

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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY20961 was initiated on 11/21/13 and concluded on 11/22/13. The Division of Health Care substantiated the allegation with a deficiency cited.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  
SS=E

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.

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

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

F 431

RESIDENTS AFFECTED

The facility replaced the diverted medications for the eight residents identified at the facility's expense. None of the eight residents identified failed to receive their prescribed medications therefore there was no negative affect to these eight residents.

01/16/2014

*1-5-14  
K. B. B. B. B.  
D. P. B.  
1-13-14*

RESIDENTS POTENTIALLY AFFECTED

An audit of 100% of residents was completed by the Director of Nursing on 11/08/2013. Six additional residents were identified as having been affected. A report of these findings was faxed to APS, OIG, LTC Ombudsman, and Mt. Washington Police Department on 11/08/2013. The fax confirmation is time stamped on 11/08/2013 at 17:24 reflecting 16 of 16 pages were successfully transmitted to the Office of inspector General.

SYSTEMIC MEASURES

A policy was developed by the Director of Nursing that reflected the procedure consistently demonstrated by all LPNs (#1 through #7) during the investigation. The Controlled Drug Records policy is included is an addendum to this Plan of Correction. All licensed nurses have been in-

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

Administrator

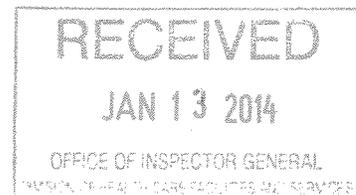
01/10/2014

any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

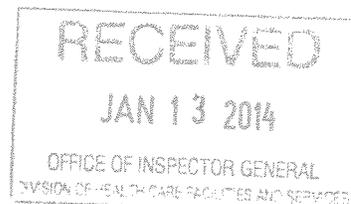
PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>		
(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	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's investigation, it was determined the facility failed to have an effective system in place to account for all controlled substances for the purpose of minimizing loss, diversion, and misappropriation. During the course of investigating an allegation of misappropriation of controlled drugs and falsification of medical records, the facility proceeded to identify additional evidence of medication diversion and misappropriation that had occurred days prior to the original allegation. The facility had no policy in place at the time of the allegation addressing procedures for accounting for controlled substances or for periodically reconciling residents' drug records. Due to the facility's ineffective system for accounting for its narcotic medications, the facility failed to identify and investigate several other narcotic issues until several days after the event.  The findings include:  On 11/07/2013, the facility reported an allegation to the State Survey Agency in which an employee (Registered Nurse #2) had confessed on 11/06/13 to misappropriating narcotic pain medications belonging to two residents living on the Apple Hall (Residents #1 and #2). The medications included seven (7) tablets of Percocet 5/325 and one (1) tablet of OxyContin 40 mg. belonging to Resident #1, and one (1)	F 431	Continued From page 1 serviced on Controlled Drug Records policy which includes but is not limited to accounting of controlled medications, contacting the Director of Nursing if count is not accurate, documenting controlled substances including date, time and signature, and proper documentation of wasting controlled substances. The in-service of all licensed nurses was initiated on 12/06/2013 and completed on 12/30/2013. The Controlled Drug Records policy requires that both the off-going nurse and the on-coming nurse both look at the controlled drug record, blister pack containing medication and narcotic shift count sheet to ensure the counts match.  MONITORING MEASURES The Director of Nursing, prior to the investigation completed on 11/22/2013, was conducting the following audits: 1) Review of all Controlled Drug Record documents, upon completion, and 2) Monthly review of the Controls Utilization Report generated by the contracted Pharmacy. Now, in addition to these existing reviews, the Director of Nursing reviews the Narcotic Shift Count Sheet for all residents on a weekly basis. These reviews serve to help identify patterns of narcotic usage. The QA Committee will review the report provided by the Director of Nursing on a monthly basis to monitor the effectiveness of the Plan of Correction, policy and/or audits. This report to the QA Committee will summarize the visual monitoring of the actual narcotic counts between shifts to determine the licensed nursing staff's competency after having been provided		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

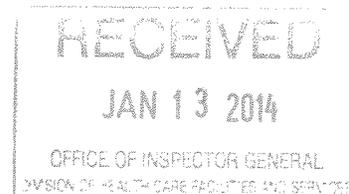
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/22/2013
NAME OF PROVIDER OR SUPPLIER  GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(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	Continued From page 2 tablet of Norco 5/500 belonging to Resident #2. As a result of its investigation, the facility determined that six (6) of Resident #1's Percocet tablets had been signed-out by RN #2 using fictitious or illegible staff names along with false dates and times; a seventh Percocet tablet had been removed from the packet with no documentation whatever; and one tablet of Resident #1's OxyContin 40 mg. had been documented by RN #2 as having been "wasted", but without a witness. In addition, RN #2 had signed-out one tablet of Lortab 5/500 belonging to Resident #2 using an illegible staff name and illegible date and time. When the noted irregularities were discovered at approximately 6:00 AM on 11/06/13, staff proceeded to notify the DON (Director of Nursing) who then conducted a preliminary investigation and ultimately notified Law Enforcement. When interviewed by Law Enforcement that morning, RN #2 confessed to falsifying the two resident's records and diverting their medications. The nurse subsequently resigned from the facility and was arrested.  On 11/12/13, the DON notified the State Survey Agency the facility had identified six (6) additional residents who may have been victimized by the nurse. Those residents included Residents #3, 4, 5, 6, 7, and 8.  1. Resident #3 who lived on the Oak Hall had an order for Lortab 7.5/500 to be used "as needed" (i.e., PRN) for pain. The resident's Narcotic Sign-Out Sheet revealed the medication had only been given approximately 15 times over the previous 7 months. However, the Narcotic Shift Count Sheet revealed two (2) tablets of the Lortab had been signed-out for Resident #3 during the 2-10 shift on 10/31/13. The resident's	F 431	Continued From page 2 education on the policy. The Director of Nursing and Quality Assurance/Risks Management Nurse will visually monitor the actual narcotic counts between shifts on a weekly basis for six months. Findings of this monitoring will be put in writing and presented to the QA Committee on a monthly basis by the Director of Nursing. The facility would like to respectfully clarify the following: 1. The nurse identified as RN#2 was not in rehab prior to or at the time of hire. When a family contact came to the facility on 11/11/2013 to pick up RN#2's paycheck, the family contact informed the Director of Nursing that RN#2 was seeking treatment at a drug rehab facility in Elizabethtown, Kentucky. 2. Once concerns were identified on 11/06/2013, the facility self reported these concerns to OIG and initiated an audit of 100% of all resident's Narcotic Shift Count sheets. During this investigation six additional residents were identified as having been affected prior to 11/06/2013. The facility upon this discovery faxed to OIG on 11/08/2013 at 17:24, sixteen (16) pages to notify OIG of the discovery of these additional residents having been affected. Perhaps due to the fact the fax was transmitted on a Friday evening and the fact that Monday, 11/11/2013 was a holiday, the information sent by fax does not reflect as being received by OIG until 11/12/2013. 3. Finally, the facility did have a system in place that was reflected by all LPNs (#1-#7) consistently following the established procedure		



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

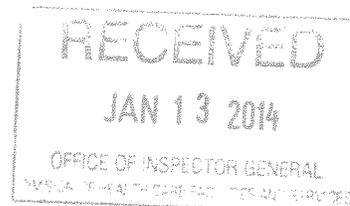
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>	
(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 3</p> <p>Narcotic Sign-Out Sheet; however, revealed the staff person signing-out the two tablets documented the transaction using an illegible name, dates and times. There was no evidence anyone had previously discovered or questioned the discrepancy.</p> <p>2. Resident #4 (also living on the Oak Hall) had orders for Morphine Sulfate SA 15 mg. to be used routinely twice daily for pain and Percocet 7.5/325 to be used PRN for breakthrough pain. Review of Resident #4's medical record revealed the resident had been out to the hospital from 10/28/13 through 11/04/13. However, the Narcotic Shift Count Sheet revealed three (3) Morphine tablets and four (4) Percocet tablets had been used by the resident during the 2-10 shift on 10/31/13. Review of the resident's Narcotic Sign-Out Sheets revealed the staff person signing-out the tablets documented the transactions using illegible names, dates and times. There was no evidence these discrepancies had been previously discovered or questioned.</p> <p>3. Resident #7 who lived on the Cherry Hall had an order for Percocet 5/325 which was used PRN for pain. The Narcotic Shift Count Sheet revealed that two (2) tablets had been provided to the resident on the 2-10 shift on 11/04/13. Review of the resident's Narcotic Sign-Out Sheet revealed the two transactions had been documented using illegible names and times. In that instance, there was no evidence that staff had previously discovered or questioned the discrepancies.</p> <p>4. Resident #5, living on the Apple Hall, had an order for Norco 5/325 to be used twice daily routinely in addition to twice daily PRN for pain.</p>	F 431	<p>Continued From page 3</p> <p>for counting narcotics and wasting controlled substances requiring two nurses to be present during the wasting process. Thank you.</p>



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

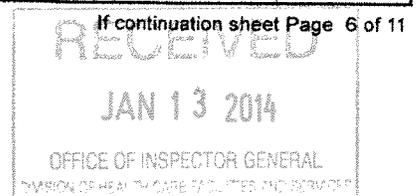
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>		
(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	Continued From page 4 The Narcotic Shift Count Sheet revealed two (2 tablets) had been provided to the resident on the 10-2 shift. However, the Narcotic Sign-Out Sheet revealed that one of the tablets was signed-out during that shift on 11/06/13 at "200" (i.e., 2:00 AM) by a staff person who had not been assigned to the med cart at that time. There was no evidence anyone had questioned the transaction.  5. Resident #6, living on the Cherry Unit, had an order for Norco 5/325 to be given twice daily routinely as well as every 4 hours PRN for pain. The Narcotic Shift Count Sheet revealed two (2) tablets had been provided to the resident on the 10-6 shift. However, the Narcotic Sign-Out Sheet revealed one (1) of the tablets had been signed-out at "0300" (i.e., 3:00 AM) by a staff person not assigned to the med cart at that time. Again, there was no evidence anyone had questioned the transaction.  6. Resident #8, living on the Cherry Hall, had a order for Norco 5/325 to be given every 4 hours PRN for pain. The Narcotic Shift Count Sheet revealed three (3) tablets had been provided to the resident during the 10-6 shift beginning 11/05/13. However, the Narcotic Sign-Out Sheet revealed two of the tablets had been documented as being signed-out at times and dates prior to that on the 10-6 shift as well as signed-off with illegible signatures which did not match the facility's signature record. Thus, as a result of the facility's complete investigation, it was concluded that up to as many as twenty-five (25) doses of narcotic medications may have been diverted for various residents. The irregularities involving Residents #3 through #8 were not identified until several days following the incident of 11/06/13.	F 431			



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

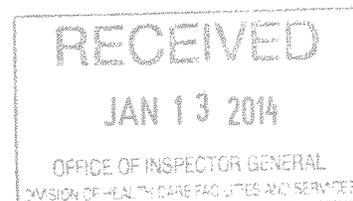
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD</b> <b>MOUNT WASHINGTON, KY 40047</b>		
(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 5</p> <p>The initial interview with the DON, on 11/21/13 at about 9:45 AM, revealed RN #2 had only worked at the facility four days. The DON explained the nurse was currently in her orientation phase on 11/06/13. Review of the nurse's personnel file revealed a hire date of 10/29/13, a satisfactory background check, and good standing with the Kentucky Board of Nursing. The nurse was hired as a Charge Nurse, PRN basis. The DON explained the nurse was currently under treatment at a rehab unit for drug dependency. The DON further explained that Residents #1 and #2 were both interviewed on 11/06/13 and expressed no recent concerns over pain/discomfort, or issues over not receiving pain medications on a timely basis. The DON explained the families of both residents were notified of the drug diversion. The additional six residents who were later identified as possibly being affected by RN #2's actions were assessed, their records reviewed, and determined to show no evidence of extraordinary pain issues at the various times in question.</p> <p>The interview with the DON, on 11/21/13 at 9:45 AM, revealed there were two (2) witnesses to the shift-change narcotic counts that occurred on the Apple Hall (RN #2's unit) on the morning of 11/06/13. On that morning, the on-coming nurse was LPN #3 and the off-going nurse was the perpetrator (RN #2) who was accompanied by LPN #4 who was assisting with the RN's orientation. Interview with LPN #3 at approximately 11:00 AM revealed RN #2 (assisted by LPN #4) checked each Narcotic Sign-Out Sheet, calling-off the name of the resident, the drug name, and the amount of medication (tablets, capsules, etc.) that should be present in the medication pack. She (LPN #3), in</p>	F 431		



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>		
(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 6</p> <p>turn, would visually check the contents of the medication pack, ensuring the amount of medication reported by the off-going nurse corresponded with the count in the pack. If the two amounts corresponded, she (LPN #3) would document and initial the correct amount on to the Narcotic Shift Change Sheet, then go through the identical process with each subsequent pack of medication. Nothing was mentioned about the on-coming nurse also visually checking the Narcotic Sign-Out Sheet to ensure the off-going nurse had quoted the correct amount, or to reconcile the Narcotic Sign-Out Sheets with the Narcotic Shift Count Sheet.</p> <p>During the interview, LPN #3 stated that a discrepancy was apparent when RN #2 called-off the amounts on Resident #1's Percocet and OxyContin 40 mg., and a similar discrepancy became apparent when RN #2 called-off the amount on Resident #2's Lortab. LPN #3 explained that, at that point, the shift counts were suspended, and the House Manager was notified, then subsequently, the DON was notified as well.</p> <p>Interview, on 11/21/13 at approximately 11:15 AM, with LPN #4 revealed he had worked with RN #2 during the 10-6 shift, primarily for the purpose of orientation. The LPN explained he had accompanied RN #2 on the nurse's initial resident medication administration, until he was told by the nurse that it caused her to be uncomfortable, having someone look over her shoulder during a med pass. LPN #4 explained that, at that point, he "backed off", doing other things, but stayed relatively close in case the nurse ran into a problem. LPN #4 further explained that RN #2 had both sets of keys to the med cart that evening and that RN #2 passed all medications</p>	F 431		



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>	

(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
--------------------	--	---------------	---	----------------------

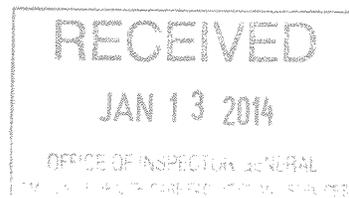
**F 431** Continued From page 7

during that shift. The LPN explained that, near the conclusion of their 10-6 shift and at approximately 6:00 AM, he assisted RN #2 in conducting the shift-change narcotic counts with the on-coming nurse, LPN #3. LPN #4 explained that, during the process of the Shift Change Counts, irregularities became apparent in the counts of Resident #1's OxyContin and Percocet as well as with Resident #2's Lorlab. He was especially concerned over how Resident #1 could have required the six signed-out Percocet tablets during the prior 8 hour (10-6) shift, in addition to a 7th tablet which was unaccounted-for. He further explained he did not recognize the signature of the person(s) who had signed-out the resident's six Percocet tablets. The content of the interviews with LPN #3 and LPN #4 regarding the incident of 11/6/13 as well as their descriptions of the facility's procedure for conducting shift change narcotic counts were consistent.

Further interview with the DON, on 11/21/13 at about 1:30 PM, included a request for a copy of the facility's policy/procedure regarding the accounting of controlled substances. At that time, the DON acknowledged the facility had no formal or written policy regarding the accounting for controlled substances. He explained that new staff were instructed during orientation that the narcotics/controlled substances must be dually counted at each shift change by the on-coming and off-going nurse.

Observation, at 2:00 PM on 11/21/13, revealed a shift change narcotic count of the Apple Hall medication cart, conducted by LPN's #1 (the on-coming nurse) and LPN #2 (the off-going nurse). LPN #2, positioned at the right end of the medication cart, was visually checking each

**F 431**



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>	

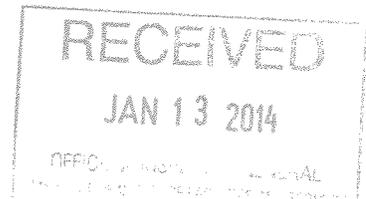
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

**F 431** Continued From page 8

Narcotic Sign-Out Sheet, calling-off the individual resident's name, the name of the medication, and the quantity of medication that should be present in the corresponding pack of medication. LPN #1, positioned at the left end of the cart, visually counted the amount of medication contained in the pack, ensuring the amount corresponded with the amount quoted by LPN #2. Noting that the amounts did not deviate, LPN #1 recorded the reported amount of medication and her initials on the Narcotic Shift Count Sheet, then repeated the process for all subsequent sign-out sheets and packs. LPN #1 was not observed to visually check the Narcotic Sign-Out Sheets, or to reconcile the Narcotic Sign-Out Sheets with the Narcotic Shift Count Sheet. Shortly following the observation, a joint interview with LPN #1 and LPN #2 was obtained in which they described the general facility procedure for conducting shift-change narcotic counts, and the content of their interviews was basically compatible with those descriptions earlier obtained from of LPN #3 and LPN #4.

On 11/22/13, additional interviews (at 11:00 AM, 11:35 AM, and 11:50 AM respectively) were obtained with LPN #5, #6, and #7 concerning the facility's customary procedure for conducting counts of their narcotics. Although these staff passed medications on units other than LPN #'s 1, 2, 3, and 4, there was no notable variation in their content. All LPNs (#1 through #7) agreed that the off-going nurse was responsible for visually checking all Narcotic Sign-Out Sheets, reporting the resident name, drug name, and current inventory of the drug. The LPNs also agreed the on-coming nurse was responsible for visually checking each corresponding pack of medication, ensuring the amount of drug

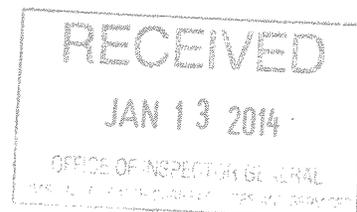
**F 431**



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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN MEADOWS HEALTH CARE CENTER 1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047</b>		
(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 9</p> <p>contained in the pack corresponded with the amount reported by the off-going nurse, and then documented the amount on the Narcotic Shift Count Sheet and initialed the entry. Thus, it was concluded that all seven medication nurses followed a consistent procedure. All nurses were aware of the accepted procedure for wasting medications and when and to whom to report discrepancies. However, no one noted the need for the on-coming nurse to visually inspect both the inventory of each narcotic pack as well as visually inspect each Narcotic Sign-Out Sheet, or to always reconcile all Narcotic Sign-Out Sheets with the Narcotic Shift Count Sheet.</p> <p>Further interview with the DON, on 11/22/13 at 4:30 PM, revealed the facility maintained a master list of signatures/initials of staff who document the administration of medications, including the signing-out of narcotics. Further observation revealed a Signature Record (Log) was present on each medication cart. However, record review revealed numerous instances in which signatures or initials, as well as dates and times, documented on Narcotic Sign-Out Sheets were illegible, and many signatures failed to match signatures present on the signature master lists. The DON stated the facility's monitoring procedure was to review all Narcotic Sign-Out Sheets upon completion of the respective medication pack (and corresponding Narcotic Sign-Out Sheet). However, depending on the frequency of use of a particular medications (especially PRN narcotics), a particular medication may remain in the narcotic drawer for days, weeks, or months before completion.</p> <p>The facility did not have a system in place to monitor the signing-out of narcotics, how</p>	F 431		



Addendum to Plan of Correction  
Green Meadows Health Care Center 1  
Provider: 185464  
Date of Abbreviated Survey: November 22, 2013  
Referenced on page 1 of 11 of Federal Survey and page 1 of 10 of State Survey

Page: 16.38  
Issued: 11/13  
Supersedes: --/--

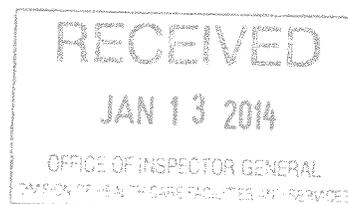
### **Controlled Drug Records**

#### **Policy**

It is the policy of this facility that records will be maintained for all controlled drugs.

#### **Procedure**

1. Oncoming nurse is to count all controlled medications with the off going nurse to ensure all controlled medications are accounted for. If the count is not accurate the Director of Nursing is to be notified immediately.
  - a. Both nurses are to verify the following forms are accurate by visual inspection-
    - I. Controlled drug record
    - II. Blister pack containing medication
    - III. Narcotic shift count sheet.
2. When controlled substances are removed from blister pack the nurse is to document (Date, time & signature) on the Controlled Drug records.
3. The oncoming nurse is to record the number of each controlled medications in each individual blister pack on the Narcotic shift count form
4. Any time a controlled medication is wasted; two (2) nurses are to witness the medication being wasted and sign the Controlled Drug Record as "wasted".



Addendum to Plan of Correction

Green Meadows Health Care Center 1

Provider: 185464

Date of Abbreviated Survey: November 22, 2013

Referenced on page 1 of 11 of Federal Survey and page 1 of 10 of State Survey

Page: 16.38  
Issued: 11/13  
Supersedes: --/--

### Controlled Drug Records

#### Policy

It is the policy of this facility that records will be maintained for all controlled drugs.

#### Procedure

1. Oncoming nurse is to count all controlled medications with the off going nurse to ensure all controlled medications are accounted for. If the count is not accurate the Director of Nursing is to be notified immediately.
  - a. Both nurses are to verify the following forms are accurate by visual inspection-
    - I. Controlled drug record
    - II. Blister pack containing medication
    - III. Narcotic shift count sheet.
2. When controlled substances are removed from blister pack the nurse is to document (Date, time & signature) on the Controlled Drug records.
3. The oncoming nurse is to record the number of each controlled medications in each individual blister pack on the Narcotic shift count form
4. Any time a controlled medication is wasted; two (2) nurses are to witness the medication being wasted and sign the Controlled Drug Record as "wasted".

