed documentation was noted. b. DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor, or Regional Nurse Consultant reconciled the medications of four (4) randomly selected residents daily to ensure compliance with medication administration. This process was continued until immediacy was lifted. c. Nurses/KMAs received education on 04/21/15 by the Regional Nurse Consultant, DON, ADONs, SDC, or Nursing Supervisor on placing the discarded pill packets/bottles in the bottom drawer of the medication cart when packet/bottle was finished. The DON, ADONs, SDC, Medical Records Nurse, MDS Coordinators, Nursing Supervisor or Regional Nurse Consultant audited, daily, ten (10) discarded packets/bottles per side compared to packets/bottles that were put into service to reconcile medications, confirm reorder process and that the medications were being given per the physician's orders [REDACTED]. The process continued until immediacy was lifted. d. Nurses/KMAs placed the date/time and their initials on the side of any new medication packet/bottle placed into service to ensure an accurate date which will allow for accurate reconciliation. Those liquid medications, a total of twenty-one (21), that could not be counted, due to opacity of container, a new bottle was obtained and placed in service by 04/22/15. e. Reorder process below will continue until immediacy was lifted: i) A nurse re-ordered medications via the ezMAR alert system when three (3) to four (4) days of medication were left to administer. ii) A nurse then placed, on the current medication bubble pack, the date of reorder, and their initials. iii) The DON and/or ADONs ran the Refill Reminder Report from the ezMAR system, Monday - Friday, and validated that all medications due to be reordered, had actually been reordered. iv) Facility Formulary Nurse, ADONs, SDC, QA Nurse, or Nursing Supervisors reconciled the Refill Reminder Report with the nightly medication manifest report with the actual medication packet on the cart or stored in overflow to ensure medications that were reordered have actually arrived at facility. f. Nurses and KMAs were educated/trained on the medication administration policy and procedure to include documentation along with the scope of practice of the KMA. KMAs will not administer or document administering any medications other than by mouth (PO) or topical. 10) All residents medications were reconciled two (2) times weekly, starting 04/20/15 by the DON, ADONs, SDC, Medical Records Nurse, QA Nurse, Nursing Supervisor, Regional Nurse Consultant or Chief Nursing Executive, to ensure reorder process system was intact and within compliance along with ensuring residents medications were administered as ordered. This process will continue for two (2) weeks and results will be reviewed in a weekly QAPI meeting. The QAPI committee will determine ongoing frequency of resident medication reconciliation at that time. 11) Education was provided for Licensed Nursing Staff by the Administrator, Assistant Administrator, DON, ADON, the SDC, or the Regional Nurse Consultant regarding the above stated plan by 04/21/15. 12) Medication pass audits were completed by the DON, ADON, SDC, Medical Records Nurse, or Regional Nurse Consultant for all nurses and KMAs by 04/22/15 to ensure that medications were administered without significant medication error. Nurses or KMAs who had not completed a medication pass observation were not allowed to work until the medication pass observations had been completed for shifts scheduled after 04/22/15. As of 04/24/15, 75% of all nurses and KMAs had completed a medication pass observation. 13) Administrative oversight of the facility was completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, weekly for four (4) weeks after removal of immediacy, then monthly. 14) The Administrator, Assistant Administrator, Special Projects, DON, Chief Operating Officer, Chief Nurse Executive or Regional Nurse Consultant audited compliance of the above stated audits/observations daily until removal of immediacy, then twice weekly for four (4) weeks and reported findings during weekly QA for four (4)weeks, for recommendations and further follow-up as indicated. 15) A Quality Assurance meeting was held on 04/17/15, and again on 04/20/15 for further recommendations regarding the plan for removal of Immediate Jeopardy. A Quality Assurance meeting will be held weekly for four (4) weeks, then monthly for recommendations and further follow up regarding the above stated plan. **The State Survey Agency validated the Immediate Jeopardy was removed as follows: 1) Review of the medical records of Residents #11, #13, #14, #15, #16, and #17 revealed the residents' physicians and POAs were notified of the potential medication errors by the administrative staff. Further review of the medical records revealed Residents #11, #13, #14, #15, #16, and #17 were assessed by the ADONs or the QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions from potential medication errors, with no issues identified. The facility obtained laboratory levels on all six (6) residents, the physician was notified of the results, and the residents' care plans were updated as needed. The residents' laboratory results were obtained on the following days by the facility: Resident #11 on 04/03/15, 04/06/15, and 04/20/15, Resident #13 on 04/03/15 and 04/19/15, Resident #14 on 04/17/15, 04/17/15 and 04/19/15, Resident #15 on 04/03/15 and 04/20/15, Resident #16 on 04/03/15 and 04/17/15 and Resident #17 on 04/20/15. The Administrative Staff counted all six (6) residents' medications and a medication reconciliation was completed for accuracy and a current count was placed on each individual pill packet and/or bottle of liquid medicine on 04/20/15 by the DON, ADONs, SDC, QA Nurse, Medical Records Nurse or Regional Nurse Consultant. 2) Review of the medical record revealed the physicians and POAs for Residents #11, #15, #16, and #17 were notified immediately upon identification of inappropriate documentation by the Administrator, DON, ADONs, SDC, QA Nurse, Nursing Supervisor, Medical Record's Nurse, or Regional Nurse Consultant on 04/20/15. Further review of the medical records revealed Residents #11, #15, #16, and #17 were re-assessed by the ADONs or QA Nurse, on 04/20/15, for any signs and symptoms of adverse reactions, with no issues identified. 3) Review of the medication audits revealed the audits were completed by the DON, ADON, SDC, Nursing Supervisor, Medical Record's Nurse or Regional Nurse Consultant, on 04/20/15, and ensured that the current medications, compared to the current Physician order [REDACTED]. Observations, on 04/24/15 revealed new bottles of medication were placed into service on 04/22/15. 4) Review of the facility's audits revealed all residents' charts were audited by the Administrator, Assistant Administrator, DON, ADONs, SDC, QA Nurse, MDS Coordinators, Nursing Supervisor, Admissions, Social Services Director (SSD), Quality of Life, Dietary Manager, Chaplain, Medical Record's Nurse or Regional Nurse Consultant by 04/22/15 for accuracy of the clinical records and that the records were complete and accurately documented. The audits revealed issues identified were corrected by the facility staff. 5) Review of the facility's audits on 04/24/15, re