STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185438	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHWOOD NURSING & REHAB	1012 RICHWOOD WAY LA GRANGE, KY 40031

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility Policy, it was determined the facility failed to provide pharmaceutical services related to receiving, and administering controlled medication to meet the needs of each resident for one (1) of five (5) sampled residents (Resident #3). Resident #3 was on palliative care and review of Physician Orders, dated June 2020, revealed orders for [MEDICATION NAME] (Concentrate) 20 MG (milligrams)/ML(milliliter), give ten (10) MG by mouth every two (2) hours scheduled for pain control, with a start date of 06/06/2020 and this order was discontinued on 06/10/2020 at 7:43 PM by Registered Nurse (RN) #1. Further review revealed physician's orders [REDACTED]. Interview with RN #1, revealed on 06/09/2020 before 9:00 PM, she notified the Physician that Resident #3 had no more [MEDICATION NAME] in the narcotic drawer, and she obtained a Verbal Order to discontinue the scheduled [MEDICATION NAME] and start [MEDICATION NAME] 20 MG/ML; give ten (10) mg by mouth every two (2) hours PRN for pain/shortness of air; however, she did not enter the new Verbal Order for [MEDICATION NAME] into the Electronic Health Record (EHR) or obtain the medication from the pharmacy or Emergency Medication Box at the facility. Resident #3's Controlled Drug Record (CDR), revealed the resident received [MEDICATION NAME] 0.5 ML on 06/09/2020 at 12:00 AM; however, there was no documented evidence [MEDICATION NAME] was administered again until 06/12/2020 at 11:40 AM; forty seven (47) hours and forty (40) minutes later. Interview with the Pharmacist and Director of Nursing, revealed the facility had no processes in effect to ensure re-ordered controlled medications were maintained. The findings include: Review of the facility's Pharmacy Services Overview Policy, dated April 2019, revealed the facility would accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications, and services of a licensed pharmacist. Additionally, Pharmacy Services were available to residents twenty-four (24) hours a day, seven (7) days a week. Continued review revealed residents should have sufficient supply of their prescribed medications in a timely manner. Further, Nursing staff were responsible to communicate prescriber orders to the pharmacy and contract the pharmacy if a resident's medication is not available for administration. Review of the facility's Reordering, Changing, and Discontinuing Orders Policy, dated 10/31/2016, revealed medications that exhaust the number of refills may require a new order and/or prescription. Additionally, the facility was encouraged to reorder medication electronically. Further, the pharmacy would indicate if the reorder was confirmed and/or required pharmacy follow up, and would contact the facility as necessary. Review of the facility's Prospective Item Withdrawal Instructions (Emergency Medications at the facility), undated, revealed a verbal authorization prior to use from pharmacy was required. Further, the authorized withdrawal quantity was documented on the Controlled Substance Authorization Log. Review of the contents of the facility Emergency Medication, revealed one (1) multi-dose bottle of [MEDICATION NAME] 20 MG/ML solution (15 ML bottle). Review of Resident #3's medical record revealed the facility admitted the resident on 07/11/2010 with [DIAGNOSES REDACTED]. Further, Palliative Care was initiated on 06/05/2020. Review of Resident #3's Significant Change Minimum Data Set (MDS) Assessment, dated 06/11/2020, revealed the facility assessed the resident as having unclear speech, rarely understood or understanding others. Additionally, the facility assessed the resident as having short and long term memory problems. Further review of the MDS Assessment, revealed the facility assessed the resident as receiving scheduled and PRN (as needed) pain medication during the last five (5) days of the assessment reference period and as having no signs and symptoms of pain. Review of Resident #3's Monthly physician's orders [REDACTED]. On 06/10/2020 at 7:43 PM, RN #1 discontinued this order with the reason noted, Already on (1) hour as needed (PRN). Further review of Resident #3's physician's orders [REDACTED]. Per record review, all orders for [MEDICATION NAME] medication were discontinued on 06/10/2020, and there was no documented evidence of new orders for [MEDICATION NAME] until 06/12/2020, two (2) days later. On 06/12/2020, new orders were received for [MEDICATION NAME] (Concentrate) 20 MG/ML; give ten (10) mg by mouth every two (2) hours as needed for pain/shortness of air. However, interview with RN #1 on 06/17/2020 at 5:30 PM, revealed she had received a Verbal Order on 06/09/2020 before 9:00 PM for [MEDICATION NAME] (Concentrate) 20 MG/ML; give ten (10) mg by mouth every two (2) hours PRN for pain/shortness of air and did not enter the order into the Electronic Health Record (EHR). Review of Resident #3's Medication Administration Record [REDACTED]. Additional review revealed the resident received scheduled [MEDICATION NAME] every two (2) hours from 06/07/2020 at 12:00 AM until 06/09/2020 at 12:00 AM. Further review revealed the resident did not receive [MEDICATION NAME] from 06/09/2020 at 12 AM until 06/12/2020 at 11:35 AM; forty-seven (47) hours and forty (40) minutes after his/her last dose. Review of Resident #3's Controlled Drug Record Form (CDR), revealed on 06/07/2020, the facility received [MEDICATION NAME] 20 mg/ml solution, twenty (20)- 0.5 milliliters (ml) syringes. Continued review revealed all twenty (20) syringes were signed out to Resident #3, from 06/07/2020 until 06/09/2020 at 12:00 AM. However, additional review of Resident #3's CDR Form, dated 06/12/2020, revealed the resident did not receive [MEDICATION NAME], for forty-seven (47) hours and forty (40) minutes, from 06/09/2020 at 12:00 AM until 06/12/2020 at 11:40 AM as there was no [MEDICATION NAME] available for administration. Further interview with Registered Nurse (RN) #1, on 06/17/2020 at 5:30 PM, revealed she was an agency nurse and had worked at the facility for approximately two (2) months. Per interview, she did not know the process for reordering medications through the Electronic Health Record (EHR) or utilizing the Emergency Medications at the facility. Per interview, she relied on other nurses at the facility to help when she was uncertain on what to do. She stated she had Face Time called the Provider on 06/09/2020 before 9:00 PM, and explained Resident #3 needed [MEDICATION NAME] as there was none in the Controlled Medication drawer, and also discussed the need for the order to be changed from every two (2) hours scheduled to every two (2) hours PRN, as well as the need for a multi-dose bottle versus a unit dose syringe. Per interview, during this call she received a Verbal Order for [MEDICATION NAME] (Concentrate) 20 MG/ML; give ten (10) mg by mouth every two (2) hours PRN for pain/shortness of air. Additional interview with RN #1, revealed after receiving the Verbal Order from the Provider, she discontinued the order for [MEDICATION NAME] every two (2) hours scheduled, but she did not enter the new Verbal Order for [MEDICATION NAME] every two (2) hours PRN into the EHR because she was unsure how to enter the orders, and she assumed the Provider would enter the order because he told her he would call the pharmacy. Additional interview revealed she did not receive the [MEDICATION NAME] from the pharmacy or remove it from the Emergency Medications at the facility during her shift on 06/09/2020. Further, she did not follow up with the pharmacy or the Provider during the remainder of her shift to ensure the medication was being sent to the facility and was not aware the medication was available in the Emergency Medications. Continued interview revealed she did not pass along in report to the oncoming nurse that she had spoken with the Provider related to Resident #3's [MEDICATION NAME] nor did she inform them the medication had not been received from pharmacy. When questioned what an acceptable timeframe would be for a palliative resident to receive pain medications once ordered and pharmacy was made aware, she stated she was uncertain, but twenty-four (24) hours or less. However, she stated medications should be administered to residents as per physician's orders [REDACTED]. Phone interview with the Pharmacy

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185438	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RICHWOOD NURSING & REHAB	**1012 RICHWOOD WAY LA GRANGE, KY 40031**

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Manager, on 06/16/2020 at 4:30 PM, revealed on 06/09/2020 at 9:00 PM, the facility's Physician called the Pharmacy and gave authorization for the facility to obtain the multi-dose bottle of [MEDICATION NAME] 20 MG/ML solution (15 ML bottle), from the Emergency Box for Resident #3. Per interview, the Pharmacy called the facility six (6) times before Midnight to give authorization to the nursing staff to access the Emergency box; however, they were not able to get anyone to answer the calls. Continued interview revealed at midnight the authorization from the Physician would be invalid and a new script would be required. The Pharmacy Manager stated there was no documented evidence of the six (6) phone call attempts. Further, she was unable to contact the pharmacy staff on duty the night of 06/09/2020, to determine what the pharmacy's actions were after unsuccessfully reaching the nursing staff at the facility. However, she stated it was Pharmacy protocol to continue either making calls to the facility until contact was made, or pass the information along to the oncoming Pharmacy shift to continue to reach out to the facility. Additional interview with the Pharmacy Manager, on 06/16/2020 at 4:30 PM, revealed the Pharmacy received an electronic discontinue order on 06/10/2020 at 3:00 AM for the [MEDICATION NAME] 20 MG/ML every two (2) hours and assumed the resident had passed away and did not fill the [MEDICATION NAME] order. Per interview, the Pharmacy did not contact the facility to confirm the resident did in fact pass away and there was no further need for the [MEDICATION NAME]. Continued interview revealed the Pharmacy should have called to verify the discontinue order with the facility on 06/10/2020 because they had received a script for [MEDICATION NAME] 20 MG/ML from the Physician. Further, the Pharmacy did not have any inquiry from the facility related to Resident #3's [MEDICATION NAME] on 06/11/2020; however, on 06/12/2020 the facility contacted the Pharmacy and verbal authorization was given to obtain the multi-dose bottle of [MEDICATION NAME] 20 MG/ML solution (15 ML bottle), from the Emergency Box for Resident #3. Per interview, it was important for the Pharmacy to have systems and processes in place to ensure controlled medications were provided to meet the needs of each resident. Interview with Director of Nursing (DON), on 06/16/2020 at 12:10 PM, revealed she had worked at the facility for four (4) years. Per interview, the facility ran out of Resident #3's [MEDICATION NAME] on 06/09/2020, and notified the Pharmacy who in turn stated a new prescription was needed for the [MEDICATION NAME]. Additionally, on 06/10/2020, the facility notified the Physician several times about needing a new prescription for the medication. Per interview, on 06/11/2020 at 5:00 PM, the Physician called the facility and spoke with the DON inquiring about Resident #3's [MEDICATION NAME] status; however, the Pharmacy was closed and the DON did not call the Pharmacy. Continued interview revealed on the morning of 06/12/2020, the DON called the Pharmacy to confirm the pharmacy had received a prescription for Resident #3's [MEDICATION NAME]. At that time she was given verbal authorization to obtain the [MEDICATION NAME] from the Emergency box. Further, the Pharmacy stated they would also STAT over the medication to the facility. Continued interview with the DON, on 06/16/2020 at 12:10 PM, revealed it was facility protocol for the direct care nurse to notify the pharmacy if there was a need for a controlled medication. The pharmacy would inform the direct care nurse if a new prescription was required from the Physician. Then the direct care nurse would contact the Physician informing him of the need for a new prescription and obtain a verbal order for the medication. Additionally, the direct care nurse would enter the order into the EHR, which would automatically be sent to the Pharmacy and the direct care nurse would follow up with pharmacy to ensure they received the order and script. Per interview, the direct care nurse would also place paper documentation of the new order for controlled medications in a box by the DON's office. Further, the DON would review all new orders in the EHR, the paper documentation in the box and pharmacy deliveries of controlled medication each morning during clinical meeting to ensure medications that were ordered were received timely and necessary follow up was made. Interview with DON, on 06/18/2020 at 4:00 PM, revealed since the COVID-19 pandemic, hallways had been closed off for the past six (6) weeks, and the above process was impossible. Per interview, this was because offices moved and hallways were closed down and access to her office from all hallways was not possible. The DON stated she had not been monitoring controlled medication using this process. Additionally, she had not identified any concerns with obtaining medications to meet resident needs until this occurrence with Resident #3. Per interview, forty-seven (47) hours and forty (40) minutes was not an acceptable timeframe for medications to be unavailable for administration to a resident. She stated it was her expectation direct care nursing staff follow up with the Pharmacy and the DON if there was a delay in obtaining medications. Per interview, she also expected the Pharmacy to follow up with the facility to ensure medications were provided as ordered to residents. Further, it was important residents receive appropriate care, and ensure comfort and no pain. Interview with the Administrator, on 06/18/2020 at 4:40 PM, revealed he had been at the facility for four (4) years. Per interview, it was his expectation pharmacy services was a partner with good communication to ensure physician's orders [REDACTED]. Per interview, he ensured this process was followed through Quality Assurance committee meetings, which the Pharmacy staff attended, and pharmacy reports. Continued interview revealed this process did not identify any concerns or issues and the facility was currently satisfied with pharmacy services. However, he stated it was his expectation facility nursing staff and pharmacy staff ensure medications were provided to meet the needs of the resident (s) in a reasonable timeframe. Further, it was important for residents not to suffer a painful condition when help could be in place to comfort them, such as ordered pain medications.