STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185281	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP HEALTH AND REHAB, LLC	**7400 FRIENDSHIP DRIVE PEWEE VALLEY, KY 40056**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, it was determined the facility failed to implement the individualized care plan for two (2) of four (4) sampled residents, Resident #1, and Resident #2. Staff failed to administer ordered and care planned medications to Resident #1 and failed to provide gastrostomy tube feeding treatments and ordered medications as care planned for Resident #2. The findings include: Review of the policy and procedure, Care Plans, Comprehensive Person-Centered dated 12/2016, revealed a comprehensive, person-centered care plan was developed and implemented for each resident to meet their physical, psychosocial and functional needs. The facility admitted Resident #2 on 01/17/06. Current [DIAGNOSES REDACTED]. Additional [DIAGNOSES REDACTED]. Observation of Resident #2 on 08/05/2020 revealed the resident to be non-verbal, awake, and sitting up in a chair. The resident was odor-free, and appeared clean. He/she was dressed appropriately for the season. [MEDICATION NAME] at seventy (70) milliliters (ML) per hour was infusing via pump through a gastrostomy tube. Gastrostomy tube observed with staff, and appeared dry and intact to the resident's abdomen without leakage or odor. Review of the Annual Minimum Data Set (MDS), signed and dated 06/10/2020, revealed a Brief Interview for Mental Status Exam score of ninety-nine (99) and the facility determined the resident was not interviewable. Continued review revealed the facility assessed the resident to have a feeding tube. Review of the plan of care (no date) revealed the focus of a potential for alteration in nutrition related to nothing per oral (NPO) need for tube feeding. Interventions listed included NPO and provide tube feeding as ordered. An additional focus was Resident #2 has a [MEDICAL CONDITION] disorder, which placed him/her at risk of injury and interventions included to give [MEDICAL CONDITION] medication as ordered by doctor, observe/document side effects and effectiveness. Review of the Medication Administration Record, [REDACTED]. The omitted treatments included [MEDICATION NAME] AC (a tube feeding formula) at seventy (70) ML per hour continuously, and levetiracetam solution (an anticonvulsant) one hundred (100) milligrams (MG) per ML, give fifteen (15) ML via gastrostomy tube two (2) times a day related to Convulsions. Continued review of Resident #2's MAR indicated [REDACTED]. The missed treatments and medications included [MEDICATION NAME] AC at seventy (70) ML per hour continuously, and levetiracetam solution one hundred (100) MG/ML, give fifteen (15) ML via gastrostomy tube two (2) times a day related to Convulsions. 2. The facility readmitted , Resident #1 on 11/12/2019 from an acute care hospital. Current [DIAGNOSES REDACTED]. Other [DIAGNOSES REDACTED]. Review of the Significant Change in Status MDS, dated [DATE] revealed Resident #1 to have both short term, and long term memory problems, and the resident was not interviewable. Review of Resident #1's plan of care, no date, revealed the focus Resident #1 was at risk for complications related to use of anticoagulant medication with a history of bilateral lower extremity [MEDICAL CONDITIONS]. Interventions for this focus included medications as ordered. An additional focus was Resident #1 had a risk for or actual alteration related to [MEDICAL CONDITION], impaired vision, [MEDICATION NAME] degeneration and was unable to participate in vision testing due to impaired cognition. Other focus included Resident #1 had a history of [REDACTED]. Review of Resident #1's MAR, dated 07/01/2020 through 07/31/2020, revealed staff did not document the administration of the following physician ordered medications on 07/20/2020: [MEDICATION NAME] Propionate fifty (50) Micrograms (MCG) one (1) spray in both nostrils, one (1) time a day related to Allergic Rhinitis and Eliquis U-D five (5) MG tablet, one (1) tablet by mouth two (2) times a day related to Embolism and [MEDICAL CONDITION] of arteries of the Lower Extremities (missed morning dose). Other medications included [MEDICATION NAME] zero point five percent (0.5%) drops, one (1) drop in both eyes two (2) times a day related to [MEDICAL CONDITION] (missed morning dose), and OloPatadine HCL ([MEDICATION NAME]) zero point one percent (0.1%), one (1) drop in both eyes two (2) times a day (missed morning dose). Continued review of Resident #1's MAR indicated [REDACTED]. Other medications include Eliquis U-D five (5) MG tablet one (1) tablet by mouth two (2) times a day related to Embolism and [MEDICAL CONDITION] of arteries of the Lower Extremities (missed morning dose), [MEDICATION NAME] zero point five percent (0.5%) drops one (1) drop in both eyes two (2) times a day related to [MEDICAL CONDITION] (missed morning dose), and OloPatadine HCL ([MEDICATION NAME]) zero point one percent (0.1%) one (1) drop in both eyes two (2) times a day (missed morning dose). Telephonic interview with Registered Nurse #1 revealed a resident's care plan was individualized and made staff aware of how to take care of each resident. He stated a negative outcome could occur if the plan of care was not followed. Telephonic interview with the Administrator on 08/11/2020 at 12:54 PM revealed it was a facility expectation staff follow the individualized care plan to meet the needs of each resident.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to ensure two (2) of four (4) sampled residents received treatment and care in accordance with the physician orders [REDACTED].#2). Resident #1 did not receive medications as ordered and Resident #2 did not receive gastrostomy tube feedings and medications as ordered. The findings include: Review of the policy and procedure, Administering Medications, dated 04/2019, revealed medications were to be administered in a safe and timely manner, and as prescribed. 1. The facility admitted Resident #2 on 01/17/06. [DIAGNOSES REDACTED]. Other [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS), signed and dated 06/10/2020, revealed a Brief Interview for Mental Status Exam scored at ninety-nine (99) and the facility determined the resident was not interviewable. Additionally the facility assessed the resident to have a feeding tube. Observation of Resident #2 on 08/05/2020 revealed the resident to be non-verbal, awake, and sitting up in a chair. The resident was odor-free, and appeared clean and he/she was dressed appropriately for the season. [MEDICATION NAME] (a tube feeding formula) at seventy (70) milliliters (ML) per hour was infusing via pump through a gastrostomy tube. Gastrostomy tube observed with staff, and appeared dry and intact to the resident's abdomen without leakage or odor. Review of the Nursing Note, dated and timed 07/27/2020 at 6:54 AM, revealed the facility sent Resident #2 to the hospital Emergency Department (ED) for a gastrostomy tube replacement. Review of the Discharge Summary Report from an acute care hospital, signed and dated 07/27/2020 by the physician, revealed Resident #2 presented to the Emergency Department (ED) from the nursing home with reports of his/her gastrostomy tube as dislodged. The medication list stated no changes made to your prescriptions during this visit and the hospital discharged the resident back to the facility in stable condition. Review of the nurses' note, dated 07/27/2020 at 1:30 PM, revealed Resident #2 returned from the hospital ED with no new orders and to continue current orders. Review of the plan of care (no date) revealed the focus the potential for alteration in nutrition related to nothing per oral with need for tube feeding. Interventions included NPO (nothing by mouth), and provide tube

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

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) feeding as ordered. Continued review revealed the focus Resident #2 had a [MEDICAL CONDITION] disorder, which placed him/her at risk of injury. Interventions for this focus included for staff to give [MEDICAL CONDITION] medication as ordered by doctor, observe/document side effects and effectiveness. Review of the Medication Administration Record [REDACTED]. Other treatments included [MEDICATION NAME] Suspension, two (2) milligrams (MG) per ML, one (1) time a day related to [MEDICAL CONDITION] Reflux Disease; and [MEDICATION NAME] HCL Syrup, one hundred (100) MG via gastrostomy tube, every twelve (12) hours related gastrostomy status. Further review revealed levetiracetam Solution, one hundred (100) MG/ML, give fifteen (15) ML via gastrostomy tube two (2) times a day related to Convulsions; and Polyethylene [MEDICATION NAME] Powder seventeen (17) grams via gastrostomy tube two (2) times a day related to constipation. Continued review of Resident #2's MAR, dated 08/01/2020 through 08/31/2020, revealed the following treatments and medications were not administered 08/01/2020 through 08/03/2020 per physician orders: [MEDICATION NAME] AC at seventy (70) ML per hour continuously one (1) time a day; and [MEDICATION NAME] Suspension two (2) milligram (MG) per ML one (1) time a day related to [MEDICAL CONDITION] Reflux Disease. Other treatments included [MEDICATION NAME] HCL Syrup one hundred (100) MG, via gastrostomy tube every twelve (12) hours related gastrostomy status; and levetiracetam Solution one hundred (100) MG/ML, give fifteen (15) ML via gastrostomy tube two (2) times a day related to Convulsions. Further review revealed the treatment Polyethylene [MEDICATION NAME] Powder, seventeen (17) grams via gastrostomy tube two (2) times a day related to constipation. Telephonic interview with Licensed Practical Nurse (LPN) # 3, on 08/07/2020 at 12:58 PM, revealed she sent Resident #2 out of the facility to the Emergency Department on 07/27/2020 at approximately 7:00 AM for a gastrostomy tube placement. She stated when the resident returned to the facility, she reconnected the tube feeding; however, she did not verify a medical doctor's order because she was familiar with the resident, the tube-feeding machine was set up, so she just turned the feeding back on. Telephonic interview with Assistant Director of Nursing #1 (ADON), on 08/06/2020 at 12:08 PM revealed she provided care to Resident #2 on 07/29/2020, and she observed an empty bottle of tube feeding hanging in the residents room. She stated she thought the resident received the tube feeding during the nighttime hours. Telephonic interview with LPN #1, on 08/07/2020 at 10:13 AM, revealed she provided care to Resident #2 on 08/01/2020. She stated she did administer the resident's tube feeding as previously ordered. She stated the resident did not have any medications ordered and assumed the resident's medications were administered on another shift. Telephonic interview with LPN #4, on 08/10/2020 revealed she provided care to Resident # 2 on 08/02/2020. She revealed she did not administer medications or tube feeding to the resident because the orders were not on the Medication Administration Record [REDACTED]. Telephonic interview with LPN #2, on 08/07/2020 at 11:18 AM, revealed he identified on 08/04/2020, that Resident #2's tube feeding and medication orders were not continued after the resident had his/her gastrostomy tube replaced on 07/27/2020. He stated he reviewed the resident's medical record, and noted an order as well as a progress note dated 07/27/2020 to continue current medication/tube feeding orders. He revealed the previous night shift nurse had revealed the resident did have the tube feeding going when she had come on duty 08/03/2020. The LPN continued to reveal the resident's medications and tube feeding should have been placed on hold while the resident was out of the facility for a gastrostomy tube replacement; however, it appeared the resident's medications/tube feeding were discontinued on 07/27/2020. Telephonic Interview with the Director of Nursing, on 08/10/2020 at 1:20 PM, revealed any time a resident received services at the Emergency Department, and returned the same day to the facility, the medications/tube feedings should not be discontinued, and staff were educated on this. She stated staff should verified the orders once the resident returned to the facility on [DATE] and the orders for the resident's medication, and tube feeding should have been identified on 07/27/2020 when Resident #2 arrived back to the facility. Telephonic interview with the Medical Provider on 08/11/2020 at 9:17 AM revealed he was notified by the facility that Resident #2 missed some tube feedings, and had missed prescribed medications. The Medical Provider revealed his expectations was residents received treatments and medications exactly as ordered. 2. The facility readmitted Resident #1 on 11/12/2019 from an acute care hospital. Current [DIAGNOSES REDACTED]. Other [DIAGNOSES REDACTED]. Review of the Significant Change in Status MDS, dated [DATE] revealed Resident #1 had both short term, and long-term memory problems, and the facility determined the resident was not interviewable. Review of Resident #1's plan of care, undated, revealed the focus that Resident #1 was at risk for complications related to use of anticoagulant medication and a history of bilateral lower extremity [MEDICAL CONDITIONS]. The interventions included medications as ordered. The focus that Resident #1 was a risk for/actual alteration related to [MEDICAL CONDITION], impaired vision, [MEDICATION NAME] degeneration and was unable to participate in vision testing due to impaired cognition. The focus of Resident #1 had a history of [REDACTED]. Review of Resident #1's MAR, dated 07/01/2020 through 07/31/2020, revealed staff did not document the administration of the following physician ordered medications on 07/20/2020: Acidophillus W-Pectin, twenty-five (25) and one hundred (100) milligram (25/100) (MG) tablet, one (1) tablet by mouth, one (1) time a day for supplement and Calcium Tablet, five hundred (500) MG, one (1) tablet by mouth one (1) time a day related to [DIAGNOSES REDACTED]. Other medications included Cranberry five hundred (500) MG one (1) tablet by mouth one, (1) time a day for supplement; [MEDICATION NAME] Oxalate F/C, one (1) tablet by mouth, one (1) time a day every other day, related to Depressive Episodes and [MEDICATION NAME] Propionate fifty (50) Micrograms (MCG), one (1) spray in both nostrils, one (1) time a day related to Allergic Rhinitis. Further medications included Eliquis U-D five (5) MG tablet, one (1) tablet by mouth, two (2) times a day related to Embolism and [MEDICAL CONDITION] of arteries of the Lower Extremities (missed morning dose), [MEDICATION NAME] zero point five percent (0.5%) drops one (1) drop in both eyes two (2) times a day related to [MEDICAL CONDITION] (missed morning dose), Memantine HCL F/C ten (10) MG tablet one (1) tablet by mouth two (2) times a day related to Dementia (missed morning dose), OloPatadine HCL zero point one percent (0.1%), one (1) drop in both eyes two (2) times a day (missed morning dose). Continued review of Resident #1's MAR indicated [REDACTED]. Other medications included Cranberry five-hundred (500) MG one (1) tablet by mouth once day for supplement; [MEDICATION NAME] Oxalate F/C one (1) tablet by mouth one (1) time a day every other day, related to Depressive Episodes; and [MEDICATION NAME] Propionate fifty (50) Micrograms (MCG) one (1) spray in both nostrils one (1) time a day related to Allergic Rhinitis. Further medications included Eliquis U-D five (5) MG tablet one (1) tablet by mouth two (2) times a day related to Embolism and [MEDICAL CONDITION] of arteries of the Lower Extremities (missed morning dose); [MEDICATION NAME] zero point five percent (0.5%) drops one (1) drop in both eyes two (2)times a day related to [MEDICAL CONDITION] (missed morning dose); Memantine HCL F/C ten (10) MG tablet one (1) tablet by mouth two (2) times a day related to Dementia (missed morning dose); and OloPatadine HCL zero point one percent (0.1%) one (1) drop in both eyes two (2) times a day (missed morning dose). Telephonic interview with the Director of Nursing, on 08/10/2020 at 1:20 PM, revealed she assisted Resident #1 with his/her morning meal, and did recall the ADON administered Resident #1's morning medications, however, the nurse must have failed to sign the medications as given. She revealed the facility normally checked all the MARS/TARS monthly for any errors, however, with the advent of COVID19, the facility has not had time to check the MARs/TARs monthly for errors since around June 2020. She stated medications not signed and initialed by staff were assumed as not given to a resident. Telephonic interview with the Administrator, on 08/11/2020 at 12:54 PM, revealed the Quality Assurance Performance Improvement (QAPI) Committee met at least quarterly, and had discussed the omission of medication and treatments as prescribed by the physician.