

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

2nd SOD

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 000 INITIAL COMMENTS

An abbreviated standard survey (KY24029) was initiated on 11/09/15 and concluded on 11/10/15. The complaint was substantiated with deficient practice identified at "D" level.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D 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 to the administrator or his designated representative and to other officials in accordance

F 000 The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by Federal and State law.

- F 225
1. Resident were assessed and questioned as to any items or medication was missing. (see exhibit 1. List of resident's questioned). There were no issues discovered. The background check and abuse registry were re-examined of all employees, to ensure that no one had been found guilty of abuse, neglect, or mistreatment of residents. No issues were discovered. The past abuse investigations were audited to ensure that a thorough investigation was completed, including a sample number of residents were questions with each investigation. No issues were noted.
 2. Given the nature of the deficiency it was deemed by the IDT that all residents had the potential to be affected by the practice
 3. The Abuse policy was revised to include that a random sample of residents will be questioned individually regarding the abuse matter to ensure that no abuse has occurred throughout the facility. (See exhibit 2). All staff was in service on the new abuse policy on 11/30/2015-12/02/2015. (See exhibit 3 Abuse policy in-service sign in log and agenda).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE RN BSN DON	(X6) DATE 12-22-15
---	-------------------------	---------------------------

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.

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 225 Continued From page 1

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.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility policy and investigation revealed the facility failed to ensure an allegation concerning misappropriation of resident property was thoroughly investigated and included interviews with other facility residents for one (1) of three (3) sampled residents. Review of the facility investigation, dated 10/31/15, revealed the facility pharmacy delivered medications to the facility and facility staff left the medication unattended at the nurses' station behind the computer. When staff returned to the nurses' station two (2) of the Boxes of medication (Neurontin) were missing. This medication was prescribed and belonged to Resident #1. The facility investigated the missing medication but failed to include interviews with facility residents in the investigation to determine any similar concerns with missing medications or missing resident property.

The findings include:

Review of the facility policy titled "Abuse," revision date 10/10/13, revealed all reports of suspected or reported abuse (including financial or material exploitation) of a resident will be investigated Fully. Continued review of the policy revealed the facility staff conducting the investigation will interview other residents to whom the accused employee provides care or services.

F 225 4. The Administrator/SSD will monitor the ongoing abuse investigation to ensure that a thorough investigation is completed. This will include random resident interviews for any misappropriation of property/money/or medication. The review will be completed weekly x 4 weeks, then monthly x 2 months, then quarterly. The results will be reported and monitored by the Quality Assurance Committee

12/4/15

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 225 - Continued From page 2

F 225

Review of Resident #1's medical record revealed the facility readmitted the resident on 07/18/15 with diagnoses including Heart Failure, Hypertension, Parkinson's Disease, and Depression. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 09/17/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 which revealed the resident was interview able.

Review of the facility investigation, dated 10/31/15, revealed between 8:30 PM and 9:00 PM the facility pharmacy delivered five (5) boxes of medication to the facility which were received by Licensed Practical Nurse (LPN) #2 and were placed at the nurses' station behind the Computer. The investigation further revealed LPN #2 continued with the medication pass and returned to the nurses' station approximately 30 minutes later. The two (2) boxes of medication (Neurontin), which belonged to Resident #1, were no longer behind the computer. Continued Review of the investigation revealed LPN #2 immediately began looking for the medication and questioning the staff on the unit about the medication. The investigation revealed Administrative Staff was notified of the missing medication and LPN #2 was instructed to contact local law enforcement. Further review of the investigation revealed an officer was at the facility within 10 minutes and began to take statements from facility staff. State Registered Nurse Aide (SRNA) #3 admitted to taking the medications And hiding the medications outside the facility. The medication was found and returned to the facility. SRNA #3 was arrested at the time of the incident and her employment was terminated.

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 225 Continued From page 3

Investigation did not contain interviews with facility residents to determine if there were other allegations of misappropriation.

Interview on 11/09/15 at 1:55 PM with Resident #1 revealed the resident denied missing any medications as a result of his/her medications being taken from the facility. The interview further revealed the resident did not have any other problems with missing items.

Interview on 11/12/15 at 11:36 AM with SRNA #3 revealed the SRNA took the medication because she had been raised to be a thief. The interview further revealed the medications were sitting behind the nurses' station and the SRNA took two (2) boxes of the medication Neurontin. SRNA #3 stated she took the Neurontin outside, hid the medications, and planned to retrieve it after her shift was over. SRNA #3 revealed she had been trained by the facility on abuse and misappropriation and knew it was wrong to take the medications.

Interview on 11/09/15 at 1:15 PM with the Administrator revealed the Administrator did not do a "full blown" investigation because the police were involved and the SRNA was caught "red handed" taking the medications. The Administrator stated she felt like she had done a thorough investigation because the police were involved, the SRNA was caught, and the medications were returned to the facility. However, the Administrator revealed residents had not been interviewed as part of the facility investigation.

F 225

F 425 483.60(a),(b) PHARMACEUTICAL SVC -
SS=D ACCURATE PROCEDURES, RPH

F 425

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 425 Continued From page 4

The facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and Administering of all drugs and biological) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on interview and review of the facility policy and investigation, the facility failed to provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological to meet the needs of each resident for one (1) of three (3) sampled residents. Review of the facility investigation dated 10/31/15 revealed the facility pharmacy delivered medications to the facility and the medications were received by a nurse. The nurse (LPN #2) failed to store the medications in A secure location and left the medications unattended at the nurses' station behind a computer. When LPN #2 returned to the nurse's

F 425

1. The medications were immediately placed in a secure location. The medication that was in the tote to return to the pharmacy was placed in a secure area. LPN #2 was immediately written up and re-educated on the policy of medication storage (see exhibit 4, write up of LPN 2)
2. In considering the issues associated with the deficient practice, it was deemed that all resident's had the potential to have been affected. The DON assessed all the nurses' station/medication carts to ensure all medication was locked in a secure location. All medications were in a secure locked location
3. The policy of medication storage was updated to include that medication to be sent back to the pharmacy will be kept in the medication room under lock and key. (See exhibit #5 Medication storage policy sign in and agenda). The IDT established a quality monitor to be utilized by the DON to ensure that the medication is properly stored. (see exhibit 6 medication storage monitor)

12/4/15

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 425 Continued From page 5

Station twenty (20) to thirty (30) minutes later, two (2) boxes of the medication (Neurontin) were missing.

The findings include:

Review of the facility policy titled "Medication Ordering and Receiving From Pharmacy," not dated, revealed a licensed nurse or authorized individual at the facility who passes medication receives medications delivered to the facility and documents that the delivery was received on the medication delivery receipt. The policy further revealed the medications are to be delivered to the appropriate secure storage area.

Review of the facility investigation, dated 10/31/15, revealed the facility pharmacy delivered five (5) boxes of medications to the facility which were received by Licensed Practical Nurse (LPN) #2. The investigation further revealed LPN #2 placed the medications at the nurses' station behind the computer and continued the medication pass. Continued review of the investigation revealed LPN #2 returned to the nurses' station approximately 20 to 30 minutes later and two (2) boxes of the medication (Neurontin) were missing. Review of the investigation revealed the incident was investigated by the facility and the medications were returned.

Interview on 11/10/15 at 10:45 AM with LPN #2 revealed the LPN was in the middle of a medication pass when the facility pharmacy delivered five (5) boxes of medications to the facility and the LPN placed the medications at the nurses' station behind the computer to put away when the medication pass was completed. The

F 425

4. The DON will randomly monitor medication storage on all shifts for one month or until no less than 100% compliance achieved. Then monthly for 3 months or until no less than 100% compliance is achieved. The DON will monitor medication storage by making rounds on various shifts. The monitoring will include: ensuring medication are in a locked secure location, the medication carts are locked, that there is no medication left out unattended on carts, no medications are left on the nurses' station desk, that the medication room is locked, and no medication is left lying out in the medication room. Finding will be reported to the QA committee

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

PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033
--	---

(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 425 Continued From page 6

Interview further revealed LPN #2 returned to the nurses' station approximately 20 to 30 minutes later and two (2) boxes of medication (Neurontin) were missing. LPN #2 revealed she had been trained to immediately put medications away in the appropriate place; however, the LPN was busy with a medication pass and left the medications at the desk unattended.

Interview on 11/09/15 at 1:15 PM with the Administrator revealed LPN #2 should not have left the medications at the nurses' station unattended and the medication should have immediately been locked up. The interview further revealed facility staff had been trained to immediately put medication in the appropriate storage place when delivered to the facility.

F 425