

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

PRINTED: 10/24/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/11/2011 |
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| NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031 |
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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 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 431 SS=D | <p>483.80(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>I. a) Registered Nurse #1 was terminated on 9/24/11 for not following policy and regulations regarding the proper storage of medications and leaving her keys unattended. KMA #2 was terminated on 9/24/11 for an unacceptable urine drug test. SRNA #4 was terminated on 9/24/11 for an unacceptable urine drug test.</p> <p>b) There have been no further narcotics or other drugs unaccounted for since 9/24/11.</p> <p>c) Resident #1 and #2 have shown no signs or symptoms of distress related to the missing Lortab.</p> <p>d) The MDs and pharmacy were contacted immediately to assure that neither resident #1 or #2 would miss a dose of Lortab. The cost of the Lortab replacement for both resident #1 and #2 was at the expense of Grand Haven Nursing Home and not to either resident.</p> <p>II. The DON and ADON completed a narcotic count on 9/24/11 to assure accuracy of the narcotics and no other narcotics were missing.</p> <p>III. a) The DON conducted an in-service to all Nurses and all KMA's regarding proper medication storage, key security, and narcotic count procedure which was completed on 9/26/11.</p> <p>b) A new component to the narcotic count procedure was implemented following inservicing which was completed on 9/26/11 which includes a double count at the beginning of each shift where the two persons counting narcotics switch spots as to avoid any potential errors.</p> <p>IV. A quality assurance tool has been developed and the quality assurance nurse or ADON will conduct a random audit of the narcotic count procedure weekly x4 and then monthly to assure that the double count system is in place and that the nurse or KMA is properly securing the keys to medication carts. The results of the audit will be presented to the QA committee during the weekly meetings x4 weeks and then monthly thereafter until substantial compliance is met.</p> | Completion Date: 10/12/11 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas E. N...</i> | TITLE LNNA | (X6) DATE 11/01/2011 |
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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 | <p>Continued From page 1 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medications were stored in accordance with state and federal regulations. The facility failed to ensure only authorized personnel had access to medication cart keys as evidenced by interview on 10/11/11 with Registered Nurse (RN) #1 who revealed the keys to the medication carts were stored in her jacket pocket, which was left on the back of her chair unattended.</p> <p>The findings include:</p> <p>Review of a letter from the facility, dated 09/24/11, revealed twenty-seven (27) Lortab tablets were noted missing from the medication carts on the morning of 09/24/11. Seven (7) Lortab 5/600 tablets were missing from one medication cart, and twenty (20) Lortab 10/500 tablets were missing from a second medication cart. These discrepancies were discovered by Licensed Practical Nurse (LPN) #2 and Kentucky Medication Aide (KMA) #3, respectively.</p> <p>Interview with the Director of Nursing (DON), on 10/11/11 at 8:34 AM, revealed she received a call from LPN #2, the nurse coming on day shift, at 6:55 AM on the morning of 09/24/11. LPN #2 reported seven (7) Lortab 5/500 tablets belonging to Resident #1 were missing from the narcotic count. The DON stated she began calling other supervisory staff and law enforcement at that</p> | F 431 | | |

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| F 431 | <p>Continued From page 2</p> <p>time, and conveyed to LPN #2 that no one (staff) was to leave the facility. The DON revealed she received a call shortly thereafter from LPN #2 reporting that twenty (20) Lortab 10/500 tablets belonging to Resident #2 were missing from the other medication cart.</p> <p>LPN #2 could not be reached during the course of the survey. Interview with KMA #3, on 10/11/11 at 1:20 PM, revealed she worked first shift on 09/24/11. She revealed she counted narcotics the morning of 09/24/11 with RN #1, as was facility procedure at the beginning of each shift, and discovered twenty (20) Lortab 10/500 tablets belonging to Resident #2 were missing from the narcotic count.</p> <p>Review of facility staffing information revealed RN #1, KMA #2, and LPN #1 were assigned to medication pass the night of 09/23/11 from 11:00 PM until 7:00 AM on 09/24/11. Additionally, two (2) State Registered Nurse Aides (SRNAs) were working that night. SRNA #4 and SRNA #5.</p> <p>Interview with Registered Nurse (RN) #1, on 10/11/11 at 11:07 AM, revealed she worked a double shift, 2nd and 3rd, on 09/23/11. RN #1 revealed when she counted medications with LPN #1 and KMA #2 at the end of second and beginning of third shift, the count on both medication carts was correct. RN #1 revealed she counted medications while LPN #1 and KMA #2 read the numbers off for each medication cart.</p> <p>Interview with LPN #1, on 10/11/11 at 2:20 PM, revealed when she had been assigned to do medication pass, she kept the keys to the med cart in the pocket of her scrubs. Further, LPN #1</p> | F 431 | | | |

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| F 431 | <p>Continued From page 3</p> <p>revealed she would not leave the keys to the med cart unattended under any circumstances.</p> <p>Interview with KMA #1, on 10/11/11 at 8:29 AM, revealed medication carts were kept locked unless actively attended by staff. KMA #1 further revealed keys were not to be left unattended.</p> <p>Continued interview with RN #1, on 10/11/11 at 11:10 AM, revealed she had no pockets on her scrubs, and that the only place she could keep the keys to each medication cart, to keep them both accessible and out of her way, was in her jacket pocket. RN #1 stated she took her jacket off for approximately one hour the night of 09/23/11, and forgot the medication cart keys were in her jacket pocket. RN #1 revealed medication cart keys should not be left unattended.</p> <p>Further interview with the DON, on 10/11/11, revealed facility staff working second and third shift on 09/23/11 were drug tested on the morning of 09/24/11, with SRNA #4 testing positive for marijuana and opiates, and KMA #2 testing positive for marijuana, opiates, and benzodiazepines. Both employees were terminated. Further, as RN #1 had reported leaving the medication cart keys unattended, she was terminated as well.</p> | F 431 | | |
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