

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

PRINTED: 11/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2014
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated/Extended Survey Investigating complaint KY22254, was initiated on 09/23/14 and concluded on 10/13/14. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified on 10/02/14 and determined to exist on 08/31/14 at 42 CFR 483.13 Resident Behavior (F224) at a scope and severity of a "K", 42 CFR 483.60 Pharmacy Services (F431) at a scope and severity of a "K", 42 CFR 483.75 Administration (F490, F514 and F520) at a scope and severity of a "K". Substandard Quality of Care was identified in 42 CFR 483.13 Resident Behavior (F224). The facility was notified of the Immediate Jeopardy on 10/02/14.</p> <p>On 08/31/14, during shift change review of the Morphine Sulfate (narcotic pain medicine) narcotic blister packs containing 30 tablets revealed twelve (12) blisters were empty or missing, and eighteen (18) blisters contained a tablet; however, not of the same size as the Morphine 15 milligrams (mg) tablets. The backs of the narcotic blister packs were taped closed. The nursing staff recognized there was tape on the back side of the whole narcotic blister pack; however, they failed to report this immediately to a supervisor as per policy. The staff made copies of the narcotic blister packs and slid them under the Director of Nursing's (DON) office door. The staff administered six (6) more doses of the unidentified tablets, (from the taped narcotic pack) that were in the Morphine Sulfate 15 milligrams (mg) blister pack, to Resident #1. The DON revealed Resident #1's Morphine Sulfate</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [Signature] TITLE: X Administrator DATE: X 11/21/2014

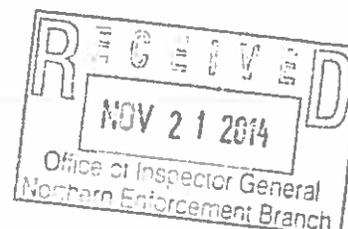
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

REGISTRY
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If continuation sheet Page 1 of 152
Office of Inspector General
Northern Enforcement Branch

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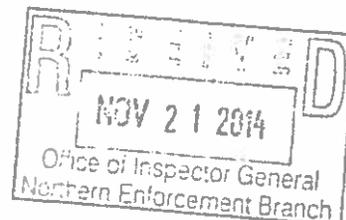
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F 000	<p>Continued From page 1</p> <p>had been replaced with a different medication of which the resident was not ordered. Once the Morphine was replaced with an unknown tablet, RN#1 did not remove any more tablets from that blister pack and started removing tablets from a second blister pack. On 09/05/14, staff stated they had discovered three (3) doses of Morphine Sulfate 15 mg was removed on 09/04/14 which was not Resident #1's normal pattern for taking this medication. Interview with the resident revealed the Morphine was only taken one time at night and he/she had not requested three doses.</p> <p>In addition, staff was not sure if Resident #5's Lorazepam 1 mg, and Morphine 5 mg, had been tampered. The DON was instructed by pharmacy on 09/09/14 to destroy these medications; however, they were not destroyed until 09/15/14. Although pharmacy had instructed the DON to destroy these medications, as they did not know if someone had tampered with the medications, the facility administered three (3) doses of these medications to Resident #5 on 09/10/14, 09/11/14 and 09/13/14.</p> <p>Resident #2 had Oxycodone 2.5 mg, 1/2 tablet every eight (8) hours as needed. There were two narcotic blister packs and each had a narcotic count sheet. The second Oxycodone 2.5 mg narcotic blister pack, had paper tape behind more than half of the blisters. Review of the Narcotic Count Sheets revealed documentation that dosing of Hydromorphone 2.5 mg appeared on both of the narcotic sheets.</p> <p>The facility documented medications were reordered too soon for Resident #6 who received Primidone, 50 mg, at night. The documentation on the Medication Administration Record (MAR)</p>	F 000			



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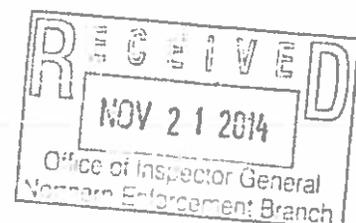
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F 000	Continued From page 2 revealed there were multiple missed doses, or the medication was not available, even though the pharmacy was sending the medication. Unsampled Resident A's Oxycodone was ordered 5/325 mg two (2) tablets every 6 hours as needed and it was documented the resident received six (6) tablets of Oxycodone 5/325 mg. in a six (6) hour period. Unsampled Resident B was ordered Oxycodone 5 mg, one (1) or two (2) tablets every four (4) hours as needed. RN #1 documented the removal of Oxycodone 5 mg on two different narcotic count sheets for the same day at the same time for a total of three (3) tablets given. The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.13 Resident Behavior (F224), 42 CFR 483.60 Pharmacy Services (F431), 42 CFR 483.75 Administration (F490, F514 and F520) with the scope and severity lowered to an "E" while the facility monitors the effectiveness of the implemented plan of correction.	F 000		
F 224 SS=K	An additional deficiency was cited at 483.20 Resident Assessment (F275) at a scope and severity of a "D". 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 224	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. F224 Completion Date: 11/05/2014 SS=E 483.13(c) Prohibit Mistreatment/Neglect/Misappropriation	



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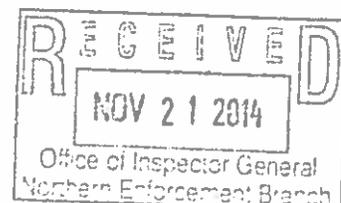
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F 224	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure an effective system was in place to identify and report diversion of medications for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5, #6) and two (2) of two (2) unsampled residents (Unsampled Residents A and B). The facility failed to identify and report misappropriation of resident property, and diversion of medications/narcotics when staff found tape on the back side of narcotic blister packs, and the narcotics (Morphine/narcotic analgesic) were replaced with other unidentified medications. In addition, staff borrowed Buspirone (anti-anxiety), Escitalopram (anti-depressant), for other residents' use, even though staff had been trained in June 2014 not to borrow medications. (Refer to F431) On 08/31/14, during shift change (7:00 PM - 7:00 AM) review of Resident #1's narcotic blister packs revealed Morphine Sulfate (narcotic pain medication) tablets were missing, and/or the pack was opened with a small slit. The Morphine tablets were replaced with tablets that were a different size and the pack was then taped back. Licensed Practical Nurse (LPN) #2 and LPN #6 recognized there was tape on the back side of the whole narcotic blister pack, but they failed to report this immediately to a supervisor. The staff made copies of the narcotic blister packs and	F 224	In good faith and per requirements, the facility self-reported the allegation of alleged drug diversion on 9/8/2014. This was reported to the State Agency (OIG), Adult Protective Services (APS), Local Ombudsman, Kentucky Board of Nursing (KBN), and the Local Police. The facility immediately implemented a plan to identify, correct, and prevent further recurrence on 9/12/2014. The specific residents affected by the alleged deficient practice were as follows: Resident #1 tampered medications were pulled from circulation on 9/8/2014 by the Director of Nursing and destroyed on September 10, 2014. The facility replaced the medication at no cost to the resident. Residents was interviewed on 9/8/2014 and stated that he did feel relief for his medication received prior to 9/8/2014. Resident #2 medications were pulled from the Medication cart on 9/3/2014, when the resident was admitted to HMH Hospital. This resident never received any of these medications. The Narcotic cards were locked up. Upon return on 9/10/2014, the narcotics were determined to have been tampered with and the police were immediately notified. The Narcotics and	



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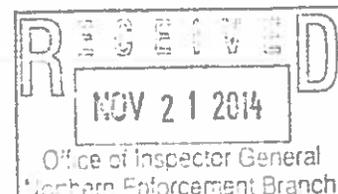
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F 224	<p>Continued From page 4</p> <p>gave them to the Director of Nursing (DON) under her office door. Review of Resident #1's narcotic count sheet revealed they continued to administer six (6) doses of the unknown tablets, that were in the blister pack of Morphine Sulfate 15 milligrams (mg), for Resident #1. The DON revealed Resident #1's Morphine Sulfate had been replaced with a different medication of which the resident was not ordered.</p> <p>On 09/05/14, LPN #3 and Registered Nurse (RN) #4 discovered Resident #1 received three (3) doses of Morphine Sulfate, 15 mg, on 09/04/14 which was not Resident #1's normal pattern for taking this medication. Review of LPN #3's note provided to the DON revealed the resident's normal pattern was one tablet at night time. It was also determined Resident #1 had eighteen (18) tablets available on one medication card (this card had tape on the back and the Morphine had been replaced) yet RN #1 documented she removed doses from Resident #1's untampered pack of Morphine.</p> <p>Interview on 09/26/14 at 1:29 PM, with the DON, revealed she was not sure if someone had tampered with the Lorazepam 1 mg, and the Morphine 5 mg. The DON stated she was instructed by pharmacy on 09/09/14 to destroy these medications. However, these medications were not destroyed until 09/15/14, after Resident #5 had received three (3) doses of these medications on 09/10/14, 09/11/14 and 09/13/14.</p> <p>In addition, Resident #2 had two (2) Oxycodone, 2.5 mg, narcotic sheets and two blister packs. The second Oxycodone 2.5 mg narcotic blister pack had paper tape behind more than half of the</p>	F 224	<p>their containers were turned over to the local police department by facility administration for investigation. The case number is on file at the facility. The narcotics were replaced for the resident at no cost. Resident was out of the facility during this investigation and no clinical assessment was therefore made of this resident, and because resident did not receive any of the tamper medication from this card. Resident was Palliative care (end-of-life-care), and as of 9/13/2014 no longer a resident of the facility</p> <p>Resident #3 — the Director of Nursing (DON) began an investigation on 9/8/2014 regarding the accuracy of the narcotic counts due to "write-overs" or "scratch thru" on the narcotic reconciliation sheets based on documentation discrepancies. Appropriate disciplinary action was taken by the Director of Nursing with RN#1, who was suspended on 9/8/2014 and terminated on 9/12/2014 and did not work in the facility again.</p> <p>Resident #5 medication, 9/16/14 pharmacist auditing carts suggested to DON that RN had the opportunity and may have tampered with refrigerated narcotic Lorazepam. As suggested by pharmacist, narcotic was destroyed by DON and ADON. After research, the Medication was delivered to the facility on 9/12/14, RN in question was suspended on 9/8/2014 and terminated on</p>	



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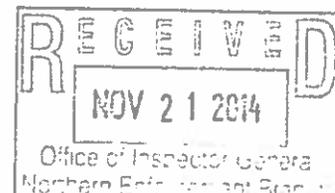
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F 224	<p>Continued From page 5</p> <p>blisters. Resident #3's physician order stated Hydromorphone 2.5 mg, one (1) tablet every four (4) hours. Review of the first narcotic sheet, dated 08/01/14, and a second narcotic sheet dated 08/06/14, revealed RN #1 removed three (3) narcotics on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. RN #1 documented this medication was removed from the blister pack every two (2) hours instead of every (4) hours as ordered. Resident #6 was ordered to receive Primidone, 50 mg, at night. Review of the Medication Administration Record (MAR) documentation revealed multiple missed doses or the medication was not available to administer. However, the pharmacy was sending the medication routinely. Unsampled Resident A received or was documented as given six (6) doses of Oxycodone 5/325 mg, in a six (6) hour period instead of every two (2) hours as ordered. RN #1 had documentation on the two (2) narcotic count sheets for Unsampled Resident B's Oxycodone 5 mg as being removed from the narcotic blister packs at the same time on the same date.</p> <p>The facility's failure to ensure an effective system was in place to identify and report misappropriation/drug diversion and tampering of resident medications and controlled substances placed residents at risk in a situation that has caused or was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of the Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14.</p>	F 224	<p>9/12/14 and worked no hours between those dates. There was no opportunity for this nurse or crossover for diversion, or misappropriation and resident was showing no adverse reactions.</p> <p>Resident #6 noted Medication was missing on 7/7/14 and was replaced at facility cost, and resident continues to be receiving medications. Two nurses were given disciplinary action, regarding the missed doses of medication, by the Director of Nursing on 7/11/2014.</p> <p>Unsampled Resident A had a changed physician order in her medical record dated 8/19/14 to increase Oxycodone APAP 5/325 mg to 2 tablets every 6 hours. Therefore, RN#1 gave the correct dose on 9/4/2014 at 12:00 (Noon) this resident as ordered. Then RN#1 gave 2 more tablets at 6:00 p.m. as ordered and this did complete this medication card. However, it appears RN#1 then pulled 2 more tablets from a new medication card also at 6:00 p.m. on 9/4/2014. It is unknown as to whether this resident actually received the extra 2 tablets. Resident did not suffer from any adverse side effects. Facility replaced the medication at facility cost. RN#1's last day worked was 9/4/2014 and was never returned to work because was suspended on</p>		



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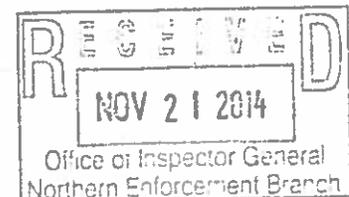
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F 224	<p>Continued From page 6</p> <p>after training of facility staff was verified completed 10/10/14, at 42 CFR 483.13 Resident Behavior and Facility Practices (F224) with a scope and severity lowered to an "E" while the facility monitors the effectiveness of the implemented plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Recognizing Signs and Symptoms of Abuse", revised April 2011, revealed the facility would not condone any form of resident abuse. To aid in abuse prevention, all personnel were to report any signs and symptoms of abuse to their supervisor, or to the Director of Nursing Services immediately. Signs of actual physical neglect would be improper use/administration of medications.</p> <p>Review of the facility's policy, "Inventory Control of Controlled Substances", revised 01/01/13, revealed the facility would ensure staff immediately reported suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation and timely follow-up in accordance with facility policy. Upon receipt of such a report, the facility would ensure the appropriate facility personnel confirmed the discrepancy and followed facility policy and applicable laws regarding documentation of the incident. The facility would also conduct an investigation to determine: if a dose was in fact administered; and, if so, the reason the administration was not charted and if a dose was refused.</p> <p>Review of the facility's "Loss and Theft" policy effective 12/01/07, revealed when facility staff</p>	F 224	<p>9/8/2014 and after an investigation was termed from employment at the facility.</p> <p>Unsampled Resident B on 7/26/2014 at 7:30 p.m., from review of narcotic sheets, it appears RN#1 gave 1 tablet of Oxycodone IR 5 mg that completed a medication card and then RN#1 pulled two more tablets from a new medication card on 7/26/2014 at 7:30 p.m. This resident was a discharged 7/26/2014. This medication issue was not discovered until this complaint investigation.</p> <p>The two sharp containers that were found in the public restrooms (women's and men's) that contained straws, blister packs, paper tape, pill crusher sleeves, partial pills, and cigarette wrappers were turned over to the local police department detective on 9/15/2014.</p> <p>Other Residents with Potential to be Affected:</p> <p>All Residents receiving physician ordered Controlled Substance Medication commonly referred to as Narcotics, are at risk due to misappropriation of such medication. The facility must provide sufficient safeguards and monitoring practices to prevent theft or diversion within the facility control.</p>		



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F 224	<p>Continued From page 7</p> <p>suspected theft or loss of medications, the facility staff would take such actions as required by applicable laws and facility policy. Appropriate actions may include: immediately reporting suspected theft or loss of drugs to a supervisor/manager or the Director of Nursing for appropriate investigation and follow-up. Investigating and reconciling discrepancies and notifying the appropriate facility Administrator of the controlled substance discrepancies and if such discrepancies were not reconciled, notifying the appropriate law enforcement agencies according to applicable laws and facility policy.</p> <p>1. Review of Resident #1's Morphine Sulfate IR (immediate release), 15 mg, narcotic blister pack with a quantity of thirty (30) tablets, revealed tablets number twenty-four (24) through thirty (30) were empty, tablet number twenty-one (21) was also empty; and, blister number one (1) through twenty (20), twenty-two (22) and twenty-three (23) were full. Review of the 08/31/14 documentation on the Morphine Sulfate IR 15 mg narcotic count sheet, revealed LPN #2 and LPN #6 had signed and verified blister #21 was missing a pill. Review of a photo copy of the back of the Morphine Sulfate IR, 15 mg blister pack revealed all thirty (30) tablets' foil backing had been cut with a tiny slit, the tablets removed, and replaced with an unknown medication and taped across the back of the card. Continued review of the photo copy revealed two (2) Morphine Sulfate IR 15 mg blister packs. One (1) of the blister packs was ordered on 08/14/14 with a remaining correct count of eighteen (18) tablets. The second Morphine blister pack was ordered on 08/31/14 with a remaining correct count of twenty-seven (27) tablets. Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at</p>	F 224	<p>The Director of Nursing and facility administration have conducted 100% audit of narcotic orders and records beginning on 9/8/14 and continuously have provided education to specific nurses for compliance and for any new nursing staff. Since 9/8/14 there has been no suspicious activity or tampering with narcotics noted through daily audits by nursing administration.</p> <p>Pharmacy Consultant Manager from Omnicare Pharmacy (facility contract) reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation. This review was completed October 3, 2014. No signs of Diversion or tampering were found.</p> <p>In addition, the consulting pharmacist on her monthly visit to the facility on 10/22/2014 again reviewed and analyzed narcotic medications dispensed and administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation, and reviewed and analyzed the EDK and found no indications of diversion or tampering.</p>		



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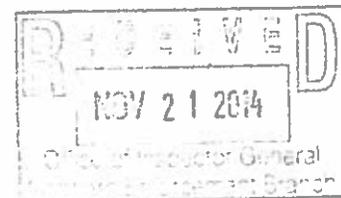
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2014
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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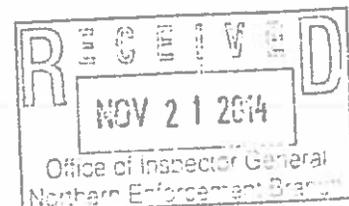
F 224	<p>Continued From page 8</p> <p>9:30 AM, revealed if the facility was reordering the medication through the computer system Pharmacy would not know if it was reordered too soon. The facility had an automated system which generated a fax to the facility notifying the facility the medication was reordered too soon. However, per interview, if the DON signed the fax Pharmacy would fill the reorder without question. Interview with the DON, on 09/25/14 at 2:18 PM, revealed she did sign the too soon reorder notices to get the medications delivered. Further interview with the DON, on 09/24/14 at 3:48 PM, revealed the two (2) Morphine Sulfate IR blister packs were destroyed on 09/10/14 because she suspected someone had tampered with the medications.</p> <p>2. Review of the Narcotic count sheets revealed two (2) of Resident #5's Lorazepam 1 mg liquid and one (1) of Morphine (Floxanol), 5 mg, liquid had been destroyed on 09/15/14 for fear the medication had been tampered. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON asked the pharmacy consultant if there was any other possible narcotics that could be tampered with and the pharmacist stated in the refrigerator. RN #1 had documented she administered this medication and the DON and the pharmacist could not tell if the liquid had been replaced with another liquid. Although pharmacy had instructed the DON to destroy this medication on 09/09/14, the facility administered three (3) more doses of these medications on 09/10/14, 09/11/14, and 09/13/14 to Resident #5. However, post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed she could not remember when the pharmacist told her to destroy these medications and thought it was on 09/15/14 the day she destroyed the medications.</p>	F 224	<p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Education provided to the nursing staff by the Director of Nursing included medication misappropriation, which included notification to the Director of Nursing, the nurse on call and/or the Administrator. This notification is to be immediate if there is any suspicious activity regarding misappropriation of medications, tampering of medication packaging, or appearance of falsification of narcotic records. This was completed by 10/08/2014.</p> <p>In addition, Director of Nursing and Administrator were educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 9/12/2014. The Education included training on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessments, Accuracy of Notes, Change of Condition, Abuse and Neglect, and Narcotic Balance Process.</p> <p>As part of the AOC nursing education was provided to all licensed nursing staff by</p>	
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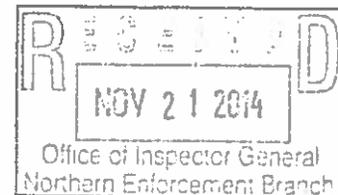
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F 224	<p>Continued From page 9</p> <p>3. Observation of Resident #2's Oxycodone 2.5 mg, narcotic blister packs revealed there were two (2) narcotic cards. The first Oxycodone 2.5 mg, revealed Resident #2 had received a total of twelve (12) of thirty (30) half tablets that had no evidence they were tampered. The second Oxycodone 2.5 mg, narcotic card, had paper tape behind more than half of the blisters. It was determined Resident #2 did not receive any of these narcotic because the blister pack still had unknown tablets taped inside the card. Interview on, 09/24/14 at 3:48 PM, the DON stated the medication looked like Lexapro and Lasix.</p> <p>4. Review of Resident #3's narcotic count sheet for Hydromorphone 2 mg, ordered every 4 hours as needed, for the month of August, dated 08/01/14 with signatures dated 08/01/14 through 08/08/14 and a second narcotic sheet dated 08/06/14 with signature dates of 08/06/14 through 08/11/14, revealed RN #1 removed three (3) Hydromorphone tablets, one (1) each on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. In addition, RN #1 removed the last Hydromorphone tablet on 08/06/14 at 12:00 PM, on the second sheet. RN #1 removed one (1) Hydromorphone tablet on 08/06/14 at 10:00 AM and then again at 2:00 PM, which was every two (2) hours instead of the every four (4) hours as needed, as the medication was ordered. Review of the MAR revealed the administration times were listed as 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. The 12:00 PM dose was not documented as administered.</p> <p>In addition, the RN removed narcotics from two (2) different blister packs on the same date at the same time and documented they were</p>	F 224	<p>Omnicare Pharmacy Nursing Consultants on 10/7/2014.</p> <p>Licensed Nurses who handle medication carts have been in-serviced on the following programs:</p> <p>Pain Assessment and Mgt. SilverChair 9/28/2014 Pass Accuracy of Notes, Doc. Change of Cond. SilverChair 9/28/2014 Pass PRN Medication Management SilverChair 9/28/2014 Pass Medication Pass-Indicators, Side effects, reporting, errors etc SilverChair 9/28/2014 Pass Prevent/Recognize, Reporting Patient Abuse SilverChair 9/28/2014 Pass</p> <p>Pharmacy Training Guide (Returns/Controlled Meds in EDK) Dir. Of Nursing 9/22/2014 One on One EDK Process, physician orders, medications, wasted Medication, Physician Notifications, Matching Inventory sheet, Narcotic Balance Process and destruction Dir. Of Nursing 9/27/2014 One on One K.A.R.s Operation Guide 902 KAR 20:048 Controlled Substance Notification Dir. Of Nursing 9/22/2014 One on One</p> <p>The Facility Policies and Procedures for Delivery, Monitoring and Documentation of</p>	



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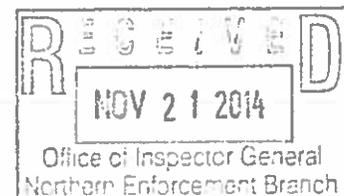
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F 224	<p>Continued From page 10 administered to Resident #3. On the same two narcotic count sheets, RN #1 documented on the first count sheet she removed the last tablet on 08/06/14 at 10:00 AM leaving a balance of zero.</p> <p>She then removed one tablet from the second count sheet at 10:00 AM on 08/06/14. She then scratched out her initials for 10:00 AM on the first sheet and documented she removed a tablet at 12:00 PM as a PRN dose leaving a balance of zero on an already zero balanced count sheet. The RN documented she removed a medication from a narcotic count sheet that already had a zero balance.</p> <p>Review of the clinical record for Resident #3 revealed a 06/13/14 Quarterly Assessment that indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15). Interview with Resident #3, on 09/23/14 at 8:57 AM, revealed the facility had ran out of multiple medications for him/her and had to reorder them early, he/she further stated he/she suffered from pain all the time and wondered if he/she was receiving the pain medications.</p> <p>Review of Resident #3's, Hydromorphone, 2 mg, revealed two narcotic sheets. The first narcotic count sheet, dated 08/27/14 through 09/01/14; and, the second narcotic count sheet dated 08/31/14 through 09/06/14. The first narcotic count sheet, revealed RN #1 removed narcotics on 08/30/14 at 10:00 AM, 2:00 PM and 6:00 PM, which left six (6) available tablets in the narcotic blister pack. Then on the second narcotic count sheet, RN #1 removed narcotics on 08/30/14 at 10:00 AM and 2:00 PM. RN #1 documented she removed tablets on the same date at the same time from two separate blister packs.</p>	F 224	<p>Narcotic Medications have been reviewed but no changes were deemed necessary. Those policies reviewed included the following:</p> <p>Adverse Reaction to Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Controlled Substances – Misappropriations Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Adverse Consequences and medication Errors Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Accepting Delivery of Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Administering Medication Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Loss or Theft of Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Discarding or Destroying of Medication Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>Security of the Medication Cart Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>The in-services noted above are part of the new employee (Licensed Nurse) orientation program, effective 10/06/2014.</p> <p>Facility Administration made the discussion to expand upon "Abuse Training" and developed an "Abuse Program Competency Test", that required a competency of at least 90%. This was administered and completed by all facility staff by 10/24/2014. All new</p>		



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F 224	<p>Continued From page 11</p> <p>Hydromorphone was removed from the blister packs without documentation of administration on the MAR.</p> <p>5. Review of Unsampled Resident A's Physician Orders, dated 08/09/14, revealed an order for Oxycodone APAP (Acetaminophen and Propoxyphene) 5/325 mg, one tablet every six (6) hours as needed for pain. The narcotic count sheet, revealed on 09/04/14 at 12:00 PM, RN #1 removed two (2) tablets leaving a total of two (2) tablets in the blister pack. RN #1 then removed two (2) Oxycodone APAP 5/325 mg at 8:00 PM on 09/04/14 and finished the blister pack. RN #1 then removed Oxycodone APAP 5/325 mg from a new narcotic count sheet on 09/04/14 at 8:00 PM. RN #1 documented on the Medication Administration Record and the narcotic count sheet that Unsampled Resident A received a total of six (6) tablets within six (6) hours.</p> <p>6. Review of Unsampled Resident B's narcotic sheet for the month of July dated 07/24/14 through 07/26/14, revealed Unsampled Resident B was ordered Oxycodone IR, one 5 mg tablet every four (4) hours, as needed. On 07/26/14 at 7:30 PM, RN #1 removed one (1) tablet, the last narcotic, from the blister pack. On a new narcotic sheet for the same drug, RN #1 removed two (2) tablets on 07/26/14 at 7:30 PM from the second narcotic count sheet: for a total of three (3), 5 mg tablets at the same time.</p> <p>7. Review of Resident #6's, MAR for the month of May 2014, revealed Resident #6's Primidone (anti-seizure medication), 50 mg, was not given on 05/01/14, 05/02/14, 05/04/14, 05/05/14, 05/08/14, 05/07/14, 05/08/14, 05/09/14, 05/10/14, 05/13/14, 05/15/14, 05/16/14, 05/24/14, and</p>	F 224	<p>staff will complete this as part of their orientation, effective 10/25/2014.</p> <p>Facility Nursing Administration (DON, ADON, and/or Unit Manager) will be checking and monitoring the two sharp containers in the facility public restrooms (women's and men's) to ensure that containers are free from paper tape, pill crusher sleeves, blister packs, straws, partial pills, and cigarette wrappers. This will be monitored weekly for the next 3 months, and then month for 3 additional months, and then when full and changed out.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation:</p> <p>During morning meeting Monday through Friday(which started on 10/6/2014) the Director of Nursing and/or Nursing Administration report on Narcotic Count Records as well as the Medication Administration Records (MAR) and review narcotic medication to ensure tampering or diversion has not taken place. This will continue until 11/30/2014. If there have been no diversions or suspicious activities noted; the QA Committee will make a decision whether to continue 5 days per week monitoring or reduce to weekly reporting, after 11/30/2014. Whenever/If suspicion is identified by Nursing, the</p>		

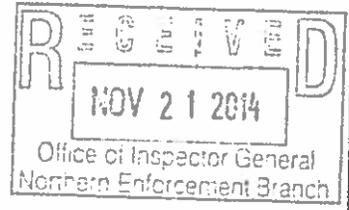


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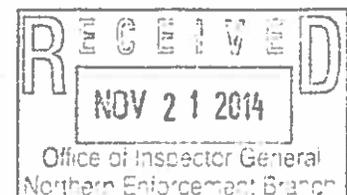
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F 224	<p>Continued From page 12</p> <p>05/29/14. There was no documentation for the reason the medication was not given, except for 05/10/14, 05/14/14, 05/24/14, when it was documented the medication was not available and on 05/08/14, 05/07/14 and 05/24/14 when it was documented the resident refused the medication. Review of Resident #8's MAR for the month of June 2014, revealed Resident #8's Primidone, 50 mg, was not given on 06/07/14, 06/11/14, 06/14/14, 06/15/14, 06/16/14, 06/17/14, 06/18/14, 06/19/14, 06/20/14, 06/21/14, 06/22/14, and 06/24/14. There was no documentation to indicate why the medications were circled for the days of the 05/07/14, 05/19/14, 05/21/14, and 05/24/14. The dates of 05/11/14 and 05/14/14 were blank with no initials or documentation as why the boxes were left blank. Review of Resident #6's, MAR for the month of July 2014, revealed Resident #6's Primidone, 50 mg, was not given on 07/02/14, 07/03/14, 07/04/14, 07/05/14, 07/06/14 and 07/07/14. There was no documentation as to why this medication was not administered except for 07/02/14 and 07/05/14 it was indicated the medication was not available and pharmacy was notified. Review of the Work Order Fill form, not dated, revealed this medication was replaced by pharmacy at the facility's expense.</p> <p>8. Review of the narcotic count sheets, the corresponding blister packs, and the contents of two sharps containers (labeled men and women) confiscated by the local Police Department, on 10/01/14 at 8:10 AM, revealed slits were cut into the foil backing of the blister packs, taped closed with paper tape and contained all sizes of tablets cut in half. These tablets could not be identified because of their size and the manufacture's marking was obliterated. In addition, there were</p>	F 224	<p>Director of Nursing will immediately contact the Pharmacy and begin an internal investigation. Additionally, all proper authorities will be notified including, OIG, DCBS, local Police, and in certain situations, the Kentucky Board of Nursing. This notification practice was done on 9/8/2014 with this complaint survey that was self-reported.</p> <p>If there are any weekend discrepancies with the system the on call nurse will be immediately notified and the Nurse on call will call the Administrator or Director of Nursing and will refer to QA any concerns received with immediate investigation started. The Quick Step for Loss or Theft of Medication Protocol will be followed:</p> <ol style="list-style-type: none"> Immediately report suspicion to Nursing Supervisor/Manager or the Director of Nursing for appropriate investigation and follow up. The Nursing Supervisor/Manager, or Director of Nursing, will investigate and reconcile discrepancies immediately. The Nursing Supervisor/Manager, Director of Nursing, or Administrator will provide verbal direction to safeguard medication cards,/controlled substances and records until such time as they arrive at the facility to continue the investigation. If the Nursing Supervisor/Manager or Director of Nursing and/or Administrator 	



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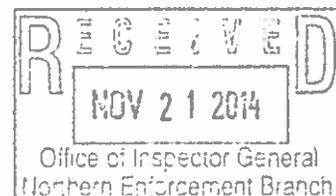
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F 224	<p>Continued From page 13</p> <p>two (2) Sharps boxes, one labeled Men's and one Women's Sharps that had also been confiscated by the police and determined to be used by RN #1. The Women's Sharps box was observed to have paper tape, clear pill crusher sleeves with white residue, nine (9) opened, empty blister packs of Lasix (diuretic) 20 mg, clear plastic cigarette wrapper with white residue in it, a partial pill (unidentifiable) and straws, one of which was found still in a clear pill crusher sleeve. The Men's Sharps box was observed to have four (4) straws, clear pill crusher sleeves with powder residue in them and two (2) partial pills to small to identify.</p> <p>Unsuccessful attempts were made to interview RN #1, on 09/24/14 at 2:29 PM; and, on 09/25/14 at 9:18 AM on her home phone and, at 9:20 AM on her cell phone. Messages were left three (3) times to call back. No return calls were received.</p> <p>Interview with LPN #2, on 10/10/14 at 9:30 AM, revealed he did not know when he found the narcotic blister packs with tape across the back for Resident #1 at the end of August that it was misappropriation of property. However, the Loss and Theft of Medications policy indicated the facility staff should immediately report suspected theft or loss of drugs to a supervisor/manager or Director of Nursing.</p> <p>Interview with LPN #8, on 10/10/14 at 3:30 PM, revealed she was not aware the missing narcotics was misappropriation of property at the time.</p> <p>Interview with LPN #3, on 10/01/14 at 2:02 PM, revealed at the time she did not consider the medication being given more than one time to be abuse. She identified it to be more of a medication error. She was aware to report abuse</p>	F 224	<p>will be contacted. The Director of Nursing and /or Administrator will notify the appropriate law enforcement agencies according to applicable Law and Facility Policy.</p> <p>The Director of Nursing presented to the Quality Assurance Committee on 10/6/2014 the results of the Consultant Pharmacist analysis of:</p> <ol style="list-style-type: none"> Audit of Narcotic to label review; Narcotic to counted balance sheet; Review of MAR to Balance Sheet Review of actual Medication for accuracy of inventory Review of the EDK for Inventory to stated inventory. After review, no discrepancies were found, no sign or symptom of diversion or potential for diversion. This review was initially completed 10/03/2014 and will be part of the consulting pharmacist's monthly review for the facility, which was completed on 10/22/2014 and will continue monthly. <p>QA Committee members have reviewed daily (Monday – Friday) the narcotic auditing that is completed by nursing administration. This started on 10/6/2014 and will continue through 11/30/2014 — for 5 days a week. If there has been no diversion and/or suspicious activities with narcotics noted and the QA Committee agrees then auditing may be reduced to one</p>		



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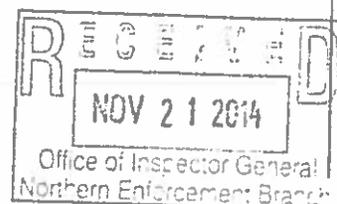
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F 224	<p>Continued From page 14</p> <p>Immediately and now she recognized that she should have reported the incident sooner. LPN #3 stated she knew the residents' pain probably was not being addressed and could cause increased pain for the residents. LPN #3 stated the resident could have also had an allergy to the unknown medication which could lead to an allergic reaction or death.</p> <p>Interview with the Unit Manager, on 09/30/14 at 10:00 AM, revealed it did not cross her mind that the medication had been tampered. She stated she should have immediately informed the DON of the paper tape to the back of the medication blister pack because of possible misappropriation; however, she was not aware at the time that it was neglect.</p> <p>Interview with the DON, on 09/25/14 at 2:37 PM, revealed she was not thinking about abuse at the time, she was trying to figure everything out in her mind. The DON stated she did not notify the Administrator at the time, because she was trying to wrap her brain around the use of tape.</p> <p>Continued interview with the DON, on 09/25/14, revealed when she went to interview the staff, the staff stated they were borrowing medications from other residents, so the residents without medications could have their medications. The DON stated she had repeatedly informed the staff not to borrow medications from residents. At that time, the DON stated she could not see the bigger picture. She was not thinking about abuse at the time, she was trying to figure everything out in her mind.</p> <p>Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed she was made aware of the diversion of medication on 09/08/14 and not</p>	F 224	<p>time weekly thereafter. The Quality Assurance committee is specifically looking for Diversion, Misappropriation, missed dosage, etc. The Quality Control Committee will review and recommend or direct action based upon the results of audits or reports and will provide management with an action plan if necessary to meet the ongoing needs of the facility.</p> <p>Regional Nurse Consultant or the Regional Direct of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings per the protocol noted above, effective for 10/3/2014.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed as outlined above and monitored by the Quality Committee for ensuring on-going compliance. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, Director of Nursing, Unit Managers, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director and consulting pharmacist.</p>		



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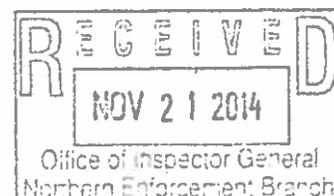
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F 224	<p>Continued From page 15</p> <p>before that time. The Administrator and the DON initiated an investigation on 09/08/14 and determined Resident #1 received all the medication as ordered, terminated RN #1 for failure to document on the MAR that the Morphine Sulfate had been administered, not completing a pain assessment prior to administering the pain medication, nor indicating the pain medication was effective or not. Interview with the Administrator on 10/02/14 at 4:58 PM, revealed taking of resident medication was misappropriation of property.</p> <p>Interview with the Medical Director, on 09/25/14 at 3:47 PM, revealed he was made aware of the Primidone medication error, but not the narcotic concerns. He was not notified of the misappropriation of property until 09/08/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> 1. Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. 2. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. 	F 224	The Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.		



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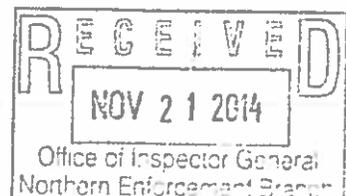
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F 224	<p>Continued From page 16</p> <p>3. All medications found to be tampered with were reordered at the facility's expense.</p> <p>4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14.</p> <p>5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense.</p> <p>6. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed.</p> <p>7. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages.</p> <p>8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits</p>	F 224		



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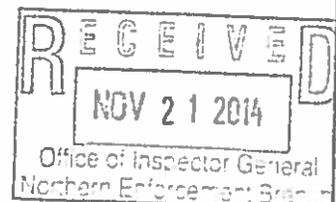
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F 224	<p>Continued From page 17</p> <p>starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering.</p> <p>9. Education provided to the nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator.</p> <p>10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance.</p> <p>11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th.</p> <p>12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and</p>	F 224			



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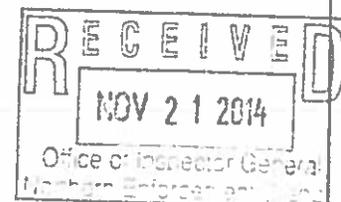
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F 224	<p>Continued From page 18</p> <p>Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14.</p> <p>13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/08/14.</p> <p>14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14.</p> <p>15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON.</p>	F 224			



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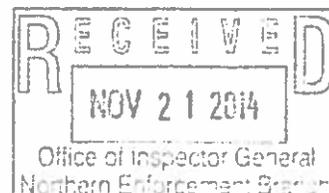
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F 224	<p>Continued From page 19</p> <p>16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy.</p> <p>17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 08/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions.</p> <p>Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14.</p> <p>1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14.</p> <p>2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the</p>	F 224			



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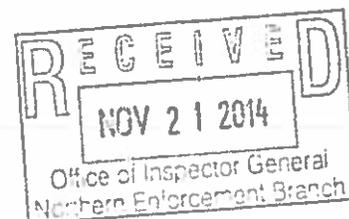
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F 224	<p>Continued From page 20</p> <p>Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14.</p> <p>3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/28/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/28/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed.</p> <p>4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of Morphine Sulfate were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that appeared tampered.</p> <p>5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) morphine narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other morphine narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility</p>	F 224		



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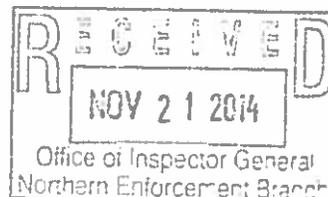
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F 224	<p>Continued From page 21</p> <p>purchased the re-ordered medications which were destroyed.</p> <p>6. Review of Resident #5's Morphine and Lorazepam narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed Morphine and Lorazepam on 09/15/14.</p> <p>7. Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders to ensure they matched what was in the computer between the days of 09/09/14 and 09/15/14 and daily there after. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14.</p> <p>8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at all orders, verified the MAR matched the orders, and that the pink narcotic sheets matched the drug labels. Then all narcotic counts were verified. The review revealed no signs of diversion for any of the residents. Interview with the Pharmacy Clinical Manager, on 10/13/14 at 11:34 AM, via telephone, revealed she came into the facility to review controlled substances orders, make sure the directions of the orders matched the narcotic sheets. She did an inventory with nursing and inspected the medications and ensured that the narcotic counts matched. The</p>	F 224			



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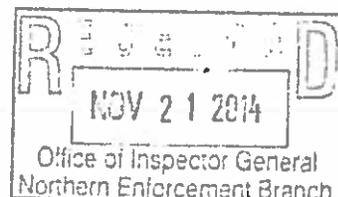
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F 224	<p>Continued From page 22</p> <p>Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards, especially when the medication changed from routine to PRN. She stated she reviewed all four (4) medication carts and looked at the Emergency Drug Kit (EDK) box, which revealed no concerns with the shift change counts. She then provided the facility with a report. Interview with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14.</p> <p>9. Review of the education content confirmed the education was completed on 09/30/14 by the DON for eleven (11) LPNs, and five (5) RNs, there was no PRN staff, none on FMLA (Family Medical Leave Act) or vacation and the facility did not use contract staffing. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3 on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7 on 10/13/14 at 1:26 PM; and ,RN #4, on 10/10/14 at 10:38 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately.</p> <p>10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the pharmacy, such as a record of all the items that needed to be ordered by pharmacy and then use the information to audit the MAR and compare to what was in the drawer and the physician's order, Misappropriation and Diversion, the EDK box, Destruction of Narcotics. Interview with the</p>	F 224			



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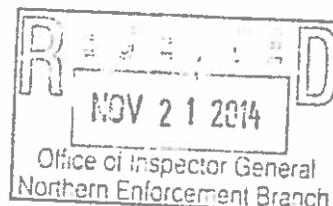
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F 224	<p>Continued From page 23</p> <p>Regional Nurse Consultant, on 10/13/14 at 3:42 PM, revealed she completed education on 09/08/14 and 09/12/14 with the DON and Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on abuse and misappropriation of medications. The Regional Nurse Consultant stated she talked to the DON about replacing all medications because it was the resident's property. The DON was educated on monitoring the narcotic sheets, MARs and Pain assessment sheets daily. The destruction of medication and ensuring two (2) nurses were present. Also, monitoring the EDK box and ensuring the serial numbers matched everyday. The DON was also educated on different methods of tampering with medication and not having tape placed on the back of narcotic cards.</p> <p>11. Interview with LPN #3, on 10/10/14 at 1:20 PM, revealed she was not educated by the Clinical Services Nurse. LPN #3 stated she was not in the building on 10/06/14, 10/07/14 or 10/08/14 in which the Consulting Pharmacists were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole shift on 10/10/14 without being educated. Review of the In-service Education on 10/08/14, by the Clinical Services Nurse from pharmacy for the loss/theft of medications, revealed only six (6) LPNs were educated, one (1) RN, and the ADON was educated out of a total of sixteen (16) licensed staff members. LPN #3 was not on the sign in list as being educated. Interview with the Regional</p>	F 224			



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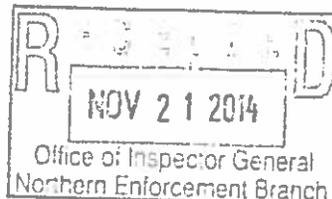
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F 224	Continued From page 24 Nurse Clinician for pharmacy, revealed she completed a quick training with the staff because she was told the staff had already been in-serviced. The training was supposed to be a quick reference tool. She stated she observed a shift to shift narcotic count. The Regional Nurse Clinician stated she wanted to ensure the nurses, when counting narcotics, monitored the card numbers and looked at the narcotic sheets to ensure they matched. The DON stated she knew LPN #3 was not trained and was going to train LPN #3 at the end of her shift. The DON stated LPN #3, knew she had been trained on most of the information; however, she was not trained on how to destroy narcotic medication and who was responsible to destroy the medications. Everything the Regional Nurse Clinician educated staff on, the DON had already went over with the staff. So though the Regional Nurse Clinician did not get the opportunity to educate all the nursing staff, all nurses were provided the same information. Review of the daily QA meetings on 10/08/14 through 10/10/14, revealed no documented evidence that the training went to QA; however, there was evidence on the 10/07/14 QA meeting where they talked about the pharmacy and their role and participation in the correction of the deficiency. Interview with the Regional Director of Operations, on 10/10/14 at 2:21 PM, revealed staff was not to work unless they had been educated. He stated he was not aware LPN #3 was on the floor the whole shift. He stated he was at fault for this. The Regional Director of Operations (RDO) stated he knew he stated in the Allegation of Compliance (AOC), all the nursing staff was educated, but he meant to say the staff could not work if all were not educated and would fix it immediately. Interview with the RDO, on 10/10/14 at 2:04 PM, revealed	F 224			



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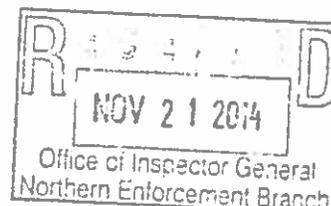
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F 224	<p>Continued From page 25</p> <p>he had the information in the AOC wrong. Review of the training for loss or theft of medications revealed an additional six (6) nurses were educated on 10/10/14 by the DON.</p> <p>12. Review of the Pain Assessment and Management training provided from 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on pain medications. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of pain assessments and the fact they had to be completed before and after administration of pain medications. The trainings were completed on 09/27/14.</p> <p>Review of the training on the Ine and Outs of Documentation, provided 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on documentation. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of accurate documentation of the MAR's and narcotic sheets. The training was completed for all nursing staff by 09/28/14.</p> <p>Review of the training on PRN Medication Management, provided on 09/01/14 through 10/05/14, revealed all licensed staff, eleven (11) LPNs and five (5) RNs had been in-served on PRN medication management and ensuring an assessment was completed on all residents</p>	F 224			



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F 224	<p>Continued From page 26</p> <p>before and after PRN medication was given. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of PRN medication management. The training was completed by all nursing staff by 09/29/14.</p> <p>Review of the training on Medication Pass, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on the proper way to perform a medication pass, side effects of giving the wrong medications and reporting errors immediately to the DON or Administrator. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable about the Medication Pass requirements. The training was completed on 09/29/14.</p> <p>Review of the training on Preventing, Recognizing and Reporting Resident Abuse, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs were educated on abuse, misappropriation and the importance of notifying the DON and Administrator as soon as abuse was observed. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of identifying and reporting abuse. The training was completed by all nursing staff by 09/30/14.</p>	F 224			



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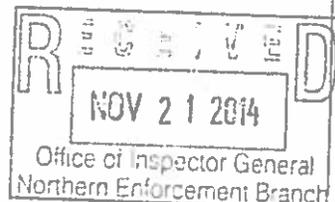
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F 224	<p>Continued From page 27</p> <p>Review of the training on the Pharmacy Training Guide, EDK Process and KAR's Controlled Substance Notification, provided on 09/17/14, revealed nine (9) LPN's and five (5) RN's were educated and two LPN's were educated on a later date. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the physician order process, EDK process, and reconciliation of narcotics. The training was completed by all nursing staff by 10/10/14.</p> <p>13. Review of a training provided by the Regional Nurse Clinician and the DON on Policies and Procedures with copies provided on the following: loss and theft of medications; adverse consequences; medication destruction and disposal of controlled substances; security of the medication cart; documentation medication administration; administering medications; and, accepting delivery of medications and controlled substances. Review revealed all eleven (11) LPNs and five (5) RNs were inserviced from 10/07/14 through 10/10/14. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the policies and procedures for narcotics and medication administration. The training was completed by all nursing staff on 10/10/14.</p> <p>14. Review of the QA meetings minutes and sign in sheets, dated 10/06/14, 10/07/14, 10/08/14,</p>	F 224			

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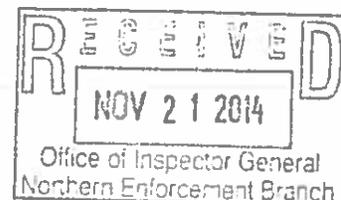
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F 224	<p>Continued From page 28</p> <p>10/09/14 and 10/10/14, revealed the Administrator, DON, Unit Manger, Medical Director, Consulting Pharmacist and Regional Director of Operations had attended daily meetings Monday through Friday. Interview with the DON, on 10/13/14 at 10:29 AM, revealed there was a QA meeting every morning. Review of the Controlled Substance Audit, dated 10/06/14 through 10/10/14, revealed the audits were completed without concerns. The DON stated she would report back to the QA committee with any diversion they would initiate an investigation immediately and report to all agencies. Interview with the Regional Director of Operations, on 10/13/14 at 2:28 PM, revealed he would attend QA daily while he was in the facility.</p> <p>15. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:28 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable to call the DON immediately if they observed any discrepancies with narcotics. The staff was also aware to report to the DON if they had witnessed tape behind a narcotic medication card.</p> <p>16. Review of the Pharmacy consults, dated 10/03/14, revealed the MARs were verified to match the pharmacy delivery tickets; and, matched the labels. All counts, and all tablets were verified to be accurate and no signs of diversion. Direction change stickers (to be placed on the Narcotic count sheets when the directions for administering the narcotics is changed) were applied. Interview with the Pharmacy Consultant Manager, on 10/13/14 at 11:34 AM, revealed on 10/13/14, she came in and reviewed 100% of the</p>	F 224			



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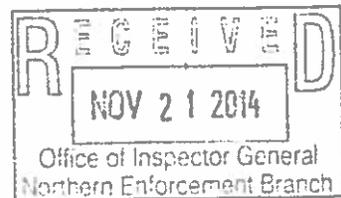
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F 224	Continued From page 29 control substance orders, made sure the directions matched the narcotic pinks sheets. She conducted an inventory of what narcotics were available, with the nursing staff. Interview with the Pharmacy Regional Manager, on 10/13/14 at 9:31 AM, revealed to his understanding the new Consultant Pharmacist would be completing 100% audits, looking at narcotic cards and narcotic count sheets. The Regional Manager, stated the Consultant would ensure the narcotic count was accurate and there had been no tampering with the medications. The Consultant was expected to exit with the facility, attend QA meetings monthly and quarterly and review weekly Narcotic delivery worksheets. 17. Interview with the Regional Director of Operations, on 10/13/14 at 2:28 PM, revealed the Administrator notified him on 09/08/14. A conference call with the Regional Nurse Consultant took place on 09/08/14, to discuss Resident #1 in which it was stated it was pretty evident Resident #1 did not receive all of his/her medications. Review of the narcotic count sheets revealed a collection of count sheets on the DON's desk. Interview with Detective #1, 09/22/14 at 3:23 PM, revealed the facility had contacted them to report the allegation of drug diversion. Review of the signature section of the policies and procedures revealed they were reviewed by the DON and ADON on 10/06/14 with no changes to the policies and procedures.	F 224			
F 275 SS=0	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.	F 275	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is		



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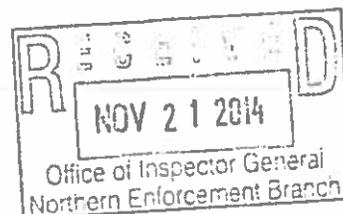
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F 275	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Minimum Data Set (MDS) 3.0, it was determined the facility failed to ensure an assessment was completed every twelve (12) months for one (1) of nine (9) sampled residents (Resident #9). The facility failed to complete an Annual MDS assessment due in August, 2014. The findings include: Interview with the MDS Coordinator, on 10/08/14 at 10:00 AM, revealed the facility did not have a policy on MDS assessments, the facility used the MDS Manual 3.0 as their policy. Review of the Resident Assessment Instrument, (RAI), MDS Manual 3.0, Chapter 2, page 2-15, RAI OBRA-required Assessment Summary revealed an annual comprehensive assessment was to be completed no later than the Assessment Reference Date (ARD) of the previous Omnibus Budget Reconciliation Act (OBRA) Comprehensive Assessment plus 366 calendar days and the ARD of the previous OBRA Quarterly Assessment plus 92 calendar days. Review of Resident #9's clinical record, revealed the facility admitted the resident on 03/28/13 and then readmitted him/her on 03/01/14, with diagnoses of Atrial Fibrillation, Deep Vein Thrombosis, Chronic Heart Failure, Hypertension, Urinary Tract Infections, Late effective Cerebrovascular Disease, Mental Disorder, Reflux Esophagitis, Hypothyroidism, Diabetes Mellitus Type II, Constipation, Ataxia,	F 275	prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. F275 Completion Date: 11/05/14 SS=D 483.20(b)(2)(iii) Comprehensive Assess At Least Every 12 Months The specific resident that was cited in the statement of deficiency as having been affected was as follows: Resident # 9 had an annual assessment that was not completed within 366 days after the ARD of the most recent comprehensive resident assessment. This annual assessment was completed as of 10/13/2014. Other Residents with Potential to be Affected: All Residents are at risk of being missed for an annual resident assessment. Facility census was at 61 on the day this regulatory tag was cited on 10/13/2014.	



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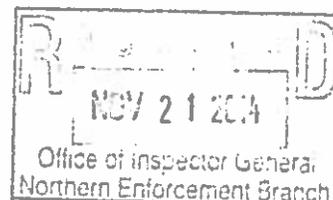
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F 275	<p>Continued From page 31</p> <p>Encephalopathy, Pneumonia, Speech Delay do to hearing loss, Difficulty Walking and Muscle Weakness. Review of Resident #9's assessments, revealed Resident #9 had an Admission Assessment completed on 07/27/13 and a most recently Quarterly Assessment on 06/06/14. The Annual assessment was due to be completed 08/11/14, making the assessment sixty (60) days late.</p> <p>Observation of Resident #9, on 10/08/14 at 8:38 AM, revealed Resident #9 was asleep in the bed with covers pulled up. A wheelchair was at bedside with a chair alarm attached to wheelchair. On 10/08/14 at 10:15 AM, Resident #9 was sitting up at the dining room table drinking coffee independently.</p> <p>Interview with the MDS Coordinator, on 10/08/14 at 10:00 AM, revealed she had been in the role as an MDS Coordinator since April of 2014. The MDS Coordinator stated the Regional Manager wanted her to utilize the computer system to track when the assessments needed to be completed and not her own record. The MDS Coordinator stated obviously the backup system which was the computer was not working because it missed Resident #9's assessment. The MDS Coordinator stated when assessments were late; there was obviously some sort of penalty in which she was not familiar. The MDS Coordinator stated for now she was going to use her personal schedule with the computer schedule for accuracy. The missing assessment tool utilized in the computer did not pick up Resident #9 as due the month of September or October. The Interdisciplinary Team did not complete the full assessment and this could have affected Resident #9 in the care planning process.</p>	F 275	<p>On 10/13/2014, the Regional MDS Nurse Consultant reviewed with the facility LPN MDS Coordinator how to utilize our software scheduling grid for assessments and appropriate date ranges to monitor to make sure that no assessments are missed. Special attention giving to ensure that monitoring for compliance with quarterly and yearly due dates are adhering to both dates.</p> <p>LPN MDS Coordinator will be pulling this schedule grid daily (Monday – Friday) to check this to make sure that no annual assessments are overdue, that all necessary ARDs are set, making sure open assessments are closed for the day, and routinely checking for any assessments that may have been closed but not transmitted.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>On 10/13/2014, the Regional MDS Nurse Consultant reviewed with the facility LPN MDS Coordinator how to utilize our software scheduling grid for assessments and appropriate date ranges to monitor to make sure that no assessments are missed. Special attention giving to ensure that monitoring for compliance with quarterly</p>	



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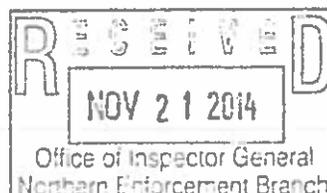
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F 275	Continued From page 32 Interview with Social Services, on 10/09/14 at 1:03 PM, revealed she was aware of a resident's assessment coming up missing before, but it had been months since something like that occurred. Social Services stated she was aware the facility was transitioning into the new computer system. Social Services stated she saw that she could look into the computer system and see when the next assessment was due; however, she did not notice Resident #8 had not received an assessment. She stated Resident #9 had not changed very much since his/her last assessment because she monitored the resident's behaviors every day and looked at the Accue Nurse System in the computer for changes. Interview with the Director of Nursing, on 10/13/14 at 10:29 AM, revealed she was not aware the MDS Coordinator had missed an assessment. If a resident was to have an annual assessment completed, the MDS Coordinator would send a schedule and Social Services would coordinate with the Activities Director and Dietary Manager. They made sure the Nurse Aids capture the Activities of Daily Living (ADL)'s for the Resident for two (2) weeks. The DON stated the difference between a full assessment and a quarterly assessment was the oral health and there was about five (5) or six (6) more different assessments than the quarterly. The care plan was also assessed for accuracy. The DON stated as far as she was aware Resident #9 did not have any changes in condition. Interview with the Regional Reimbursement Nurse Specialist, on 10/13/14 at 11:40 AM, revealed she came into the facility to identify if	F 275	and yearly due dates are adhering to both dates. LPN MDS Coordinator will be pulling this schedule grid daily (Monday – Friday) to check this to make sure that no annual assessments are overdue, that all necessary ARDs are set, making sure open assessments are closed for the day, and routinely checking for any assessments that may have been closed but not transmitted. This activity started on 10/13/2014 and will be on-going. Regional MDS Nurse Consultant educated the Administrator on how to pull the grid schedule for assessments that need to be scheduled and how to view the report that would show if any assessments were late. This education was provided on 10/13/2014. Per Regional MDS Nurse Consultant, as of 10/13/2014 through her review and auditing of system reports, the facility does not have any resident assessments that are untimely as of 10/13/2014. The following monitoring has been put into place to ensure for compliance with this regulation: LPN MDS Coordinator will be pulling this schedule grid daily (Monday – Friday) to check this to make sure that no annual assessments are overdue, that all necessary		



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F 275	Continued From page 33 there were any concerns with the system. The Specialist stated in the meantime the MDS Coordinator would use her paper calendar as well as the computer system to ensure no other assessments would come up missing. If an assessment was missed, it could affect the payment and stated the resident would be monitored everyday in the morning meeting. The Regional Reimbursement Nurse Specialist stated she had re-educated the MDS Coordinator on how to schedule, recalculate OBRA assessments and see what was due and compare to the paper calendar.	F 275	assessments are overdue, that all necessary ARDs are set, making sure open assessments are closed for the day, and routinely checking for any assessments that may have been closed but not transmitted. This activity started on 10/13/2014 and will be on-going. There has been no issues with late quarterly or annual assessments since 10/13/2014. (continued on page 34a)		
F 431 SS=K	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. 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.	F 431	Disclaimer: Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of federal and state law require it. The Provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. F431 Completion Date: 11/05/2014 SS=E 483.60(b), (d), (e) Drug Records, Label/Store Drug & Biologicals		



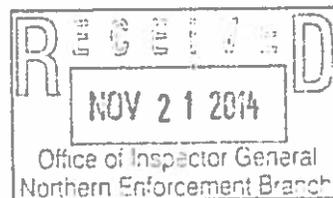
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Administrator will be conducting weekly reviews and monitoring of the scheduling grid for assessments to ensure that no assessments are untimely. This is effective starting for the week of 10/12/2014. There has been no issues with late quarterly or annual assessment since 10/13/2014.

This regulatory noncompliance of this annual resident assessment being untimely was taken through the facility QA on 10/14/14 and the monthly QA Meeting on 10/22/14, to outline the monitoring that had been implemented to ensure that facility has on-going compliance with this requirement.

This plan of correction for monitoring compliance will be integrated into the facility's quality system where results will be reviewed weekly for 12 weeks and then monthly as outlined above and monitored by the Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for over a 9 month period, then Quality Committee will make a decision as to whether or not to continue monthly monitoring. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator (who is the Director of the QA Committee), Director of Nursing, Unit (continued on page 34B)

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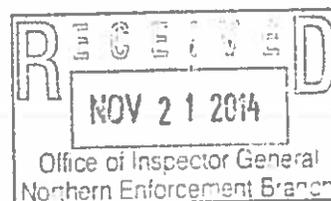
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Managers, Staff Development Nurse, Social Services, Activities Director, and the Dietary Director. Contracted membership includes the Medical Director and consulting pharmacist.

The Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns

are identified during this monitoring process, the Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

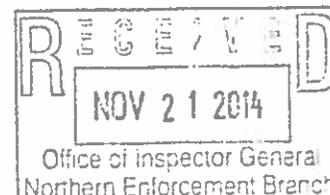
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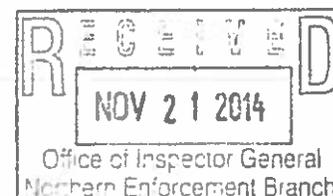
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 431	<p>Continued From page 34</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, Pharmacy job descriptions and Pharmacy contract, it was determined the facility failed to ensure the Consultant Pharmacist established an effective system for monitoring, reconciliation and destruction of medications and failed to ensure Pharmacy determined drug records were in order, maintained and reconciled. In addition, the facility failed to ensure resident medications were not borrowed for the use of another resident even though staff had been inserviced on not borrowing medication in June 2014. These failures affected five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #6); and, two (2) of two (2) unsampled residents (Unsampled Residents A and B).</p> <p>Interview and record review revealed narcotic blister packs were tampered with for Residents #1 and Resident #2. On 08/31/14 during shift change, Licensed Practical Nurse (LPN) #8 and LPN #2 completed a narcotic review of the narcotic lock box on the medication cart for Lincoln Lane. The review included one (1)</p>	F 431	<p>In good faith and per requirements, the facility self-reported the allegation of alleged drug diversion on 9/8/2014. This was reported to the State Agency (OIG), Adult Protective Services (APS), Local Ombudsman, Kentucky Board of Nursing (KBN), and the Local Police. The facility immediately implemented a plan to identify, correct, and prevent further recurrence on 9/12/2014.</p> <p>The specific residents affected by the alleged deficient practice were as follows:</p> <p>Resident #1 tampered medications were pulled from circulation on 9/8/2014 by the Director of Nursing and destroyed on September 10, 2014. The facility replaced the medication at no cost to the resident. Residents was interviewed on 9/8/2014 and stated that he did feel relief for his medication received prior to 9/8/2014.</p> <p>Resident #2 medications were pulled from the Medication cart on 9/3/2014, when the resident was admitted to HMH Hospital. This resident never received any of these medications. The Narcotic cards were locked up. Upon return on 9/10/2014, the narcotics were determined to have been tampered with and the police were immediately notified. The Narcotics and their containers were turned over to the local police department by facility administration</p>		



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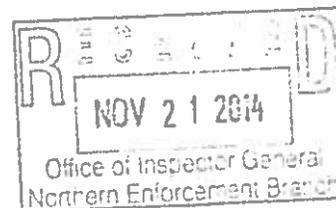
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F 431	<p>Continued From page 35</p> <p>Morphine Sulfate (narcotic pain medicine) narcotic blister pack, for Resident #1, containing thirty (30) tablets which revealed twelve (12) blisters were empty or missing, and eighteen (18) blisters contained a tablet; however, these tablets were not the same size as the Morphine 15 milligrams (mg) tablets. The back of the narcotic blister pack contained paper tape to hold the pill inside the foil enclosure. The nursing staff recognized there was tape on the back side of the whole narcotic blister pack; however, they failed to report this immediately to a supervisor, as per policy. Instead, LPN #6 and LPN #2 made copies of the narcotic blister pack and placed it under the door of the Director of Nursing (DON). Staff administered six (6) doses of the unidentified tablets that were in the Morphine Sulfate 15 milligrams (mg) blister pack, to Resident #1.</p> <p>Interview with the DON revealed Resident #1's Morphine Sulfate had been replaced with a different medication the resident was not ordered. The DON stated after the Morphine was replaced with an unknown tablet by Registered Nurse (RN) #1, she did not remove any more tablets from that blister pack and started removing tablets from a second blister pack. Staff interview revealed on 09/05/14, they discovered three (3) doses of Morphine Sulfate 15 mg that was removed on 09/04/14; however, this was not Resident #1's normal pattern for taking this medication. Interview with Resident #1 revealed the Morphine was only taken one time at night and he/she had never requested three doses.</p> <p>Resident #2 had a Oxycodone 2.5 mg, narcotic blister pack with paper tape across more than half of the tablets.</p>	F 431	<p>for investigation. The case number is on file at the facility. The narcotics were replaced for the resident at no cost. Resident was out of the facility during this investigation and no clinical assessment was therefore made of this resident, and because resident did not receive any of the tamper medication from this card. Resident was Palliative care (end-of-life-care), and as of 9/13/2014 no longer a resident of the facility</p> <p>Resident #3 --- the Director of Nursing (DON) began an investigation on 9/8/2014 regarding the accuracy of the narcotic counts due to "write-overs" or "scratch thrus" on the narcotic reconciliation sheets based on documentation discrepancies. Appropriate disciplinary action was taken by the Director of Nursing with RN#1, who was suspended on 9/8/2014 and terminated on 9/12/2014 and did not work in the facility again.</p> <p>Resident #5 medication, 9/16/14 pharmacist auditing carts suggested to DON that RN had the opportunity and may have tampered with refrigerated narcotic Lorazepam. As suggested by pharmacist, narcotic was destroyed by DON and ADON. After research, the Medication was delivered to the facility on 9/12/14, RN in question was suspended on 9/8/2014 and terminated on 9/12/14 and worked no hours between those dates. There was no opportunity for this nurse or crossover for diversion, or</p>	



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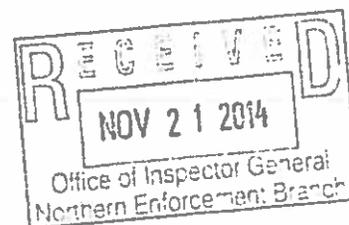
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F 431	<p>Continued From page 36</p> <p>Interview and record review revealed the narcotic count sheet balances did not reconcile and entries indicated double dosing for Resident #3, Unsampled Resident A and Unsampled Resident B. Review of the narcotic count sheets for the Hydromorphone 2.5 mg revealed doses were removed on the same date and at the same time on two different narcotic count sheets for administration to Resident #3. Unsampled Resident A had Oxycodone 5/325 mg, ordered two tablets every six (6) hours; however, it was documented as four (4) tablets administered at 6:00 PM. RN #1 documented the removal of Oxycodone 5 mg on two different narcotic count sheets for the same day at the same time. Unsampled Resident B had Oxycodone IR 5 mg, every four (4) hours; however, RN #1 documented on 07/26/14 at 7:30 PM that three (3) tablets were administered for a total of 15 mg.</p> <p>Interview and record review revealed Resident #5 was administered three doses of a narcotic after the pharmacy instructed the facility to destroy it. Interview with the DON revealed Resident #5's Lorazepam 1 mg, and Morphine 5 mg, may have been tampered. Pharmacy instructed the DON on 09/09/14 to destroy these medications; however, they were not destroyed until 09/15/14. Resident #5 received three (3) doses of these medications on 09/10/14, 09/11/14 and 09/13/14.</p> <p>In addition, Busprone and Escitalopram were reordered too soon for Resident #3 and Resident #6 who received Primidone. The documentation on the Medication Administration Record (MAR) revealed there were multiple missed doses; however, the medication was not available for the resident.</p>	F 431	<p>misappropriation and resident was showing no adverse reactions.</p> <p>Resident #6 noted Medication was missing on 7/7/14 and was replaced at facility cost, and resident continues to be receiving medications. Two nurses were given disciplinary action, regarding the missed doses of medication, by the Director of Nursing on 7/11/2014.</p> <p>Unsampled Resident A had a changed physician order in her medical record dated 8/19/14 to increase Oxycodone APAP 5/325 mg to 2 tablets every 6 hours. Therefore, RN#1 gave the correct dose on 9/4/2014 at 12:00 (Noon) this resident as ordered. Then RN#1 gave 2 more tablets at 6:00 p.m. as ordered and this did complete this medication card. However, it appears RN#1 then pulled 2 more tablets from a new medication card also at 6:00 p.m. on 9/4/2014. It is unknown as to whether this resident actually received the extra 2 tablets. Resident did not suffer from any adverse side effects. Facility replaced the medication at facility cost. RN#1's last day worked was 9/4/2014 and was never returned to work because was suspended on 9/8/2014 and after an investigation was termed from employment at the facility.</p> <p>Unsampled Resident B on 7/26/2014 at 7:30 p.m., from review of narcotic sheets, it appears RN#1 gave 1 tablet of Oxycodone</p>		



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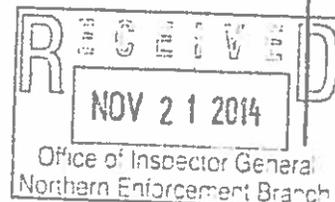
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F 431	<p>Continued From page 37</p> <p>The facility's failure to ensure an effective system was in place to prevent/detect misappropriation/drug diversion and tampering of resident medications including controlled substances placed residents at risk in a situation that has caused or likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.60 Pharmacy Services (F431) with a scope and severity lowered to an "E" while the facility monitors the effectiveness of the implemented plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Inventory Control: for Controlled Substances, revised 01/01/13, revealed the facility would ensure staff immediately reported suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation and timely follow-up in accordance with facility policy. Upon receipt of such a report, the facility would ensure the appropriate facility personnel confirmed the discrepancy and followed facility policy and applicable laws regarding documentation of the incident. The facility would also conduct an investigation to determine: if a dose was in fact administered and, if so, the reason the administration was not charted and if a dose was</p>	F 431	<p>IR 5 mg that completed a medication card and then RN#1 pulled two more tablets from a new medication card on 7/26/2014 at 7:30 p.m. This resident was a discharged 7/26/2014. This medication issue was not discovered until this complaint investigation.</p> <p>Pharmacy Consultant Manager from Omnicare Pharmacy (facility contract) reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation. This review was completed October 3, 2014. No signs of Diversion or tampering were found.</p> <p>In addition, the consulting pharmacist on her monthly visit to the facility on 10/22/2014 again reviewed and analyzed narcotic medications dispensed and administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation, and reviewed and analyzed the EDK and found no indications of diversion or tampering.</p> <p>Other Residents with Potential to be Affected:</p>		



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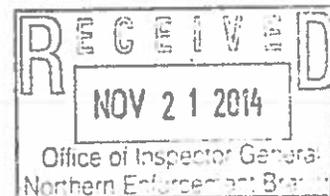
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F 431	<p>Continued From page 38</p> <p>refused. A facility representative would regularly check the inventory records to reconcile inventory. The facility would regularly reconcile the current and discontinued inventory of controlled substances against the log used in the facility's controlled medication inventory system. The current inventory should be compared to the controlled medication declining inventory record and to the residents' Medication Administration Record (MAR) and unused controlled substances held in storage for destruction to the declining inventory record.</p> <p>Review of the facility's policy regarding Loss and Theft, effective 12/01/07, revealed when facility staff suspect theft or loss of medication, the facility staff would take such actions as required by applicable laws and facility policy. Appropriate actions may include: Immediately reporting suspected theft or loss of drugs to a supervisor/manager or the Director of Nursing for appropriate investigation and follow-up. Investigating and reconciling discrepancies and notifying the appropriate Administration of controlled substance discrepancies and if such discrepancies are not reconciled, notifying the appropriate law enforcement agencies according to applicable laws and facility policy.</p> <p>Review of the facility's policy, regarding Documentation of Medication Administration, revised April 2007, revealed a nurse or Certified Medication Aide would document all medications administered to each resident's Medication Administration Record (MAR). Administration of medication must be documented immediately after (never before) it was given.</p> <p>Review of the facility's policy, regarding</p>	F 431	<p>All Residents receiving physician ordered Controlled Substance Medication commonly referred to as Narcotics, are at risk due to misappropriation of such medication. The facility must provide sufficient safeguards and monitoring practices to prevent theft or diversion within the facility control.</p> <p>The Director of Nursing and facility administration have conducted 100% audit of narcotic orders and records beginning on 9/8/14 and continuously have provided education to specific nurses for compliance and for any new nursing staff. Since 9/8/14 there has been no suspicious activity or tampering with narcotics noted through daily audits by nursing administration.</p> <p>Pharmacy Consultant Manager from Omnicare Pharmacy (facility contract) reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation. This review was completed October 3, 2014. No signs of Diversion or tampering were found.</p> <p>In addition, the consulting pharmacist on her monthly visit to the facility on 10/22/2014 again reviewed and analyzed narcotic medications dispensed and administered for any discrepancies or tampered packaging,</p>		



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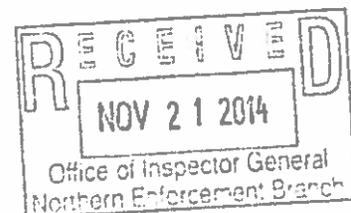
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F 431	<p>Continued From page 39</p> <p>Administering Medications, revised December 2012, revealed medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication would initial and circle the MAR space provided for that drug and dose. If a resident used an as needed (PRN) medication frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist, as needed, would re-evaluate the situation, examine the individual as needed, determine if there was a clinical reason for the frequent PRN use, and consider whether a standing dose of medication was clinically indicated.</p> <p>Review of the Consultant Pharmacist's job description, effective 03/09/11, revealed the consultant pharmacist's key responsibilities included: ensure facility remains compliant with federal regulations; clinical reviews as required by federal and state regulations; own issue resolution and communicate early warning signs of potential issues; conduct executive reviews and other customer meetings as required; perform medication regimen reviews and provide written reports of these reviews; utilize the MDS 3.0 to identify specific residents needing targeted focus; complete the quality improvement consultant pharmacist summary report for all facilities; provide quarterly reports reflecting facility-level drug utilization; attend quarterly Quality Assurance Committee meetings and provide written reports; and, coordinate or perform review of controlled substance utilization, reconciliation and documentation.</p>	F 431	<p>documentation of narcotic sheets and medication administration records for reconciliation, and reviewed and analyzed the EDK and found no indications of diversion or tampering.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Any changes in narcotic order dispensing system, Omnicare must notify the Administrator and Director of Nursing as well as provide education on those changes. In addition, all pharmacy consulting visits starting on October 3, 2014 and ongoing will include at a minimum review of the entire narcotic dispensing system and analyzing narcotic counts records, medication administration records, labels and packaging and compare to current orders to ensure there has been no tampering of packaging, suspicious administration, ordering, documentation or destruction that may indicate drug diversion. This will include current orders and discontinued narcotic medications. There were no issues of diversion noted on the Consultant visit reports of 10/3/2014 and 10/22/2014. These visits included a detailed review of the narcotic EDK as well.</p>		



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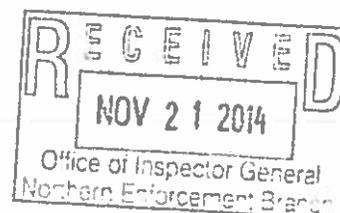
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F 431	<p>Continued From page 40</p> <p>Review of the Consultant Extender job description (referred to self as the Quality Assurance Technician QAT), effective date June 2012, revealed the QAT inspects medication storage and medication pass audits; conducts inspections of all drug storage areas per Federal and State regulations and requirements; review narcotic proof of use sheets and narcotic change of shift logs for completeness; provides education to licensed staff; and, reports to the Consultant Pharmacist.</p> <p>Review of the Pharmacy contract, effective 07/01/12, revealed the pharmacy would maintain a drug profile on each facility resident serviced by pharmacy; make a representative of pharmacy available for attendance at facility's quality assurance committee, infection control committee and other committee meetings that relate to pharmacy products and services; provide drug information and consultation to the facility's licensed professional staff regarding pharmacy products ordered; provide pharmacy policy and procedures; and, collaborate with the facility to coordinate pharmacy documentation processes. The contract further stated Required Consultant Services included: the consultant shall provide consultation regarding all material aspects of providing pharmaceutical services to the facility; a written report regarding the provision of pharmaceutical services would be provided to the facility quarterly; the consultant shall collaborate with the Medical Director; shall conduct a medication regimen review for each facility resident at least once a month; shall identify any irregularities as defined in the State Operations Manual (SOM); shall within three (3) business days of conducting a medication regimen review, provide the facility with a written report; shall</p>	F 431	<p>The pharmacy consultant will also review for any possible administration of narcotics that may elude to suspicious activity i.e., one nurse administering and other nurses not or not as frequent giving scheduled and PRN narcotic medications together. This was done on the monthly visit of 10/22/2014 and no issues were identified and reported.</p> <p>Destruction medication records for narcotics will be reviewed by the consultant pharmacists at each consulting visit. This was done on monthly visit of 10/22/14.</p> <p>A copy of current narcotic orders will be provided from Omniview for the consultant pharmacist to reconcile with the current orders on the residents chart to ensure ordering accuracy from Omnicare. This was done on the monthly visit of 10/22/2014.</p> <p>The Administrator, Director of Nursing, for Elizabethtown Nursing and Rehabilitation Center as well as the Regional Nurse Consultant and the Regional Director of Operations for Preferred Care Partners Management Group called, on October 3, 2014, and spoke with the Regional Manager for Kentucky with Omnicare as verbally advised him of these requirements which were acknowledged and agreed upon. This was implemented on 10/3/2014 Pharmacy Consultant Manager's Visit report.</p>	



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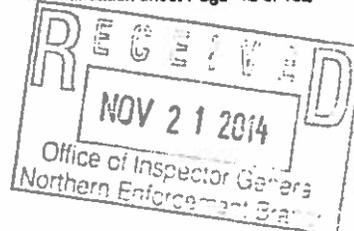
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F 431	<p>Continued From page 41</p> <p>assist the facility in reviewing the safe and secure storage of medications in locked compartments; and, shall assist the facility in developing and implementing safeguards and systems to control, account for, and periodically reconcile controlled medications. Optional Consultant Services Included: medication observation evaluations; non-financial audits relating to the provisions of medications; potential narcotic diversion investigation; drug utilization and/or evaluation activities; narcotic and/or drug destruction, regardless of whether such task is required by applicable law; and, services provided by consultant as part of corrective action plans.</p> <p>1. Interview and record review revealed the narcotic blister packs were tampered with for Residents #1 and Resident #2.</p> <p>Review of Resident #1's clinical record, revealed the facility admitted the resident on 07/23/14, with diagnoses of Malignant Neoplasm of the Nasal Cavities, Difficulty Walking, Cerebral Vascular Accident, Dysarthria, Lack of Coordination, Human Immune Virus Disease, Chronic Pain Syndrome, Muscle Weakness and Depression. Review of Resident #1's Minimum Data Set (MDS) Admission Assessment, dated 07/30/14, revealed the facility assessed Resident #1 with a Brief Interview of Mental Status (BIMS) score of twelve (12), which indicated Resident #1 was interviewable. Resident #1 was also identified on the Admission Assessment to have pain.</p> <p>Review of Resident #1's Morphine Sulfate IR, (immediate release) 5 mg, narcotic card with a quantity of thirty (30) tablets, revealed tablet number twenty-one (21) and number twenty-four (24) through thirty (30) were empty. Further</p>	F 431	<p>The Director of Nursing and Administrator were educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 9/12/2014. This education included the following: Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, and Destruction of Narcotics, and Pain Assessments. Accuracy of Notes, Change of Condition, Abuse and Neglect, Narcotic Balance Process.</p> <p>As part of the AOC nursing education was provided to all licensed nursing staff by Omnicare Pharmacy Nursing Consultants on 10/7/2014.</p> <p>Licensed Nurses who handle medication carts have been in-serviced on the following programs by the Director of Nursing and/or nursing administration:</p> <p>Pain Assessment and Mgt. SilverChair 9/28/2014 Pass Accuracy of Notes, Doc. Change of Cond. SilverChair 9/28/2014 Pass PRN Medication Management SilverChair 9/28/2014 Pass</p> <p>Medication Pass-Indicators, Side effects, reporting, errors etc SilverChair 9/28/2014 Pass Prevent/Recognize, Reporting Patient Abuse SilverChair 9/28/2014 Pass</p>		



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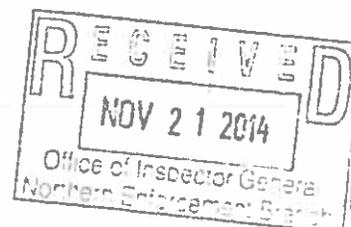
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F 431	<p>Continued From page 22</p> <p>review of the medication revealed blister number one (1) through twenty (20), twenty-two (22) and twenty-three (23) were full. Documentation on the Morphine Sulfate IR, 15 mg, Narcotic Sheet, for 08/31/14 revealed LPN #2 and LPN #6 had signed and verified blister #21 was missing a pill. Review of the back of the Morphine Sulfate IR, 15 mg, card revealed all thirty (30) tablets had been cut; replaced with an unknown medication; and, paper tape placed across the back of the card.</p> <p>Interview with LPN #2, on 09/24/14 at 8:38 AM, revealed LPN #2 and LPN #6 were counting narcotics (could not give a time frame), when LPN #2 discovered a tablet had fallen out of Resident #1's Morphine Sulfate Narcotic Card (tablet number twenty-one [21]). LPN #2 stated he then addressed it with the Unit Manager and the Unit Manager had him make a copy of the narcotic card. LPN #2 stated the Unit Manager told him she would have the DON take care of it.</p> <p>Interview with LPN #6, on 09/26/14 at 2:33 PM, revealed around 08/22/14, she and LPN #2 were counting Resident #1's Morphine Sulfate card and noticed a missing tablet at the bottom of the card and LPN #2 noticed a small slit in the foil backing. LPN #6 informed LPN #2 she just noticed the discrepancy and it was a mistake because there was no pill in the blister at all and there was a micro cut in the foil backing. LPN #6 stated sometimes the pills would get out and if someone so much as rubbed against the card it would push a pill out and then she would just re-enforce the foil with tape. LPN #6 stated she did not observe tape a lot and never really looked at the back of the medication cards.</p> <p>Interview with the Unit Manager, on 09/30/14 at</p>	F 431	<p>Pharmacy Training Guide (Returns/Controlled Meds in EDK) Dir. Of Nursing 9/22/2014 One on One EDK Process, physician orders, medications, wasted Medication, Physician Notifications, Matching Inventory sheet, Narcotic Balance Process and destruction Dir. Of Nursing 9/27/2014 One on One K.A.R.s Operation Guide 902 KAR 20:048 Controlled Substance Notification Dir. Of Nursing 9/22/2014 One on One</p> <p>The Facility Policies and Procedures for Delivery, Monitoring and Documentation of Narcotic Medications have been reviewed but no changes were deemed necessary. Those policies reviewed included the following:</p> <p>Adverse Reaction to Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014 Controlled Substances – Misappropriations Dir. Of Nursing 10/6/2014 QA 10/7/2014 Adverse Consequences and medication Errors Dir. Of Nursing 10/6/2014 QA 10/7/2014 Accepting Delivery of Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014 Administering Medication Dir. Of Nursing 10/6/2014 QA 10/7/2014 Loss or Theft of Medications Dir. Of Nursing 10/6/2014 QA 10/7/2014 Discarding or Destroying of Medication</p>	



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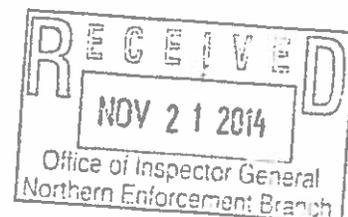
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F 431	<p>Continued From page 43</p> <p>10:00 AM, revealed it was at the end of August, 2014 when LPN #2 and LPN #6 had brought to her attention Resident #1's narcotic card. The staff seemed to think the medication had come from pharmacy taped. The Unit Manager stated she did not remove the narcotic card to ensure non-use of the medication. She stated she was not aware if the staff continued to give the narcotic after she was informed of the missing medications. Further interview with the Unit Manager revealed she did not observe the narcotic card, nor did it cross her mind that the narcotic had been tampered. The Unit Manager stated she had been a nurse since 2007 and never witnessed the pharmacy deliver narcotics with paper tape to the back of the narcotic card. She stated she should have pulled the narcotic card right then and there and destroyed the medication. The Unit Manager stated she thought she sent word through a text to the DON to inform her of Resident #1's medication, but she should have immediately informed the DON of the paper tape to the back of the narcotic card. However, interview with the DON, on 09/30/14 at 6:00 PM, revealed she had no evidence of a text from the UM only the information placed under her office door by LPN #2 on 08/31/14.</p> <p>Review of Resident #1's Morphine Sulfate IR, 15 mg, narcotic count sheet, dated 08/31/14, revealed it originally contained thirty (30) tablets that were taped across the back of the blister pack and seven (7) tablets had been removed with number 21 missing. Interview with Registered Nurse (RN) #4 revealed the DON was notified on 09/05/14 by LPN #3 and RN #4 of the suspicious blister packs with tape; however, the facility continued to administer three (3) additional doses of the unidentified medication on 09/03/14,</p>	F 431	<p>Dir. Of Nursing 10/6/2014 QA 10/7/2014 Security of the Medication Cart Dir. Of Nursing 10/6/2014 QA 10/7/2014</p> <p>The in-services noted above are part of the new employee (Licensed Nurse) orientation program, effective 10/6/2014.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation:</p> <p>During morning meeting Monday through Friday (which started on 10/6/2014) the Director of Nursing and/or Nursing Administration report on Narcotic Count Records as well as the Medication Administration Records (MAR) and review narcotic medication to ensure tampering or diversion has not taken place. This will continue until 11/30/2014. If there have been no diversions or suspicious activities noted; the QA Committee will make a decision whether to continue 5 days per week monitoring or reduce to weekly reporting, after 11/30/2014. Whenever/if suspicion is identified by Nursing, the Director of Nursing will immediately contact the Pharmacy and begin an internal investigation. Additionally, all proper authorities will be notified including, OIG,</p>		



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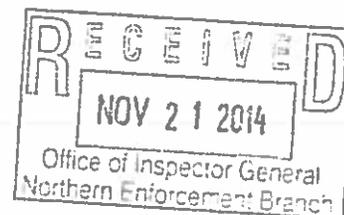
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F 431	<p>Continued From page 44</p> <p>09/04/13, and 09/05/14, for a total of eleven (11) unknown tablets being administered. There were eighteen (18) tampered narcotics left on the card.</p> <p>In addition to record review, an interview with LPN #3, on 09/24/14 at 3:20 PM, revealed that on 09/05/14, while LPN #3 and RN #4 were completing their narcotic count, it was discovered RN #1 had removed three (3) doses of Morphine Sulfate IR, 15 mg, on 09/04/14 at 10:00 AM, 2:00 PM; and, at 8:00 PM on a separate Morphine Sulfate IR, 15 mg Narcotic Count Sheet (the new narcotic card that had not been tampered).</p> <p>Interview with LPN #3, on 09/24/14 at 3:20 PM, revealed she was aware Resident #1 liked to receive his/her pain medications at night. When she and RN #4 went to count the narcotic sheet at the beginning of her shift on 09/05/14, she realized that both narcotic cards for Morphine Sulfate, 15 mg, had been used. LPN #3 stated RN #1 had pulled three (3) doses of Morphine Sulfate, 15 mg, all on 09/04/14 at 10:00 AM, 2:00 PM and 8:00 PM while using a new narcotic card for Resident #1. LPN #3 stated this was really odd for Resident #1 to obtain three (3) doses in one day, so she made a copy of both of the Morphine Sulfate, 15 mg, narcotic sheets and slid the copies under the DON's door for review.</p> <p>Interview with the DON, on 09/24/14 at 3:48 PM, revealed on 09/08/14 when she came to work, she found the copies and was wondering why RN #1 would pull narcotics from a different narcotic card.</p> <p>Interview with Resident #1, on 09/23/14 at 11:30 AM, revealed he/she had always asked for pain medication at night because he/she suffered from</p>	F 431	<p>DCBS, local Police, and in certain situations, the Kentucky Board of Nursing. This notification practice was done on 9/8/2014 with this complaint survey that was self-reported.</p> <p>If there are any weekend discrepancies with the system the on call nurse will be immediately notified and the Nurse on call will call the Administrator or Director of Nursing and will refer to QA any concerns received with immediate investigation started. The Quick Step for Loss or Theft of Medication Protocol will be followed:</p> <ol style="list-style-type: none"> Immediately report suspicion to Nursing Supervisor/Manager or the Director of Nursing for appropriate investigation and follow up. The Nursing Supervisor/Manager, or Director of Nursing, will investigate and reconcile discrepancies immediately. The Nursing Supervisor/Manager, Director of Nursing, or Administrator will provide verbal direction to safeguard medication cards,/controlled substances and records until such time as they arrive at the facility to continue the investigation. If the Nursing Supervisor/Manager or Director of Nursing and/or Administrator will be contacted. The Director of Nursing 	



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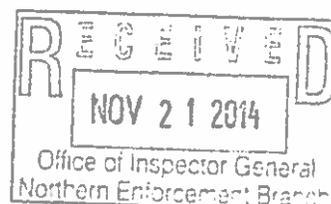
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F 431	<p>Continued From page 45</p> <p>pain to the right leg. Resident #1 stated he/she had five (5) surgeries to his/her leg. Resident #1 stated he/she did not receive the pain medications that the nurse documented he/she had received on 09/04/14.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 09/24/14 at 2:45 PM, revealed while she was conducting an assessment of Resident #1, she was reviewing Resident #1's Medication Administration Record (MAR) when she noticed Resident #1 was given a lot of medications in a 24-hour period. Resident #1 had verbalized to her he/she did not like to take his/her pain medication because it made him/her sleepy. The MDS Coordinator stated she suggested to Resident #1 to take his/her Tylenol (pain medication) as this medication would not make him/her sleepy and he/she could participate in therapy and become stronger. Sometime during the week of 09/08/14 the MDS Coordinator informed the DON of what she had found and the DON stated she was doing an investigation and instructed her to obtain a statement from Resident #1. The MDS Coordinator stated Resident #1 verbalized he/she did not receive any of the medication.</p> <p>Continued interview with the DON, on 09/24/14 at 3:48 PM revealed the DON discovered on 09/08/14 that Resident #1's narcotic cards had been cut open, narcotics replaced and then taped closed. The DON stated she felt she had to call the police and start an investigation to identify how many residents had been affected.</p> <p>Closed record review for Resident #2 revealed the facility admitted the resident on 11/26/13, with diagnoses of Congestive Heart Failure, Vascular</p>	F 431	<p>and /or Administrator will notify the appropriate law enforcement agencies according to applicable Law and Facility Policy.</p> <p>The Director of Nursing presented to the Quality Assurance Committee on 10/6/2014 the results of the Consultant Pharmacist analysis of:</p> <ul style="list-style-type: none"> a. Audit of Narcotic to label review b. Narcotic to counted balance sheet; c. Review of MAR to Balance Sheet d. Review of actual Medication for accuracy of inventory e. Review of the EDK for Inventory to stated inventory. After review, no discrepancies were found, no sign of symptom of diversion or potential for diversion. This review was initially completed 10/03/2014 and will be part of the consulting pharmacist's monthly review for the facility, which was completed on 10/22/2014 and will continue monthly. <p>QA Committee members have reviewed daily (Monday – Friday) the narcotic auditing that is completed by nursing administration. This started on 10/6/2014 and will continue through 11/30/2014 --- for 5 days a week. If there has been no diversion and/or suspicious activities with narcotics noted and the QA Committee agrees then auditing may be reduced to one time weekly thereafter. The Quality</p>	



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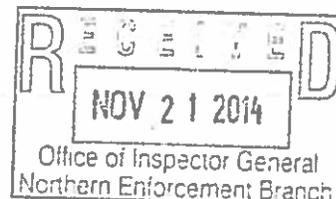
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F 431	<p>Continued From page 48</p> <p>Dementia, Pure Hypercholesterolemia, Chronic Kidney Disease, Late Effective Coronary Vascular Disease, Cerebral Vascular Accident and Depression. Review of Resident #2's MDS Admission Assessment, dated 08/27/14, revealed the facility assessed Resident #2 with a Brief Interview of Mental Status score of fifteen (15) which meant the resident was interviewable.</p> <p>Review of Resident #2's Nurses Notes, revealed on 09/03/14 at 6:30 PM, Resident #2 had complained about having pain everywhere. Resident #2 complained that his/her pacemaker was burning him/her and he/she was having left side hand and neck pain. The nurse administered Diazepam and Oxycodone for pain as prescribed, but Resident #2 continued to have pain. At 6:45 PM and 7:40 PM, the doctor was notified and orders were written to send Resident #2 to the hospital for evaluation and treatment.</p> <p>Interview with the DON, on 09/24/14 at 3:48 PM, revealed she locked Resident #2's Oxycodone cards and narcotic sheets in a locked box, so that when Resident #2 came back to the facility Resident #2's pain medication would be available.</p> <p>Further interview with the DON, on 09/24/14 at 3:48 PM, revealed when Resident #2 came back to the facility on 09/10/14, she went to remove Resident #2's narcotics from the locked box and discovered tape to the back of the Oxycodone 2.5 mg, narcotic card.</p> <p>Review of Resident #2's, Oxycodone, 2.5 mg, revealed there were two (2) narcotic cards. The first Oxycodone 2.5 mg, revealed Resident #2 had received a total of twelve (12) of thirty (30) half tablets that had no evidence of cuts in the foil</p>	F 431	<p>Assurance committee is specifically looking for Diversion, Misappropriation, missed dosage, etc. The Quality Control Committee will review and recommend or direct action based upon the results of audits or reports and will provide management with an action plan if necessary to meet the ongoing needs of the facility.</p> <p>Regional Nurse Consultant or the Regional Direct of Operations for the Management Company, Preferred Care Partners, Management Group will review, comment, recommend and/or approve QA meetings per the protocol noted above, effective for 10/3/2014.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed as outlined above and monitored by the Quality Committee for ensuring on-going compliance. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, Director of Nursing, Unit Managers, Social Services, Activities Director, and the Dietary Director.</p>		



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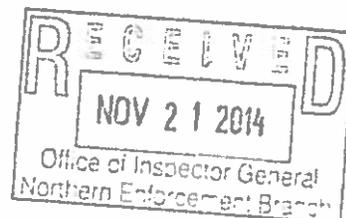
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F 431	<p>Continued From page 47</p> <p>backing or any tape applied. The second Oxycodone, 2.5 mg, narcotic card, had paper tape behind more than half of the blisters. Per interview with the DON, on 09/24/14, it was determined by the DON Resident #2 did not receive any of the the Oxycodone because the blister pack still had an unknown tablet taped inside the card. The DON stated the medication looked like Lexapro (antidepressant medication) and Lasix (diuretic).</p> <p>Continued interview with the DON, on 09/24/14 at 3:48 PM, revealed when she interviewed the nurses, the nurses verbalized the narcotic cards were coming from pharmacy with tape on the back of the narcotic cards.</p> <p>Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed he told the DON during the investigation he thought pharmacy was delivering the narcotic cards with the tape on the back of them because it began to seem like a normal thing to him. LPN #2 stated he felt it had been going on for a couple of months. He also stated he always observed a few narcotics taped, though he never studied the backs of the narcotic cards. LPN #2 stated he was not aware that diversion of drugs should be reported immediately to a supervisor, as stated in the policy.</p> <p>Interview with LPN #7, on 10/02/14 at 4:42 PM, revealed she saw the tape on the back of the narcotic cards ever since she started at the facility in June 2014. LPN #7 stated she had not questioned the paper tape behind the narcotics.</p> <p>Interview with LPN #3, on 10/01/14 at 2:02 PM, revealed she had noticed the tape on the backs of the narcotic cards as early as July 2014. LPN</p>	F 431	<p>Contracted membership includes the Medical Director and consulting pharmacist.</p> <p>The Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>		



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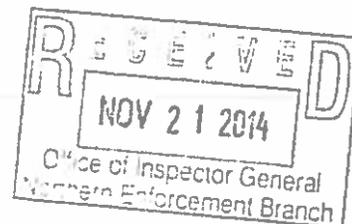
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F 431	<p>Continued From page 48</p> <p>#3, stated she attempted to remove a narcotic from the blister and had a hard time pushing the medication through the foil backing. LPN #3 stated she did not think the narcotics were coming from pharmacy taped, she just thought the staff was placing the tape too tight to the back of the card. LPN #3 stated she had not observed any others blister packs with tape, but she was not looking either to identify if there were anymore packs with tape.</p> <p>Interview with the DON, on 09/24/14 at 3:48 PM, revealed she reviewed the narcotics on all four (4) medication carts and could not identify any concerns with tampering of the medications on the Heritage Hall. The DON stated Residents #1 and #2 all lived on the Lincoln Hall and received medications from the odd half cart utilized by RN #1. The DON stated she then destroyed any narcotics cards that looked like they were "bent" to prove a point to staff that the narcotic cards did not come from pharmacy in that condition. The DON stated she then informed the staff that if they saw tape on the back side of a narcotic card, they needed to report to her immediately.</p> <p>Further interview with the DON, on 09/25/14 at 2:37 PM, revealed the Consulting Pharmacist came into the building on 09/09/14 and 09/15/14 to review carts and narcotics for any discrepancies. The DON began to check the orders and narcotic administration records to ensure the orders and MARs matched what was in the computer. Also to ensure the narcotics matched the count by the end of the month. The DON stated she asked the Consulting Pharmacist to pay special attention to the Lincoln Lane medication carts on 09/09/14 even though the pharmacist completed monthly medication</p>	F 431			



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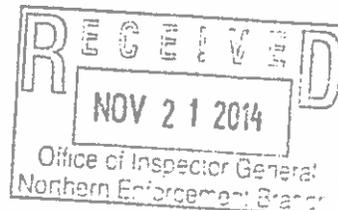
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 431	<p>Continued From page 49 checks.</p> <p>However, review of the Pharmacy Quality Assurance Summary Report, dated 09/09/14 revealed there was a special focus on the Heritage Hall carts (which was not identified to be the hall in question). The controlled substances on Heritage Hall were observed to be: double locked; controlled substances were not tampered; controlled substances were within date; timed orders were completed and pulled; the controlled substances were signed by two (2) nurses when the narcotics were counted at the end of shift; and, the controlled substance count matched the count sheets on Heritage Hall. However, there was no documented evidence that Lincoln Hall's Controlled Substance Storage/Documentation or carts had been checked.</p> <p>Post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed she informed the Consulting Pharmacist to look at both halls when the diversion occurred. However, the DON did not monitor the Pharmacist to ensure the audit was completed, nor did she know what the Pharmacist actually reviewed.</p> <p>2. Interview and record review revealed Resident #5 was administered three (3) doses of a narcotic after the pharmacy instructed the facility to destroy it.</p> <p>Review of Resident #5's record, revealed the facility admitted the resident on 07/28/14, with diagnoses of Hyperlipidemia, Coronary Artery Disease, Hypertension, Vitamin D Deficiency, Urinary Problems, and Diabetes Mellitus. Review of Resident #5's Physician Orders, dated 09/01/14, revealed Resident #5 had an order for</p>	F 431			



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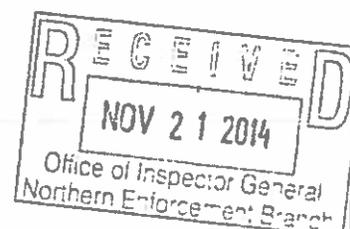
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F 431	<p>Continued From page 50</p> <p>Lorazepam (anti-anxiety), 1 mg, every four (4) hours as needed for agitation, and Roxanol (narcotic pain medication), 5 mg, every hour for pain and shortness of breath.</p> <p>Review of the Narcotic sheets revealed two (2) of Resident #5's Lorazepam, 1 mg; and, one (1) Morphine (Roxanol), 5 mg had been destroyed on 09/15/14 for fear the medication had been tampered. Although pharmacy had instructed the DON to destroy this medication on 09/09/14, the facility continued to administer this medication to Resident #5; three (3) doses were given, one on 09/10/14, 09/11/14, and 09/13/14.</p> <p>Review of the Quality Improvement: Consultant Pharmacist Summary, period covered 09/01/14 through 09/30/14, revealed Consultant Pharmacist checked the remaining controlled medication for tampering. She suggested for Resident #5 that one (1) thirty (30) milliliters (ml) Morphine be destroyed and also one (1) Lorazepam thirty (30) ml, as both of the medications were open and the contents could not be verified.</p> <p>Interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed on 09/09/14, the DON decided she wanted a sense of security to ensure what was remaining in the medication carts had not been tampered. There was some Morphine that had been opened for Resident #5. The Consulting Pharmacist stated the Morphine liquid was blue and the Lorazepam liquid was clear. The Consulting Pharmacist stated she informed the DON to dispose of the medications because she was unaware if the medication had been tampered. The Consultant Pharmacist did not destroy the medication with the DON.</p>	F 431			



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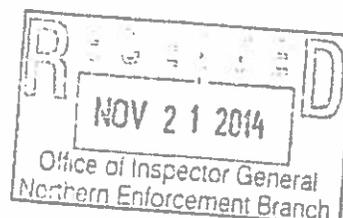
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F 431	<p>Continued From page 51</p> <p>Post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed she could not remember when the pharmacist told her to destroy these medications and thought it was on 09/15/14 the day she destroyed the medications.</p> <p>3. Interview and record review revealed the facility staff was reordering medications too soon due to not being available for use for Resident #3 and Resident #6 although the pharmacy had sent the medications. In addition, review of Resident #6's MAR indicated several missed doses with no explanation why the medication was not administered.</p> <p>Review of Resident #3's record revealed the facility admitted the resident on 07/19/14, with diagnoses of Muscle Weakness, Chronic Heart Failure, Diabetes Mellitus, Headaches, Hypothyroidism and Hypertension. Review of Resident #3's MDS Quarterly Assessment, dated 08/13/14, revealed the facility assessed Resident #3 with a BIMS score of fifteen (15), which meant Resident #3 was interviewable.</p> <p>Review of Resident #3's May, 2014 Physician orders, revealed orders for Busprone HCL (anti-anxiety) 15 mg, by mouth three times a day (TID); Escitalopram, (anti-depressant) 20 mg, by mouth daily, and, Dilaudid, (narcotic pain analgesic) 2 mg, by mouth every four (4) hours as needed.</p> <p>Review of Resident #3's September, 2014 Physician Orders, revealed Resident #3 was currently taking: Busprone HCL, 15 mg, by mouth three times a day; Dilaudid, 2 mg, by mouth every four hours per resident request;</p>	F 431			



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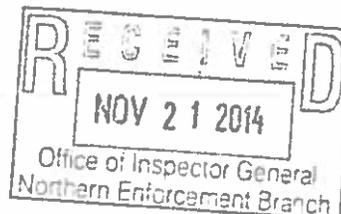
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F 431	<p>Continued From page 52</p> <p>Lorazepam, (anti-anxiety) 0.5 mg, by mouth three times a day; and, Benadryl, (anti-histamine) 25 mg, by mouth every six hours for itching.</p> <p>Review of a pharmacy invoice for the months of April, May and June 2014, revealed the facility had to reorder multiple doses of Buspirone and Escitalopram. Review of the March 2014, invoice revealed Resident #3's Buspirone HCL, 15 mg, and Escitalopram, 20 mg, had to be reordered and paid for by the facility.</p> <p>Review of Resident #6's record revealed the facility admitted the resident on 01/23/14, with diagnoses of Dementia with Behavior Disturbance, Anxiety, Hypertension, Mental Disorder, Difficulty Walking, Muscle Weakness and Tremors. Review of Resident #6's physician orders dated 01/23/14 revealed revealed an order for Primidone, 50 mg, every night at bedtime.</p> <p>Review of Resident #6's, MAR for the month of May 2014, revealed Resident #6's Primidone, 50 mg, was not given on 05/01/14, 05/02/14, 05/04/14, 05/05/14, 05/08/14, 05/07/14, 05/08/14, 05/09/14, 05/10/14, 05/13/14, 05/15/14, 05/16/14, 05/24/14, and 05/29/14. Review of the MAR revealed for 05/10/14, 05/14/14, and 05/24/14 it was documented the medication was not available. There was no documentation to indicate why the medications were not administered on the other dates.</p> <p>Review of the pharmacy's Work Order Fills form, for Resident #6 for the month of May 2014, revealed the Pharmacy sent a total of thirty (30), Primidone tablets on 05/05/14 and again on 05/30/14, for a total of sixty (60) tablets. However, review of Resident #6's MAR revealed</p>	F 431			



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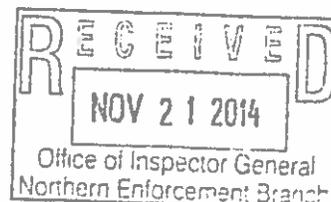
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F 431	<p>Continued From page 53 no documented evidence the resident received fourteen (14) doses in May.</p> <p>Review of Resident #6's, MAR for the month of June 2014, revealed Resident #6's Primidone, 50 mg, was not given on 06/07/14, 06/11/14, 06/14/14, 06/15/14, 06/16/14, 06/17/14, 06/18/14, 06/19/14, 06/20/14, 06/21/14, 06/22/14 and on 06/24/14. There was no documentation to indicate why the medications were not administered.</p> <p>Review of the pharmacy's Work Order Fills form, for Resident #6 for the month of June 2014, revealed the Pharmacy sent a total of thirty (30) Primidone tablets on 06/24/14. However, review of Resident #6's MAR revealed no documented evidence the resident received twelve (12) doses in June.</p> <p>Review of Resident #6's, MAR for the month of July 2014, revealed Resident #6's Primidone, 50 mg, was not given on 07/02/14, 07/03/14, 07/04/14, 07/05/14, 07/06/14 and 07/07/14. Review of the MAR revealed for 07/02/14 and 07/05/14 it was indicated the medication was not available and pharmacy was notified. There was no documentation to indicate why the medications were not administered on the other dates.</p> <p>Review of Resident #6's, Advanced Practice Registered Nurse (APRN) worksheet, dated 07/08/14, revealed upon review of the MARs it was identified that Resident #6 had been without Primidone (anti-seizure medication) medication for the entire month because the pharmacy had failed to send the medication. The plan was to call the pharmacy to send the Primidone to the</p>	F 431			



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F 431	<p>Continued From page 54 facility.</p> <p>Attempted interview with the APRN, on 09/30/14 at 11:00 AM, revealed a refusal to interview because she did not work for the facility any longer.</p> <p>Review of the pharmacy's Work Order Fills Form, for Resident #8 for the month of July 2014, revealed the Pharmacy sent nine (9) tablets of Primidone on 07/08/14 and nine (9) tablets on 07/19/14.</p> <p>Interview with LPN #8, on 09/26/14 at 2:33 PM, revealed she kept reordering the Primidone, because it would be there one day and not the next.</p> <p>Post survey interview with the Medical Director, on 11/04/14 at 2:38 PM, revealed if he had identified that Resident #6 was not receiving his/her Primidone, he would have tried to figure out what the gaps in the MAR meant. He stated he would have done this by calling the facility and the pharmacy. He also would have tried to determined the breakdown in communication, to see if pharmacy was sending the medication.</p> <p>Interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed she just missed the fact the resident had not received the Primidone. The Consulting Pharmacist stated she always picked a sample of MARs to review when she came to the facility, but also stated she did chart reviews monthly for each resident. Although she checked the MARs she did not identify that Resident #6 was not receiving his/her Primidone.</p>	F 431			



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F 431	<p>Continued From page 55</p> <p>Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed he did not remember any conversations with the APRN during the months of May, June or July 2014, but this would have prompted them to look at the dispensing of the Primidone. That call would have been brought to his attention and he would have searched for evidence that it was dispensed and proof of delivery.</p> <p>In addition, further review of the pharmacy invoices revealed seven (7) residents were effected in April, four (4) in May and seven (7) residents in June in which the facility had to pay out of pocket because the medications were reordered too soon.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/25/14 at 9:25 AM, revealed there was a time when the facility had to reorder Primidone (anti-seizure), Wellbutrin (anti-depressant) and Lasix (diuretic) and she could not remember which residents were effected by the reordering of the medications. The ADON stated she monitored the medications to make sure the medications did not need to be reordered too soon. The ADON stated it was also monitored by the Quality Assurance (QA) Committee. However, no investigation was conducted as the committee thought it was just nurses borrowing medications for other residents and not ordering timely.</p> <p>Continued interview with the DON, on 09/24/14 at 3:48 PM, revealed she noticed when she obtained a report from the pharmacy, the facility was being charged for medications such as Wellbutrin and Lexapro. The DON stated she asked a field representative from the pharmacy</p>	F 431			

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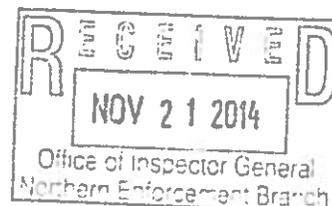
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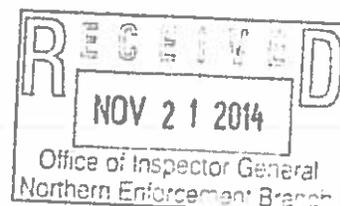
F 431	<p>Continued From page 56</p> <p>how this could occur. The DON stated the medications were not expensive, but when she went to interview staff, the staff stated they were borrowing medications from other residents, so the resident without medication could have their medications. The DON stated she had repeatedly informed the staff not to borrow medications from residents. The DON completed an in-service for the month of June. At that time, the DON stated she could not see the bigger picture.</p> <p>Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed there were no requests to look at drug costs in May, June or July 2014 and he did not remember if the facility requested the pharmacy to do a 100% audit of carts during the month of May, June or July 2014. He further stated if the facility was reordering the medications through the computer system they would not know if it was reordered too soon, because it was an automatic system and it would generate a fax to the facility that it was a "too soon reorder" and if the DON signed that they knew it was reordered too soon, it would be filled without question. If the reorder request went to the dispensing pharmacist as in a phone call, they would question it and talk with the facility to find out where the medication was going and it would be placed in the suspended mode, dependant on the payment plan.</p> <p>Interview with the DON, on 09/25/14 at 2:18 PM, revealed if it was too soon to refill a prescription, the pharmacy would kick it back and she or the Unit Manager would have to sign to reorder the medication.</p> <p>Post survey interview with the Administrator, on 11/04/14 at 1:37 PM, revealed she thought the</p>	F 431		
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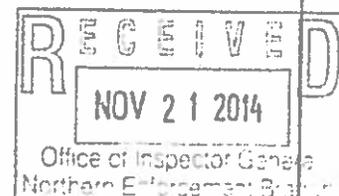
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F 431	<p>Continued From page 57</p> <p>facility had fixed the problem when she asked the pharmacy to send resident medications and that the facility would pay for it. However, the Administrator stated she did not look at all the MARs or medications that were needing to be reordered for all the residents identified in QA. Thus she could not ensure the reordering of medications was resolved.</p> <p>4. Interview and record review revealed the narcotic count sheet balances did not reconcile and entries indicated double dosing for Resident #3, Unsampld Resident A and Unsampld Resident B.</p> <p>Review of Resident #3's physician orders revealed the resident had a Physician's Order for Dilaudid, (narcotic pain analgesic) 2 mg, by mouth every four (4) hours as needed and Lorazepam, (anti-anxiety) 0.5 mg, by mouth three times a day.</p> <p>Review of Resident #3's Hydromorphone (Dilaudid), 2 mg, narcotic sheet, revealed there were two (2) narcotic blister packs for the month of June. One had signatures dated 06/15/14 through 06/20/14 and had multiple lines going through 06/17/14 over RN #1's name, date and time of medication; however, there was no "error" documented above RN #1's name, nor an initial to document the error. A second narcotic sheet with signatures dated 06/19/14 through 06/25/14 it was documented that RN #1, pulled narcotics from the second narcotic blister pack on 06/19/14, when there were still six (6) doses of narcotics available in the first narcotic blister pack.</p> <p>Review of Resident #3's narcotic sheet for</p>	F 431			



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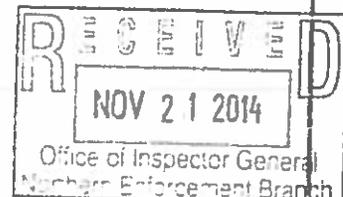
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F 431	<p>Continued From page 58</p> <p>Hydromorphone, 2 mg, dated 08/01/14 through 08/06/14 and a second narcotic sheet for the month of 08/08/14 through 08/11/14, revealed RN #1 removed three (3) narcotics on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. In addition, RN #1 removed the last narcotic on 08/08/14 at 12:00 PM, on the second sheet. RN #1 removed one narcotic on 08/06/14 at 10:00 AM and then again at 2:00 PM, which was every two (2) hours. In addition, the RN removed narcotics from two different cards on the same date at the same time. Further review revealed the first narcotic count sheet, had signatures dated 08/27/14 through 09/01/14 and the second narcotic count sheet had signatures dated 08/31/14 through 09/08/14. The first narcotic sheet, revealed RN #1 removed one narcotic tablet on 08/30/14 at 8:00 PM, which left six (6) available tablets in the narcotic blister pack. Then on the second narcotic count sheet, RN #1 removed two tablets on 08/30/14 at 10:00 AM and 2:00 PM. Review of the MAR revealed these narcotics were not documented as administered.</p> <p>Interview with Resident #3, on 08/23/14 at 8:57 AM, revealed the facility ran out of multiple medications, such as his/her pain medications and Ativan. Resident #3 stated it had been occurring since he/she got out of the hospital in December 2013. Resident #3 stated he/she suffered from pain all the time.</p> <p>Review of Resident #3's narcotic sheet for Lorazepam (Ativan), 0.5 mg, ordered by mouth three (3) times a day, dated 05/26/14 revealed on 05/31/14, 08/01/14, 08/02/14, 08/12/14 and 08/14/14, RN #1 obliterated her signature, date and time on narcotic administration sheets, with no documented error above the lines or initials</p>	F 431		



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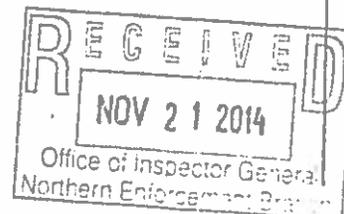
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(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 59</p> <p>above the lines, nor were there two (2) nursing signatures documented to verify the error. RN #1 had scribbled through her signatures, with no second signature verifying an error had occurred on 05/31/14, 06/01/14 and 06/14/14.</p> <p>Interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed when she observed Resident #3's Lorazepam 0.5 mg, she noted quite a bit of scribbling and stated her rational was sometimes the nurse may remove from the wrong narcotic count sheet or the nurse may sign the wrong narcotic sheet.</p> <p>Review of Unsampled Resident A's physician orders revealed Oxycodone APAP 5/325 mg every six (6) hours as needed. The narcotic count sheet, revealed on 09/04/14 at 12:00 PM, RN #1 removed two (2) tablets leaving a total of two (2) tablets in the blister pack. RN #1 then removed Oxycodone APAP 5/325 mg at 6:00 PM on 09/04/14 and finished the blister pack. RN #1 then removed Oxycodone APAP 5/325 mg from a new narcotic sheet on 09/04/14 at 6:00 PM. Thus, it appeared Unsampled Resident A received a total of six (6) tablets within six (6) hours. Review of the MAR revealed the two (2) doses were not administered.</p> <p>Interview with RN #2, on 09/25/14 at 8:52 AM, revealed she noticed two (2) narcotics were given twice, at the same time to Unsampled Resident A. She further stated she did not report this information immediately, but questioned RN #1. RN #1 could not tell RN #2 what she had done. RN #2 then made copies of the two (2) narcotic sheets and placed them under the DON's door for review on 09/05/14, the same time LPN #3 had placed her copies for Resident #1 under the</p>	F 431			



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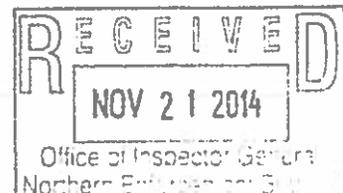
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F 431	<p>Continued From page 60 DON's door.</p> <p>Review of Unsampled Resident B's narcotic sheet for the month of July dated 07/24/14 through 07/26/14, revealed Unsampled Resident B was ordered Oxycodone IR, 5 mg, every four (4) hours, as needed. On 07/26/14 at 7:30 PM, RN #1 removed one (1) tablet, the last narcotic, from the blister pack. On a new narcotic sheet for the same drug, RN #1 removed two (2) tablets on 07/26/14 at 7:30 PM. This was a total of three (3) narcotics at the same time for a total of 15 mg of Oxycodone.</p> <p>Continued interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed if an error occurred on the narcotic sheet, she thought the nurses were to circle the error and initial. She was not sure as to what the nurses should document. She stated she would have to look at her policy to ensure she was telling it correctly. The Consulting Pharmacist stated she did not see any concerns with the scribbles because there were different nurses giving the medications and all doses were accounted for, although review of the narcotic count sheets revealed the counts were not correct. This was not shared with the DON or Administrator because she only looked at a ten (10) percent sample and it may not have included these count sheets. Based on the facility's census on 09/23/14, this would only be six (6) residents reviewed.</p> <p>Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed there was no rule that a pharmacist had to look at ten (10) percent of the census. They normally looked at enough residents to determine if there</p>	F 431			



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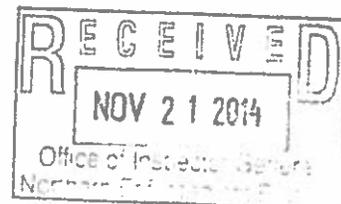
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F 431	<p>Continued From page 61 was a pattern to their concerns.</p> <p>5. Interview and record review revealed RN #1 was suspected of replacing diverted narcotics with other medications.</p> <p>Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed when he would count with RN #1, RN #1 would always have to fix the narcotic sheets and would actually be writing as they counted. RN #1 did not have the narcotics signed out like she should. LPN #2 stated when he came in for the shift, RN #1 would say, that he would be proud of her because she had everything signed off. LPN #2 stated sometimes it seemed odd and other times he knew the nurses may have had a lot of admissions and so it did not seem so odd. He further stated he thought it was just RN #1's routine, but now that he thought about it, it was odd.</p> <p>Interview with LPN #3, on 09/24/14 at 3:20 PM, revealed RN #1 became upset when working an extra shift because LPN #3 was on the Lincoln Lane odd medication cart. LPN #3 informed RN #1 that she had been working on the cart since 8:00 AM. She stated RN #1 became completely out of sorts and informed LPN #3 she needed to stop undermining her.</p> <p>Interview with the DON, on 09/25/14 at 2:18 PM, revealed she pulled invoices on 06/11/14 in which she identified the medications were being taken from one cart (Lincoln Lane odd cart) in which RN #1 worked. The DON interpreted the information to mean the staff was borrowing residents' medications. The DON stated they were either being stolen or borrowed. She stated she asked RN #1 about the missing medications because</p>	F 431			



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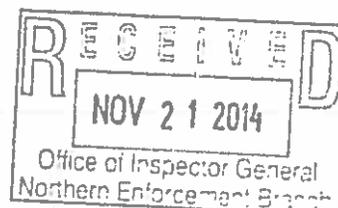
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F 431	<p>Continued From page 62</p> <p>she was aware RN #1 was on an anti-depressant. The DON stated she then took the information to the Administrator. The information went to the QA Committee, who determined the medications were being borrowed. She stated she began monitoring the number of pills in the Lincoln cart and compared them to the MAR.</p> <p>Interview with the DON, on 09/25/14 at 6:00 PM, and post survey interview on 11/04/14 at 2:07 PM, revealed she identified RN #1 was giving a lot of pain medications. She educated RN #1 by explaining to RN #1 that she needed to complete a pre and post assessment of the resident when administering pain medications. RN #1 was educated to call the physician if the resident's pain continued. The DON stated she told RN #1 when she did not document the pain assessment it looked suspicious. The DON stated RN #1 had documented some of her assessments for pain. The DON stated she audited the narcotic sheet and then looked at RN #1's documentation and could see that it had improved. The DON stated she thought the situation was "fixed".</p> <p>Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed it was brought to her attention in June that some drugs were having to be reordered too soon. She stated she brought the information to the Quality Assurance (QA) Committee 06/06/14 and came up with a plan to triple check by reviewing each nurse's documentation for accuracy. The Unit Manager would check the AHT system in the computer to make sure the medication orders were placed on the MAR appropriately then the DON would update the care plan. As an added measure the staff was educated on the importance of reviewing the five (5) rights and three (3) checks</p>	F 431			



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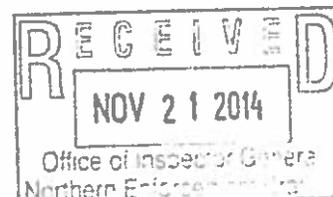
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F 431	<p>Continued From page 63</p> <p>of medication orders. The Administrator stated she then followed-up on 08/30/14 during the QA meeting and it was reported the in-service had been completed and the DON had worked individually with the nurses who had issues with medication errors and that there had been great improvements. The Pharmacy came and checked their records to see if the nurses were reordering and checking the MARs. The Administrator stated in July the Consultant Pharmacist came and audited and stated the orders and carts looked "really really good".</p> <p>Review of the July 2014 Consulting Pharmacist Review, revealed forty-eight (48) records were reviewed for this report and a notation at the bottom read "based on a sample of current residents in facility". Irregularities were noted in new order transcription; medications properly monitored; gradual dose reductions; and, medications reordered in the emergency drug supply with a notation to see pharmacy recommendations. However, the report did not include any recommendations. Further review indicated an evaluation of controlled substances with no irregularities as the documentation was accurate and complete; inventory was reconciled according to facility procedures; and, controlled substances were destroyed in a timely manner. A widespread issue was observed with Medication Administration Records that indicated medications not available for administration were also noted as resolved during the facility visit. In addition, the report indicated documentation was complete including as needed documentation and sites of administration. The report stated the exit was held with the ADON as the DON was not in the building that day. The form was not signed or dated by any person indicated on the form:</p>	F 431			



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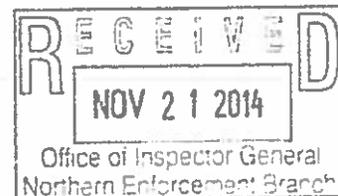
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F 431	<p>Continued From page 64</p> <p>Consultant Pharmacist; Administrator; or Director of Nursing.</p> <p>Interview with the Pharmacy Quality Assurance Technician (QAT), on 09/30/14 at 1:37 PM, revealed she started reviewing the narcotics in July of 2014. She would come into the facility and look at the narcotic cards in general to make sure the narcotic card and the narcotic sheet were matching up. The QAT stated she did not examine the cards at all, just ensured the numbers matched. The QAT stated she thought it was nursing's responsibility to monitor the narcotic sheets and narcotic cards. The QAT stated she documented which medication cart she looked at and not the individual resident she assessed. She provided a report to the Consulting Pharmacist. The QAT stated she also looked at the drugs for expiration dates and did not compare them to the MAR. The QAT stated the Consulting Pharmacist had not asked her to look at specific items when she came to the facility.</p> <p>Interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed the QAT came into the facility to complete cart checks. The Consulting Pharmacist stated she reviewed the carts by picking a random sample of the carts. She checked to make sure the medication carts were locked; that personal items were covered; straws were available; and, the medication cart was clean. She stated she would do a random MAR check to ensure the dosage was being signed out. The Consulting Pharmacist stated she reviewed the narcotic sheets monthly and would check to ensure there was not a lot of wasting of narcotics or multiple signatures jumping out at her. She would not keep notes as</p>	F 431			



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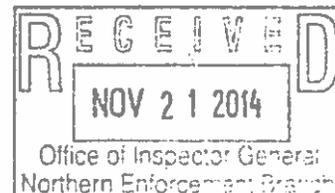
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F 431	<p>Continued From page 65</p> <p>to which cart she observed or which resident medications she checked. An example of what she would monitor for was a Hydrocodone medication that was given at 8:00 PM every night and only one nurse had given the medication and no other nurses. The Consulting Pharmacist stated she was not aware there were any other concerns with medications until the diversion of the medications had been discovered. She stated Lasix and Primidone medication were coming up short around July or August.</p> <p>Interview with the DON, on 10/01/14 at 12:30 PM, revealed whenever she saw the Consulting Pharmacist in the building, she would see her looking at her computer, with no chart. The DON stated she was not aware the Consulting Pharmacist was looking at MARs, but thought she completed just the Gradual Dose Reductions.</p> <p>Interview with the Pharmacy Clinical Manager, on 10/02/14 at 1:12 PM, via telephone revealed she would have expected the Consultant Pharmacist to look at the drug orders in the medical record to ensure the orders and drug labs were entered correctly. She stated the Consultant looked at the PRN medications for usage; audited and spot checked that the PRN medications were signed out. The Clinical Manager stated the consultant did not typically look at the back of the narcotic cards. She stated they do spot checks to ensure at shift change the nurses were reconciling their narcotics. The Clinical Manager stated the consultant would also look at when the PRN medications were pulled and the documentation noted on the MAR matched the narcotic sheet. She stated the consultant did not normally look at the documentation on the narcotic sheet, but she was aware when the nurses had an error, they</p>	F 431			



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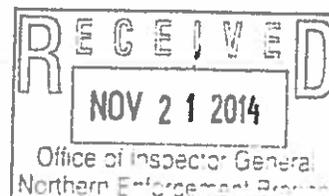
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F 431	<p>Continued From page 66</p> <p>were to document with one line through the error, write error above the line and initial. The Clinical Manager stated she personally would have notified the facility if she observed scribbling on the narcotic sheets. She stated she did not monitor the Consulting Pharmacist while in the facility. She stated she was not aware the Consulting Pharmacist was not monitoring the narcotic count sheets appropriately to identify scribbling on the narcotic count sheets.</p> <p>Continued interview with the Consulting Pharmacist, on 09/30/14 at 8:35 AM, revealed since she was aware the narcotic sheets were going to Medical Records to be filed, she ensured the narcotic count sheets were being filled out appropriately by picking a sample and reviewing them. She further stated just because you may see a couple of scribble lines on a narcotic sheet did not mean there was a concern. The Consulting Pharmacist could not give an answer as to how she identified concerns.</p> <p>Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed the Consulting Pharmacist was to look at each resident profile in the computer system. They have a series of alerts and labs they look at dependant on what drug the resident is taking. The Consultant Pharmacist was to look at 100% of the 30 day reviews; check to see if policies and procedures were in the building; check to see if the medication room was locked; and, inspect the medication carts. Only if the facility said they were having problems with medication pass, does the pharmacist look at medication pass. The pharmacist would conduct inservices if requested by the facility. He stated he did not know if the consultant pharmacist looked at the MARs of</p>	F 431			



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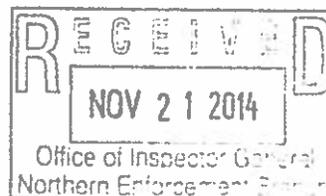
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F 431	<p>Continued From page 67</p> <p>each resident. Their focus was on non-use of as needed medications. The GM stated he did not think the consultant pharmacist looked at all of the narcotic sheets or all the narcotic blister packs. They look at systems in place to ensure the narcotics were locked, usually they are going to do an audit to see if there is a system in place, was there a count sheet and was each medication cart locked.</p> <p>Interview with the DON, on 09/25/14 at 2:37 PM, revealed when she had started in March 2014, she received no training on the reconciliation of the narcotic process. The DON stated she had not received the empty narcotic cards or the narcotic sheets. The narcotic sheets went straight to Medical Records for filing. The DON stated since the diversion of narcotics occurred in September she started to review the narcotic sheets and narcotic cards for every resident.</p> <p>Interview with the Administrator, on 10/01/14 at 3:01 P.M, revealed neither herself nor the DON were looking at the narcotic sheets before they were filed. The Narcotic sheets went straight to Medical Records for filing. The Administrator stated she expected the Consulting Pharmacist to be her eyes and was responsible to complete audits and provide reviews. The Administrator stated she expected the Consulting Pharmacist to look at the different drugs and ensure they were not mixed. If the Consulting Pharmacist was finding problems with medication administration she should then make sure the facility was aware of the concern. The Administrator stated she thought the Consulting Pharmacist or the technician would have been looking at the narcotic sheets. The Administrator stated she had no concerns with the pharmacy, but was aware at</p>	F 431			



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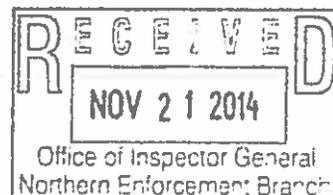
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F 431	<p>Continued From page 88</p> <p>times there were delays in obtaining medications. The Administrator stated she expected the pharmacy to alert the facility when there were changes or concerns, especially when it came to narcotics.</p> <p>Interview, on 09/24/14 at 3:48 PM and on 10/01/14 at 2:49 PM, with the DON revealed she identified more discrepancies with MARs, Narcotic sheets and documentation which was provided to the Police Department. She stated through facility audits of the Narcotic sheets, it was identified that twenty-five (25) additional residents may have been involved by the possible diversion of medications/narcotics.</p> <p>Attempted interview with RN #1, on 09/24/14 at 2:29 PM, on 09/25/14 at 9:18 AM and at 9:20 AM; messages were left all three times to call this office. There has been no contact made as of 10/17/14.</p> <p>Interview with Detective #2, on 10/16/14 at 11:25 AM, revealed when he interviewed RN #1, on 10/15/14, RN #1 confessed to stealing the residents' medications. Detective #2 stated RN #1 stated all the items in the Sharps' containers were hers, such as the needles, straws and clear medication envelopes which were used to crush the medications.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy.</p>	F 431		



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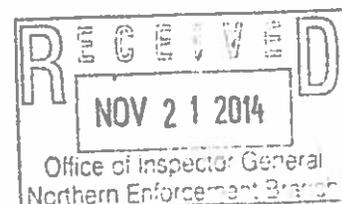
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 431	<p>Continued From page 89</p> <ol style="list-style-type: none"> Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. All medications found to be tampered with were reordered at the facility's expense. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been 	F 431			



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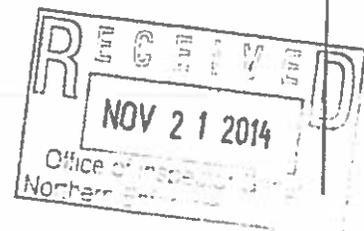
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
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F 431	<p>Continued From page 70</p> <p>no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages.</p> <p>8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering.</p> <p>9. Education provided to the nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator.</p> <p>10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance.</p> <p>11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes</p>	F 431			



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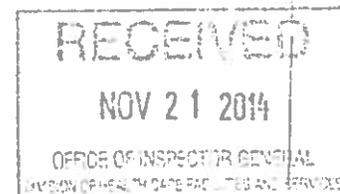
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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F 431	Continued From page 71 seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th. 12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14. 13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/08/14. 14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified,	F 431		



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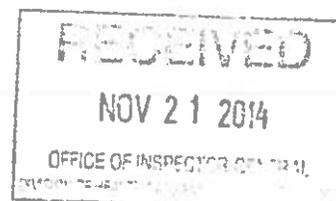
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
(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 72</p> <p>the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14.</p> <p>15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON.</p> <p>16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy.</p> <p>17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions.</p> <p>Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14.</p> <p>1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of</p>	F 431			



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F 431	<p>Continued From page 73</p> <p>Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14.</p> <p>2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14.</p> <p>3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/26/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed.</p> <p>4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of Morphine Sulfate were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that</p>	F 431			



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F 431	<p>Continued From page 74 appeared tampered.</p> <p>5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) morphine narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other morphine narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility purchased the re-ordered medications which were destroyed.</p> <p>6. Review of Resident #5's Morphine and Lorazepam narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed Morphine and Lorazepam on 09/15/14.</p> <p>7. Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders to ensure they matched what was in the computer between the days of 09/09/14 and 09/15/14 and daily thereafter. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14.</p> <p>8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at</p>	F 431		

