| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185317 | A. Building<br>B. Wing | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Greenville Nursing and Rehabilitation | 521 Greene Drive<br>Greenville, KY 42345 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>46565<br><br>Based on interview, record review, and facility policy review, the facility failed to ensure 3 (Residents (R) 30, R38, and R46) of 22 sampled residents received their nighttime medications at a time preferred by the residents.<br><br>The findings include:<br><br>Review of the facility's policy titled, Medication Administration, copyright 2024, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.<br><br>An undated document titled, Medication times provided by the facility revealed evening medication times were from 6:00 PM to 10:00 PM.<br><br>1. Review of R30's Admission Record revealed the facility readmitted R30 on 01/13/2023 with diagnoses that included respiratory failure, type II diabetes, other sleep disorders, and anxiety disorder.<br><br>Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2024, indicated R30 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.<br><br>Review of R30's Medication Administration Audit Report, for the timeframe of 06/06/2024 to 06/07/2024, revealed medications ordered was to be administered on 06/06/2024 at 6:00 PM, 8:00 PM, and 9:00 PM, and were documented to have been administered on 06/07/2024 at 12:48 AM by Licensed Practical Nurse (LPN) #16.<br><br>Review of R30's Medication Administration Audit Report, for the timeframe of 06/15/2024 to 06/16/2024, revealed the medications were ordered to be administered on 6/15/2024 at 6:00 PM, 8:00 PM, and 9:00 PM; however, the medications were documented to be administered on 06/16/2024 at 1:12 AM and 1:13 AM by LPN #16.<br><br>During an interview on 06/17/2024 at 10:44 AM, R30 stated they could not get their nighttime medication until midnight. The resident stated midnight was too late. Further, the resident stated staff had to wake them to take their medication, and they were unable to go back to sleep afterward.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of R38's Admission Record revealed the facility readmitted R38 on 11/25/2023 with diagnoses that included polymyalgia rheumatica (muscle pain and stiffness), atrial fibrillation, and heart failure.<br><br>Review of R38's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/21/2024, revealed R38 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.<br><br>Review of R38's Medication Administration Audit Report, for the timeframe of 06/06/2024 to 06/07/2024, revealed the resident's medications were ordered to be administered on 06/06/2024 at 6:00 PM; however, review of the record revealed the resident's medications were administered 06/07/2024 at 12:51 AM by LPN #16.<br><br>Review of R38's Medication Administration Audit Report, for the timeframe of 06/16/2024 to 06/17/2024, revealed the the resident's medications were ordered to be administered on 06/16/2024 at 6:00 PM; however, review of the record revealed the resident's medications were administered 06/16/2024 at 11:18 PM by LPN #16.<br><br>During an interview on 06/18/2024 at 5:15 PM, R38 stated LPN #16 always gave their night medication after 10:30 PM or 11:00 PM, sometimes as late as 2:00 AM. R38 stated they preferred to get their medication around 7:00 PM or 8:00 PM, so they could go to bed earlier.<br><br>3. Review of R46's Admission Record revealed the facility readmitted R46 on 06/10/2022 with diagnoses which included: generalized anxiety disorder, polyneuropathy (pain in multiple nerves), restless leg syndrome, and other sleep disorders.<br><br>Review of R46's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/2024, revealed R46 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.<br><br>Review of R46's Medication Administration Audit Report, for the timeframe of 06/06/2024 to 06/07/2024, revealed the resident's medications were ordered to be administered on 06/06/2024 at 6:00 PM and 9:00 PM. However, review of the record revealed the resident's medications were administered 06/07/2024 at 12:49 AM by LPN #16.<br><br>Review of R46's Medication Administration Audit Report, for the timeframe of 06/15/2024 to 06/16/2024, revealed the medications ordered to be administered on 06/15/2024 at 6:00 PM and 9:00 PM, however, review of the documentation revealed the resident's medications were administered on 06/16/2024 at 1:13 AM by LPN #16.<br><br>During an interview on 06/17/2024 at 12:14 PM, R46 stated they had been receiving their nighttime medications at 12:00 AM, that was too late, and staff had to awaken them to give the medications.<br><br>During a telephone interview on 06/19/2024 at 10:06 PM, LPN #16 stated she finished administering medications by 10:30 PM each night, but if things got hectic it could be as late as 11:30 PM.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/20/2024 at 4:33 PM, the Director of Nursing Services (DNS) stated if a resident had a preference for medications, that a grievance should be completed and the facility should attempt to accommodate the preference of the resident and give the medications at a better time. Further, the DNS stated it was her expectation the facility would accommodate the residents' time preferences. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>28196<br><br>Based on interview, facility document review, and facility policy review, the facility failed to ensure the posted staffing document included the total number of staff working for each discipline. This had the potential to affect all 59 residents residing in the facility.<br><br>The findings include:<br><br>Review of the facility's policy titled, Nurse Staffing Posting Information, copyright 2023, revealed, It is the policy of this facility to make nurse staffing information [sic] readily available in a readable format to residents and visitors at any given time. The policy also indicated, 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides.<br><br>Review of the facility's daily staff postings for the time frame from 05/21/2024 through 06/19/2024 revealed the name of the facility, facility census, the date, the actual hours worked for registered nurses (RNs), licensed practical nurses (LPNs), and aides/medtechs [medication technicians]. Further review of the document revealed it did not reflect the total number of RNs, LPNs, and unlicensed nursing staff scheduled to work each day.<br><br>During an interview on 06/20/2024 at 11:37 AM, the Scheduler stated she was trained regarding how to complete the daily staff postings by the previous Scheduler, and she had never been told to include the number of RNs, LPNs, and certified nurse aides (CNAs) or medication aides.<br><br>During an interview on 06/20/2024 at 2:51 PM, the Director of Nursing Services (DNS) stated her expectation was that the Scheduler followed the policy for completing the daily staff postings.<br><br>During an interview on 06/20/2024 at 3:21 PM, the Executive Director (ED) stated she was unaware that the daily staff postings needed to include the actual number and hours worked for RNs, LPNs, and CNAs or medication aides. The ED stated she expected staff to follow the policy when completing daily staff postings. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>29358<br><br>Based on observation, interview, record review, and facility policy review the facility failed to ensure the medication error rate was less than 5 percent (%). The facility had 2 medication errors out of 35 opportunities, affecting 1 (Resident (R)14) of 3 residents reviewed during the medication administration task, resulting in a medication error rate of 5.71%.<br><br>The findings include:<br><br>Review of the facility's policy titled, Medication Administration, copyright 2024, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy further indicated, 11. Review MAR [medication administration record] to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc. [et cetera, other similar things]) with MAR to verify resident name, medication name, form, dose, route, and time.<br><br>Review of R14's Admission Record revealed the facility admitted R14 on 04/07/2023 with diagnoses to include type two diabetes mellitus with diabetic nephropathy and chronic kidney disease.<br><br>Review of R14's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2024, revealed R14 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.<br><br>Review of R14's Order Summary Report, listing active orders as of 06/18/2024, contained an order, dated 06/12/2024, for prednisolone acetate ophthalmic suspension 1%, one drop in left eye three times a day for eye surgery until 06/26/2024. The Order Summary Report also contained an order, dated 06/12/2024, for ofloxacin ophthalmic solution 0.3%, one drop in left eye three times a day for eye surgery until 06/26/2024.<br><br>During an observation of medication pass on the 300 Hall on 06/18/2024 at 8:33 AM, Qualified Medication Aide (QMA) #1 administered one drop of prednisolone acetate ophthalmic suspension 1% into both of R14's eyes. The label affixed to the prednisolone box specified to instill one drop in both eyes four times a day. QMA #1 also administered one drop of ofloxacin ophthalmic solution 0.3% into both of R14's eyes. The label affixed to the ofloxacin box specified to instill one drop in both eyes four times a day.<br><br>During an interview on 06/20/2024 at 8:34 AM, QMA #1 stated the process for administering medications was to verify the five rights by verifying the name of the resident, checking for the right medication and dosage, and matching the order in the computer with the label on the medication. QMA #1 stated if something did not match, she should verify the order, and if the label was wrong, she would tell the nurse, and the nurse would have her put a label on the medication that read, Directions Changed Refer to Chart. QMA #1 said she followed the medication label on the eye drops instead of the active order in the resident's chart. QMA #1 stated the physician's orders were to administer one drop in the resident's left eye three times a day until 06/26/2024 and confirmed she should have only put the drops in the resident's left eye.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/20/2024 at 8:52 AM, Registered Nurse (RN) #2 stated if a QMA noticed an order did not match the medication label, they should notify the nurse, the nurse would clarify the order, make any needed corrections, and involve the nurse practitioner. RN #2 stated they would then put a sticker on the medication that would direct staff to refer to the order in the resident's chart.<br><br>During an interview on 06/20/2024 at 11:45 AM, the Director of Nursing Services (DNS) stated if a QMA noticed an issue with a medication, they should double check the computer and the medication, take it to the charge nurse, then the nurse would verify the order, call the physician, and place a sticker on the medication to make sure the order in the chart was followed. The DNS said QMA #1 should have looked at the orders before administering the medications and followed the orders. The DNS stated her expectation was for staff to follow the policy and procedure for medication administration.<br><br>During an interview on 06/20/2024 at 12:39 PM, the Executive Director (ED) stated QMA #1 should have checked the orders prior to administering the medications. The ED stated her expectation was for the staff to follow the policy and procedure. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>29358<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure routine dental services were provided for 1 (Resident #12) of 2 residents reviewed for dental care.<br><br>The findings include:<br><br>Review of the facility's policy titled, Dental Services, copyright 2024, indicated, It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Definitions: 'Routine dental services' means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g. [exempli gratia, for example], taking impressions for dentures and fitting dentures. The policy also indicated, The dental needs of each resident are identified through the physical assessment and MDS [Minimum Data Set] assessment processes, and are addressed in each resident's plan of care.<br><br>Review of R12's Admission Record revealed the facility admitted R12 on 01/11/2024 with diagnoses that included: dysphagia (difficulty or discomfort with swallowing), anxiety disorder, depression, and chronic ischemic heart disease.<br><br>Review of a document titled, Nursing Admission/Readmission Evaluation, dated 01/11/2024 at 5:44 PM, indicated R12 had missing teeth or dentures.<br><br>Review of a document signed by R12's responsible party (RP) on 01/12/2024 reveled the RP's signature was their request and consent to any services not checked as declined. The document reflected R12's RP consented to vision, podiatry, dental, and audiology services.<br><br>Review of R12's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2024, revealed R12 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for eating and oral hygiene, had no swallowing problems, had a feeding tube, and received a mechanically altered diet while a resident of the facility. The MDS also indicated the resident had no natural teeth or tooth fragments and had obvious or likely cavity or broken natural teeth.<br><br>Review of R12's quarterly MDS, with an ARD of 04/15/2024, revealed R12 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for eating and oral hygiene, had no swallowing problems, had a feeding tube, and received a mechanically altered diet while a resident of the facility. The MDS indicated the resident did not have mouth or facial pain and did not have discomfort or difficulty with chewing.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R12's care plan included a focus area, initiated on 01/11/2024 and revised on 01/18/2024, that indicated the resident had natural bottom teeth with missing teeth and rotten teeth. Interventions dated 01/11/2024 directed staff to coordinate arrangements for dental care and to observe for signs of oral/dental problems needing attention, such as missing, loose, broken, eroded, or decayed teeth.<br><br>Review of the facility's contracted dental company's documentation revealed 26 residents had scheduled dental appointments on 02/01/2024. R12, however, was not on the list to be seen by the dentist.<br><br>Review of the facility's contracted dental company's documentation revealed 28 residents had scheduled dental appointments on 05/07/2024. Further review revealed R12 was not on the list to be seen by the dentist.<br><br>Review of R12's social services Progress Notes for the timeframe from 03/14/2024 to 05/31/2024 revealed no documentation related to R12's dental care or dental referrals.<br><br>During a concurrent observation and interview on 06/17/2024 at 10:04 AM, R12 stated they would like to have some top dentures. The resident was observed with natural teeth on bottom with some teeth missing and the ones that remained were brown in appearance. The resident did not have teeth on the top.<br><br>During an interview on 06/18/2024 at 1:48 PM, State Registered Nurse Aide (SRNA) #3 stated if anything new was going on with a resident's mouth, like pain, it would be reported to the nurse. SRNA #3 stated R12 had a lot of breakage in their teeth and had complained about their teeth at times.<br><br>During an interview on 06/18/2024 at 2:16 PM, Licensed Practical Nurse (LPN) #5 stated if a resident had mouth problems and it was something she could not resolve, she would notify the physician to get an order or would tell the Social Services Director (SSD) and put it on the computer medical records program home page. LPN #5 stated issues she would report to the SSD were missing teeth, ill-fitting dentures, no dentures, and no teeth, whether it was a new or old issue. LPN #5 reviewed R12's record and stated she could not find where the resident had seen the dentist, but the resident did have a consent filed under the contracted dental service consents.<br><br>During a follow-up interview on 06/18/2024 at 2:34 PM, LPN #5 observed R12's mouth in the resident's room. LPN #5 stated the resident did not have any teeth on the top and on the bottom, were teeth with decay and missing teeth. LPN #5 stated the resident should have been seen by the dentist, and she did not know why the resident had not been seen.<br><br>During an interview on 06/18/2024 at 2:05 PM, Family Member (FM) #4 stated R12 wanted dentures. FM #4 said the resident had a few teeth on the bottom but none on the top. FM #4 stated the resident had not been seen by a dentist while living at the facility but had seen a dentist a year ago before they came to the facility and all the resident's top teeth had been pulled. FM #4 stated R12 was very self-conscious about their teeth and appearance.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/18/2024 at 2:38 PM, the SSD stated when a resident was admitted to the facility, the Admission Director had the resident sign the contracted dental service consents if the resident wanted the company's services. The SSD stated she then would email the contracted dental company representative the name of the resident and the resident would get added to the list to be seen by the dental company. The SSD stated the dentist made trips to the facility every three months or if there was a problem. The SSD reviewed R12's record and said the resident had a consent for the dental services but she did not see any dental notes for the resident. The SSD stated no one had reported any problems to her concerning R12's teeth.<br><br>During an interview on 06/19/2024 at 9:26 AM, the Director of Nursing Services (DNS) stated upon a resident's admission, the nurse would do a full body assessment, check for missing teeth, mouth pain, and any other problems. The DNS stated that during the admission process the resident or family would sign the contracted dental company's consent form. She stated the SSD would then put the resident on the dental list in the medical record program. The DNS stated the dentist came in the facility every three months. She stated if a resident had a concern and had signed a consent, they should be seen for a routine visit within three months. The DNS stated she did not know if R12 had been seen by the dentist but should have been seen at least once since their admission to the facility. The DNS stated she expected the staff to follow the process for dental services.<br><br>During an interview on 06/19/2024 at 9:58 AM, the Executive Director (ED) stated that when a resident was admitted to the facility, the nurse completed an assessment, including an oral assessment. The ED stated on admission there was a 360 care form the resident could sign for dental services. The ED stated if the resident had broken or missing teeth, the nurse would notify the SSD to see if the resident signed a consent for dental services. She stated every resident who had signed a consent for dental services was referred to the dental service company. The ED said if there was no pain and the resident did not complain, they would not be referred to the dentist on admission but should have a routine visit. The ED stated R12 should have had a routine dental visit and that she expected the staff to follow the process for all admissions related to dental services. |