

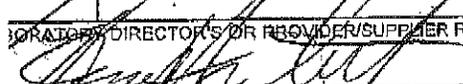
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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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 000 F 157 SS=D	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An abbreviated survey investigating KY#00018359 and KY#00018493 was initiated on 05/14/12 and was concluded on 05/25/12. KY#00018359 was unsubstantiated with regulatory deficiencies cited. KY#00018493 was substantiated with no deficiencies.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 000 F 157	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Grant Manor Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
			<p>F157</p> <p>1. LPN #1 assigned to Resident #5 at the time of condition change was re-educated on facility policy "Change in Condition of resident and including Physician and Responsible Party notification" on January 1, 2012 by the Director of nursing. RN#3 nurse assigned to Resident #6 re-educated on facility policy "Change in Condition of resident including physician and responsible party notification" on May 18, 2012 by the Director of Nursing.</p>	

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REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrative	(X6) DATE 6/29/12
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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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to immediately inform the Physician and/or the resident's legal representative when there was a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer the resident from the facility for two (2) of thirteen (13) sampled residents (Resident #5 and Resident #2). Resident #5 had a change in condition on 01/01/12 related to respiratory difficulty requiring notification to the Physician for the change in condition. New Physician's Orders were received to transfer the resident to the hospital emergency room on 01/01/12. Although the resident refused to be transferred to the emergency room, there was no documented evidence the resident's Durable Power of Attorney (DPOA) for health was notified of the resident's change in condition or of the refusal to be transferred to the emergency room. The resident expired at the facility on 01/01/12. Resident #6 had an increase in Seroquel (antipsychotic medication) on 04/12/12 and was noted to be lethargic on 04/20/12 as per the Interdisciplinary Progress Note completed on day shift (7:00 AM until 3:00 PM shift); and as per the	F 157	2. The charts of current residents were reviewed as of May 23, 2012 going back 30 days to determine if any changes of conditions were noted and if physician and responsible party notification was completed as appropriate by the Regional Director of Clinical Operations, Director of Nursing, Assistant Director of Nursing or Unit Managers. There were two charts identified with issues and the Medical Director and responsible party were notified on May 23, 2012. In addition, a review of 24 hour reports for the past 30 days to determine changes of resident condition with physician and responsible party notification was completed by Director of Nursing on May 21, 2012.. 3. Licensed Nurses were re-educated on "Change of Condition of resident" with emphasis on physician and responsible party notification. The Unit Managers were re-educated by the Director of Nursing on May 21, 2012 regarding the daily clinical meeting process to review the 24 hour report and resident charts as indicated. The 24 hour reports are taken to the daily clinical meeting Monday thru Friday to review for changes in condition with the necessary physician and responsible notification. In addition, the charts of residents with changes in condition will also be brought to the daily clinical meeting to review to determine that physician and responsible party notification was completed as indicated.	

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F 157	<p>Continued From page 2</p> <p>Twenty-Four (24) Hour Report on 04/20/12 on the day and evening shift (3:00 PM-11:00 PM); however, there was no documented evidence of an assessment of this resident related to the lethargy, or of Physician notification related to the change in condition.</p> <p>The findings include:</p> <p>Review of the facility "Change in Condition of a Resident" Policy, dated 01/08, revealed "It is the policy of the center to take appropriate action and provide timely communication to the resident's physician and responsible party relating to a change in condition of a resident". Further review revealed the licensed nurse determines if there has been a change in condition of a resident and notifies via telephone the attending physician and the resident's responsible party of the specific nature of the change in condition.</p> <p>1. Review of Resident #5's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure and Chronic Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 10/01/11, revealed the facility assessed the resident as having no cognitive impairment.</p> <p>Review of the Interdisciplinary Progress Notes, dated 01/01/12 at 4:18 PM, and completed by Registered Nurse (RN) #2, revealed the resident was in no distress for the most part of the shift, and after lunch the resident was transferred from the wheelchair to the bed and began to have difficulty breathing. Further review revealed the resident's vital signs were Temperature-97.6,</p>	F 157	<p>4. The Director of Nursing and or the Assistant Director of Nursing will review the 24 hour report 5x per week x 12 weeks to identify changes in the resident condition and to determine that physician and family notification and were completed as indicated. The Director of Nursing, Assistant Director of Nursing and or Unit Managers will complete a review of 5 residents medical record each week to determine changes in condition to determine that physician and responsible party notification is completed and documented as indicated. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation.</p> <p>5. Completion date: June 23, 2012</p>	

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F 157	<p>Continued From page 3</p> <p>Pulse 100, Respirations 20, and Blood Pressure 100/50. The resident's oxygen saturation on room air was 92 percent (%). Resident #5's head of the bed was elevated, and a breathing treatment was administered.</p> <p>Interview, on 06/23/12 at 2:15 PM, with RN #2 revealed she was assigned to Resident #5 on the day shift on 01/01/12 and the resident always struggled to breath, but became more short of breath at the end of her shift. She stated she obtained the vital signs and oxygen saturation, administered the nebulizer treatment, and gave report to Licensed Practical Nurse (LPN) #1 who was taking over for her on the second shift. RN #2 informed LPN #1 of the resident receiving the nebulizer treatment and told her (LPN #1) the Physician may need to be notified if the treatment was not effective.</p> <p>Further review of the Interdisciplinary Progress Notes, dated 01/01/12 at 3:30 PM, completed by LPN #1 revealed the Certified Nursing Assistant (CNA) reported that the resident was "breathing funny" and she checked on the resident. Further review revealed she encouraged the resident to use his/her chest/lungs to breath and the resident denied pain/discomfort. The resident's oxygen was increased from two (2) liters to three (3) liters per nasal cannula.</p> <p>The next entry of the Interdisciplinary Progress Notes, dated 01/01/12 at 3:45 PM, revealed the Physician was called in reference to Resident #5's breathing and the Physician wanted to send the resident to the emergency room. Further review revealed the resident refused to go to the emergency room and the Physician then ordered</p>	F 157		

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F 157	<p>Continued From page 4 Orders.</p> <p>Review of the Physician's Orders dated 01/01/12 revealed orders to obtain a stat chest x-ray.</p> <p>The next entry of the Interdisciplinary Progress Notes, dated 01/01/12 at 7:00 PM, revealed the chest x-ray was done and the resident was fed supper and ate 100 percent (%) and drank 480 milliliters (ml's). No signs and symptoms of distress or pain.</p> <p>The next entry of the Interdisciplinary Progress Notes, dated 01/01/12 at 8:00 PM, revealed at 7:20 PM the CNA called LPN #1 into the resident's room and the resident did not respond to voice or touch and no heartbeat was detected. The Notes stated it was determined the resident had expired. Further review revealed the Physician and the Family were notified.</p>	F 157		
	<p>Interview, on 05/23/12 at 3:00 PM with LPN #1, revealed on 01/01/12 the resident was breathing funny and the resident's diaphragm was moving, but not his/her chest. She stated the resident looked short of breath and the resident's color was not good and towards the gray side. Continued interview revealed she listened to the resident's lungs and there was very little air movement. Further interview revealed she notified the physician who wanted to send the resident to the emergency room. She stated the resident refused to go to the emergency room, she notified the Physician of the refusal and a chest x-ray was obtained. She further stated the resident perked up a little and ate supper; however, she was still worried about the resident and the resident's breathing remained labored.</p>			

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F 157	<p>Continued From page 5</p> <p>Further interview revealed she thought she called the resident's brother to let him know the resident would not go to the ER; however, forgot to chart it and also failed to chart the resident's lung assessment and vital signs.</p> <p>Interview, on 05/25/12 at 2:30 PM, with Resident #5's DPOA for healthcare revealed she was the person who was to be notified of a change in condition for this resident and she was upset because she was not notified of the resident's change in condition nor was she notified of the resident's refusal to be transferred to the emergency room on 01/01/12. She stated she talked to staff at the facility regarding her concern when she was notified the resident had expired.</p> <p>Interview, on 05/25/12 at 3:15 PM, with the Director of Nursing (DON), revealed the DPOA should have been notified of the resident's change in condition, new Physician's Orders, and refusal to be transferred to the emergency room. She further stated she was aware of this situation and had already spoke with LPN #1 regarding this.</p> <p>2. Further review of the facility "Change in Condition of a Resident" Policy, dated 01/08, revealed the licensed nurse documents in the interdisciplinary progress notes and on the 24 Hour Report; the condition of the resident, whom was notified and when, care and treatment orders dictated by the Physician, implementation of physician orders, care interventions in the resident's plan of care and residents response to interventions.</p> <p>Review of Resident #6's medical record revealed</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>diagnoses which included Dementia with Behavioral Disturbance, Psychosis, Bipolar Disorder, Alcohol Induced Persisting Demantia, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/14/12, revealed the facility assessed the resident as severely impaired in cognitive skills.</p> <p>Review of the Psychiatric Evaluation, dated 04/07/12, revealed staff reported the resident continued to have behaviors of digging in rectum and playing with feces and staff reported the resident also had behaviors of trying to ingest the matter. The recommendations were to increase Seroquel (antipsychotic medication) to 100 milligrams (mg's) three times a day.</p> <p>Review of the Physician's Orders, dated 04/12, revealed the resident was receiving psychotropic medications including Seroquel 100 milligrams three times a day, Depakote Extended Release 1000 mg's twice a day (medication used for seizures or behavioral disturbance), Remeron (anti-depressant medication) 30 mg's at night, and Lorazepam (anti-anxiety medication) one (1) mg twice a day. Further review of the Physician's Orders revealed the Seroquel had been increased on 04/12/12 from 100 mg twice a day to 100 milligrams three times a day.</p> <p>Review of the Interdisciplinary Progress Notes, dated 04/20/12 at 3:00 PM, revealed Resident #8 was lethargic, unable to arouse sufficiently to eat lunch, and an aide stated the resident barely woke up during change of attends.</p> <p>Interview, on 05/18/12 at 10:45 AM, with Registered Nurse (RN) #3, who completed the</p>	F 157		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185265

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

05/25/2012

NAME OF PROVIDER OR SUPPLIER

GRANT MANOR CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

201 KIMBERLY LANE
WILLIAMSTOWN, KY 41097

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY)

(X5)
COMPLETION
DATE

F 157

Continued From page 7
Interdisciplinary Progress Notes dated 04/20/12 at 3:00 PM, revealed she did not obtain vital signs or neuro checks or do any assessment of this resident because she did not notice anything unusual with this resident except lethargy. She further stated the resident would occasionally sleep through a meal; however, it was unusual for this resident to be "that sleepy". Continued interview revealed the resident probably just received his/her Seroquel (antipsychotic medication) prior to finding him/her lethargic. Further interview revealed she thought she had made a note on the 24 Hour Report related to the resident being lethargic and the nurses were to check the 24 Hour Report for any changes. She stated, the nurses on the next shift probably felt like the resident was back to normal and did not chart anything.

F 157

The next entry of the Interdisciplinary Progress Notes, dated 04/23/12 at 11:00 PM, revealed a skin check was done and no open areas were noted, and the resident was confused.

The last entry of the Interdisciplinary Progress Notes, dated 04/24/12 at 10:55 AM, revealed Resident #5 was slumped over in the wheelchair with emesis on the floor, was unresponsive, and unable to obtain a pulse. Further review revealed the resident was placed on the bed and the responsible party and Physician were notified.

Interview, on 05/18/12 at 3:30 PM, with LPN #7 who was assigned to the resident the next shift, on 04/20/12, from 3:00 PM until 11:00 PM, revealed the resident was lethargic and sleepy the last week before he/she expired and would fall asleep in the wheelchair. Further interview

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F 157	<p>Continued From page 8</p> <p>revealed she documented this in the Interdisciplinary Progress Notes and had notified the Physician. However, record review revealed there was no documented evidence of this LPN documenting in the Interdisciplinary Progress Notes on this resident or notifying the Physician of any changes in condition for this resident during the last week before the resident expired.</p> <p>This surveyor was unable to reach RN #8 who worked 04/20/12-4/21/12 on the 11:00 PM till 7:00 AM shift for interview.</p>	F 157		
	<p>Record review of the twenty-four 24 Hour Report revealed the resident was noted on the Report for 04/20/12 on the day shift and evening shift for being lethargic on day shift and evening shift; however, there was no further information including; the condition of the resident, whom was notified and when, care and treatment orders dictated by the Physician, implementation of physician orders, care interventions in the resident's plan of care and residents response to interventions as per policy.</p> <p>Review of the Medication Administration Record (MAR) dated 04/12 revealed a section stating "does the resident show signs of sedation, yes or no" and a section stating "is the resident exhibiting side effects from the medication, yes or no". Further review revealed both sections were marked "no" on 04/20/12 for the day and evening shift, although there was a notation on the 24 Hour Report related to the resident being lethargic.</p> <p>Interview, on 05/22/12 at 3:30 PM, with the Director of Nursing (DON), revealed the nurses</p>			

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F 157	Continued From page 9 were to assess the resident's and document the assessment for a change in condition. She stated if the resident was lethargic she would expect to see an assessment and documentation of the assessment in the Interdisciplinary Progress Notes. She stated she would expect to see follow-up assessment and charting if the problem was still an issue on the next shift. Continued interview revealed notification to the physician would depend on the nursing assessment in this situation. She stated, she would expect to see an assessment related to lethargy and follow up charting on this resident after the notation in reference to the lethargy on 04/20/12 at 3:00 PM. Further interview revealed the side effects of medication or signs and symptoms of sedation should be charted on the MAR. She further stated, she did not think the Notes accurately reflect this resident's last days because she saw him/her up as usual with no changes during his/her last days. Continued interview revealed she audited a few charts a month; however, did not check Progress Notes daily.	F 157		
F 159	Interview, on 05/25/12 at 1:30 PM, with the Attending Physician revealed he was not notified of the resident having lethargy in the days prior to the resident's death. He further stated if the resident was lethargic he would have expected neuro checks to be done as well as an assessment of the resident and if there was a change in status he would expect the nurses to inform him. Continued interview revealed if the resident was having true lethargy he would have needed to be notified in order to draw laboratory data. 483.10(c)(2)-(5) FACILITY MANAGEMENT OF	F 159		

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F 159 SS=E	<p>Continued From page 10</p> <p>PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the</p>	F 159	<p><u>F159</u></p> <ol style="list-style-type: none"> 1. No specific resident identified. 2. Residents were informed that personal funds would be available 7 days per week and during off hours as of June 22, 2012 by the administrator via the Resident Council. Letters have been mailed to the responsible parties of current residents regarding the availability of personal funds by the Administrator as of June 22, 2012. 	
			<ol style="list-style-type: none"> 3. The Administrator was educated to have petty cash available by the Regional Director of Clinical Operations on June 6, 2012. The Social Services Director and Staff Managers have been educated to the availability of petty cash for personal funds on off hours and weekends by the Administrator as of June 22, 2012. The Business Office Manager will keep \$50 cash in small bills from petty cash in a designated medicine cart, locked in a safe during off hours and weekends to allow residents to have access to personal funds. Nurse supervisors will be responsible for signing and documenting resident cash requests and keeping a daily log. The daily log will be reconciled routinely by Business office manger. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 06/29/12
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 05/25/2012
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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F 159	Continued From page 11 resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide resident's access to their personal funds, held within their resident trust, on an ongoing basis as evidenced by residents not having access to petty cash after the business office closed, including on the weekends. The findings include: Interview with the Social Service Director (SSD), on 05/24/12 at 12:45 PM, revealed the facility's process for removal of petty cash was the money had to be requested before the business office closed Monday through Friday. She stated the business office was closed on the weekend and if residents needed money out of their account they would have to make arrangements for the money to be taken out of the account before the business office closed or they would not be able to get any money out of their account. She further stated if a resident wanted money out of the resident trust when the business office was closed they would not be able to get their money. Interview with the Administrator, on 05/25/12 at 4:00 PM, revealed the residents were aware they	F 159	4. An audit of the petty cash daily log will be completed by the Business Office Manager or Administrator weekly x12 weeks to determine that funds are available and provided to residents for personal funds as requested. A summary of findings will be submitted to the monthly Performance Improvement Committee for 3 months for further recommendation and review. 5. Completion date: June 23, 2012	

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F 159 F 224 SS=D	Continued From page 12 needed to request any money they might have needed before the business office closed Monday through Friday and before the weekends. 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 159 F 224		
	This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility policy, it was determined the facility failed to ensure all the residents were free from misappropriation for one (1) of fifteen (15) sampled residents (Resident #9). The facility failed to conduct an investigation and report to state agencies, after Resident #9 reported his/her quilt was missing. The findings include: Review of the facility's abuse policy, titled "Prohibition of abuse, neglect, mistreatment, and misappropriation of the residents property", dated 01/08, revealed the administrator/designee reports alleged violations and substantiated incidents to the state agency and to all other agencies as required. Further review of the facility policy revealed the administrator/designee ensures that events will be identified, investigated and reported to the appropriate authorities per state/federal regulation.		F224 1. State agencies were made aware of the missing quilt for resident #9 when in the facility on May 24, 2012. An investigation was completed and a final report was submitted to the state agencies by the Administrator on June 21, 2012 that misappropriation was not substantiated. 2. The Administrator completed an audit of the grievance log x30 days to determine that any allegation of misappropriation or other forms of abuse were reported and investigated as required on June 21, 2012. No other concerns were identified.	

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F 224	<p>Continued From page 13</p> <p>Review of the medical record revealed the facility admitted Resident #9 on 03/23/10 with diagnosis which included Anxiety Disorder and other Persistent Mental Disorder. The facility assessed the resident, using the Minimal Data Set (MDS) Assessment, on 03/06/12 as having a Brief Interview for Mental Status (BIMS) score of fifteen (15), which meant the resident was cognitively intact.</p> <p>Interview with Resident #9, on 05/21/12 at 4:00 PM, revealed two (2) weeks prior he/she had reported a quilt missing from his/her room. He/she stated they had been coming back from the dining room and saw another resident coming out of his/her room but was unable to see if the resident had anything with them. He/she further stated when he/she went back into his/her room the quilt was gone. He/she stated they reported the missing quilt to the Social Service Director (SSD) the same day and a couple of the nurses looked for the quilt and was not able to find the quilt. He/she further stated they sell the Quilts for money but knows he/she did not sell this quilt.</p> <p>Interview with the SSD, on 05/24/12 at 12:45 PM, revealed Resident #9 had reported a missing quilt to her on 05/15/12; however, had told her the quilt had been missing for two (2) weeks. She stated she filled-out a resident grievance form, she then spoke with the resident and offered to search the resident's room; however, the resident said someone else had already searched the room and the quilt was gone. She further stated the resident had stated he/she could not prove the other resident had taken the quilt because he/she had not seen the resident with the quilt; however,</p>	F 224	<p>3. The Administrator, Social Service Director, and Director of Nursing were re-educated on the Company's policy "Prohibition of abuse, neglect, mistreatment and misappropriation of the residents property on June 6, 2012 by the Regional Director of Clinical Operations. Facility staff have been re-educated to the "Prohibition of abuse, neglect, mistreatment and misappropriation of the residents property." policy as of June 22, 2012 by the Director of Nursing, Social Services Director, or Administrator. Grievances will be reviewed in the daily (Monday thru Friday) morning stand up meeting with the Interdisciplinary team.</p> <p>4. An audit of the grievance log will be completed weekly x4 weeks and then monthly x2 months to determine that any allegations of misappropriation or abuse are reported and investigated as per policy by the Administrator, Social Services Director and Director of Nursing. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further recommendation and review.</p> <p>5. Completion date: June 23, 2012</p>	

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F 224	Continued From page 14 knew the quilt was gone. She stated she then notified the resident's family and they stated they would search the resident's room when they came up. Three (3) days after the allegation was made, the resident's family came to see the resident and cleaned the resident's room and the quilt still was not found. The SSD further stated she spoke with the family and they stated they felt the resident had sold the quilt because he/she had been selling them to make some extra money. She further stated when she asked the resident if he/she had sold the quilt the resident stated he/she didn't think so. She further stated an investigation was not initiated and the missing quilt was not reported to all state agencies; however, an investigation should have been initiated and the incident reported to all state agencies because it was misappropriation of resident's property.	F 224		
F 225	Interview with the Director of Nursing (DON), on 05/25/12 at 4:00 PM, revealed when the SSD reported to her the quilt was missing a search of the resident's room and facility was initiated; however, when the SSD interviewed Resident #9, he/she stated they could have sold the quilt. She further stated the family was contacted and then came in three (3) days later to search the room and the quilt still was not found. Further interview with the DON revealed an investigation was not conducted and state agencies were not notified of the missing quilt. Interview with the Administrator, on 05/25/12 at 4:00 PM, revealed Resident #9's quilt was still missing and there had not been an investigation conducted related to Resident #9's missing quilt. 483.13(o)(1)(ii)-(iii), (o)(2) - (4)	F 225		

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F 224 F 225 SS=E	<p>Continued From page 15 4:00 PM, revealed Resident #9's quilt was still missing and there had not been an investigation conducted related to Resident #9's missing quilt.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported 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</p>	F 224 F 225	<p><u>F225</u></p> <p>1. The Allegations of Abuse involving LPN#8 was reported to the State agencies, LPN #8 was suspended and an investigation was initiated by the Administrator on May 11, 2012. A final report was submitted to the state agencies by the Administrator reflect that the center was not able to substantiate the allegations on May 16, 2012. LPN #8 remains on suspension pending police investigation.</p> <p>2. An assessment of current residents was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to determine any signs of sedation on May 18, 2012. No concerns were identified. The injectable medication vials were audited by the Director of Nursing and or Assistant Director of Nursing on May 18, 2012 to determine that medications vials are accounted for. No issues were identified. The medical records of all residents who passed away at the facility from the date LPN #8 was hired May 17, 2011 to current was reviewed by the Regional Directors of Clinical Operations and Director of Nursing as of May 16, 2012 to determine any trends or patterns in the events leading up to the resident's passing away. No trends or patterns of events were identified.</p>	

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F 225	<p>Continued From page 16 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 interview and review of the facility policy, it was determined the facility failed to ensure all allegations of abuse were reported when staff failed to report two (2) allegations of abuse. This was related to an allegation a nurse made a statement referring to keeping a vial of medication in her pocket, which she used to expedite the death of residents who were end of life, as well as the statement she kept residents sedated so they would stay in the bed and not use their call light.</p> <p>The findings include: Review of the facility's policy, titled "prohibition of abuse, neglect, mistreatment, and misappropriation of resident property", dated 01/08, revealed the department head educates employees to report allegations of abuse without fear of reprisal. Further review revealed staff must not engage in nor permit anyone else to engage in abuse of a resident.</p> <p>Interview with Dietary Aid #2, on 05/17/12 at 7:45 AM, revealed approximately two (2) months ago, she was on the back dock taking a smoke break with Licensed Practical Nurse (LPN) #8 and they started to talk about the increased number of deaths at the facility. She further stated LPN #8 stated she kept a vial of medication in her pocket because sometimes residents who were at the</p>	F 225	<p>3. Facility staff including Dietary Aid #1, Dietary Aid #2, and CAN #6 have been re-educated to the "prohibition of abuse, neglect, mistreatment, and misappropriation policy" with emphasis on reporting all suspicions of any type of abuse immediately regardless if there is proof and to the availability of the company employee hotline if they feel the need to report anonymously by the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Services as of June 6, 2012.</p>	
			<p>4.. The Administrator and or Social Service Director will interview 5 staff members weekly x4 weeks and then monthly x2 months to determine any concerns with abuse and their understanding and willingness of reporting any allegations or suspicion of abuse to their supervisor or the Administrator immediately. A summary of findings from these employee interviews will be submitted to the Performance Improvement Committee monthly x3 months for further recommendation and review.</p> <p>5. Completion date: June 23, 2012</p>	

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F 225	Continued From page 17 medication but stated LPN #8 had said the medication would slow down the resident's breathing and they would pass away sooner. She further stated LPN #8 also made the statement if a resident was trying to get out of bed she would sedate them to keep them in bed. Further interview revealed Dietary Aid #2 did not report this to her supervisor at the facility because she did not have any proof. She further stated the facility had trained her on reporting all allegations of abuse and she should have reported these statements to her supervisor.	F 225		
	Interview with Dietary Aid #4, on 05/16/12 at 11:30 AM, revealed she had heard LPN #8 make the statement "if a resident would not keep their ass in bed, she would sedate them". She further stated she had not reported this statement to her supervisor or anyone at the facility. Further interview revealed the facility trained staff to report all allegations of abuse and she should have reported this statement to her supervisor. Interview with Certified Nursing Assistant (CNA) #6, on 05/23/12 at 2:00 PM, revealed she had heard LPN #8 make the statement "if a resident would not keep their ass in bed, she would sedate them". She further stated she had also heard LPN #8 state she was going to take care of a resident who was using their call light frequently because she was unable to get her work done because of answering call lights. Further interview revealed she did not report these statements to her supervisor or anyone at the facility. She further stated the facility trained staff to report all allegations of abuse to their supervisor immediately; no matter if the allegation was witnessed or just reported to them and she			

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F 225	Continued From page 18 facility. She further stated the facility trained staff to report all allegations of abuse to their supervisor immediately; no matter if the allegation was witnessed or just reported to them and she should have reported these statements to her supervisor. Interview with the Administrator, on 05/25/12 at 4:00 PM, revealed staff was trained to report all allegations of abuse to their supervisor and him immediately. He further stated staff should have reported all the statements LPN #8 had made to their supervisor and to him, immediately after she allegedly made the statements.	F 225		
F 281 SS-EE	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services provided met professional standards of quality for three (3) of fifteen (15) sampled residents (Residents # 4, #5 and #6). Resident #4 was admitted to the facility without a written Physician's order for a specific diet. The facility failed to ensure the Physician was notified to obtain a diet order. Resident #5 had a change in condition on 01/01/12 related to respiratory difficulty requiring notification to the Physician and new Physician's	F 281	<u>F281</u> 1. Residents #4, #5, and # 6 have been discharged. Resident #4 was discharged on May 2, 2012. Resident #5 was discharged January 1, 2012. Resident #6 was discharged on April 4, 2012. 2. An audit was completed by the Regional Director of Clinical Operations to determine that each current resident has a diet order from the physician on May 2, 2012. The Director of Nursing, and Unit Managers completed a review of all current residents progress notes for the past 30 days and assessed the residents current status for any changes in condition that included but was not limited to lethargy or shortness of breath with the appropriate documentation in the medical record as of May 23, 2012.	

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F 281	<p>Continued From page 19</p> <p>Orders. Although the 7-3 shift obtained and documented vital signs at 4:10 PM, there was no documented evidence of a respiratory assessment or vital signs for this resident after 4:10 PM. Interview revealed the resident continued to have labored breathing throughout the shift and expired on 01/01/12 at 7:20 PM.</p> <p>Resident #6 had an increase in Seroquel (antipsychotic medication) on 04/12/12 and was noted to be lethargic on 04/20/12 as per the Interdisciplinary Progress Note completed on day shift (7:00 AM until 3:00 PM shift); and as per the Twenty-Four (24) Hour Report on 04/20/12 on the day and evening shift (3:00 PM-11:00 PM). However, there was no documented evidence of an assessment of this resident related to the lethargy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the medical record revealed the facility admitted Resident #4, on 04/30/12 at 1:30 PM, with diagnosis which included Cerebral Ataxia (a loss of muscle coordination) and Dysphagia (the medical term for the symptom of difficulty in swallowing). Review of the Nursing Assessment completed on 04/30/12, revealed the resident was assessed as having chewing and swallowing problems. Review of the Adult Transfer Form dated 04/30/12, revealed the section for the type of diet was not marked and the Medication Reconciliation form dated 04/30/12 did not have a diet ordered by the Physician. Review of the resident's care plan dated 04/30/12, revealed the resident was care planned for chewing difficulty, swallowing 	F 281	<ol style="list-style-type: none"> Licensed staff have been re-educated by the Director of Nurses and Assistant Director of Nurses regarding the necessity to obtain physicians order for diets, the Change of Condition policy and procedure, and the process of completing then documenting the appropriate assessment as indicated by the resident condition as well as referencing "Perry and Potter Clinical Nursing Skills and Procedures" and "Resident Care Management system", "Lippincott manual of nursing practice, 7th ed." as of June 22, 2012. The Director of Nurses was re-educated by the Regional Director of Clinical Operations on the daily (Monday thru Friday) clinical meeting process on May 11, 2012 to review the 24 hour report, and progress notes of residents with changes in condition to determine that resident status and the indicated assessments are completed and accurately reflected in the progress notes, in addition to reviewing all new admission orders to determine that a diet order was obtained from the physician. 	

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F 281	<p>Continued From page 20</p> <p>difficulty, and inability to self-feed, with interventions which included diet as ordered, offer comfort food, and feed resident.</p> <p>Interview with Registered Nurse (RN) #10, on 05/24/12 at 4:30 PM, revealed Resident #4 was accompanied to the unit on 04/30/12 by his/her spouse and the resident's Hospice Nurse, who both reported to her the resident was eating a regular diet. She further stated she had the medication cart and when Resident #4 was served his/her dinner, she had not yet assessed the resident to determine if he/she could tolerate a regular diet. She further stated she had not been told she had to have a Physician's order for a diet, but would take the diet she had received in report and this would be the diet she would order. Further interview revealed the only orders she would fax to the Physician were the orders on the Medication Reconciliation form, which did not have an area for the diet ordered. She further stated she was aware Resident #4 had a diagnosis of Dysphagia; however, the Hospice Nurse and the spouse reported to her the resident had been eating a regular diet. She further stated she should have assessed the resident before he/she ate dinner, as well as received an order for the resident's diet from the Physician.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 05/23/12 at 3:30 PM, revealed whatever diet a resident came in on was the diet she would order. She further stated she would not notify the Physician for an admission diet order. Further interview revealed if a resident was admitted from home, whatever the resident or family reported as the diet the resident was tolerating at home was</p>	F 281	<p>4. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will complete an audit of newly admitted residents chart to determine that a diet order was in place weekly x4 weeks and then monthly x2. The Director of Nursing, Assistant Director of Nursing and or Unit Managers will complete a review of 5 residents medical record each week to determine that any changes of condition have been assessed and documented as appropriate weekly x 4 weeks and then monthly x 2. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation. "</p> <p>5. Completion date: June 23, 2012</p>	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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F 281	<p>Continued From page 21</p> <p>resident was probably not compliant with an altered diet when they were at home.</p> <p>Interview with the Director of Nursing (DON), on 05/24/12 at 7:00 PM, revealed all new admission diet orders should have been received from the Physician. She further stated she would expect her nurses to use the same professional standards that she would use when assessing a resident. She further stated a Physician must order the diet for a new admission before the resident was served a meal to ensure the appropriate diet. Further interview revealed she would assess a new admission before the resident was served a meal and would expect her nurses use the same professional standards that she would use, and assess a resident before they would feed them.</p> <p>2. Review of the Lippincott Manual of Nursing Practice, eight edition, used by the facility as the source for nursing assessments, revealed a physical examination of the chest was to be done using inspection, palpitation, percussion, and auscultation to determine respiratory status. This was to include respiratory rate, depth and pattern, use of accessory muscles, appearance of sputum, distention of jugular veins, lung sounds, and peripheral edema.</p> <p>Review of Resident #5's clinical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure and Chronic Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/01/11, revealed the facility assessed the resident as having no cognitive impairment.</p>	F 281		

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F 281	<p>Continued From page 22</p> <p>Review of the Interdisciplinary Progress Notes, dated 01/01/12 at 4:18 PM and completed by Registered Nurse (RN) #2, revealed after lunch the resident was transferred from the wheelchair to the bed and began to have difficulty breathing. Further review revealed the resident's vital signs were obtained; Temperature-97.6, Pulse-100, Respirations- 20, and Blood Pressure- 100/50. The Note stated, the resident's oxygen saturation on room air was 92 percent (%), the head of the bed was elevated, and a breathing treatment was administered.</p>	F 281		
	<p>Interview, on 05/23/12 at 2:15 PM, with RN #2 revealed she was assigned to Resident #5 on the day shift on 01/01/12 and the resident became more short of breath at the end of her shift. She stated she obtained the resident's vital signs and oxygen saturation, administered a nebulizer treatment, and gave report to Licensed Practical Nurse (LPN) #1 who was taking over for her on the second shift. Further interview revealed RN #2 informed LPN #1 of the resident receiving the nebulizer treatment and told her (LPN #1) the Physician may need to be notified if the treatment was not effective.</p> <p>Further review of the Interdisciplinary Progress Notes, dated 01/01/12 at 3:30 PM, completed by LPN #1 revealed the Certified Nursing Assistant (CNA) informed her the resident was "breathing funny" and she checked on the resident. The Note stated, she encouraged the resident to use his/her chest/lungs to breath and the resident denied pain/discomfort. The Note stated the LPN increased the resident's oxygen from two (2) liters to three (3) liters per nasal cannula.</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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F 281	<p>Continued From page 23</p> <p>The next entry of the Interdisciplinary Progress Notes dated 01/01/12 at 3:45 PM revealed the Physician was notified of Resident #5's breathing and the Physician wanted to transfer the resident to the emergency room. The Note stated, the resident refused to go to the emergency room and the Physician then ordered a chest x-ray.</p> <p>Review of the Physician's Orders dated 01/01/12 revealed orders to obtain a stat chest x-ray.</p> <p>The next entry of the Interdisciplinary Progress Notes dated 01/01/12 at 7:00 PM, revealed the chest x-ray was done and the resident was fed supper and ate 100 percent (%) and drank 480 milliliters (ml's). The Note stated, there was no signs and symptoms of distress or pain.</p> <p>The next entry of the Interdisciplinary Progress Notes dated 01/01/12 at 8:00 PM, revealed at 7:20 PM the CNA called LPN #1 into the resident's room, the resident was unresponsive to voice or touch, and no heartbeat was detected. The Note stated it was determined the resident had expired.</p> <p>Interview, on 05/23/12 at 3:00 PM, with LPN #1 revealed on 01/01/12 the resident was "breathing funny" and the resident's diaphragm was moving, but not his/her chest. She stated the resident looked short of breath and the resident's color was not good and towards the gray side. Continued interview revealed she listened to the resident's lungs which were clear with very little air movement. She further stated vital signs were obtained, and she could not remember if they were abnormal. Further interview revealed she notified the physician who wanted to send the</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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F 281	<p>Continued From page 24.</p> <p>resident to the emergency room. She stated the resident refused to go to the emergency room, she notified the Physician of the refusal and a chest x-ray was obtained. She further stated the resident perked up a little and ate supper; however, she was still worried about the resident and the resident's breathing remained labored. Further interview revealed she thought the resident's vital signs were obtained and not documented and she should have documented the lung assessment.</p> <p>Interview, on 05/24/12 at 7:00 PM and 05/25/12 at 3:15 PM, with the Director of Nursing (DON), revealed the facility had self identified there was concerns related to changes in resident's condition, and assessment and documentation, and the facility was in the process of re-implementing re-education to the nursing staff. Further interview revealed she had not recognized the vital signs and lung assessment were not documented in Resident #5's chart on the second shift when she reviewed the Interdisciplinary Notes after the resident's death.</p> <p>3. Review of the Lippincott Manual of Nursing Practice, eight edition, used by the facility as the source for nursing assessments, revealed conditions requiring a nursing assessment included lethargy.</p> <p>Review of Resident #8's clinical record revealed diagnoses which included Dementia with Behavioral Disturbance, Psychosis, Bipolar Disorder, Alcohol Induced Persisting Dementia, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/14/12 revealed the facility assessed the</p>	F 281		

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F 281	<p>Continued From page 25</p> <p>resident as severely impaired in cognitive skills for daily decision making.</p> <p>Review of the Psychiatric Evaluation, dated 04/07/12, revealed staff reported the resident continued to have behaviors of digging in rectum and playing with feces and staff reported the resident had behaviors of trying to ingest the matter. Recommendations were to increase Seroquel (antipsychotic medication) to 100 milligrams three (3) times per day.</p> <p>Review of the Physician's Orders, dated 04/12, revealed the resident was receiving psychotropic medications which included Seroquel 100 milligrams three times a day, Depakote Extended Release 1000 mg's twice a day (medication used for seizures or behavioral disturbance), Remeron (anti-depressant medication) 30 mg's at night, and Lorazepam (anti-anxiety medication) one (1) mg twice a day. Further review revealed the Seroquel had been increased on 04/12/12 from 100 mg twice a day to 100 milligrams three times a day.</p> <p>Review of the Interdisciplinary Progress Notes, dated 04/20/12 at 3:00 PM, revealed the resident was lethargic, unable to arouse sufficiently to eat lunch, and aide stated the resident barely woke up during change of attends.</p> <p>The next entry of the Interdisciplinary Progress Notes was dated 04/23/12 at 11:00 PM which stated a skin check was done and no open areas were noted, and the resident was confused.</p> <p>The last entry of the Interdisciplinary Progress Notes dated 04/24/12 at 10:55 AM revealed the</p>	F 281		

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F 281	<p>Continued From page 26</p> <p>resident was slumped over in the wheelchair with emesis on the floor, was unresponsive, unable to obtain pulse. The Note stated the resident was placed on the bed and the responsible party and Physician were notified.</p> <p>Interview on 05/18/12 at 10:45 AM with Registered Nurse (RN) #3, who completed the Interdisciplinary Progress Notes dated 04/20/12 at 3:00 PM, revealed she did not obtain vital signs or neuro checks or do any assessment of this resident because she did not note anything unusual with this resident except lethargy. She stated the resident would occasionally sleep through a meal; however, it was unusual for this resident to be "that sleepy". She further stated the resident probably just received his/her Seroquel (antipsychotic medication) prior to finding him/her lethargic. Further interview revealed stated she thought she had made a note on the 24 Hour Report related to the resident being lethargic and the nurses were to check the 24 Hour Report for any changes. Continued interview revealed the nurses on the next shift probably felt like the resident was back to normal and did not chart anything.</p> <p>Interview on 05/18/12 at 3:30 PM with LPN #7 revealed the resident was lethargic and sleepy the last week before he/she expired and would fall asleep in the wheelchair. She stated she had documented this in the Interdisciplinary Progress Notes and had notified the Physician. However, there was no documented evidence of this LPN documenting in the Interdisciplinary Progress Notes on this resident or notifying the physician of any changes in condition for this resident during the last week before the resident expired.</p>	F 281		

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F 281	<p>Continued From page 27</p> <p>This surveyor was unable to reach RN #9 who worked 04/20/12 on the 11 PM till 7:00 AM shift for interview.</p> <p>Record review of the twenty-four 24 Hour Report revealed the resident was noted on the Report for 04/20/12 on the day shift and evening shift for being lethargic on day shift and evening shift.</p> <p>Review of the Medication Administration Record (MAR) dated 04/12 revealed a section which stated "does the resident show signs of sedation, yes or no" and a section which stated "is the resident exhibiting side effects from the medication, yes or no". Further review revealed both sections were marked "no" on 04/20/12 for the day and evening shift, even though there was a notation on the 24 Hour Report related to the resident being lethargic.</p> <p>Interview, on 05/22/12 at 3:30 PM, with the Director of Nursing (DON), revealed the nurses were to assess the resident's and document the assessment for a change in condition. She further stated if the resident was lethargic she would expect to see an assessment and documentation and follow up assessment and charting if the problem was still an issue on the next shift or later in the shift. She further stated the side effects of medication should be charted on the MAR. Continued interview revealed she would have liked to have seen follow up charting on this resident after the notation in reference to the lethargy on 04/20/12 at 3:00 PM. She stated, she did not think the Notes accurately reflect this resident's last days because she saw him/her up as usual with no changes during his/her last days.</p>	F 281		

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F 281	Continued From page 28 Further interview revealed she audited a few charts a month; however, did not check Progress Notes daily. Interview, on 05/25/12 at 1:30 PM, with the Attending Physician revealed he was not informed of the resident having lethargy in the days prior to the resident's death. He stated if the resident was lethargic he would have expected neuro checks to be done as well as an assessment of the resident. He further stated if the resident was having true lethargy he would have needed to be notified in order to draw laboratory data.	F 281		
F 282 SS=D	489.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for two (2) of thirteen (13) sampled residents (Resident #5 and Resident #6). Resident # 5 had a Plan of Care dated 12/30/11 stating the resident had altered respiratory status related to Pneumonia with interventions which included; observe for alterations in respiratory status including shortness of breath, and abnormal lung sounds and obtain temperature,	F 282	<p><u>F282</u></p> <ol style="list-style-type: none"> 1. No current residents identified. 2. The Director of Nursing, Assistant Director of Nursing, Unit Managers and Nursing Supervisors completed a review of current resident care plans to determine that services are provided in accordance to the plan of care as of May 23, 2012. 3. Licensed nurses have been re-educated to providing resident services in accordance with the plan of care as of June 10, 2012 by the Director of Nursing. 	

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F 282	<p>Continued From page 29</p> <p>and report abnormalities to the Physician. However, there was no documented evidence of a respiratory assessment or vital signs from 4:00 PM until 7:20 PM on 01/01/12, although the Interdisciplinary Progress Notes dated 01/01/12 at 3:45 PM revealed the Physician was notified related to the resident's breathing.</p> <p>Resident #6 had a Plan of Care dated 01/27/12 with a problem which stated; use of drugs having an altered effect on the mind related to diagnoses of Depression, Bipolar Disorder, Psychosis, and Anxiety. The interventions included evaluating the effectiveness and side effects of medications for possible decrease or elimination of psychotropic drugs and monitoring resident's mental status functioning on an ongoing basis. On 04/20/12 the Interdisciplinary Progress Note stated the resident was lethargic and unable to arouse sufficient to eat. However, there was no documented evidence of assessment and monitoring of this resident related to the lethargy in order to evaluate for the side effects of the psychotropic medications and to monitor the resident's mental status.</p> <p>The findings include:</p> <p>Review of the facility Care Plan Policy, dated 01/06, revealed the Interdisciplinary Team (IDT) develops care plans addressing the resident's most acute problems and the the IDT implements the care plan.</p> <p>1. Review of Resident #5's medical record revealed diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure and Chronic</p>	F 282	<p>4. The Director of Nursing, Assistant director of nursing, Unit Manager and or Nurse Supervisors will audit the plan of care for 5 residents per week x4 weeks to determine that services are provided per the plan of care and then monthly x2 months. A summary of findings will be submitted to Performance Improvement committee monthly for 3 months for further reviewed and recommendation.</p> <p>5. Completion date: June 23, 2012</p>	

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F-282	<p>Continued From page 30</p> <p>Pneumonia. Review of the Admission Minimum Data Set (MDS) Assessment dated 10/1/11, revealed the facility assessed the resident as having no cognitive impairment.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 10/25/11 revealed the resident was on antibiotics for Pneumonia, and experienced shortness of breath with exertion related to Congestive Heart Failure, Chronic Airway Obstruction, Emphysema, and Acute and Chronic Respiratory Failure.</p> <p>Review of the Comprehensive Plan of Care dated 12/30/11 revealed the resident had altered respiratory status related to Right Lower Lobe Pneumonia with a goal stating the Pneumonia would resolve without complications. The interventions included observing for alterations in respiratory status including; shortness of breath, pain/discomfort with breathing, and abnormal lung sounds, and report abnormalities to the Physician.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/01/12 at 4:18 PM and completed by Registered Nurse (RN) #2, revealed Resident #5 after was transferred from the wheelchair to the bed and began to have difficulty breathing after lunch. Further review revealed the residents vital signs were obtained; Temperature-97.6, Pulse 100, Respirations 20, and Blood Pressure 100/50. According to the Note, the resident's oxygen saturation on room air was obtained and was 92 percent (%), the resident's head of the bed was elevated, and a breathing treatment was administered.</p>	F 282		

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F 282 Continued From page 31
Interview, on 05/23/12 at 2:15 PM, with RN #2 revealed she was assigned to Resident #5 on the day shift on 01/01/12 and although the resident always struggled to breath, he/she became more short of breath at the end of her shift. She confirmed she obtained vital signs and oxygen saturation, administered a nebulizer treatment, and gave report to Licensed Practical Nurse (LPN) #1 who was assigned to the resident on the second shift. RN #2 stated she informed LPN #1 of the resident receiving the nebulizer treatment and told her (LPN #1) the Physician may need to be notified if the nebulizer treatment was ineffective.

F 282

Further review of the interdisciplinary Progress Notes dated 01/01/12 at 3:30 PM completed by LPN #1 revealed a Certified Nursing Assistant (CNA) reported the resident was "breathing funny" and she checked on the resident. Further review revealed LPN #1 encouraged the resident to use his/her chest/lungs to breath and the resident denied pain/discomfort. According to the Note, the resident's oxygen was increased from two (2) liters to three (3) liters per nasal cannula.

The subsequent entry of the Interdisciplinary Progress Notes dated 01/01/12 at 3:45 PM revealed the Physician was called in reference to Resident #5's breathing and the Physician wanted to send the resident to the emergency room. Further review revealed the resident refused to go to the emergency room and the Physician then ordered a chest x-ray. However, there was no documented evidence of a lung assessment or vital signs obtained prior to informing the Physician of the resident's change in condition.

FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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NAME OF PROVIDER OR SUPPLIER GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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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 282	<p>Continued From page 32</p> <p>Review of the Physician's Orders dated 01/01/12 revealed orders to obtain a stat chest x-ray.</p> <p>The subsequent entry of the Interdisciplinary Progress Notes dated 01/01/12 at 7:00 PM, revealed the chest x-ray was done and the resident was fed supper and ate 100 percent (%) and drank 480 milliliters (ml's). No signs and symptoms of distress or pain.</p> <p>The subsequent entry of the Interdisciplinary Progress Notes dated 01/01/12 at 8:00 PM, revealed at 7:20 PM the CNA called LPN #1 into the resident's room and the resident did not respond to voice or touch and no heartbeat was detected. According to the Notes, it was determined the resident had expired.</p> <p>Interview, on 05/23/12 at 3:00 PM, with LPN #1 revealed on 01/01/12 the resident was "breathing funny" and she described this as the resident's diaphragm was moving, but not his/her chest. She described the resident as short of breath and the resident's color towards the gray side. She could not recall if the nebulizer treatment which was administered at the beginning of her shift was effective. Continued interview revealed she listened to the resident's lungs and there was very little air movement. She also stated she would have ensured vital signs were obtained; however, could not remember if they were abnormal. Further interview revealed she notified the physician who wanted to send the resident to the emergency room. She stated the resident refused to go to the emergency room, she notified the Physician of the refusal and a chest x-ray was obtained. She further stated the resident perked up a little and ate supper;</p>	F 282		

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F 282	<p>Continued From page 33</p> <p>however, she was still worried about the resident and the resident's breathing remained labored. Further interview revealed a respiratory assessment for a resident having difficulty breathing should include vital signs, and lung sounds. She stated she thought she did this and failed to chart it in the medical record.</p> <p>Interview, on 05/24/12 at 7:00 PM and 05/25/12 at 3:15 PM, with the Director of Nursing (DON), revealed the facility had self identified concerns related to changes in resident's condition, assessment and documentation, and the facility was currently in the process of re-implementing re-education to the nursing staff. (Refer to F-157 and F-281)</p>	F 282		
	<p>2. Review of Resident #6's clinical record revealed diagnoses which included Dementia with Behavioral Disturbance, Psychosis, Bipolar Disorder, Alcohol Induced Persisting Dementia, and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/14/12 revealed the facility assessed the resident as severely impaired in cognitive skills for daily decision making.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 11/02/11 revealed on the day of the interview the resident was very lethargic and at times exhibited this type of behavior which fluctuated. Review of the CAAS dated 11/03/11, revealed the resident received psychotropic medications and nursing staff was to continue to monitor medications and side effects. Further review revealed the resident appeared to be tolerating these medications with minimal side effects.</p>			

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F 282	<p>Continued From page 34</p> <p>Review of the Comprehensive Plan of Care dated 01/27/12 revealed a problem; use of drugs having an altering effect on the mind related to diagnoses which included Depression, Bipolar Disorder, Psychosis, and Psychosis. The interventions included evaluating the effectiveness and side effects of the medications for possible decrease or elimination of psychotropic drugs and monitor resident's mental status functioning on an ongoing basis.</p> <p>Review of the Psychiatric Evaluation dated 04/07/12 revealed staff reported the resident</p>	F 282		
	<p>continued to have behaviors of digging in rectum and playing with feces and had behaviors of trying to ingest the matter. According to the Evaluation, the recommendations were to increase Seroquel (antipsychotic medication) to 100 milligrams three times a day.</p> <p>Review of the Physician's Orders dated 04/12 revealed the resident was receiving psychotropic medications which included Seroquel 100 milligrams three times a day, Depakote Extended Release 1000 mg's twice a day (medication used for seizures or behavioral disturbance), Remeron (anti-depressant medication) 30 mg's at night, and Lorazepam (anti-anxiety medication) one (1) mg twice a day. Further review revealed the Seroquel had been increased on 04/12/12 from 100 mg twice a day to 100 milligrams three times a day.</p> <p>Review of the Interdisciplinary Progress Notes dated 04/20/12 at 3:00 PM, revealed the resident was lethargic, unable to arouse sufficiently to eat lunch, and the aide stated the resident barely</p>			

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F 282	<p>Continued From page 35</p> <p>woke up during change of attends.</p> <p>The next entry of the Interdisciplinary Progress Notes was dated 04/23/12 at 11:00 PM which stated a skin check was done and no open areas were noted, and the resident was confused.</p> <p>The last entry of the Interdisciplinary Progress Notes dated 04/24/12 at 10:55 AM revealed the resident was slumped over in the wheelchair with emesis on the floor, was unresponsive, unable to obtain pulse. The Note stated the resident was placed on the bed and the responsible party and Physician were notified.</p>	F 282		
	<p>Interview on 05/18/12 at 10:45 AM with Registered Nurse (RN) #3, who completed the Interdisciplinary Progress Notes dated 04/20/12 at 3:00 PM, revealed she did not obtain vital signs or neuro checks or assess this resident because she did not note anything unusual with this resident except lethargy. Further interview revealed the resident would occasionally sleep through a meal; however, it was unusual for him/her to be "that sleepy". She further stated the resident probably just received his/her Seroquel (antipsychotic medication) prior to finding him/her lethargic. Further interview revealed she thought she followed up with writing a note on the 24 Hour Report related to the resident being lethargic and the nurses were to check the 24 Hour Report for any changes. She stated, the nurses on the next shift probably felt like the resident was back to normal and did not chart anything.</p> <p>Interview on 05/18/12 at 3:30 PM with LPN #7 revealed the resident was lethargic and sleepy</p>			

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F 282	<p>Continued From page 36</p> <p>the last week before he/she expired and would fall asleep in the wheelchair. She stated she had documented this in the Interdisciplinary Progress Notes and had informed the Physician. However, review of the medical record revealed there was no documented evidence of this LPN documenting in the Interdisciplinary Progress Notes on this resident or notifying the physician of any changes in condition for this resident during the last week before the resident expired.</p> <p>This surveyor was unable to reach RN #9 who worked 04/20/12 on the 11 PM till 7:00 AM shift for interview.</p>	F 282		
	<p>Record review of the twenty-four 24 Hour Report revealed Resident #8 was noted on the Report on 04/20/12, on the day shift and evening shift, for being lethargic.</p> <p>Although the resident was noted on the 24 Hour Report as being lethargic on 04/20/12 on the day and evening shift, review of the Medication Administration Record (MAR) dated 04/20/12 on the day and evening shift, revealed the sections asking if the resident showed signs of sedation, or was the resident exhibiting side effects from the medication were marked "no".</p> <p>Interview on 05/22/12 at 3:30 PM with the Director of Nursing (DON), revealed if the resident was lethargic she would expect to see an assessment and documentation and follow up assessment and charting if the problem was still an issue on the next shift. She further stated the side effects of medication should be charted on the MAR. Continued interview revealed she would expect assessment and follow up charting</p>			

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F 282	Continued From page 37 on this resident after the notation in reference to the lethargy on 04/20/12 at 3:00 PM. After the assessment, the decision would be made as to whether the Physician should be notified. Interview on 05/25/12 at 1:30 PM with the Attending Physician revealed he was not informed of the resident having lethargy in the days prior to the resident's death. However, he stated if the resident was lethargic he would have expected neuro checks to be done as well as an assessment of the resident. He further stated if after the assessment, the resident was having true lethargy, he would have needed to be notified in order to draw laboratory data.	F 282		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedures, it was determined the facility failed to ensure residents were kept free from significant medication errors for one (1) of thirteen (13) sampled residents (Resident #10). Resident #10 received four (4) additional doses of an antibiotic without a current Physician's order. The antibiotic had been discontinued but the facility continued administering the medication. The findings include: Review of the facility's policy entitled,	F 333	F333 1. Resident #10 was assessed for any potential side effects and the physician was notified of the doses of Macrobid administered on December 25, 2011 by a licensed nurses. No concerns identified. 2. The medical record, Medication Administration records, and medication carts were audited by the Director of Nurses, Assistant Director of Nurses, and Unit Managers to determine that all discontinued medications had been removed from the medication carts as indicated as of May 25, 2012. Any medications identified were removed from the cart and returned to the pharmacy for credit as appropriate by a licensed nurse.	

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F 333	<p>Continued From page 38</p> <p>"Disposal/Destruction of Expired or Discontinued Medication", dated May 2010, indicated that once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply.</p> <p>Review of the facility's policy entitled, "Change in Condition of a Resident", dated January 2008, revealed, the Physician will provide orders to direct the care of the resident.</p> <p>Review of Resident #10's clinical record revealed, the facility admitted Resident #10 with the admitting diagnoses to include: Other Specified Rehabilitation Procedure; other, Encounter for Palliative Care, Urinary Tract Infection, and Dementia Unspecified without Behavioral Disturbance.</p> <p>Review of the Physician's Orders, dated 12/22/11, revealed an order for Macrobid (antibiotic) 100 milligram (mg), taken by mouth, twice a days for ten (10) days for an Urinary Tract Infection. Further review of the Physician's order revealed this order was printed on 12/22/11 at 12:37 PM.</p> <p>Review of the Medication Administration Record (MAR), dated 12/01/11-12/31/11, revealed the Macrobid 100 mg was administered at 8:00 PM on 12/22/11, from the emergency box.</p> <p>Review of a Physician's Order, dated 12/23/11, revealed the Macrobid 100 mg order was discontinued by the Physician. Further review of the Physician's order revealed, this order was printed at 2:56 PM. Continued review revealed, the Macrobid was no longer to be administered.</p>	F 333	<p>3. Licensed nurses have been re-educated to the Disposal/Destruction of Expired or Discontinued Medication policy and procedure as well as the necessity to follow physician orders by the Director of Nursing as of June 10, 2012.</p>	
			<p>4. Director of Nursing, Assistant Director of Nursing, Unit Manager and or Nurse Supervisor will review Physicians orders in daily clinical meeting and determine that discontinued medications have been discontinued from the Medication Administration Record and then removed from the medication cart for 5 residents per week x 4 weeks and then 5 residents per month x2 months. A summary of findings will be submitted to Performance Improvement committee monthly for 3 months for further review and recommendation.</p> <p>5. Completion date: June 23, 2012</p>	

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F 333	<p>Continued From page 39</p> <p>Continued review of the MAR, dated 12/01/11-12/31/11, revealed, the Macrobid 100 mg was administered at 8:00 PM on the 23rd, at 8:00 AM on the 24th, 8:00 PM on the 24th, 8:00 AM on the 25th and then marked as discontinued as of 12/25/11.</p> <p>Continued review of Resident #10's medical record revealed, there was no documentation of the Physician being notified that the medication had been given.</p> <p>Interview with Registered Nurse (RN) #7, on 05/24/12 at 3:25 PM, revealed she was the RN</p>	F 333		
	<p>taking care of Resident #10 when she received the Macrobid 100 mg order from the Physician and ensured the medication was on the MAR. Further interview revealed, she was also the RN caring for Resident #10 when the Physician discontinued the Macrobid. Continued interview revealed, she could not recall as to why the medication was not removed from the MAR, but the medication should have been marked as discontinued. RN #7 further indicated, the medication should have also been removed from the cart as the medication was no longer an active order.</p> <p>Interview with the Director of Nursing (DON), on 05/24/12 at 5:00 PM, revealed the Macrobid was discontinued on 12/23/11 at 2:50 PM and should have been removed from the current MAR. After further reviewing the MAR, the DON validated the MAR had been signed indicating the medication was administered. Further interview revealed, the medication was given for an additional four (4) doses without a Physician's order. Continued interview revealed, per the facility's policy, the</p>			

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F 333 F 431 SS=F	Continued From page 40 medication should have been removed from the cart and returned to the pharmacy. 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 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.	F 333 F 431	<u>F431</u> 1. The medications identified with improper labeling was destroyed by two licensed nurses and replaced at no charge to the resident and properly labeled by the pharmacy and stored appropriately in the center on May 23, 2012. 2. The Director of Nursing, Assistant Director of Nursing and Unit Managers	
	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. 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. 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.		completed an audit of the medication carts and storage to determine that all medications were stored and labeled appropriately. Any medications not stored or labeled appropriately that were identified were removed from the medication cart or storage area and destroyed or returned to the pharmacy per policy then replaced at no charge to the resident. Contracted Pharmacy Management staff audited and reconciled the emergency narcotic box and audited medication carts and storage on May 25, 2012.	

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F 431	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedures, it was determined the facility failed to label drugs and biologicals used in the facility in accordance with currently acceptable professional principles. The facility failed to ensure an accurate reconciliation of controlled drugs was maintained and failed to determine that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. During review of the controlled drugs, it was observed the facility had improperly labeled oral narcotic medications in the refrigerator with only the last names of seven (7) residents. Also, during the verification of drugs in the emergency box of house stock, the sign out sheet did not match the drugs. The findings include: Review of the facility's policy entitled, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles", dated 12/01/07, revealed the facility should ensure that drugs and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. Further review of the policy revealed, the facility should ensure that the drugs and biologicals for each resident are stored in their originally received containers. Continued review of the policy validated the facility should destroy and reorder drugs and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels. In addition, per the policy, the facility should ensure	F 431	3. The Director of Nurses was re-educated by the Regional Director of Clinical Operations on May 23, 2012 to the Storage, and Expiration dating of Drugs, Biologicals, Syringes and Needles. Licensed nurses were re-educated to the Storage and Expiration, dating of Drugs, Biologicals, Syringes, and Needles policy in addition to the Narcotic Count procedure by the Director of Nursing as of May 30, 2012..	
			4. The Director of Nursing, Assistant Director of Nursing, and or Unit Managers will complete an audit of medication carts and storage to determine proper labeling and storage of medications weekly x4 weeks and then monthly x2 months. The Director of Nursing, Assistant Director of Nurses and or Unit Managers will complete an audit of the narcotic count sheets with the medication skids weekly x4 weeks and then monthly x2 months. A summary of findings will be submitted to the Performance Improvement Committee monthly x3 months for further review and recommendation. 5. Completion date: June 23, 2012	

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F 431	<p>Continued From page 42</p> <p>that all controlled substances are stored in a manner that maintains their integrity and security. Further review identified, that facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis.</p> <p>Review of the facility's policy entitled, "Inventory Control of Controlled Substances", dated 12/01/07, revealed with respect to Schedule III through V controlled substances, the facility should ensure that facility staff count all Schedule III through V controlled substances in accordance with facility policy and applicable law. Further review revealed, a facility representative should regularly check the inventory records to reconcile inventory.</p>	F 431		
	<p>Observation of the refrigerator of the Providence Unit, on 05/23/12 at 2:00 PM, with Registered Nurse (RN) #2, revealed there were seven (7) bottles of Lorazepam Lotensol lying in the locked narcotic box with only the last names of the residents to whom the medication belonged. Further observation revealed, five (5) of the bottles had not been opened; however, two (2) of the bottles had been opened. Continued observation revealed, the bottles had been taken from their original box they were delivered in and the last names of the residents had been written on the bottle's original label for identification purposes.</p> <p>Interview with RN #2, on 05/23/12 at 2:00 PM, revealed the Lorazepam Lotensol had been taken from the boxes because the boxes were too big to fit in the locked narcotic box. Further interview revealed, the facility had been doing this practice</p>			

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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 43 as long as she could remember. Continued interview revealed she did not think the medication was properly labeled.</p> <p>Interview with License Practical Nurse (LPN) #4, on 05/23/12 at 2:30 PM, revealed the narcotic box was too small to accommodate the boxes the Lorazepam Lotensol was sent in from the pharmacy. Further interview revealed, in order to get the medication to fit into the locked box the facility's protocol was to remove the medication from the box and place only the bottle in the box with the last name written on the bottle. Continued interview with LPN #4 validated, the facility was not following their policy on properly labeling of medications.</p>	F 431		
	<p>Interview with the Pharmacy's General Manager, on 05/24/12 at 4:15 PM, revealed removing the liquid narcotic medication from the box it was sent in and labeling the bottle with the last name of the resident would not be considered properly labeled. Further interview revealed, the medication should have been left in the original box because the individual bottles were not labeled by the pharmacy. Continued interview revealed, no medication should have been given from the bottles as they were improperly labeled.</p> <p>Interview with the Director of Nursing (DON), on 05/24/12 at 4:30 PM, revealed the facility had used this process for some time and had never felt it was an issue. Further interview revealed, the pharmacy sent a Quality Assurance (QA) person to complete medication audits quarterly. Continued interview revealed, the QA personnel from pharmacy never had any issues with the improperly labeling. Further interview revealed,</p>			

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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F 431	<p>Continued From page 44</p> <p>the facility had not followed their policy on properly labeling of medications.</p> <p>Observation of the narcotic house stock of the Heritage Unit, on 05/23/12 at 3:00 PM, with RN #6, revealed there were seventeen (17) skids of medications and seventeen (17) narcotic sign out sheets. Further observation revealed: there were five (5) tablets of Lorazepam 0.6 milligram (mg), but there were six (6) sign out sheets; there were three (3) tablets of Oxycodone/Acetaminophen 6/325 mg, but there were four (4) sign out sheets; there were five (5) tablets of Hydrocodone/Acetaminophen 5/500 mg, but there were two (2) sign out sheet with a place for three (3) signatures; there were two (2) vials of Diazepam fliptop, 5 mg/5 milliliter (mL), but there were three (3) sheets.</p> <p>Interview with RN #6, on 05/23/12 at 3:00 PM, revealed when the two (2) nurses counted the house stock emergency box, they counted the number of skids and the number of sign out sheets and if the numbers match then the count would be considered correct. Further interview revealed, the nurses did not match the medication to the sign out sheet when the end of shift count was being completed. Continued interview identified, there were discrepancies in the sign out sheets and the actual medication in the emergency box.</p> <p>Interview with the LPN #3, on 05/23/12 at 3:20 PM, after observation of surveyor and RN #6 completing the narcotic count again, revealed the process the facility utilized was incorrect. Further interview revealed, the medication should have been matched to it's sign out sheet.</p>	F 431		

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F 431	Continued From page 45 Review of the Quality Assurance Summary Report, dated 02/27/12, revealed the Emergency Box was inspected with no additions or deletions. Further review of the report, revealed the PRN (as needed) Audit of Controlled Substances was one hundred (100) percent compliant; however, one (1) of the sign out sheets that remained in the emergency stock file was for one (1) of the Diazepam vials. The sign out sheet was present, but the medication was not. Interview with the Director of Nursing (DON), on 05/23/12 at 3:30 PM, validated the process that RN #6 and the surveyor completed. Further interview revealed, the nurses do count the skids and compare it to the the number of sign out sheets. Continued interview identified, the nurses were not comparing the actual drug with the drug's sign out sheet for comparison. Further interview confirmed, the sign out sheets did not match the drugs.	F 431		