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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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F 000	INITIAL COMMENTS	F 000	This plan of correction constitutes Mercy Sacred Heart Village's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	The facility does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or employ individuals who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. The facility would report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	

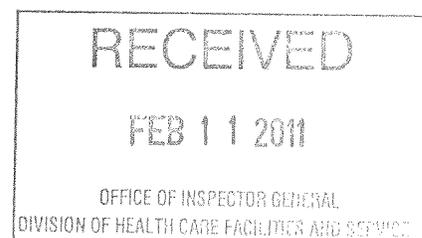
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jason T. Quinn* TITLE *X President* (X8) DATE *2/11/11*

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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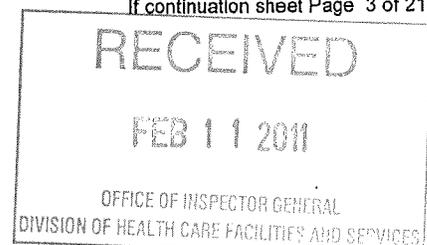
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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure the nurse aide abuse registry check had been completed on two (2) of the twelve (12) sampled employees on or before the date of hire.</p> <p>The findings include:</p> <p>Review of the facility's policy dated 07/2006 revealed that all individuals applying for a position must have a state nurse aide registry check completed for each state in which the applicant has worked to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file.</p> <p>Record review of five (5) Employee personnel files on 01/20/11 revealed that Employee #1 was hired on 03/15/10 with a previous work history in two states. Employee #1 did not have the nurse aide abuse registry results for all the states of previous employment until 01/20/11, which is ten months after hire. Employee #4 was hired on 06/26/06 with a previous work history in three states. Employee #4 did not have a nurse aide abuse registry check completed on two of the three states.</p>	F 225	<p>The facility further ensured that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility maintains evidence that all alleged violations have been thoroughly investigated, and prevents further potential abuse while any investigation is in progress.</p> <p>The results of all investigations are reported to the administrator or designee and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken,</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p>		



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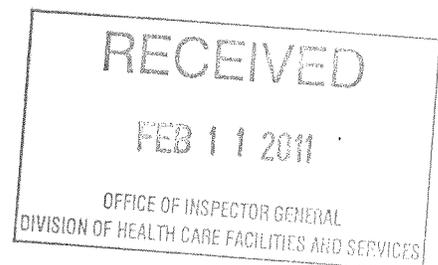
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F 225	Continued From page 2 Interview with the Director of Human Resources on 01/20/11 at 12:15pm revealed she was not aware the nurse aide abuse registry check should be done on all states where a perspective employee has worked. The Director of Human Resources has been employed at the facility since 2008 and states she was never trained to do abuse checks in states other than Kentucky. She also stated she did not know that two of the employees had worked in other states but did admit to having called the other states for a reference check. Interview with the Administrator on 01/20/11 at 2:50pm revealed that the Director of Human Resources reports directly to the corporate office in Cincinnati, Ohio. The administrator states she was not aware the nurse aide abuse checks were not being done in other states of employment. She did confirm that not completing the nurse aide abuse registry checks could potentially place the residents at risk. An attempt was made to contact the Director of Human Resources in Cincinnati, Ohio by phone on 01/20/11 at 3:20pm, but she could not be reached for an interview at that time.	F 225	The nurse aide registry check was completed for the States in which the two employees identified had worked with no concerns found. How will the facility identify other residents having the potential to be affected? HR Director/Designee will complete an audit of all current employee files to verify abuse registry checks have been completed on any individual having worked in more than one State. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? HR Director will be in-serviced on the facilities established policy and procedure to complete abuse registry checks on employees who have been identified working in more than one State prior to hire. The checklist requirements form for employment consideration has been revised to include past history of working in more than one State.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:			



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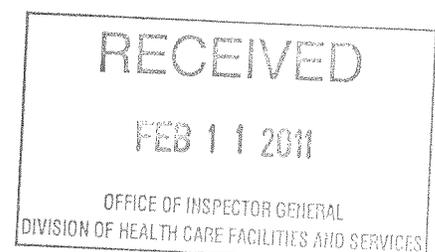
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F 226 SS=D	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	The facility has developed and implemented written policies and procedures that prohibit mistreatments, neglect, and abuse of residents and misappropriation of resident property. What corrective action will be accomplished for those residents found to have been affected?	



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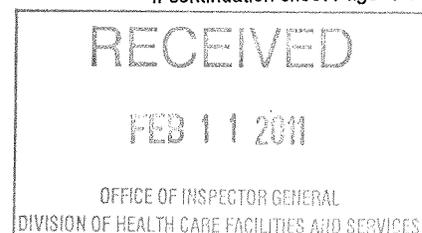
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F 226	<p>Continued From page 3</p> <p>Based on record review and interview, it was determined the facility failed to implement the facility's current policy on screening procedures related to abuse, neglect, mistreatment, and misappropriation of property for all potential employees. The facility did not complete the nurse aide abuse registry check on two (2) of the twelve (12) sampled employees on or before the date of hire.</p> <p>The findings include:</p> <p>Review of the facility's policy dated 07/2006 revealed that all individuals applying for a position must have a state nurse aide registry check completed for each state in which the applicant has worked to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file.</p> <p>Interview with the Director of Human Resources on 01/20/11 at 12:15pm revealed she was not aware the nurse aide abuse registry check should be done on all states where a perspective employee has worked. The Director of Human Resources has been employed at the facility since 2008 and states she was never trained to do abuse checks in states other than Kentucky. She also stated she did not know that two of the employees had worked in other states but did admit to having called the other states for a reference check.</p> <p>Interview with the Administrator on 01/20/11 at 2:50pm revealed that the Director of Human Resources reports directly to the corporate office in Cincinnati, Ohio. The administrator states she was not aware the nurse aide abuse checks were</p>	F 226	<p>The nurse aide registry check was completed for the States in which the two employees identified had worked with no concerns found.</p> <p>How will the facility identify other residents having the potential to be affected?</p> <p>HR Director/Designee will complete an audit of all current employee files to verify abuse registry checks have been completed on any individual having worked in more than one State.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>HR Director will be in-serviced on the facilities established policy and procedure to complete abuse registry checks on employees who have been identified working in more than one State prior to hire.</p> <p>The checklist requirements form for employment consideration has been revised to include past history of working in more than one State.</p>	



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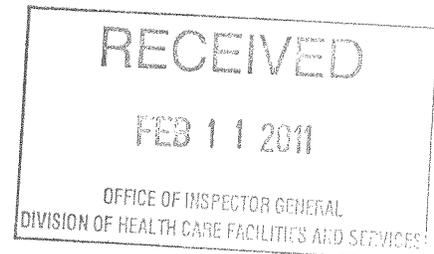
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F 226	Continued From page 4 not being done in other states of employment. She did confirm that not completing the nurse aide abuse registry checks could potentially place the residents at risk. An attempt was made to contact the Director of Human Resources in Cincinnati, Ohio by phone on 1/20/11 at 3:20pm, but she could not be reached for an interview at that time.	F 226	How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An abuse registry audit of employees working in more than one State will be completed monthly for three months and then quarterly for the remainder of the year to verify appropriate out of state registries have been verified before hire. Findings will be reported to the QA committee.	03/01/2011
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to conduct a comprehensive assessment within fourteen (14) days after a significant change occurred in more than two areas for one (1) of twenty-three (23) sampled residents (Resident #3). The findings include:			



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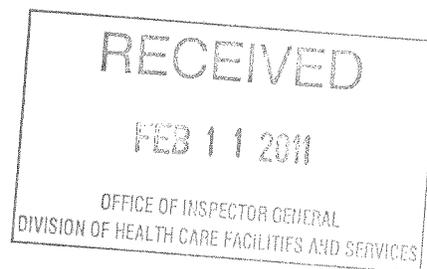
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F 274	Continued From page 5 Review of the facility's Minimum Data Set (MDS) 3.0 policy dated 10/20/10 revealed that a significant change MDS will be completed within fourteen (14) days of when the significant change is/was identified. Record review on 01/18/11 revealed Resident #3 was admitted to the facility on 11/12/09 with the diagnoses of Dementia, Anxiety, Gastroesophageal Reflux Disease, Epilepsy, Osteoarthritis, Osteoporosis, Hyperlipidemia, Depression, and status post Cerebral Vascular Accident and Coronary Artery Bypass Graft. Resident #3's clinical record revealed an annual MDS assessment was completed on 11/04/10. The MDS identified the resident as having a cognitive score of 10, which is moderately impaired. The resident was independent with transfers, ambulation, eating, toileting, and required only supervision with dressing. The MDS also had the resident assessed as always continent of both bowel and bladder. Review of the physician's progress notes dated 12/02/10 discussed a decline of both the resident's physical and cognitive status. The physician progress notes revealed a discussion with the family concerning the residents declining condition and prognosis and it was determined at that time to begin palliative care. Observation of the resident on 01/18/11 at 11:40am revealed the resident lying in bed with eyes closed. The resident did not respond to questioning and family members were noted at the bedside. Interview with the resident's family member on	F 274	The facility conducts a comprehensive assessment within 14 days after the facility determines, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on one or more that area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both. What corrective action will be accomplished for those residents found to have been affected? An MDS was completed on 2/8/11 to reflect the resident #3's significant change in condition with an ARD of 1/25/11. How will the facility identify other residents having the potential to be affected? All Palliative care residents will have a chart review to verify that an appropriate MDS has been completed.	



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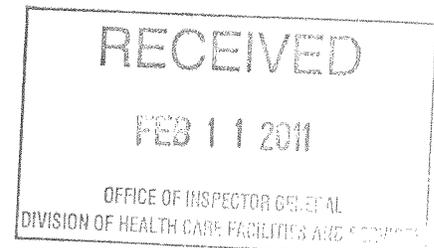
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F 274	<p>Continued From page 6</p> <p>01/18/11 at 11:40am revealed the resident did not always respond. The family stated they had been staying with the resident for eight (8) weeks due to the resident's change of condition and being placed on palliative care. The family stated the resident rarely ate, did not get out of bed, and required staff to turn him/her every two hours.</p> <p>Observation of the resident on 01/18/11 at 12:10pm revealed the resident sitting up in bed drinking soda, which was being held by a family member. The resident was pushing away the family members hand when offered food.</p> <p>Interview with the family on 01/18/11 at 12:10pm revealed they had refused a December weight check. The family stated they knew the resident had lost weight and did not see any reason to check anymore. The family also stated the resident was incontinent of bowel and occasionally incontinent of bladder.</p> <p>Interview with a Licensed Practical Nurse (LPN) on 01/18/11 at 3:00pm revealed staff were aware the resident had declined in cognitive status. The LPN stated the resident would occasionally answer questions, the resident was incontinent of bowel, would get up to the bedside commode to urinate, but required the assistance of two staff members to get out of bed.</p> <p>Interview with the MDS Coordinator on 01/19/11 at 11:10am revealed she had not completed a significant change assessment. The MDS Coordinator stated she was aware there was a change in the resident's condition and was also aware the resident was on palliative care. The MDS Coordinator stated she has a meeting every morning with the unit managers to discuss the</p>	F 274	<p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The MDS team will be in-serviced on when to complete a significant change MDS assessment.</p> <p>The interdisciplinary team will be in-serviced on reporting any significant changes in a resident's condition at morning meeting.</p> <p>How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>Written minutes with signatures of attendance at morning meeting will indicate the need for the completion of an MDS. The DON/Designee will review the MDS within 14 days to ensure that it reflects the significant change in status reported by the interdisciplinary team.</p>	



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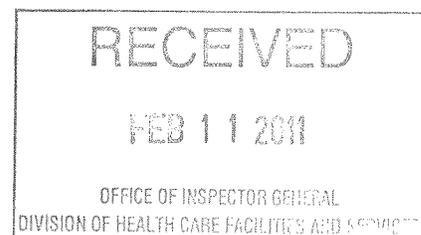
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F 274	Continued From page 7 facility's residents and any changes that may have occurred, although she could not remember when Resident #3 was last discussed in the meeting. She stated she had been monitoring the resident since December to see if there had been any fluctuations in his/her condition, but was unable to produce any notes, a log monitoring system or observation dates. The MDS Coordinator was not aware there was a timeline of two weeks for a significant change assessment to be completed. The MDS Coordinator confirmed that she should have completed a significant change comprehensive assessment. Interview with the 300 Unit Manager on 01/19/11 at 11:40am revealed she does attend the morning meetings every day regarding each resident's condition. She was not aware that a significant change assessment had not been completed. She stated she did not check to ensure a comprehensive assessment had been done within the two week timeframe.	F 274	Director of Nursing/Designee will audit 20% of resident population monthly for three months and then quarterly for the remainder of the year to verify significant changes have been addressed as needed. Findings will be reported to the QA committee. Director of Nursing/Designee will audit 20% of resident population monthly for three months and then quarterly for the remainder of the year to verify significant changes have been addressed as needed. Findings will be reported to the QA committee.	03/01/2011
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	The facility uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan describes the following:	



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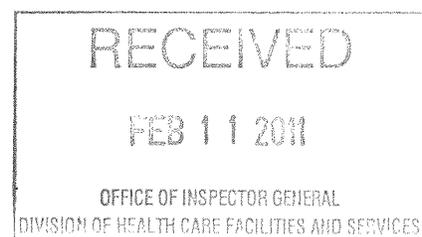
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206	
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F 279	<p>Continued From page 8</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and interview it was determined the facility failed to develop a comprehensive plan of care for one (1) of the twenty-three (23) sampled residents (#3). The facility failed to integrate the facility care plan for palliative care for Resident #3.</p> <p>The findings include:</p> <p>The facility failed to produce a policy and procedure for care planning of Palliative care by the exit date of 01/20/11.</p> <p>Record review on 01/18/11 revealed Resident #3 was admitted to the facility on 11/12/09 with the diagnoses of Dementia, Anxiety, Gastroesophageal Reflux Disease, Epilepsy, Osteoarthritis, Osteoporosis, Hyperlipidemia, Depression, and status post Cerebral Vascular Accident and Coronary Artery Bypass Graft. Resident #3 began Palliative care on 12/02/10. Palliative care was not noted on the most recent Minimum Data Set (MDS) assessment dated 11/04/10 and a significant change assessment had not been initiated.</p> <p>Review of the physician's progress notes dated 12/02/10 revealed a decline of both the resident's</p>	F 279	<p>The services are furnished to attain or maintain the resident's highest practicable physical, Mental, and psychosocial well-being as required under 483.25; and Any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #3 had a palliative care plan implemented on 1/25/11.</p> <p>How will the facility identify other residents having the potential to be affected?</p> <p>All residents receiving palliative care will have a chart review to verify a palliative care plan is in place.</p> <p>What measure will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?</p>



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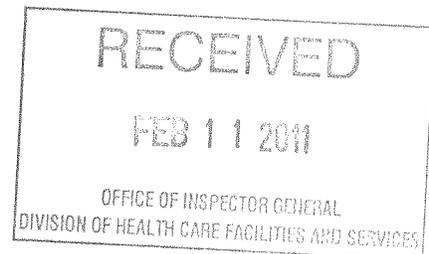
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F 279	Continued From page 9 physical and cognitive status. The physician's progress notes revealed a discussion with the family concerning the resident's declining condition and prognosis and it was determined at this time to begin palliative care. Review of the comprehensive plan of care did not reveal a care plan to address palliative care. Interview on 01/19/11 at 11:10am with the MDS Coordinator revealed that the managers and the MDS Coordinator meet every morning to discuss resident status and change of condition. The MDS Coordinator is responsible for initiating Palliative care plans. She admits that a care plan should have been initiated but could not provide rationale for not having a care plan completed at the time the resident was placed on palliative care. Interview on 01/19/11 at 12:00pm with the Licensed Practical Nurse (LPN) revealed the Unit Manager and the MDS Coordinator were responsible for initiating care plans. She further stated that all nurses were responsible for monitoring care plans and ensuring they were updated according to residents' condition. Interview on 01/19/11 at 3:00pm with the 300 Unit Manager revealed that she was not aware a palliative care plan had not been initiated. She confirmed that she does attend resident status meetings every morning. She stated the MDS Coordinator was responsible for ensuring palliative care plans are initiated.	F 279	The MDS team will be in-serviced or implementing a palliative care plan on those residents receiving palliative care per policy and procedure of care planning of Palliative care. Licensed staff will be in-serviced on implementing a palliative care plan on those residents receiving palliative care per policy and procedure of care planning of Palliative care. How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Director of Nursing/Designee will audit 20% of resident population monthly for three months and quarterly for the remainder of the year to verify palliative care plans are in place for those residents receiving palliative care. Findings will be reported to the QA committee.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		03/01/2011



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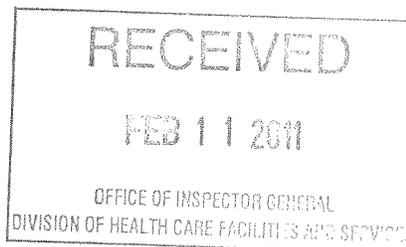
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F 431	<p>Continued From page 10</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain medications in the original packaging with a pharmaceutical label and failed to ensure each resident received all prescribed medications</p>	F 431	<p>The facility employs and obtains the services of a licensed pharmacist who—Establishes a system of records of receipt and disposition of all controlled drugs in the sufficient detail to enable an accurate reconciliation; and Determines that drug records are in order and that an account of all controlled drugs in maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility stores all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>	



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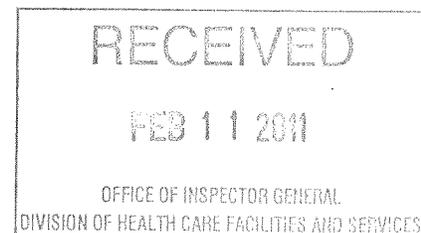
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F 431	<p>Continued From page 11</p> <p>as one hundred and four (104) unlabeled and loose medications were stored in the bottom of the medication drawers in four (4) medication carts. The facility failed to label multi-dose vials when the vial was opened and failed to discard expired multi-dose vials. The facility failed to maintain a system for reconciliation of controlled medications on four (4) medication carts, and failed to perform and document glucometer quality control checks for five (5) glucometers.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Record review of the facility's Medication Administration Policy revealed that all drugs should be stored in an orderly manner in drawers, carts, and refrigerators, and that unit dose tablets/capsules were dispensed directly into a medication cup. Also medications that fall onto the floor or become contaminated should be discarded. The policy states that multi-dose vials expire thirty (30) days after the vial was opened. <p>Observation on 01/20/11 at 7:55am, revealed nineteen (19) unlabeled and unpackaged medications in the bottom of the medication cart drawer on the Unit 500 Long Hall.</p> <p>Interview on 01/20/11 at 8:10am with Licensed Practical Nurse (LPN) #4 who worked on Unit 500, revealed she was trained to hold the medication card over the cup and press the medication into the cup. LPN #4 stated that sometimes the medications drop out of the packages into the drawer and cannot be located.</p> <p>Interview on 01/20/11 at 8:15am with the Unit 500-600 Manager, revealed that sometimes medications drop into the drawer and cannot be</p>	F 431	<p>The facility provides separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose is readily detected.</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>No specific resident identified.</p> <p>How will facility identify other residents having the potential to be affected?</p> <p>All medication carts thoroughly reviewed for unlabeled and unpackaged medications.</p> <p>All multi-dose vials reviewed to verify they have been dated and discarded after 30 days from being opened.</p> <p>Narcotic sheets will be initiated on all medication carts.</p>



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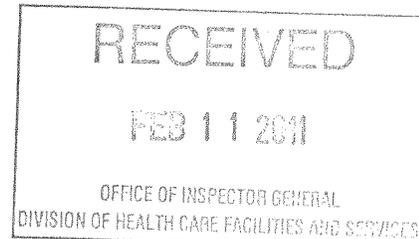
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F 431	<p>Continued From page 12</p> <p>found, therefore the staff " pops" another medication from the card without locating the loose medication. The Unit 500-600 Manager revealed the Unit 500 Long Hall medication cart was used by nursing students assigned to the facility, and stated this could account for the loose medications in the drawer. The Unit 500-600 Manager did not think other medication carts would contain loose medications in the drawers and requested additional medication carts be reviewed.</p> <p>Observation on 01/20/11 at 8:40am revealed eighteen (18) unlabeled and unpackaged medications in the bottom of the medication cart drawer on the Unit 500 Short Hall.</p> <p>Interview on 01/20/11 at 8:40am with the Unit 500-600 Manager revealed she was surprised to find this many loose medications in the drawer and stated this was a problem.</p> <p>Observation on 01/20/11 at 8:50am revealed three (3) unlabeled and unpackaged medications in the bottom of the medication cart drawer on Unit 600 top-half cart (rooms 600-612). Further observation on 01/20/11 at 9:15am of the Unit 600 medication room refrigerator, revealed two (2) multi-dose vials of Influenza Virus with expiration dates of 03/31/11, one vial was not dated when opened, and the other vial was dated as opened on 10/26/10.</p> <p>Interview on 01/20/11 at 8:50am with LPN #5 revealed she inventoried the medication cart on Unit 600 (rooms 600-612) and removed the loose medications from the drawer. LPN #5 worked as the Charge Nurse on 600 unit and reported that she "just checked the drawers for loose</p>	F 431	<p>Unable to correct missing documentation on glucometer logs. All glucometer logs will be reviewed for documentation/completion by the DON/Designee.</p> <p>What measure will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?</p> <p>All Licensed staff will be in-serviced on the following: 1) that medication is counted for and dispensed properly to the resident 2) that no medication can remain in a medication cart that is not labeled or in proper packaging 3) multi-dose vials are to be dated and discarded after thirty (30) days 4) Narcotic counts are to be completed with documentation on the Narcotic Count Sheet 5) glucometer logs are to be documented of their daily control checks</p> <p>How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place?</p>



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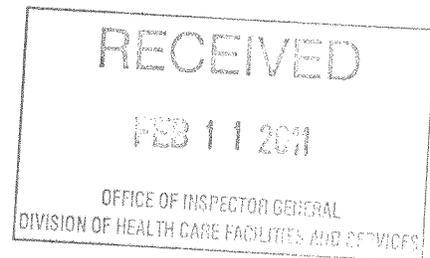
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F 431	<p>Continued From page 13</p> <p>medications, I must have missed those." LPN #5 stated she tried to check the drawers daily because "those pills fall out of the packs all of the time."</p> <p>Observation on 01/20/11 at 9:10am of a medication pass prepared by Registered Nurse (RN) #1, on the Unit 600 medication cart (rooms 613-625), revealed two (2) medications removed from the medication card by RN #1, missed the medication cup sitting on top of the medication cart, fell onto the top of the cart, and were discarded.</p> <p>Interview on 01/20/11 at 9:10am with RN #1 on Unit 600, revealed medications become displaced in the bottom drawer of the medication cart because staff pushed the medications out of the medication card over the drawer, rather than into the medication cup. RN #1 said sometimes she loses a medication in the drawer, although she always holds the medication card over the cup sitting on the medication cart. RN #1 said it is possible to lose a medication in the drawer without the staff noticing the medication did not go into the medication cup, which would result in a resident not getting all of the prescribed medication.</p> <p>Interview on 01/20/11 at 9:15am with the Unit 500-600 Manager revealed multi-dose vials should be dated when opened and discarded after thirty (30) days.</p> <p>Observation on 01/20/11 at 9:30am revealed sixty-four (64) unlabeled and unpackaged medications in the bottom of the drawer of the medication cart on Unit 300 (rooms 300-319). Further observation of the medication room</p>	F 431	<p>Director of Nursing/Designee will complete a weekly audit for one month, monthly for three months and then quarterly for the remainder of the year to verify medication is properly packaged and labeled. Findings to be reported to the QA committee.</p> <p>Director of Nursing/DON will complete weekly audit for one month, monthly for three months and then quarterly for the remainder of the year to verify multi-dose vials are dated and discarded after 30 days of being opened.</p> <p>Director of Nursing/Designee will complete a weekly audit for one month, monthly for three months and then quarterly for the remainder of year to verify completion of Narcotic Count Log.</p> <p>Director of Nursing/Designee will complete weekly audit for one month, monthly for three months and then quarterly for the remainder of the year to verify completion/documentation of daily control checks for glucometer.</p>	03/01/2011



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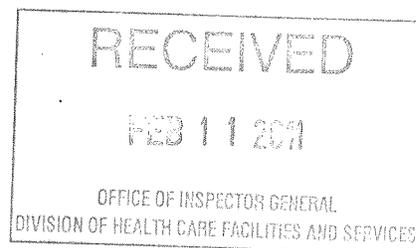
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F 431	<p>Continued From page 14</p> <p>refrigerator revealed a multi-dose vial of Tubersol with an expiration date of 05/2012 was dated as opened on 12/07/10.</p> <p>Interview on 01/20/11 at 9:30am with the Unit 300 Manager and LPN #2, revealed that the Unit 300 Manager did not know how the medications got into the bottom of the medication cart drawer and was surprised to find as many as sixty-four (64) loose medications. LPN #2 stated she was trained to place the medication cup on the top of the cart and press the medication into the cup, and stated that sometimes the medication goes into the drawer or onto the floor and it was difficult to find the medication when it fell into the drawer. The Unit 300 Manager verified this was the accepted technique used at the facility to administer oral medications and that staff were trained on this method. The Unit 300 Manager stated the bottle of Tubersol opened on 12/07/10 should have been discarded, as it was the facility policy to discard multi-dose vials thirty (30) days after the vial was opened.</p> <p>Interview on 01/20/11 at 1:40pm with the Director of Nursing (DON) revealed she was surprised that one-hundred and four (104) medications were found unlabeled and unpackaged in the drawers of four medication carts. The DON stated the finding of the medications was significant and required immediate action. The DON stated that she cleaned a medication cart drawer two or three weeks ago, and she found many loose medications. The DON did not count the number of medications, and stated it was not enough "to raise a level of concern" because there had not been any prior reports of problems with loose medications in the carts.</p>	F 431		



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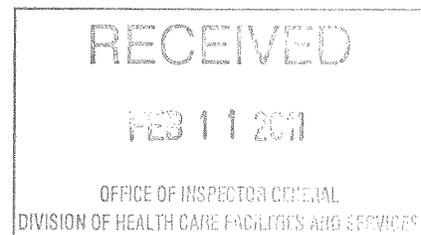
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F 431	<p>Continued From page 15</p> <p>2. Record review of the facility's policy for control of medications revealed that controlled drugs must be counted at the end of each shift by the nurse coming on duty and the nurse going off duty and that discrepancies must be documented and reported to the Director of Nursing Services.</p> <p>Observation on 01/20/11 at 8:50am of two (2) medication carts on the 600 Unit revealed Narcotic Count Sheets were not in use on the carts to document required counts at the end of each shift.</p> <p>Interview on 01/20/11 at 8:50am with LPN #5 on Unit 600, revealed she completed the narcotic count on this morning with a night shift nurse and said, "We do a narcotic count at the end of each shift, but there has never been a log." LPN #5 said she did not know how to prove the narcotic count was completed without documentation on a Narcotic Count Sheet.</p> <p>Observation on 01/20/11 at 9:25am of the Narcotic Count Sheets of two (2) medication carts on the 500 Unit revealed missing documentation of required narcotic counts. The Unit 500 Short Hall medication cart was missing documentation of counts for day shift on 01/01, 01/02, 01/04, 01/05, 01/06, 01/08, and 01/17, and missing documentation of counts for night shift on 01/02, 01/04, 01/08, and 01/18. The Unit 500 Long Hall medication cart was missing documentation of counts for day shift on 01/01, 01/08, 01/10, 01/11, 01/12, 01/18, and 01/19, and missing documentation of counts for night shift on 01/09/11.</p> <p>Interview on 01/20/11 at 9:35am with the Unit 500-600 Manager revealed she was unaware the</p>	F 431		



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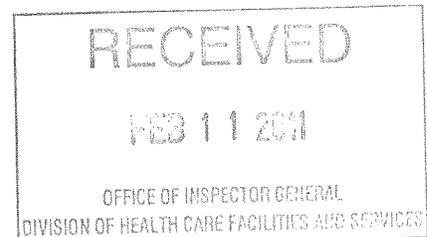
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F 431	<p>Continued From page 16</p> <p>narcotic counts were not being documented at the end of each shift. The Unit 500/600 Manager stated the facility policy mandated narcotics be counted at the end of each shift. The Unit 500/600 Manager was not aware Narcotic Count Sheets were not available on Unit 600, and said this was a problem which was to be addressed immediately.</p> <p>Interview on 01/20/11 at 1:40pm with the Director of Nursing (DON) revealed the facility policy required narcotic counts to be completed at the end of each shift, by two nurses. The DON stated the lack of Narcotic Count Sheets on the 600 Unit Medication Carts was, "an oversight."</p> <p>3. Record review of the facility's policy for Maintenance of the Glucometer stated the performance of the Optium Blood Glucose Monitoring System would be maintained through proper calibration of the monitor and daily control testing when the monitor was in use. The policy further stated daily control testing was recommended in a multi-user setting to ensure that the systems were operating properly.</p> <p>Record review on 01/20/11 at 8:40am of the Daily Quality Control Record on Unit 500, revealed two (2) glucometers logs lacked documentation of daily control checks. The Daily Quality Control Record for the 500 Unit Short Hall was missing documentation of quality control tests for thirteen (13) days for the month of January, 2011, prior to the record review date. The Daily Quality Control Record for the 500 Unit Long Hall was missing documentation of quality control tests for seventeen (17) days for the month of January, 2011, prior to the record review date.</p>	F 431		



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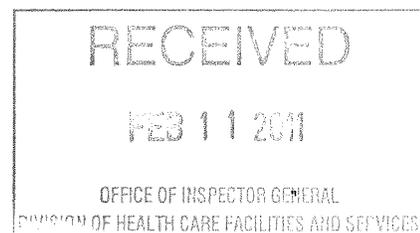
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 17</p> <p>Record review on 01/20/11 at 8:50am of the Daily Quality Control Record on Unit 600, revealed two (2) glucometers with logs lacked documentation of daily control checks. The Daily Quality Control Record for the 600 Front Hall did not have any control test documentation for January, 2011, and the most current Quality Control Record was dated September, 2010. The Daily Quality Control Record for the 600 Back Hall was not found.</p> <p>Interview on 01/20/11 at 9:25am with the Unit 500/600 Manager revealed she did not know the Daily Quality Control Records were incomplete, and stated the night shift staff were required to complete the control tests every twenty-four (24) hours. The Unit 500/600 Manager was certain the controls had been completed on Unit 600, although no current record was located. The Unit 500/600 Manager stated the daily controls were important to ensure proper functioning of the glucometer, and appropriate insulin treatment for the residents.</p> <p>Record review on 01/20/11 at 9:30am of the Daily Quality Control Record on Unit 300, revealed one (1) glucometer with a log which lacked documentation of daily control tests on 01/01, 01/09, 01/13, 01/16, and 01/18 for the month of January, 2011, prior to the record review date.</p> <p>Interview on 01/20/11 at 9:40am with the Unit 300 Manager revealed the staff were assigned to complete control tests every twenty-four (24) hours on night shift, and did not realize the daily control checks had not been completed and was not sure why the control tests were not completed in accordance with the facility policy.</p>	F 431		



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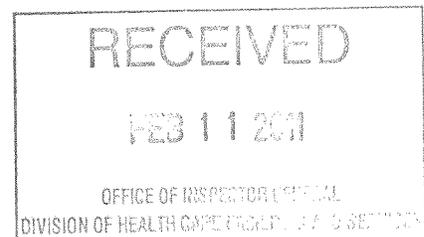
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F 431	Continued From page 18 Interview on 01/20/11 at 1:40pm with the Director of Nursing (DON) revealed the staff are responsible to perform and document the glucometer control tests on each night shift. The DON stated the glucometer controls were completed on the 600 Unit, and said the records would be provided as soon as possible when they were located. The DON said the daily controls were necessary to ensure quality care of the residents. No additional Quality Control Records were received.	F 431		
F 465	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain a safe, functional, and comfortable environment for residents, staff, and the public. A hall on the 300 unit was used to store medication and treatment carts which created a narrow passage and a safety risk for staff and residents who ambulated through the hall. The findings include: Record review revealed, upon request of the Executive Director and the Director of Maintenance, the facility did not have a policy regarding maintenance of an egress in the hallways.	F 465	The facility provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public. What corrective action will be accomplished for those residents found to have been affected? No specific residents were identified to be affected. How will the facility identify other residents having the potential to be affected? Maintenance Director will complete a facility audit to identify areas of building in which medication carts or	



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F 465	<p>Continued From page 19</p> <p>Observation on 01/18/11 at 11:20am in the hallway between rooms 320 and 325 revealed two (2) medication carts and a treatment cart stored in the hallway where staff and residents demonstrated difficulty passing in the hall.</p> <p>Observation on 01/19/11 at 2:20pm in the hallway between rooms 320 and 325 revealed a resident who ambulated with a walker, waited as residents in wheelchairs passed through the hall where two (2) medication carts and a treatment cart were stored along the hallway.</p> <p>Observation on 01/19/11 at 3:30pm in the hallway between rooms 320 and 325, revealed a resident who ambulated with a walker and a resident in a wheelchair experienced difficulty passing through the hall simultaneously as the ambulatory resident repositioned the walker to accommodate the passage of the wheelchair. Two medication carts and a treatment cart were stored along the wall of the hallway.</p> <p>Observation on 01/20/11 at 7:30am in the hallway between rooms 320 and 325 revealed medication carts and a treatment cart stored in the hallway.</p> <p>Interview on 01/20/11 at 9:30am with the 300 Unit Manager and Certified Medication Technician (CMT) #1 revealed the CMT experienced difficulty working from the medication cart which was stored in the hallway between rooms 320 and 325 as residents pass behind the CMT during medication passes. The Unit Manager stated that residents congregated in the open area in front of the Nurse's Station, and sometimes the staff move the carts to the narrow hall to accommodate the residents who gather in front of the Nurse's Station. The Unit Manager said the</p>	F 465	<p>other equipment is being stored in the hallway.</p> <p>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>All Licensed staff will be in-serviced to store their medication cart at the nurse's station when not in use to create a safe passage for residents who ambulate through the hall.</p> <p>How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Maintenance Director/Designee will complete a monthly audit for three months and then quarterly for the remainder of the year to verify medication carts are not being stored in the hallway. Findings to be reported to the QA committee.</p>	03/01/2011



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F 465	<p>Continued From page 20</p> <p>carts were to be stored in the open area near the Nurse's Station, but depending on which staff are working, the carts might be moved back to the narrow hall. The 300 Unit Manager acknowledged the egress of the hall was not adequate with the carts stored in the narrow hallway and created a potential hazard. The Unit Manager moved the medication carts and the treatment cart to the open area in front of the Nurse's Station, and stated this was the location where the carts should be maintained.</p> <p>Observation on 01/20/11 at 12:10pm revealed two medication carts and a treatment cart lined the hallway between rooms 320 and 325.</p> <p>Interview on 01/20/11 at 3:35pm with the Maintenance Director and the Executive Director, revealed the hallway between rooms 320 and 325 measured sixty-seven (67) inches wide. With the medication carts and treatment cart stored along the wall, the egress measured forty-five and one-half (45.5) inches. The Executive Director stated the carts should not be stored in the hallway, and added that staff have not done a good job of keeping them out of the hallway to avoid a potential tripping or fall hazard. The Maintenance Director stated the medication carts were replaced in October with new carts which are larger in size.</p>	F 465			

