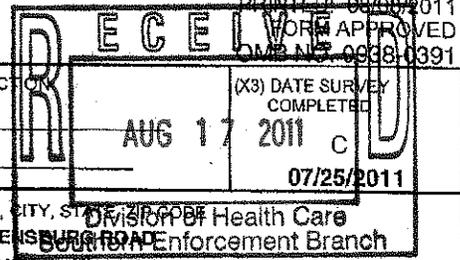


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2011
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF CAMPBELLSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG RD CAMPBELLSVILLE, KY 42718
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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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system 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</p>	F 431	<p>The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law.</p>	08/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nelda Beard Administrator TITLE: _____ (X8) DATE: 8-17-11

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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F 431	Continued From page 1 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility records, it was determined the facility failed to have a system in place to ensure controlled medications were not diverted from the facility. The facility was notified on 07/19/11, by the local Sheriff's Department that controlled medications had been taken from the facility and used in the commission of a crime. The findings include: Review of the facility policy/procedure "Medication Administration" (dated as revised October 2008) revealed staff was required to use the Drug Disposal Record or the proof-of use sheet (narcotic count sheet) provided by the pharmacy to document any destroyed medication. The policy stated staff was to destroy all controlled substances in the presence of two licensed nurses designated by the Director of Nursing or according to State regulation. According to the policy/procedure, the proof-of-use sheet would be attached to the controlled substance and given to the nursing management per facility policy for safekeeping until destruction. There was no provision in the policy/procedure to ensure the controlled medications to be destroyed were overseen by two staff persons during transport by nursing management to the facility safe. Observations of controlled medication storage on	F 431	F-431 1. A 100% audit will be completed by the Director of Nursing and Education Training Director of all narcotics delivered in the past thirty (30) days to ensure that all were given, destroyed or are secured in the medication cart. This audit will be completed by 08/19/11. Discrepancies, if any, will be investigated for resolution and reported as necessary to the appropriate agency. 2. A 100% audit will be completed by the Director of Nursing and Education Training Director of all narcotics delivered in the past thirty (30) days to ensure that all were given, destroyed or are secured in the medication cart. This audit will be completed by 08/19/11. Discrepancies, if any, will be investigated for resolution and reported as necessary to the appropriate agency.	08/19/11

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F 431	<p>Continued From page 2</p> <p>07/25/11, at 12:10 PM, revealed the medications in use were stored in a locked drawer in the locked medication cart. The safe used to store discontinued controlled medications for destruction was in a locked closet and the safe was locked. At the time of the investigation the Director of Nursing (DON) did not have access to the safe and no controlled medications were being placed into the safe due to the ongoing investigation by the local authorities.</p> <p>Interviews on 07/25/11, from 12:45 PM to 2:20 PM, with three residents (Residents #4, #5, and #6) who received controlled medications revealed the residents received their medications when requested and were never denied medication.</p> <p>A review of the closed medical record of Resident #1 was conducted on 07/25/11. Resident #1 had been admitted to the facility on 02/04/11, with diagnoses that included a fracture of the femur. The resident was documented as expired on 04/24/11. Review of the controlled drug record for Resident #1 revealed the resident had received six doses of Hydrocodone APAP 5 mg/500 mg starting on 03/03/11. Resident #1 had also received liquid morphine sulfate 100 mg/ml (20 mg per dose), one dose, that was dispensed on 04/24/11. There was no disposition of the morphine sulfate documented in the record. There was no evidence in the drug destruction records that the drug had been destroyed as required.</p> <p>Review of the closed medical record of Resident #2 revealed the resident had been admitted to the facility on 05/02/11, with diagnoses that included coronary artery disease, congestive heart failure,</p>	F 431	<p>3. A new Policy and Procedure has been implemented as well as a new narcotic Log Books (bound & numbered pages) have been established. Upon receipt of a Narcotic delivered to the facility, it is verified that it is correct, then recorded into the "bound" narcotic book on the inventory log page and on an individual control drug page and then stored in a double lock medication cart. Upon discontinuing of a Narcotic medication, the DON will be notified and the Narcotic will be destroyed at the medication cart by the DON and another licensed nurse or by two licensed nurses designated by the DON. All licensed nurses were re-trained on the process by 7/27/11.</p>	08/19/11

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F 431	<p>Continued From page 3</p> <p>and arthritis. The record documented the resident had been discharged home on 07/08/11. Review of the physician's orders dated 05/02/11, revealed an order for liquid morphine sulfate 10 mg (milligrams) to be given two times a day. The medication administration record for Resident #2 revealed the record documented the resident received the morphine sulfate two times a day on 05/08/11, 05/09/11, and 05/10/11, and one time on 05/11/11. The morphine sulfate had not been reordered after 05/18/11. There was no record of the disposition of the morphine sulfate after the drug was discontinued. There was no evidence the drug had been destroyed as required.</p> <p>Review of the closed medical record of Resident #3 revealed the resident had been admitted to the facility on 02/18/11, with diagnoses that included malignant neoplasm of the lung, and brain tumors. The record documented the resident had expired at the facility on 04/05/11. Review of the physician's orders dated 04/04/11, revealed an order for the resident to receive morphine sulfate 20 mg three times a day. The medication administration record for Resident #3 revealed the morphine sulfate had been dispensed by the pharmacy on 04/04/11. The resident's physician had ordered Diazepam 5 mg/ml syringe for injection on 04/04/11. Review of the pharmacy's proof of delivery revealed the facility had received two of the syringes of Diazepam. The controlled drug administration records for the morphine sulfate and the Diazepam could not be located in the resident's medical record. The facility could not produce any documentation to indicate the drug had been destroyed or all doses completed.</p> <p>Interview on 07/25/11, at 11:55 AM, with the local</p>	F 431	<p>4. The DON, Education and Training Director and/or Unit Manager will complete a audit of Narcotics delivered and Narcotics given and/or destroyed to ensure proper storage and destruction of all Narcotics. This audit will occur weekly for four (4) weeks, then bi-weekly for four (4) weeks and then monthly for one (1) month. The results of these audits will be reviewed during the monthly Quality Assurance Meeting for three (3) months. If at any time concerns are identified, the Quality Assurance Committee with convene to review and make further recommendations as needed. The Quality Assurance Committee will be comprised of at a minimum, the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Education and Training Director, the Social Services Director with the Medical Director attending at least quarterly.</p>	08/19/11	

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F 431	<p>Continued From page 4</p> <p>county Sheriff's Department detective revealed during the investigation of a crime the detective learned controlled medications had been taken from the facility by a facility staff member and used in the commission of a crime. The Sheriff's Department detective stated the alleged perpetrator had confessed to taking controlled medications out of the facility that had been designated for destruction.</p> <p>Interview with the DON on 07/25/11, at 11:20 AM, revealed the DON was one of two administrative staff persons designated by the facility to remove controlled medications from the medication carts and place the medications in the facility safe pending destruction. According to the DON, staff was required to count the controlled medications at each shift change and report any discrepancies to the DON or Assistant Director of Nursing (ADON). The DON stated when a resident had been discharged or died the medications were removed from the medication cart. A licensed staff person and the DON or ADON would count the controlled medications of the discharged resident and the DON or ADON was responsible for transporting the medications to the safe until they could be destroyed. The DON stated she and the ADON participated in the destruction of the controlled medications. The DON was unaware any controlled medications were missing until a subpoena arrived from the local authorities. The DON stated there was no check to ensure the controlled medications counted at the medication cart were placed into the safe.</p> <p>Interview with the facility Administrator on 07/25/11, at 11:45 AM, revealed the Administrator had been notified by the local authorities that</p>	F 431		

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F 431	<p>Continued From page 5</p> <p>during a criminal investigation the authorities had learned the alleged perpetrator of the crime, a facility staff member, had confessed to taking controlled medications from the facility. The Administrator stated after she learned of the problem the DON was suspended and the ADON was terminated. The facility's corporate nurses came to the facility and started an investigation. According to the Administrator it was discovered the controlled medications had been taken sometime between the count at the cart and being placed into the safe for destruction. The Administrator stated only two facility staff persons, the DON and ADON, were authorized to remove controlled medications from the cart and place into the safe. The Administrator confirmed the facility had no system in place to ensure the authorized personnel actually placed the controlled medications into the safe.</p> <p>Interview with the facility Regional Director of Clinical Services (RDCS) on 07/25/11, at 1:35 PM, revealed the RDCS and several other corporate staff persons had conducted an audit of the facility's controlled medications. The RDCS stated she had concentrated on the controlled medications from 04/01/11 to 06/20/11. The RDCS found medications that had been dispensed to three residents but no record of the medications destruction after the residents had been discharged. According to the RDCS, two people in the facility were authorized to remove discontinued controlled medications from the medication carts and place in the safe, the DON and ADON. The RDCS confirmed there was no system in place to ensure authorized personnel placed the medications into the safe.</p>	F 431		