STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/30/2016**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of hospital records, review of the facility's policy and procedure, and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure professional standards of quality were provided for one (1) of three (3) sampled residents (Resident #1) related to administering medications as ordered. Review of Resident #1's 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 system to ensure physicians' orders were transcribed to the EZMAR correctly was ineffective. The facility checked the Administrative side (physician order [REDACTED]. However, the facility failed to identify there was no hour of administration (HOA) which would have caused the order for [MEDICATION NAME] to not be renewed on the on the Administration side of the EZMAR. In addition, the facility failed to check the Administration side (medication pass side) that the nurses use to administer the medication, which resulted in the facility failing to identify that the order had been discontinued on the EZMAR. This resulted in Resident #1 missing seventeen (17) doses of [MEDICATION NAME] (05/27/16-06/12/16). 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 to increase the resident's INR due to missing the doses of [MEDICATION NAME]. 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. The findings include: Review of the KBN, AOS #14 Patient Care, last revised October 2010, revealed licensed nurses were responsible for the administration of medication and treatment as prescribed by the physician and/or advanced practice registered nurse. 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. 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 Progress Notes, dated 06/12/16 at 9:37 AM, and interview with LPN #1 on 06/15/16 at 11:45 AM and on 06/25/16 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] 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. 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 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.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE CARE & REHABILITATION CENTER	**190 EAST HWY. 136 CALHOUN, KY 42327**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
who received [MEDICATION NAME] to ensure their orders were in place in the system and that [MEDICATION NAME] was 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 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 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 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.
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] 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 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 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 [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 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 removal of the immediacy of the jeopardy, beginning 06/13/16, then weekly for four (4) weeks, then monthly.

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NAME OF PROVIDER OF SUPPLIER **RIVERSIDE CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **190 EAST HWY. 136 CALHOUN, KY 42327**	

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 concerns and revealed this had been completed on 06/12/16. 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 [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 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] 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 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 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 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 the 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 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. 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 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 identified. 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

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F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

(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 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.
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 four (4) weeks, then monthly.

F 0333

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure that residents are safe from serious medication errors.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, 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) 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.
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.
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] Fibrillation, [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's room 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 tried to evaluate Resident #1's grasp by instructing the resident to grasp both of her hands at the same time. Resident #1 would grasp one (1) hand, then release and grasp the other hand and release. Resident #1 was then instructed to grasp and hold LPN #1's hands. When Resident #1 grasped both hands, his/her left sided grasp 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 120/80{millimeter of Mercury}mm/Hg); Pulse 47- irregular (normal range 60-100); Oxygen (O2) 92% (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). A skin assessment was completed with no skin issues noted. Report was called to the Regional Hospital (RH). The resident was transferred to the hospital.
Review of Resident #1's Hospital Records, dated 06/12/16, revealed he/she was admitted to the hospital with [REDACTED]. His/Her INR was 1.02 (Reference range 0.84-1.17) and vital signs were Blood Pressure-87/97 mmHg; Pulse-64; Temperature-97.8 degrees; Respirations-15; and Oxygen (O2)-93% (Pulse oximetry interpretation: Hypoxic).
Review of the Facility Progress Notes, dated 06/12/16 at 12:33 PM, recorded by LPN #1, revealed the emergency room (ER) Physician called the facility at approximately 11:00 AM to question about Resident #1 receiving [MEDICATION NAME]. Review of the MAR revealed the last dose the resident received was on 05/26/16. LPN #1 called the hospital at approximately 11:30 AM and followed up with the ER Physician and informed him that Resident #1 had not received his/her [MEDICATION NAME].
Further review revealed the Neurologist from the hospital called the facility to inquire about Resident #1's signs and symptoms prior to sending him/her to the hospital. Review of the documentation revealed the Neurologist stated Resident #1 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 ER
Physician she would have to call him back, and that was when she noticed there was not an hour of administration (HOA) beside 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/30/2016**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0333

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 4)
register to her that they were to receive medication. When entering an order into the Administrative side, she did not go back and verify the order was on the Administration side of the EZMAR, as that was not part of what she did when entering an order.
Interview with Registered Nurse (RN) #1, on 06/15/16 at 7:41 PM, revealed she was very familiar with Resident #1, but not his/her medications. Further interview revealed that if Resident #1's name did not pop up on the administration screen, she would not have known Resident #1 was to have received [MEDICATION NAME] at 4:00 PM. Further interview revealed she relied entirely on the EZMAR system to alert her to whom received medications and what time those medications were due to be administered.
Interview with LPN #6, on 06/16/16 at 8:22 AM, revealed she was not aware of any process in place to verify the EZMAR for accuracy. She 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. Further interview revealed she was not familiar with Resident #1's medications and would have to rely on the EZMAR system to tell her who received medications and what time to administer them.
Interview with LPN #7, on 06/16/16 at 4:10 PM, revealed she had never been instructed to go back into the EZMAR system to verify the physician's orders [REDACTED].#7 stated she had never been part of the process for entering physician's orders [REDACTED].#1.
Interview with the Business Development Analyst, on 06/15/16 at 3:41 PM and on 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 physicians' orders that did not have an hour of administration. He stated this did not take place on 05/27/16, when the nurse entered the physician's orders [REDACTED]. Further interview revealed a bug/glitch was found in the software of the EZMAR system that was not compatible with the Internet Explorer 11 of the corporation's desktop. He stated, We were unaware Internet Explorer eleven (11) was not compatible with the EZMAR software until this issue occurred. He stated in this situation, there was nothing in place that would have alerted the nurse that the order was not saved over onto the medication page for administration, because it was an Internet Explorer issue. Further interview revealed that through the facility's 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.
During interview with the Pharmacy Customer Field Services, on 06/16/16 at 1:30 PM; and, on 06/22/16 at 8:59 AM he stated, We have researched the issue and found an order was entered into the EZMAR without an Hour of Administration (HOA). When I looked into the order, there was no HOA, which should have been entered. If an HOA is not entered, the facility should follow their policy and procedure on how to correct the concern. Up until now, the order could be entered without an HOA or without a stop date, but as I stated before, we are rolling out today a process that will not allow any order to be entered without an HOA. There is nothing built into the system itself that would have alerted them the order would have been discontinued and not have carried over to the medication pass page. Once an order is entered, the nurses can go over to see if the order has been successfully entered correctly, that would be the medication administration page.
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 she first became aware of the missed [MEDICATION NAME] for Resident #1 when LPN #1 notified her on 06/12/16. She stated the facility notified all appropriate authorities and immediately started their investigation. The DON stated that during the facility's investigation, they found some type of technical problem regarding an update with the Internet Explorer system that somehow allowed an order to be saved without an HOA.
Further interview with the DON revealed Resident #1 had missed seventeen (17) doses of [MEDICATION NAME], which would be considered a significant medication error. She stated, However, it would be my expectation as the DON that a resident who has been receiving medication on a routine basis and suddenly that medication is not on the MAR for administration, for the nurse to go check the physician's orders [REDACTED]. She stated, We have had an influx of inconsistent nursing staff on that unit for the last several weeks, not a shortage, but not the same staff who were familiar with Resident #1's routine medications, and when working the floor, the nursing staff relied heavily on the EZMAR system to know who to administer medications to and what time the medications were due.
Continued interview with the DON revealed when LPN #2 entered the physician's orders [REDACTED]. She stated if the stop date had been entered into the system this would not have occurred. The DON stated this was found when reviewing the system. Further interview revealed the Interdisciplinary Team (IDT) reviewed all new Physicians' Orders daily Monday through Friday. During that process, LPN #8 reviewed the written orders with the orders in the EZMAR System. The DON stated the HOA not being on the order was a technical problem and the clinical team reviewer should have caught that when the orders were reviewed on 05/31/16 with the previous process. Further interview revealed she spoke with LPN #8 and she too was unaware how the order was missed. She stated, The order was there all along for the nurse to view, it just did not have a stop date or an HOA. We did not require the nursing staff to double check the physician's orders [REDACTED].
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 of the EZMAR for accuracy. Then she sent the signed physicians' orders to the physician for review. Further interview revealed it was not part of the process to go into the Administration portion 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. Further interview, revealed she had reviewed multiple orders on 05/31/16, and could not recall the exact details of Resident #1's orders. LPN #8 stated she could not say whether she viewed the actual HOA, but she was aware the order should not have populated over into the Administration side (for medication pass) without an HOA. She stated, It has not been our process in the past to verify orders by going over into the medication pass side of the EZMAR. However, we may have to add this process to verify the HOA is actually there.
Interview with the facility's Pharmacist, on 06/15/16 at 12:21 PM, revealed he became aware of the missing doses of [MEDICATION NAME] when he was notified by e-mail on 06/13/16 by the DON of the facility. He stated missing doses of [MEDICATION NAME] could be severe, depending on the patient. The Pharmacist stated [MEDICATION NAME] required close monitoring of labs to ensure the resident was at a therapeutic or established level.
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 became aware of the incident involving Resident #1's missed [MEDICATION NAME] when the DON notified him on 06/12/16. He immediately came to the facility to initiate an investigation. Further interview revealed he felt there was a technical problem with the EZMAR system. He stated he would consider missing seventeen (17) doses of [MEDICATION NAME] to be a significant medication error and his expectation was that Resident #1 should have received his/her medication as ordered by his/her physician. Further interview revealed he had taken this matter very seriously and had been working diligently with the EZMAR Pharmacy Company (the company who provided their EZMAR system) to ensure this did not happen again. 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 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 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 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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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0333

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 5)
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 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.
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] 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 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 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 [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 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 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.
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 [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

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F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 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 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] 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 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
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 total 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 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. 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 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 identified as having left sided weakness; non-verbal, and his/her left pupil was pinpoint and nonreactive. 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 INR being low. Review of the Physician's Order, dated 05/27/16, revealed to continue [MEDICATION NAME] 6 milligrams (mg) daily, and recheck his/her INR in one (1) month. However, review of Resident #1's May 2016 and June 2016 EZMAR, revealed the order to administer [MEDICATION NAME] 6 mg, was not documented on the EZMAR after 05/26/16. This resulted in the resident missing seventeen (17) doses of [MEDICATION NAME] from 05/26/16 through 06/12/16, when the resident was sent to the hospital with 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. 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. 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 not happen again. **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 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 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 Order Sheets (POS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/30/2016**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 7)
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 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 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.
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] 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 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 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 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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/30/2016**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

Level of harm - Immediate jeopardy

Residents Affected - Few

(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 [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; 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] 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 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 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 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 the
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 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.
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 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 identified.
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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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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) 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 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. 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 four (4) weeks, then monthly.