at 11:45 AM revealed LPN #1 was called to Resident #1's room due to Resident #1 acting different. LPN #1 identified Resident #1 had left sided weakness, the resident's left pupil was pinpoint and nonreactive, and the resident was nonverbal. The resident's physician and Emergency Medical Services (EMS) were notified at this time. LPN #1 stated the hospital Physician called and asked about the resident's [MEDICATION NAME] and that was when she identified the order had been discontinued on 05/26/16 and the resident had not received [MEDICATION NAME] for seventeen (17) days. Review of Resident #1's Hospital Records, dated 06/12/16, revealed the resident was admitted to the hospital with [REDACTED]. The resident was placed on [MEDICATION NAME] Drip due to low (International Normalized Ratio) INR. Review of the physician's orders [REDACTED]. However, review of the May 2016 EZMAR, revealed the order for [MEDICATION NAME]

NAME]
6 mg, give one (1) tablet daily, was discontinued after the 05/25/16 dose was administered. Review of the June 2016 EZMAR, revealed there was no documented evidence the order was continued.

Interview with Licensed Practical Nurse (LPN) #2, on 06/15/16 at 11:24 AM, revealed she entered the new order into the Administrative side of the EZMAR and hit save but she did not check the EZMAR to ensure the order was on the EZMAR, as this was not the facility's process. In addition, she stated she did not recall if she had included the HOA and or stop date, which was needed to ensure the medication, would renew on the Administration side of the EZMAR.

Interviews on 06/16/16 with LPN #6 at 8:22 AM and LPN #7 at 4:10 PM; and on 06/15/16 with LPN #3 at 3:10 PM, and LPN #4 at 3:18 PM, revealed the nurses enter the physician's orders [REDACTED]. They stated they do not go into the Administration side (medication pass side) of the EZMAR to verify the order was there, as it was not part of their process. The LPNs stated the facility did not have a system to verify that all the physicians' orders had been transferred over to the EZMAR from month to month from month to month.

Interview with LPN #8, on 06/20/16 at 2:15 PM, revealed part of her responsibility as part of the Interdisciplinary Team (IDT) was to review all the new written physicians' orders to make sure they were in the EZMAR correctly. She stated she compared the written order in the Administrative portion (physician order [REDACTED]. She further revealed it was not part of the facility's process to go into the Administration portion side (medication pass side) of the EZMAR screen where the nurses sign off the medications. She stated she just verified the slips with the orders on the Administrative side of the

EZMAR.

Interview with the Director of Nursing (DON), on 06/12/16 at 2:15 PM, and 5:53 PM; on 06/16/16 at 10:09 AM and 3:06 PM; on 06/17/16 at 10:45 AM; and, on 06/20/16 at 1:25 PM and 2:01 PM, revealed the Interdisciplinary Team (IDT) reviewed all new Physicians' Orders daily Monday through Friday. She stated the facility did not require the nursing staff to double check the physician's orders [REDACTED].

Interview with Resident #1's Physician, on 06/15/16 at 3:47 PM, revealed Resident #1 has been on [MEDICATION NAME] for many years for [MEDICAL CONDITION] Fibrillation and missing seventeen (17) doses of [MEDICATION NAME] would be considered

a significant medication error and could lead to a potential stroke, clot, or [MEDICAL CONDITION] Fibrillation.

Interview with the Administrator, on 06/17/16 at 9:31 AM, revealed he would expect Resident #1 to have received his/her medication as ordered by his/her physician. Further interview revealed he was not aware of anything in place to check the MARs for accuracy at the end of the month, or to determine if medications were still in the system for administration after the nurses entered a new physician's orders [REDACTED].>\*\*The facility implemented the following actions to remove the Immediate Jacopardy: Immediate Jeopardy:

1. LPN #1 completed a review of the Electronic Medication Administration Records (EZMARs) for the other three (3) residents

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11 Facility ID: 185209 If continuation sheet

STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCT	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		06/30/2016		
CORRECTION	NUMBER					
NAME OF PROVIDER OF SU	185209 PPLIER		STREET ADDRESS, CITY, STA	L ATE, ZIP		
RIVERSIDE CARE & REHAI			190 EAST HWY. 136 CALHOUN, KY 42327	,		
For information on the nursing l	nome's plan to correct this deficience	cy, please contact the nursing hon	ne or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY		
F 0281  Level of harm - Immediate	(continued from page 1) who received [MEDICATION NAME] to ensure their orders were in place in the system and that [MEDICATION NAME] was					
jeopardy	being administered to all others as ordered. This was completed on 06/12/16 with no concerns identified.  2. A physical assessment was completed on all other residents with orders for [MEDICATION NAME] (3) by LPN #1 on 06/12/16					
Residents Affected - Few	with no concerns. No changes of 3. Three (3) medication carts were		to ensure the ordered doses of [M]	EDICATION NAMEI were		
	available for all residents who have three (3) medication carts was consudit of all residents' medications 4. The DON and the Staff Develop	mpleted by the DON on 06/12/16 to include medications that requirement Coordinator (SDC) comple	with no concerns identified. In ad re monitoring was conducted. eted an audit on the electronic phy	dition, a 100% internal		
	No other orders were identified as 5. Education was initiated on 06/1 full-time and part-time Licensed I EZMAR (Electronic Medication of physicians' orders; medication medication orders; transcription or	2/16 and completed on 06/20/16 Nurses and Certified Medication Administration) policy regarding discrepancies; the seven (7) rights	by the Staff Development Coordin Aides (CMAs) regarding general in the inclusion of hours of administ is of accurate medication administration.	nedication orders; the ration (HOA); daily review ration; non-controlled		
	Records process. 6. Certified letters were drafted by FMLA (Family Medical Leave A returning to work.	the Administrator and mailed ou	t on 06/15/16 to inform all staff or	n medical leave, on		
	7. Physicians' Orders were review Restorative Nurse Manager, and I that all other medications were be	Nursing Consultant and compared	to the Electronic Medication Adı	ninistration Record to ensure		
	8. The DON or the ADON will rev [MEDICATION NAME] count sl to ensure anticoagulant medicatio	heets daily (5 days per week) for the have been administered as order	four (4) weeks then three (3) times ered which began on 06/13/16. At	s per week for four (4) weeks adits will be continued		
	based on recommendation from the (Director of Nursing, Assistant Dievelopment Coordinator) will be	irector of Nursing, Restorative Nu e assigned to review medication a	urse Manager, Medical Records N administration records to ensure ar	urse, MDS Nurse, or Staff nticoagulant medications		
	have been administered as ordered and meet intent. If concerns are identified, the DON will be notified after an assessment of the resident has been conducted in order to make sure the resident is safe. If any change is identified, the Physician and the Resident's Responsible Party will immediately be notified. If no change of condition is identified, the Physician will be notified.					
	9. On 06/13/16, the DON moved [MEDICATION NAME]/[MEDICATION NAME] to the narcotic drawer, and now requires that [MEDICATION					
	NAME]/[MEDICATION NAME] be counted and signed out by licensed nurses and/or Certified Medication Aides to ensure appropriate administration. The DON, ADON and SDC will compare the [MEDICATION NAME] count sheets to the Medication Administration Record (EZMAR) process daily (Monday through Friday). On the weekends, this will be assigned to an Administrative Nurse (DON, ADON, Restorative Nurse Manager, Medical Records Nurse, MDS Nurse, or SDC).					
	10. Residents requiring the use of anticoagulants will be discussed in the clinical meeting daily as an on-going process, attended by the interdisciplinary team to include, but not limited to the Director of Nursing, Assistant Director of Nursing, Social Services Director, Staff Development Coordinator, Dietary Manager, and Quality of Life Director, Monday through Friday. This includes review of their Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications have been administered as ordered. On weekends, an Administrative					
	Nurse will be assigned to review Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] coun sheets to ensure anticoagulant medications have been administered as ordered. This process began on 06/13/16 and will continue as an ongoing process.					
	11. Education was initiated and completed on 06/13/16 by the Nurse Consultant for the interdisciplinary team including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services, Dietary Manager, and Quality of Life Director regarding the Anticoagulation Management Policy and daily follow-up for residents who require the use of Anticoagulant medications.					
	12. On 06/15/16, directed education was completed by the Nurse Consultant for Nurses and Certified Medication Aides who were responsible for passing medications to Resident #1 at the 4:00 PM medication pass from May 27, 2016 through June 11, 2016. 13. On 06/15/16, the PharMerica Product Training and Implementation Consultant came to the facility to assist with identification of the electronic medication administration system concerns. She provided education on 06/15/16 to the					
	Director of Nursing, Assistant Dirlicensed nursing staff regarding a function. She will be available to 14. On 06/15/16, the Business Dev	pproving or rejecting orders, discl provide further assistance and tra	harging residents, leave of absence ining as indicated.	e, and readmit		
	facility to correct the identified co with the compatibility of one (1) of administration program utilized b	oncern with the electronic medical of the facility's computers with the y the facility) system. He determi	tion administration system. He ide e PharMerica (owner of the electrined if the compatibility setting wa	entified a concern onic medication as found to be on		
	Internet Explorer 10, there was no used by the licensed nursing staff. Explorer 11, which was not comp identified issue. A sign was place	On one (1) laptop computer, the atible with the PharMerica suite.	compatibility settings were found He changed the compatibility sett	to be on Internet ing to correct the		
	computers until further notice. The PharMerica with a server side upon of administration (HOA) or they	e concern with the compatibility date that was completed on 06/16/would not be accepted by the syst	of desktop computers was address 16. These corrections ensured ord	ed and resolved by lers must contain the hour		
	provide further technical assistant 15. Care plans were reviewed by tanticoagulation therapy. No Conc Team: Director of Nursing, Assist	he Nurse Consultant on 06/12/16 erns were identified. Care plans v tant Director of Nursing, Social S	were again reviewed on 06/13/16 thervices, Dietary Director, and Qua	by the Interdisciplinary ality of Life Director,		
	for residents requiring the use of anticoagulant therapy, to ensure further updates were not needed. There were no concerns identified.  16. The Nurse Consultant will audit the physician's orders [REDACTED].  17. A nurse from the regional team or home office has been available since 06/12/16. The nurses from the regional team or					
	home office are performing chart audits to compare anticoagulant orders with MARs, observing care delivery as per care plans and providing oversight and consultation to licensed staff and Certified Medication Aides. Onsite visits from the regional team or corporate office will occur daily until immediacy is removed and then weekly for four (4) weeks. Concerns					
	identified will be corrected immediately and reported to the Administrator and the Director of Nursing.  18. A Quality Assurance Performance Improvement (QAPI) meeting was held on 06/13/16 with the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Director, Quality of Life Director, Admissions Coordinator, and the Maintenance Director to discuss Resident #1; the findings of the investigation into the occurrence; and, the above stated plan of corrective actions. The Medical Director was consulted					
	regarding the plan to correct the id 19. Quality Assurance Performance Medical Director, Administrator,	dentified concerns. re Improvement (QAPI) meetings Director of Nursing, Assistant Di	will be held weekly, to include by rector of Nursing, Social Services	at not limited to, the , Dietary Director,		
	Quality of Life Director, Admissi compliance with the corrective ac until immediacy is removed, then Administrator has the oversight to timely manner and to assist in the	tion plan and for further recommendation and monthly for recommendation and ensure an effective plan is in pla development of corrective action	endations, as indicated. QAPI med d further follow up regarding the a ace to ensure facility concerns are a plans. Corporate Administrative	etings will be held weekly above stated plan. The identified in a oversight of the		
	Quality Assurance meeting will b removal of the immediacy of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 185209

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				PRINTED:5/16/2017 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 185209	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 06/30/2016	
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP				ATE ZID	
NAME OF FROVIDER OF SUFFLIER			STREET ADDRESS, CITT, STA	1 ADDRESS, CITT, STATE, ZII	
			190 EAST HWY. 136 CALHOUN, KY 42327		
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)					

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)

- (continued... from page 2)
  \*\*The State Survey Agency validated the corrective action by the facility as follows:

  1. Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she completed a review of the Electronic Medication

  Administration Records for the other three (3) residents on [MEDICATION NAME]. The review was to ensure their orders were in place in the EZMAR system; and, to ensure all medications had been administered as ordered. LPN #1 identified no
- noncerns and revealed this had been completed on 06/12/16.

  Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she completed physical assessments for the other three (3) residents with orders for [MEDICATION NAME]. No change of condition was identified on 06/12/16.

  Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she conducted three (3) medication cart audits to ensure doses of MEDICATION NAME.
- [MEDICATION NAME] were available for all residents who had orders. No concerns were identified on 06/12/16. Further interview revealed the DON went behind LPN #1 to double check the cart and identified no concerns on 06/12/16. 4. Interview with the DON, on 06/29/16 at 9:05 AM, and the SDC, on 06/28/16 at 3:40 PM, revealed an audit of the electronic physicians' orders (POS), was conducted on 06/12/16. This audit was to ensure all medication orders contained an hour of
- administration (HOA) with a focus on anticoagulation medications. No other issues were identified on 06/12/16.

  5. Interviews on 06/28/16 with LPN #1 at 3:03 PM, the ADON at 4:30 PM, and on 06/29/16 with RN #3 at 8:17 AM, LPN #3 at 10:40 AM, RN #4 at 11:55 AM, LPN #4 at 12:10 PM, RN #5 at 12:20 PM, CMA #14 at 12:50 PM, CMA #6 at 1:05 PM, CMA #15

at 1:20
PM, RN #6 at 1:25 PM, LPN #8 at 1:50 PM, RN #1 at 2:29 PM, LPN #10 at 3:47 PM, and RN #7 at 4:44 PM, revealed they had received education regarding general medication orders; the EZMAR (Electronic Medication Administration) policy regarding inclusion of hour administration (HOA); daily review of physician's orders [REDACTED]. The [MEDICATION NAME] was now

up and counted as if it was a narcotic and had to be signed out on the [MEDICATION NAME] count sheet. Also, someone from the Administrative nursing staff compares the [MEDICATION NAME] sheets to the EZMAR to ensure the [MEDICATION NAME] has

- 6. Interview with the Administrator, on 06/29/16 at 4:00 PM, revealed he drafted and mailed out certified letters to all the staff that was on vacation, medical leave, FMLA (Family Medical Leave Act), and all PRN staff requiring education prior to
- returning to work.

  7. Interviews, on 06/28/16, with LPN #1 (Restorative Nurse Manager) at 3:03 PM, the SDC at 3:40 PM, the ADON at 4:30 PM, and on 06/29/16 with the DON at 9:05 AM, the Nurse Consultant at 10:20 AM, and LPN #8 (Medical Records) revealed all on 06/29/16 with the DON at 9:05 AM, the Nurse Consultant at 10:20 AM, and LPN #8 (Medical Records) revealed all Physicians' Orders were reviewed on 06/13/16 and compared to the electronic Medication Administration Record to ensure that all medications were being administered as ordered, with no discrepancies identified.

  8. Interviews, on 06/28/16, with LPN #1 (Restorative Nurse Manager) at 3:03 PM, the SDC at 3:40 PM, the ADON at 4:30 PM; and, on 06/29/16 with the DON at 9:05 AM, LPN #8 (Medical Records) at 1:50 PM and MDS at 4:50 PM, revealed the DON or the
- ADON will review medication administration records (EZMAR), hour of administration (HOA), and review [MEDICATION NAMEL

in the count sheets daily (5 days per week) for four (4) weeks, then three (3) times per week for four (4) weeks to ensure anticoagulant medications have been administered as ordered, which began on 06/13/16. Audits will be continued based on recommendation from the Quality Assurance/Process Improvement committee. On weekends, an Administrative Nurse, (Director of Nursing, Assistant Director of Nursing, Restorative Nurse Manager, Medical Records Nurse, MDS Nurse, or Staff Development Coordinator) will be assigned to review medication administration records to ensure anticoagulant medications have been administered as ordered and meet intent. If any concerns are identified, the DON will be notified after an assessment of the process administrated as brudered and need meet. If any other is a feel the resident has been conducted in order to ensure the resident is safe. If any change is identified, the Physician and the Resident's Responsible Party will immediately be notified. If no change of condition is identified, the physician will be

notified. No concerns were identified.

In the change of condition is identified, the physician will be notified. No concerns were identified.

In the change of condition is identified, the physician will be notified. The physician will be notified by the physician will be noti

narcotic drawer. The facility now requires [MEDICATION NAME]/[MEDICATION NAME] be counted and signed out by licensed

and/or Certified Medication Aides to ensure appropriate administration. Further interview with the ADON on 06/28/16 at 4:30 PM, SDC at 3:40 PM, on 06/29/16 at 1:50 PM, and MDS at 4:50 PM, revealed someone from the nurse administrative team will be assigned to review the [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] sheets, physician orders, and medications of all residents or [MEDICATION NAME] sheets, physician orders, physici

weekends to ensure appropriate administration

10. Interview with the DON on 06/29/16 at 9:09 AM, the ADON on 06/28/16 at 4:30 PM, the SDC at 3:40 PM, the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed residents requiring the use of Anticoagulants Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed restated the meeting the use of Anticoaguiants were being discussed in the clinical meeting daily as an ongoing process. They stated the meeting was attended by the Director of Nursing, Assistant Director of Nursing, Social Services Director, Staff Development Coordinator, Dietary Manager, and Quality of Life Director, Monday through Friday. They stated they reviewed the Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications had been administered as ordered. In addition, they stated the Administrative Nurse will review the Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulant medications have been administered as ordered. They stated this process began on 06/13/16 and will continue as an ongoing process.

11. Interviews with the DON on 06/29/16 at 9:09 AM, Nurse Consultant at 10:20 AM, the ADON on 06/28/16 at 4:30 PM, the SDC at 3:40 PM, the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed education was initiated and completed on 06/13/16 by the Nurse Consultant. Those inserviced included the Director of Nursing, Assistant

- Director of Nursing, Staff Development Coordinator, Social Services, Dietary Manager, and Quality of Life Director regarding the Anticoagulation Management Policy and daily follow-up for residents who require the use of Anticoagulant
- nedications.

  12. Interviews with the SDC on 06/28/16 at 4:05 PM, the ADON at 4:30 PM, RN #3 on 06/29/16 at 8:17 AM, the DON at 9:40 AM, the Nurse Consultant at 10:20 AM, LPN #3 at 10:40 AM, and LPN #4 at 12:15 PM, revealed, on 06/15/16, directed education was completed by the Nurse Consultant. Those inserviced included the nurses and Certified Medication Aides who were responsible for passing medications to Resident #1 at the 4:00 PM medication pass from May 27, 2016 through June 11, 2016. The in-service addressed further investigation into medications that were present for a resident in the medication cart, but were not identified on the electronic medication record as being required to administer.

  13. Interview with the PharMerica Product Training and Implementation Consultant, on 06/29/16 at 11:31 AM, revealed she came
- to the facility to assist with identification of the electronic medication administration system concerns. She provided education on 06/15/16 to the DON, ADON, SDC, MDR and licensed nursing staff regarding approving or rejecting orders, discharging residents, leave of absence, and the readmit function. She will be available to provide further assistance training, as indicated.
- 14. Interview with the Business Development Analyst from the Information Technology Department, on 06/29/16 at 8:49 AM, revealed he came to the facility on [DATE] to correct the identified concern with the electronic medication administration system. He identified a concern with the compatibility of one (1) of the facility's computers with the PharMerica system. He determined if the compatibility setting was found to be on Internet Explorer 10, there were no compatibility concerns, which was the case with all but one (1) of the laptop computers used by the licensed nursing staff. On one (1) laptop computer, the compatibility settings were found to be on Internet Explorer 11, which was not compatible with the PharMerica suite. He changed the compatibility setting to correct the identified issue by setting the compatibility view setting to include the PharMerica suite. A sign was placed on desktop computers instructing users not to enter physician's orders [REDACTED]. The concern with the compatibility of desktop computers was addressed and resolved by PharMerica with a server side update that was completed on 06/16/16. These corrections ensured orders must contain the hour of administration (HOA) or they would not be accepted by the system. The Business Development Analyst will be available to provide further technical assistance as needed.

  15. Interview with the ADON on 06/28/16 at 4:30 PM, and the DON on 06/29/16 at 9:05 AM, the Nurse Consultant at 10:20 AM,
- the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed Care Plans were reviewed by the Nurse Consultant on 06/12/16 to ensure interventions were in place regarding the use of Anticoagulation therapy. No Concerns were identified. Care plans were again reviewed on 06/13/16 by the Interdisciplinary Team which included the Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Director, and Quality of Life Director, for residents requiring the use of anticoagulant therapy, to ensure further updates were not needed. There were no concerns
- 16. Interview with the Nurse Consultant, on 06/29/16 at 10:20 AM, revealed she audited physician's orders [REDACTED].

  17. Interview with the Nurse Consultant, on 06/29/16 at 10:20 AM, revealed a nurse from the regional team or home office has

Facility ID: 185209

FORM CMS-2567(02-99) Event ID: YL1011 Previous Versions Obsolete

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 06/30/2016 185209 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP RIVERSIDE CARE & REHABILITATION CENTER 190 EAST HWY, 136 CALHOUN, KY 42327 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0281 (continued... from page 3) been available since June 12, 2016. The nurse(s) from the regional team or home office are performing chart audits to compare anticoagulant orders with Medication Administration Records, observing care delivery as per care plans and providing oversight and consultation to licensed staff and Certified Medication Aides. Onsite visits from the regional team or Corporate office will occur daily until immediacy is removed and then weekly for four (4) weeks. Concerns identified Level of harm - Immediate jeopardy or Corporate office will occur daily until immediacy is removed and then weekly for four (4) weeks. Concerns identified will be corrected immediately and reported to the Administrator and the Director of Nursing.

18. Interview with the Medical Director, on 06/29/16 at 3:34 PM, Administrator at 4:00 PM, Admissions Coordinator on 06/30/16 at 8:30 AM, Quality of Life Director at 8:45 AM, Maintenance Director at 8:55 AM, Dietary Manager at 9:05 AM, Director of Nursing at 9:15 AM and the Assistant Director of Nursing at 9:30 AM, revealed a Quality Assurance Performance Improvement (QAPI) meeting was held on 06/13/16. Those in attendance included the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Director, Quality of Life Director, Admissions Coordinator, and the Maintenance Director. The discussion included Resident #1; the findings of the investigation into the occurrence; and, the above stated plan of corrective actions. The Medical Director was consulted regarding the plan to correct the identified concerns. Residents Affected - Few correct the identified concerns. correct the identified concerns.

19. Interview with the Administrator, on 06/29/16 at 3:34 PM, revealed QAPI had met on a weekly basis since 06/13/16. He stated meetings will be held on a weekly basis until the immediacy is removed, then they will be held monthly for any recommendations, as indicated. Corporate Administrative oversight of the QA meeting will be completed by the Nurse Consultant of the regional/home office team daily until removal of the immediacy beginning on 06/13/16, then weekly for Make sure that residents are safe from serious medication errors. \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* F 0333 Based on interview, record review, review of hospital records, and review of the facility's policy and procedure, it was determined the facility failed to have an effective system to ensure one (1) of three (3) sampled residents (Resident #1) Level of harm - Immediate jeopardy determined the facility failed to have an effective system to ensure one (1) of three (3) sampled residents (Resident #1) was free of significant medication errors.

Review of the physician's orders [REDACTED]. However, review of Resident #1's May 2016 EZMAR (Electronic Medication Administration Record) revealed the resident's order for [MEDICATION NAME] 6 mg, give one (1) tablet daily, was discontinued after the 05/26/16 dose was administered. The facility's failure resulted in Resident #1 not receiving seventeen (17) doses of [MEDICATION NAME].

On 06/12/16, Resident #1 was sent to the emergency room (ER) and was admitted to the hospital with [REDACTED]. The resident was placed on [MEDICATION NAME] Drip due to low (International Normalized Ratio) INR. Residents Affected - Few was placed of [http://carbox.va.mid] Drip due to low (international Normanized Nation) INK.
Immediate Jeopardy (IJ) was identified on 06/17/16 and was determined to exist on 05/26/16. The facility was notified of the Immediate Jeopardy (IJ) on 06/17/16. An acceptable Allegation of Compliance (AoC) was received on 06/27/16, alleging the removal of the Immediate Jeopardy (IJ) on 06/21/16. The State Survey Agency validated, on 06/28/16 through 06/30/16, that the Immediate Jeopardy (IJ) was removed on 06/21/16, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

The findings include:
Review of the facility's policy and procedure, Physician order [REDACTED]. Copies of the order were to be provided to the Director of Nursing (DON) or Assistant Director of Nursing (ADON), Medical Records, and the original copy stayed in the chart. Copies of the order were to be taken to the daily clinical meeting; the orders were to be compared for accuracy; and, following the clinical meeting, the DON or designee reviewed the EZMAR and chart for new order accuracy. However, the facility's policy failed to include a second step to ensure the medication was transferred to the electronic MAR (EZMAR).

Record review revealed the facility admitted Resident #1 on 02/11/10 with diagnoses, which included [MEDICAL CONDITION] [MEDICAL CONDITIONS], and Cerebral [MEDICAL CONDITION].

Review of the Progress Notes, dated 06/12/16 at 9:37 AM, revealed Licensed Practical Nurse (LPN) #1 was called to Resident #1 so rom due to Resident #1 acting different. Upon entering the room, LPN #1 observed Resident #1 with left sided weakness. The resident's left pupil was pinpoint and nonreactive, and the resident was nonverbal. Resident #1 required assistance for most movements. LPN #1 tred to evaluate Resident #1's grasp by instructing the resident to grasp both of her hands at the same time. Resident #1 under the design was noted to be weaker. While LPN #1 and the Charge Nurse were evaluating Resident #1, another Charge Nurse notified the Medical Doctor (MD) and Power of Attorney (POA), the State Guardian on call, and the Emergency Medical Systems (EMS).

Review of the 06/12/16 AM Progress Note, timed at 9:37 AM, revealed Resident #1's vital signs were as follows: Blood Pressure 108/48 (normal range 95-100%); Temperature- 97-5 degrees Fahrenheit (normal range 97.8-99.1); Blood sugar -123 mg/dl (normal range 80 to 130 mg/dl). Askin assessment was completed wi was having confusion, but he believed that was due to being in a different setting.

Review of the computer generated physician's orders [REDACTED]. However, there was no Hour of Administration (HOA) on the order. Review of Resident #1's May 2016 EZMAR, revealed the order for [MEDICATION NAME] 6 mg, give one (1) tablet daily, was discontinued after the 05/25/16 dose was administered. Review of the June 2016 EZMAR, revealed no evidence of an order for [REDACTED] Interview with LPN #2, on 06/15/16 at 11:24 AM, revealed when she received the new physician's orders [REDACTED]. However, she did not go back into the EZMAR to ensure the order was still in the EZMAR, as this was not the facility's process. Interview with LPN #1, on 06/15/16 at 11:45 AM, revealed she observed Resident #1 with left sided weakness, the left pupil was pinpoint and nonreactive, and he/she was nonverbal and required assistance from staff for most movements. Further interview revealed the ER Physician had called to inquire if Resident #1 had been receiving his/her [MEDICATION NAME]. She stated she looked at the EZMAR and noticed the order for the [MEDICATION NAME] was not on the MAR for June. She told the Physician she would have to call him back, and that was when she noticed there was not an hour of administration (HOA) Bestde the order.

Further interview with LPN #1, on 06/25/16 at 11:45 AM, revealed she did review Resident #1's Physician order [REDACTED]. After the DON looked into the system from her home, she verified Resident #1 had missed several doses of [MEDICATION NAME] and told LPN #1 to call the ER Physician back and make him aware. Further interview revealed, when entering the physician's and told LPN #1 to call the ER Physician back and make him aware. Further interview revealed, when entering the physician's orders [REDACTED]. LPN #1 stated when someone entered the stop date; it triggered the system as to when to stop the medication on the EZMAR. She stated, This is just something that I have always done when entering an order for [REDACTED]. Interview with LPN #3, on 06/15/16 at 3:10 PM, revealed she was familiar with Resident #1 and was aware he/she took [MEDICATION NAME] every day at 4:00 PM on a routine basis. LPN #3 stated when the resident's name did not pop up at the 4:00 PM medication pass she did not think anything about it. She stated it never crossed her mind that Resident #1 was not scheduled to receive his/her routine [MEDICATION NAME]. The LPN stated she relied on the EZMAR system to tell her who was due medications at a certain time. Further interview revealed once she entered a physician's orders [REDACTED]. She stated there would be no way for her to know that the HOA did not transfer over to the medication pass side. Interview with LPN #4, on 06/15/16 at 3:18 PM, revealed she was familiar with Resident #1 and knew he/she did take [MEDICATION NAME] on a routine basis. She stated she relied on the EZMAR system to tell her what medications were due at a certain time for certain residents. She stated that if the resident's name did not pop up on the screen, it would not

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FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED:5/16/2017 FORM APPROVED

				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTA. BUILDINGB. WING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED 06/30/2016
CORRECTION	185209			
NAME OF PROVIDER OF SUI			STREET ADDRESS, CITY, ST.	ATE, ZIP
RIVERSIDE CARE & REHA			190 EAST HWY. 136 CALHOUN, KY 42327	
For information on the nursing (X4) ID PREFIX TAG	home's plan to correct this deficien SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICI		Y FULL REGULATORY
F 0333	(continued from page 4)			
Level of harm - Immediate jeopardy		the Administration side of the EZ	g an order into the Administrative ZMAR, as that was not part of what	nt she did when entering
Residents Affected - Few	his/her medications. Further inter would not have known Resident a entirely on the EZMAR system to administered.  Interview with LPN #6, on 06/16/ accuracy. She stated the facility of to the EZMAR from month to me have to rely on the EZMAR system to the EZMAR from month to me have to rely on the EZMAR system thereview with LPN #7, on 06/16/ verify the physician's orders [RE. [REDACTED].#1.  Interview with the Business Deve system there were Stops set up in administration. He stated this did Further interview revealed a bug/ Internet Explorer 11 of the corpo compatible with the EZMAR sof would have alerted the nurse that an Internet Explorer issue. Furthe We have determined the pharmac During interview with the Pharmac We have researched the issue and looked into the order, there was a follow their policy and procedure without a stop date, but as I state without an HOA. There is nothin discontinued and not have carrier if the order has been successfully Interview with the Director of Nu 06/17/16 at 10:45 AM; and, on 0 NAME] for Resident #1 when LI and immediately started their inv	view revealed that if Resident #1' #1 was to have received [MEDIC o alert her to whom received medical of a let her to whom received medical on the was a lid not have a system to verify the both. Further interview revealed seem to tell her who received medical of at 4:10 PM, revealed she had not DACTED]. #7 stated she had nevel lopment Analyst, on 06/15/16 at 1 the system to keep a nurse from a not take place on 05/27/16, wher glitch was found in the software or attom to desktop. He stated, We ware until this issue occurred. He the order was not saved over onter interview revealed that through by is going to make an update to the Customer Field Services, on 04 found an order was entered into to HOA, which should have been on how to correct the concern. Ud before, we are rolling out today g built into the system itself that via over to the medication pass page of entered correctly, that would be trising (DON), on 06/12/16 at 2:15 6/20/16 at 1:25 PM and 2:01 PM, PN #1 notified her on 06/12/16. Si estigation. The DON stated that d	's name did not pop up on the adm' ATION NAME] at 4:00 PM. Furt ications and what time those medianot aware of any process in place at all the physicians' orders had be he was not familiar with Resident ations and what time to administ enver been instructed to go back it been part of the process for entering physicians' orders that din the nurse entered the physician's of the EZMAR system that was not ere unaware Internet Explorer elees attack in this situation, there was the medication page for administ the facility's investigation with their software to keep this from habol'16/16 at 1:30 PM; and, on 06/2/2 the EZMAR without an Hour of A entered. If an HOA is not entered up until now, the order could be erap until now, the order could be would have alerted them the order e. Once an order is entered, the nut the medication administration page	inistration screen, she her interview revealed she relied ications were due to be to verify the EZMAR for en transferred over #1's medications and would r them. In the EZMAR system to the EZMAR system to the EZMAR system to the EZMAR system to the EZMAR do not have an hour of orders [REDACTED]. The transfer is the tration, because it was the pharmacy company, ppening again. 216 at 8:59 AM he stated, Administration (HOA). When I the facility should thered without an HOA or order to be entered would have been rese can go over to see the too AM and 3:06 PM; on of the missed [MEDICATION ppropriate authorities hey found some type
	considered a significant medicati has been receiving medication on nurse to go check the physician's that unit for the last several week medications, and when working I medications to and what time the Continued interview with the DO had been entered into the system Further interview revealed the In Friday. During that process, LPN not being on the order was a tech reviewed on 05/31/16 with the pr how the order was missed. She st or an HOA. We did not require the Interview with LPN #8, on 06/20/(IDT) was to review all the new to compared the written order in the orders to the physician for review portion side of the EZMAR scree orders on the Administrative side and could not recall the exact detactual HOA, but she was aware the without an HOA. She stated, It has side of the EZMAR. However, with the facility's Pharn [MEDICATION NAME] when he [MEDICATION NAME] when he [MEDICATION NAME] could be monitoring of labs to ensure the Interview with Resident #1's Phyyears for [MEDICAL CONDITION is significant medication error and of the significant medication error and significant medication error and of the significant medication error and signif	on error. She stated, However, it is a routine basis and suddenly that orders [REDACTED]. She stated is, not a shortage, but not the same the floor, the nursing staff relied hemedications were due. No revealed when LPN #2 entered this would not have occurred. The terdisciplinary Team (IDT) review fall reviewed the written orders work incal problem and the clinical tea revious process. Further interview atted, The order was there all alon en nursing staff to double check the written orders were also staff to double check the written physicians' orders to make administrative portion of the EZ w. Further interview revealed it was the work of the EZMAR. Further interview ails of Resident #1's orders. LPN he order should not have populate as not been our process in the paste may have to add this process to nacist, on 06/15/16 at 12:21 PM, the was notified by e-mail on 06/13 se severe, depending on the patien resident was at a therapeutic or estician, on 06/15/16 at 3:47 PM, re ON] Fibrillation and missing severoull lead to a potential stroke, cleans the condent of the potential stroke, cleans and the process to national strokes and the patien resident was at a therapeutic or estician, on 06/15/16 at 3:47 PM, re ON] Fibrillation and missing severould lead to a potential stroke, cleans and the patien resident was at a potential stroke, cleans and the patien resident was at a potential stroke, cleans and the patien resident was at a potential stroke, cleans and the patien resident was at a potential stroke, cleans and the patien resident was at a patient patient resident was at a patient resident wa	e DÓN stated this was found whe wed all new Physicians' Orders daith the orders in the EZMAR Sys m reviewer should have caught the revealed she spoke with LPN #8 gfor the nurse to view, it just did ne physician's orders [REDACTE] er responsibility as part of the Inte sure they were in the EZMAR comment of the Interpretation of	ON that a resident who or administration, for the sistent nursing staff on sident #1's routine know who to administer  ED]. She stated if the stop date n reviewing the system. illy Monday through tem. The DON stated the HOA at when the orders were and she too was unaware not have a stop date D]. redisciplinary Team prrectly. She stated she to the signed physicians' the Administration iffed the slips with the tiple orders on 05/31/16, er she viewed the le (for medication pass) to the medication pass missing doses of e stated missing doses of e stated missing doses of ATION NAME] required close MEDICATION NAME] for man DN NAME] would be considered Fibrillation.
	Interview with the Administrator, missed [MEDICATION NAME] investigation. Further interview r consider missing seventeen (17) that Resident #1 should have rectaken this matter very seriously a their EZMAR system) to ensure to check the MARs for accuracy administration after the nurses en actions to remove the Immediate 1. LPN #1 completed a review of who received [MEDICATION N being	on 06/17/16 at 9:31 AM, revealed when the DON notified him on 0 evealed he felt there was a technic doses of [MEDICATION NAME gived his/her medication as ordered had been working diligently withis did not happen again. Further at the end of the month, or to detected a new physician's orders [R Jeopardy: the Electronic Medication Admin	d he became aware of the incident 16/12/16. He immediately came to 16/12/16. He immediately came to cal problem with the EZMAR sys.] to be a significant medication end by his/her physician. Further in with the EZMAR Pharmacy Compainterview revealed he was not awarmine if medications were still in EDACTED].>**The facility implicitation Records (EZMARs) for the in place in the system and that [Matter 1987].	involving Resident #1's the facility to initiate an tem. He stated he would ror and his expectation was terview revealed he had any (the company who provided rare of anything in place the system for emented the following the other three (3) residents

administered to all others as ordered. This was completed on 06/12/16 with no concerns identified.

2. A physical assessment was completed on all other residents with orders for [MEDICATION NAME] (3) by LPN #1 on 06/12/16 with no concerns. No changes of condition were identified.

3. Three (3) medication carts were audited by LPN #1 on 06/12/16 to ensure the ordered doses of [MEDICATION NAME] were available for all residents who have orders for [MEDICATION NAME]. No concerns were identified. A follow-up audit of the three (3) medication carts was completed by the DON on 06/12/16 with no concerns identified. In addition, a 100% internal audit of all residents' medications to include medications that require monitoring was conducted.

4. The DON and the Staff Development Coordinator (SDC) completed an audit on the electronic physician's orders [REDACTED]. No other orders were identified as not having an hour of administration (HOA).

5. Education was initiated on 06/12/16 and completed on 06/20/16 by the Staff Development Coordinator (SDC) and DON for full-time and part-time Licensed Nurses and Certified Medication Aides (CMAs) regarding general medication orders; the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 06/30/2016
	185209			
NAME OF PROVIDER OF SU RIVERSIDE CARE & REHA			STREET ADDRESS, CITY, STA 190 EAST HWY. 136 CALHOUN, KY 42327	ATE, ZIP
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hon		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0333	(continued from page 5) EZMAR (Electronic Medication	Administration) policy regarding	the inclusion of hours of administ	ration (HOA): daily review
Level of harm - Immediate jeopardy	of physicians' orders; medication medication orders; transcription of Records process.	discrepancies; the seven (7) rights of Medication Orders; the Anticoa	s of accurate medication administ gulation Management Policy; and	ration; non-controlled I, the Electronic Medical
Residents Affected - Few	6. Certified letters were drafted by the Administrator and mailed out on 06/15/16 to inform all staff on medical leave, on FMLA (Family Medical Leave Act), vacation, and all PRN (as needed) staff that they would require education prior to returning to work.			
	7. Physicians' Orders were review Restorative Nurse Manager, and Jithat all other medications were be 8. The DON or the ADON will re [MEDICATION NAME] count s to ensure anticoagulant medicatio based on recommendation from the (Director of Nursing, Assistant Director of Nursing,	Nursing Consultant and compared ing administered as ordered. No for view medication administration re heets daily (5 days per week) for 1 ons have been administered as orden e Quality Assurance/Process Impirector of Nursing, Restorative Nursing and meet intent. If concerns are d in order to make sure the resider arty will immediately be notified.	to the Electronic Medication Adi further discrepancies were identifi- scords (EZMAR), hour of adminis- four (4) weeks then three (3) time- ered which began on 06/13/16. Au- provement committee. On weeken urse Manager, Medical Records N dministration records to ensure as identified, the DON will be notifi- tit is safe. If any change is identifi- If no change of condition is ident	ministration Record to ensure ed. stration (HOA), and review of sper week for four (4) weeks adits will be continued ds, an Administrative Nurse, furse, MDS Nurse, or Staff thicoagulant medications led after an assessment ed, the Physician lifed, the Physician
	[MEDICATION NAME]/[MEDICATION NAME]/[MEDICATION NAME appropriate administration. The I Administration Record (EZMAR Administrative Nurse (DON, AD 10. Residents requiring the use of attended by the interdisciplinary t Nursing, Social Services Director through Friday. This includes rev NAME] count sheets to ensure ar Nurse will be assigned to review sheets to ensure anticoagulant mecontinue as an ongoing process.  11. Education was initiated and co Director of Nursing, Assistant Di Quality of Life Director regarding use of Anticoagulant medications	on the counted and signed out by lice of No. ADON and SDC will compare of process daily (Monday through of No. Restorative Nurse Manager, anticoagulants will be discussed it eam to include, but not limited to the state of their Medication Administration Recordications have been administered ompleted on 06/13/16 by the Nurserector of Nursing, Staff Developing the Anticoagulation Management.	rensed nurses and/or Certified Me are the [MEDICATION NAME] of Friday). On the weekends, this wimedical Records Nurse, MDS Nurnet to the clinical meeting daily as an the Director of Nursing, Assistan Dietary Manager, and Quality of radiative of the control of Nurse's Notes, Caen administered as ordered. On wids, Nurse's Notes, Care Plans, and as ordered. This process began of the Consultant for the interdisciplinatent Coordinator, Social Services, at Policy and daily follow-up for radiative the interdisciplinatent Coordinator, Social Services, at Policy and daily follow-up for radiative the interdisciplinated the coordinator, Social Services, at Policy and daily follow-up for radiative the coordinator.	dication Aides to ensure count sheets to the Medication II be assigned to an urse, or SDC). on-going process, t Director of Life Director, Monday re Plans, and [MEDICATION eekends, an Administrative I [MEDICATION NAME] count n 06/13/16 and will ary team including the Dietary Manager, and esidents who require the
	12. On 06/15/16, directed education responsible for passing medication 13. On 06/15/16, the PharMerical identification of the electronic medication of the electronic medicate of Nursing, Assistant Dilicensed nursing staff regarding a function. She will be available to 14. On 06/15/16, the Business Defacility to correct the identified of with the compatibility of one (1) administration program utilized be Internet Explorer 10, there was not used by the licensed nursing staff Explorer 11, which was not compidentified issue. A sign was place computers until further notice. The PharMerica with a server side upof administration (HOA) or they provide further technical assistant 15. Care plans were reviewed by the anticoagulation therapy. No Concarding the use of identified.  16. The Nurse Consultant will aud 17. A nurse from the regional tear home office are performing chart plans and providing oversight and regional team or corporate office	ins to Resident #1 at the 4:00 PM in Product Training and Implemental adication administration system oc rector of Nursing, Staff Developm pproving or rejecting orders, disclipprovide further assistance and train velopment Analyst from the corponcern with the electronic medicat of the facility's computers with they the facility's computers with they the facility system. He determine compatibility concern, which was compatibility concern, which was compatible with the PharMerica suite. In the discount of the discount of the facility system of the facility system. The determine compatibility concern, which was computers instructing the concern with the compatibility date that was completed on 06/16/would not be accepted by the system, as needed. The Nurse Consultant on 06/12/16 terms were identified. Care plans we tant Director of Nursing, Social Santicoagulant therapy, to ensure fulting the physician's orders [REDAC nor home office has been availab audits to compare anticoagulant of consultation to licensed staff and	medication pass from May 27, 20 tion Consultant came to the facilit oncerns. She provided education concerns. She provided education concerns. She provided education concerns from the provided education concerns. She provided education concerns the provided education concerns the fact of the provided education in the provided expectation of the she provided expectation of the electron of the ele	16 through June 11, 2016. y to assist with m 06/15/16 to the is Coordinator, and e, and readmit  Department came to the entified a concern onic medication as found to be on the laptop computers to be on Internet ing to correct the ders on the desktop sed and resolved by lers must contain the hour analyst would be available to acc regarding the use of by the Interdisciplinary ality of Life Director, here were no concerns
	identified will be corrected imme 18. A Quality Assurance Performa Administrator, Director of Nursir Life Director, Admissions Coordinvestigation into the occurrence; regarding the plan to correct the i 19. Quality Assurance Performan Medical Director, Administrator, Quality of Life Director, Administrator, Quality of Life Director, Admissi compliance with the corrective acuntil immediacy is removed, then Administrator has the oversight timely manner and to assist in the Quality Assurance meeting will be removal of the immediacy of the **The State Survey Agency valid: 1. Interview with LPN #1, on 06/2 Administration Records for the oin place in the EZMAR system; a concerns and revealed this had be 2. Interview with LPN #1, on 06/2 [MEDICATION NAME] were avinterview revealed the DON wend 4. Interview with the DON, on 06 physicians' orders (POS), was contacted in the property of the property of the pool of the place	ance Improvement (QAPI) meeting, Assistant Director of Nursing, inator, and the Maintenance Direct and, the above stated plan of cordentified concerns, se Improvement (QAPI) meetings Director of Nursing, Assistant Di ons Coordinator, the Maintenance trion plan and for further recomme monthly for recommendation and o ensure an effective plan is in plate development of corrective action be completed by the Nurse Consulticopardy, beginning 06/13/16, the ated the corrective action by the fixed the torrective action by the fixed the corrective action by the fixed the corrective action by the fixed the torrective action by the fixed the corrective action by the fixed the torrective action by the fixed the corrective action by the fixed the torrective action by the fixed the corrective action by the fixed the fixed the corrective action by the fixed the corrective action by the fixed the fixed the fixed the corrective action by the fixed the fi	g was held on 06/13/16 with the I Social Services Director, Dietary tor to discuss Resident #1; the fin rective actions. The Medical Director of Nursing, Social Services Director. The meetings are held endations, as indicated. QAPI med further follow up regarding the ace to ensure facility concerns are plans. Corporate Administrative tant or member of the regional/ho n weekly for four (4) weeks, then acility as follows: mpleted a review of the Electronic CATION NAME]. The review we been administered as ordered. LP mpleted physical assessments for ondition was identified on 06/12/nducted three (3) medication cart orders. No concerns were identified the cart and identified no concern on 06/28/16 at 3:40 PM, revealed	Medical Director, Director, Quality of dings of the eter was consulted  ut not limited to, the to Dietary Director, to ensure continued ettings will be held weekly above stated plan. The identified in a oversight of the me office team daily until monthly.  Medication as to ensure their orders were N #1 identified no the other three (3) 16. audits to ensure doses of ed on 06/12/16. Further s on 06/12/16. an audit of the electronic

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(X1) PROVIDER / SUPPLIER (X3) DATE SURVEY STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 06/30/2016 185209 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP RIVERSIDE CARE & REHABILITATION CENTER 190 EAST HWY 136 CALHOUN, KY 42327 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION) (continued... from page 6) administration (HOA) with a focus on anticoagulation medications. No other issues were identified on 06/12/16.

5. Interviews on 06/28/16 with LPN #1 at 3:03 PM, the ADON at 4:30 PM, and on 06/29/16 with RN #3 at 8:17 AM, LPN #3 at 10:40 AM, RN #4 at 11:55 AM, LPN #4 at 12:10 PM, RN #5 at 12:20 PM, CMA #14 at 12:50 PM, CMA #6 at 1:05 PM, CMA #15 F 0333 Level of harm - Immediate jeopardy PM, RN #6 at 1:25 PM, LPN #8 at 1:50 PM, RN #1 at 2:29 PM, LPN #10 at 3:47 PM, and RN #7 at 4:44 PM, revealed they had received education regarding general medication orders; the EZMAR (Electronic Medication Administration) policy regarding inclusion of hour administration (HOA); daily review of physician's orders [REDACTED]. The [MEDICATION NAME] was now Residents Affected - Few up and counted as if it was a narcotic and had to be signed out on the [MEDICATION NAME] count sheet. Also, someone from the Administrative nursing staff compares the [MEDICATION NAME] sheets to the EZMAR to ensure the [MEDICATION NAME] been given as ordered.
6. Interview with the Administrator, on 06/29/16 at 4:00 PM, revealed he drafted and mailed out certified letters to all the staff that was on vacation, medical leave, FMLA (Family Medical Leave Act), and all PRN staff requiring education prior to returning to work.

7. Interviews, on 06/28/16, with LPN #1 (Restorative Nurse Manager) at 3:03 PM, the SDC at 3:40 PM, the ADON at 4:30 PM, and on 06/29/16 with the DON at 9:05 AM, the Nurse Consultant at 10:20 AM, and LPN #8 (Medical Records) revealed all Physicians' Orders were reviewed on 06/13/16 and compared to the electronic Medication Administration Record to ensure that all medications were being administered as ordered, with no discrepancies identified. 8. Interviews, on 06/28/16, with Keep accurate, complete and organized clinical records on each resident that meet professional standards F 0514 \*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* Level of harm - Immediate Based on interview, record review, review of hospital records, and review of the facility's policies and procedures, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for one (1) of three (3) sampled residents (Resident #1). Resident #1 received an order for [REDACTED]. However, the order did not appear on the May and June 2016 Electronic Medication Administration Records (EZMAR) which resulted in Resident #1 not receiving his/her [MEDICATION NAME] for a Residents Affected - Few of seventeen (17) days (05/27/16-06/12/16). On 06/12/16, Resident #1 was sent to the emergency room (ER) and admitted to of seventeen (17) days (05/27/16-00-12) on 06/12/16, resident #1 was sent to the enline gency from (EK) and admitted to the hospital with [REDACTED]. Immediate Jeopardy (IJ) was identified on 06/17/16 and was determined to exist on 05/26/16. The facility was notified of the Immediate Jeopardy (IJ) on 06/17/16. An acceptable Allegation of Compliance (AoC) was received on 06/27/16 alleging the removal of the Immediate Jeopardy (IJ) on 06/21/16. The State Survey Agency validated, on 06/28/16 through 06/30/16, the Immediate Jeopardy (IJ) was removed on 06/21/16 as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. of the systemic changes. The findings include: Review of the facility's policy titled, Physician Orders At-A-Glance, no date, revealed medications are placed in the EZMAR for a specific resident by a designated nurse, including dosage, medication, route, and frequency of administration, stop for a specific resident by a designated nurse, including dosage, medication, route, and frequency of administration, stop time and qualifying diagnosis.

Review of the facility's policy titled, Charting and Documentation, no date, revealed services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record to ensure consistency in the charting and documentation of the resident's clinical record.

Review of the facility's policy and procedure, Physician Orders at a Glance, not dated, revealed copies of new physician orders were to be taken to the daily clinical meeting; the orders were to be compared for accuracy; and, following the clinical meeting, the DON or designee reviewed the EZMAR and chart for new order accuracy.

Record review revealed the facility admitted Resident #1 on 02/11/10, with diagnoses, which included [MEDICAL CONDITION] Fibrillation, [MEDICAL CONDITION] [MEDICAL CONDITIONS], and Cerebral [MEDICAL CONDITION].

Review of the facility's Progress Notes, dated 06/12/16 at 9:37 AM, and interview with Licensed Practical Nurse (LPN) #1, on 06/15/16 at 11:45 AM (seventeen {17} days without receiving [MEDICATION NAME]), revealed on 06/12/16, Resident #1 was sent to the hospital emergency room (ER). Review of Resident #1's Hospital Records, dated 06/12/16, revealed the resident was admitted to the hospital with [REDACTED]. The resident received [MEDICATION NAME] drip due to his/her 1NR being low. Review of the Physician's Order, dated 05/27/16, revealed to continue [MEDICATION NAME] drip due to his/her 1NR being low. Review of the Physician's Order, dated 05/27/16, revealed to continue [MEDICATION NAME] drip due to his/her 1NR being daily, and recheck his/her 1NR in one (1) month. However, review of Resident #1's May 2016 and June 2016 EZMAR, revealed the order to administer [MEDICATION NAME] 6 milligrams (mg) daily, and recheck his/her 1NR in one (1) month. However, review of Resident #1's May 2016 and June 2016 EZMAR, seventeen (17) doses of [MEDICATION NAME] from 05/26/16 through 06/12/16, when the resident was sent to the hospital w signs/symptoms of a [MEDICAL CONDITION] TIA.

Interview with LPN #2, the nurse who entered the order into the computer, on 06/15/16 at 11:24 AM, revealed that once she received the new Physician's Order, she entered it into the computer and hit save. However, she did not go back into the EZMAR to ensure the order was still in the EZMAR, as that was not the facility's process.

Interview with the Business Development Analysts, on 06/15/16 at 3:41 PM and 06/23/16 at 1:02 PM, revealed in the EZMAR system there were stops set up in the system to keep a nurse from entering orders without an hour of administration (HOA). However, this did not occur on 05/27/16, when the nurse entered the order into the system. He stated a bug was found in the software of the EZMAR system that was not compatible with the Internet Explorer used on the facility's computers. He revealed the Stop did not work, as the nurse was able to enter a physician's order without the HOA and the physician's order did not transfer over to the medication page for administration. He further stated, Through our investigation with the Pharmacy Company, we have determined the pharmacy is going to make an update to their software to keep this from happening again. the Pharmacy Company, we have determined the pharmacy is going to make an update to their software to keep this from happening again.

Interview with LPN #8, on 06/20/16 at 2:15 PM, revealed part of her responsibility as part of the Interdisciplinary Team (IDT) is to review all the new written Physician's Orders to make sure they were in the EZMAR correctly. She stated she compares the written order in the Administrative portion of the EZMAR for accuracy, but she does not compare it to the actual EZMAR, which is used by the nurses to administer the medications.

Interview with the Director of Nursing (DON), on 06/12/16 at 2:15 PM, and 5:53 PM; on 06/16/16 at 10:09 AM and 3:06 PM; on 06/17/16 at 10:45 AM; and, on 06/20/16 at 1:25 PM and 2:01 PM, revealed during their investigation, there was found to be some type of technical problem regarding an update with the Internet Explorer system that somehow allowed an order to be saved without an hour of administration. She stated Resident #1 had missed seventeen (17) doses of [MEDICATION NAME], due to this technical problem. She revealed the IDT team checked the Physicians orders with the Administrative side of the system but did not check the physician's order with the Administration side of the system and that was why they failed to identify the order had been discontinued on the EMAR. identify the order had been discontinued on the EMAR. Interview with the Administrator, on 06/17/16 at 9:31 AM, revealed there was a technical problem with the EZMAR system. He stated he had been working diligently with the EZMAR pharmacy company who provided their EZMAR system, to ensure this does \*\*The facility implemented the following actions to remove the Immediate Jeopardy:

1. LPN #1 completed a review of the Electronic Medication Administration Records (EZMARs) for the other three (3) residents who received [MEDICATION NAME] to ensure their orders were in place in the system and that [MEDICATION NAME] was administered to all others as ordered. This was completed on 06/12/16 with no concerns identified.

2. A physical assessment was completed on all other residents with orders for [MEDICATION NAME] (3) by LPN #1 on 06/12/16 with no concerns. No changes of condition were identified. with no concerns. No changes of condution were identified.

3. Three (3) medication carts were audited by LPN #1 on 06/12/16 to ensure the ordered doses of [MEDICATION NAME] were available for all residents who have orders for [MEDICATION NAME]. No concerns were identified. A follow-up audit of the three (3) medication carts was completed by the DON on 06/12/16 with no concerns identified. In addition, a 100% internal audit of all residents' medications to include medications that require monitoring was conducted.

4. The DON and the Staff Development Coordinator (SDC) completed an audit on the electronic Physician's Order Sheets (POS)

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X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 06/30/2016 185209 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP RIVERSIDE CARE & REHABILITATION CENTER 190 EAST HWY, 136 CALHOUN, KY 42327 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0514 on 06/12/16 to ensure that all medication orders had an hour of administration (HOA) with a focus on anticoagulation medications. No other orders were identified as not having an hour of administration (HOA).

5. Education was initiated on 06/12/16 and completed on 06/20/16 by the Staff Development Coordinator (SDC) and DON for full-time and part-time Licensed Nurses and Certified Medication Aides (CMAs) regarding general medication orders; the Level of harm - Immediate jeopardy EZMAR (Electronic Medication Administration) policy regarding the inclusion of hours of administration (HOA); daily review of physicians' orders; medication discrepancies; the seven (7) rights of accurate medication administration; non-controlled medication orders; transcription of Medication Orders; the Anticoagulation Management Policy; and, the Electronic Medical Residents Affected - Few Records process.
6. Certified letters were drafted by the Administrator and mailed out on 06/15/16 to inform all staff on medical leave, on FMLA (Family Medical Leave Act), vacation, and all PRN (as needed) staff that they would require education prior to returning to work.

7. Physicians' Orders were reviewed on 06/13/16 for all residents by the DON, ADON, SDC, Medical Records Nurse (MRN), Restorative Nurse Manager, and Nursing Consultant and compared to the Electronic Medication Administration Record to ensure that all other medications were being administered as ordered. No further discrepancies were identified.

8. The DON or the ADON will review medication administration records (EZMAR), hour of administration (HOA), and review of [MEDICATION NAME] count sheets daily (5 days per week) for four (4) weeks then three (3) times per week for four (4) weeks to ensure anticoagulant medications have been administered as ordered which began on 06/13/16. Audits will be continued based on recommendation from the Quality Assurance/Process Improvement committee. On weekends, an Administrative Nurse, (Director of Nursing, Assistant Director of Nursing, Restorative Nurse Manager, Medical Records Nurse, MDS Nurse, or Staff Development Coordinator) will be assigned to review medication administration records to ensure anticoagulant medications have been administered as ordered and meet intent. If concerns are identified, the DON will be notified after an assessment of the resident has been conducted in order to make sure the resident is safe. If any change is identified, the Physician and the Resident's Responsible Party will immediately be notified. If no change of condition is identified, the Physician will be notified. FMLA (Family Medical Leave Act), vacation, and all PRN (as needed) staff that they would require education prior t will be notified.

9. On 06/13/16, the DON moved [MEDICATION NAME]/[MEDICATION NAME] to the narcotic drawer, and now requires that [MEDICATION [MEDICATION NAME] be counted and signed out by licensed nurses and/or Certified Medication Aides to ensure appropriate administration. The DON, ADON and SDC will compare the [MEDICATION NAME] count sheets to the Medication Administration Record (EZMAR) process daily (Monday through Friday). On the weekends, this will be assigned to an Administrative Nurse (DON, ADON, Restorative Nurse Manager, Medical Records Nurse, MDS Nurse, or SDC).

10. Residents requiring the use of anticoagulants will be discussed in the clinical meeting daily as an on-going process, attended by the interdisciplinary team to include, but not limited to the Director of Nursing, Assistant Director of Nursing, Social Services Director, Staff Development Coordinator, Dietary Manager, and Quality of Life Director, Monday through Friday. This includes review of their Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications have been administered as ordered. On weekends, an Administrative Nurse will be assigned to review Medication Administration Records. Nurse's Notes. Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications have been administered as ordered. On weekends, an Administrative Nurse will be assigned to review Medication Administration Records. Nurse's Notes. Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medication shave been administered as ordered. On weekends, and [MEDICATION NAME] count sheets to ensure anticoagulants medication shave been administered as ordered. On weekends, and [MEDICATION NAME] count shave been administered to review Medication Administration Records. Nurse's Notes. Care Plans and [MEDICATION NAME] count shave been administered to review Medication administrative medication ad Nurse will be assigned to review Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulant medications have been administered as ordered. This process began on 06/13/16 and will continue as an ongoing process.

11. Education was initiated and completed on 06/13/16 by the Nurse Consultant for the interdisciplinary team including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services, Dietary Manager, and Quality of Life Director regarding the Anticoagulation Management Policy and daily follow-up for residents who require the Quality of Life Director regarding the Anticoagulation Management Policy and daily follow-up for residents who require the use of Anticoagulant medications.

12. On 06/15/16, directed education was completed by the Nurse Consultant for Nurses and Certified Medication Aides who were responsible for passing medications to Resident #1 at the 4:00 PM medication pass from May 27, 2016 through June 11, 2016.

13. On 06/15/16, the PharMerica Product Training and Implementation Consultant came to the facility to assist with identification of the electronic medication administration system concerns. She provided education on 06/15/16 to the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Medical Records Coordinator, and licensed nursing staff regarding approving or rejecting orders, discharging residents, leave of absence, and readmit function. She will be available to provide further assistance and training as indicated. 14. On 06/15/16, the Business Development Analyst from the corporation's Information Technology Department came to the facility to correct the identified concern with the electronic medication administration system. He identified a concern facility to correct the identified concern with the electronic medication administration system. He identified a concern with the compatibility of one (1) of the facility's computers with the PharMerica (owner of the electronic medication administration program utilized by the facility) system. He determined if the compatibility setting was found to be on Internet Explorer 10, there was no compatibility concern, which was the case with all but one (1) of the laptop computers used by the licensed nursing staff. On one (1) laptop computer, the compatibility settings were found to be on Internet Explorer 11, which was not compatible with the PharMerica suite. He changed the compatibility setting to correct the identified issue. A sign was placed on desktop computers instructing users not to enter physicians' orders on the desktop computers until further notice. The concern with the compatibility of desktop computers was addressed and resolved by PharMerica with a server side update that was completed on 06/16/16. These corrections ensured orders must contain the hour of administration (HOA) or they would not be accepted by the system. The Business Development Analyst would be available to provide further technical assistance, as needed.

15. Care plans were reviewed by the Nurse Consultant on 06/12/16 to ensure interventions were in place regarding the use of anticoagulation therapy. No Concerns were identified. Care plans were again reviewed on 06/13/16 by the Interdisciplinary Team: Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Director, and Quality of Life Director, for residents requiring the use of anticoagulant therapy, to ensure further updates were not needed. There were no concerns identified. 16. The Nurse Consultant will audit the physician's orders for residents who require anticoagulant medication and compare them to medication administration records daily for one (1) week, then weekly for four (4) weeks to ensure appropriate administration of anticoagulants, then monthly for six (6) months, at which time the QAPI (Quality Assurance Performance Improvement) Committee will determine if further action is needed. 17. A nurse from the regional team or home office has been available since 06/12/16. The nurses from the regional team or home office are performing chart audits to compare anticoagulant orders with MARs, observing care delivery as per care plans and providing oversight and consultation to licensed staff and Certified Medication Aides. Onsite visits from the plans and providing oversight and consultation to licensed staff and Certified Medication Aides. Onsite visits from the regional team or corporate office will occur daily until immediacy is removed and then weekly for four (4) weeks. Concerns identified will be corrected immediately and reported to the Administrator and the Director of Nursing.

18. A Quality Assurance Performance Improvement (QAPI) meeting was held on 06/13/16 with the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Director, Quality of Life Director, Admissions Coordinator, and the Maintenance Director to discuss Resident #1; the findings of the investigation into the occurrence; and, the above stated plan of corrective actions. The Medical Director was consulted regarding the plan to correct the identified concerns.

19. Quality Assurance Performance Improvement (QAPI) meetings will be held weekly, to include but not limited to, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Director, Quality of Life Director, Admissions Coordinator, the Maintenance Director. The meetings are held to ensure continued compliance with the corrective action plan and for further recommendations, as indicated. QAPI meetings will be held weekly until immediacy is removed, then monthly for recommendation and further follow up regarding the above stated plan. The Administrator has the oversight to ensure an effective plan is in place to ensure facility concerns are identified in a timely manner and to assist in the development of corrective action plans. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Nurse Consultant or member of the regional/home office team daily until nmery manner and to assist in the development of corrective action plans. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Nurse Consultant or member of the regional/home office team daily until removal of the immediacy of the jeopardy, beginning 06/13/16, then weekly for four (4) weeks, then monthly.

\*\*The State Survey Agency validated the corrective action by the facility as follows:

1. Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she completed a review of the Electronic Medication Administration Records for the other three (3) residents on [MEDICATION NAME]. The review was to ensure their orders were in place in the EZMAR system; and, to ensure all medications had been administered as ordered. LPN #1 identified no concerns and revealed this had been completed on 06/12/16.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:5/16/2017 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION À. BUILDING B. WING \_\_\_\_ 06/30/2016 NUMBER 185209 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP RIVERSIDE CARE & REHABILITATION CENTER 190 EAST HWY, 136 CALHOUN, KY 42327 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 8)
2. Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she completed physical assessments for the other three (3) residents with orders for [MEDICATION NAME]. No change of condition was identified on 06/12/16.
3. Interview with LPN #1, on 06/28/16 at 3:03 PM, revealed she conducted three (3) medication cart audits to ensure doses of F 0514 Level of harm - Immediate jeopardy 3. Interview with LPN #1, on U6/28/16 at 3:05 PM, revealed she conducted three (3) medication cart audits to ensure doses of [MEDICATION NAME] were available for all residents who had orders. No concerns were identified on 06/12/16. Further interview revealed the DON went behind LPN #1 to double check the cart and identified no concerns on 06/12/16.

4. Interview with the DON, on 06/29/16 at 9:05 AM, and the SDC, on 06/28/16 at 3:40 PM, revealed an audit of the electronic physicians' orders (POS), was conducted on 06/12/16. This audit was to ensure all medication orders contained an hour of determination (IOA) with a few parts of the contained and the support of the contained and the contained and the support of the contained and the contained and the support of the contained and the contained Residents Affected - Few administration (HOA) with a focus on anticoagulation medications. No other issues were identified on 06/12/16.

5. Interviews on 06/28/16 with LPN #1 at 3:03 PM, the ADON at 4:30 PM, and on 06/29/16 with RN #3 at 8:17 AM, LPN #3 at 10:40 AM, RN #4 at 11:55 AM, LPN #4 at 12:10 PM, RN #5 at 12:20 PM, CMA #14 at 12:50 PM, CMA #6 at 1:05 PM, CMA #15 at 1:20
PM, RN #6 at 1:25 PM, LPN #8 at 1:50 PM, RN #1 at 2:29 PM, LPN #10 at 3:47 PM, and RN #7 at 4:44 PM, revealed they had received education regarding general medication orders; the EZMAR (Electronic Medication Administration) policy regarding inclusion of hour administration (HOA); daily review of physician's orders; medication discrepancies; the seven (7) rights of accurate Medication Orders; the Anticoagulation Management Policy; and, the Electronic Records Process. The [MEDICATION NAME] was now locked up and counted as if it was a narcotic and had to be signed out on the [MEDICATION NAME] count sheet. Also, someone from the Administrative nursing staff compares the [MEDICATION NAME] sheets to the EZMAR to ensure the [MEDICATION NAME] as ordered. [MEDICATION NAME] has been given as ordered.

6. Interview with the Administrator, on 06/29/16 at 4:00 PM, revealed he drafted and mailed out certified letters to all the staff that was on vacation, medical leave, FMLA (Family Medical Leave Act), and all PRN staff requiring education prior to returning to work.
7. Interviews, on 06/28/16, with LPN #1 (Restorative Nurse Manager) at 3:03 PM, the SDC at 3:40 PM, the ADON at 4:30 PM, and on 06/29/16 with the DON at 9:05 AM, the Nurse Consultant at 10:20 AM, and LPN #8 (Medical Records) revealed all on 06/29/16 with the DON at 9:05 AM, the Nurse Consultant at 10:20 AM, and LPN #6 (Medicat Records) reveated an Physicians' Orders were reviewed on 06/13/16 and compared to the electronic Medication Administration Record to ensure that all medications were being administered as ordered, with no discrepancies identified.

8. Interviews, on 06/28/16, with LPN #1 (Restorative Nurse Manager) at 3:03 PM, the SDC at 3:40 PM, the ADON at 4:30 PM; and, on 06/29/16 with the DON at 9:05 AM, LPN #8 (Medical Records) at 1:50 PM and MDS at 4:50 PM, revealed the DON or the ADON will review medication administration records (EZMAR), hour of administration (HOA), and review [MEDICATION count sheets daily (5 days per week) for four (4) weeks, then three (3) times per week for four (4) weeks to ensure anticoagulant medications have been administered as ordered, which began on 06/13/16. Audits will be continued based on anticoagulant medications have been administered as ordered, which began on 06/13/16. Audits will be continued based on recommendation from the Quality Assurance/Process Improvement committee. On weekends, an Administrative Nurse, (Director of Nursing, Assistant Director of Nursing, Restorative Nurse Manager, Medical Records Nurse, MDS Nurse, or Staff Development Coordinator) will be assigned to review medication administration records to ensure anticoagulant medications have been administered as ordered and meet intent. If any concerns are identified, the DON will be notified after an assessment of the resident has been conducted in order to ensure the resident is safe. If any change is identified, the Physician and the Resident's Responsible Party will immediately be notified. If no change of condition is identified, the physician will be notified. No concerns were identified.

9. Interview with the DON, on 06/29/16 at 9:09 AM, revealed she moved the [MEDICATION NAME]/[MEDICATION NAME] to narcotic drawer. The facility now requires [MEDICATION NAME]/[MEDICATION NAME] be counted and signed out by licensed nurses and/or Certified Medication Aides to ensure appropriate administration. Further interview with the ADON on 06/28/16 at 4:30 PM, SDC at 3:40 PM, on 06/29/16 at 1:50 PM, and MDS at 4:50 PM, revealed someone from the nurse administrative team will be assigned to review the [MEDICATION NAME] sheets, physician orders, and medications of all residents on [MEDICATION NAME] on weekends to ensure appropriate administration.

10. Interview with the DON on 06/29/16 at 9:09 AM, the ADON on 06/28/16 at 4:30 PM, the SDC at 3:40 PM, the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed residents requiring the use of Anticoagulants were being discussed in the clinical meeting daily as an ongoing process. They stated the meeting was attended by the Director of Nursing, Assistant Director of Nursing, Social Services Director, Staff Development Coordinator, Dietary Manager, and Quality of Life Director, Monday through Friday. They stated they reviewed the Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications had been Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulants medications had been administered as ordered. In addition, they stated the Administrative Nurse will review the Medication Administration Records, Nurse's Notes, Care Plans, and [MEDICATION NAME] count sheets to ensure anticoagulant medications have been administered as ordered. They stated this process began on 06/13/16 and will continue as an ongoing process.

11. Interviews with the DON on 06/29/16 at 9:09 AM, Nurse Consultant at 10:20 AM, the ADON on 06/28/16 at 4:30 PM, the SDC at 3:40 PM, the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed education was initiated and completed on 06/13/16 by the Nurse Consultant. Those inserviced included the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services, Dietary Manager, and Quality of Life Director regarding the Anticoagulation Management Policy and daily follow-up for residents who require the use of Anticoagulant medications medications. 12. Interviews with the SDC on 06/28/16 at 4:05 PM, the ADON at 4:30 PM, RN #3 on 06/29/16 at 8:17 AM, the DON at 9:40 AM, the Nurse Consultant at 10:20 AM, LPN #3 at 10:40 AM, and LPN #4 at 12:15 PM, revealed, on 06/15/16, directed education was completed by the Nurse Consultant. Those inserviced included the nurses and Certified Medication Aides who were responsible for passing medications to Resident #1 at the 4:00 PM medication pass from May 27, 2016 through June 11, 2016. The in-service addressed further investigation into medications that were present for a resident in the medication cart, but were not identified on the electronic medication record as being required to administer.

13. Interview with the PharMerica Product Training and Implementation Consultant, on 06/29/16 at 11:31 AM, revealed she came to the facility to assist with identification of the electronic medication administration system concerns. She provided education on 06/15/16 to the DON, ADON, SDC, MDR and licensed nursing staff regarding approving or rejecting orders, discharging residents, leave of absence, and the readmit function. She will be available to provide further assistance and training, as indicated. 14. Interview with the Business Development Analyst from the Information Technology Department, on 06/29/16 at 8:49 AM, revealed he came to the facility on [DATE] to correct the identified concern with the electronic medication administration revealed ne came to the facility on [DA1E] to correct the identified a concern with the electronic medication administration system. He identified a concern with the compatibility of one (1) of the facility's computers with the PharMerica system. He determined if the compatibility setting was found to be on Internet Explorer 10, there were no compatibility concerns, which was the case with all but one (1) of the laptop computers used by the licensed nursing staff. On one (1) laptop computer, the compatibility settings were found to be on Internet Explorer 11, which was not compatible with the PharMerica suite. He changed the compatibility setting to correct the identified issue by setting the compatibility view setting to include the PharMerica suite. A sign was placed on desktop computers instructing users not to enter physician's orders on the desktop computers until further notice. The concern with the compatibility of desktop computers was addressed and resolved by PharMerica with a server side update that was completed on 06/16/16. These corrections ensured orders must contain the hour of administration (HOA) or they would not be accepted by the system. The Business Development Analyst will be available to provide further technical assistance as needed.

15. Interview with the ADON on 06/28/16 at 4:30 PM, and the DON on 06/29/16 at 9:05 AM, the Nurse Consultant at 10:20 AM, the Quality of Life Director on 06/30/16 at 8:45 AM, and the Dietary Manager at 9:05 AM, revealed Care Plans were reviewed by the Nurse Consultant on 06/12/16 to ensure interventions were in place regarding the use of Anticoagulation therapy. No Concerns were identified. Care plans were again reviewed on 06/13/16 by the Interdisciplinary Team which included the

Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Director, and Quality of Life Director, for residents requiring the use of anticoagulant therapy, to ensure further updates were not needed. There were no concerns 16. Interview with the Nurse Consultant, on 06/29/16 at 10:20 AM, revealed she audited physician's orders for residents who

required anticoagulants and have compared them with the physician's orders. She did this for the first week, and no concerns were identified, and she will continue to audit weekly for the next four (4) weeks to ensure appropriate administration of anticoagulants, then monthly for six (6) months, at which time the QAPI (Quality Assurance Performance Improvement) Committee will determine if further action is needed.

17. Interview with the Nurse Consultant, on 06/29/16 at 10:20 AM, revealed a nurse from the regional team or home office has

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:5/16/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 06/30/2016
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<b>Level of harm -</b> Immediate jeopardy	compare anticoagulant orders with providing oversight and consulta	th Medication Administration Rec tion to licensed staff and Certified	cords, observing care delivery as I Medication Aides. Onsite visits	per care plans and from the regional team
Residents Affected - Few	will be corrected immediately an 18. Interview with the Medical Di 06/30/16 at 8:30 AM, Quality of Director of Nursing at 9:15 AM a Improvement (QAPI) meeting work of Nursing, Assistant Director of Coordinator, and the Maintenanc occurrence; and, the above stated correct the identified concerns. 19. Interview with the Administra stated meetings will be held on a recommendations, as indicated. Concerns.	ily until immediacy is removed and dreported to the Administrator an irector, on 06/29/16 at 3:34 PM, A Life Director at 8:45 AM, Mainte and the Assistant Director of Nurs as held on 06/13/16. Those in atte Nursing, Social Services Director e Director. The discussion include I plan of corrective actions. The Matter, on 06/29/16 at 3:34 PM, reve weekly basis until the immediacy Corporate Administrative oversigh office team daily until removal of	ad the Director of Nursing. Administrator at 4:00 PM, Admis- senance Director at 8:55 AM, Die sing at 9:30 AM, revealed a Qual ndance included the Medical Di r, Dietary Director, Quality of L ed Resident #1; the findings of the fedical Director was consulted re aled QAPI had met on a weekly vis removed, then they will be he at of the QA meeting will be con-	ssions Coordinator on tary Manager at 9:05 AM, ity Assurance Performance rector, Administrator, Director fe Director, Administrator into the envestigation into the regarding the plan to basis since 06/13/16. He eld monthly for any upleted by the Nurse

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