

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

PRINTED: 02/02/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/18/2012
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 243 WATER STREET DAWSON SPRINGS, KY 42408
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F 000	INITIAL COMMENTS  An abbreviated survey (KY#17573) was conducted on 01/17/12 through 01/18/12. KY #17573 was substantiated with deficiencies cited at the highest S/S of an "E."	F 000	<b>F224</b> <b>1. Corrective Action:</b>  Res #1, 2, 5, 6 Residents #1, 2, 5, and 6 are being provided medications and services daily as ordered and any refusals are referred to the Charge Nurse for follow up.  Each resident is being monitored daily by the evening shift licensed staff at the end of the day to assure medications and services are being provided correctly.  Policy on Abuse, Neglect, or Exploitation was reviewed and revised by the Concord Health Systems Policy Committee on 2-7-12 to include multiple medication omissions as an example of neglect. <b>See Exhibit #1</b>  DON and ADM re-educated by Corporate Compliance Nurse on 2-7-12 regarding abuse, neglect, and exploitation, recognizing and reporting.	
F 224 SS=E	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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to ensure residents were free from neglect for four residents (#1, #2, #5 and #6), in the selected sample of six residents. The facility failed to follow the "Abuse, Neglect, or Exploitation" policy/procedure to ensure residents received the necessary services to avoid the potential for physical harm. On 01/07/12, Certified Medication Technician (CMT) #1 disposed of Resident #1's medications in a trash can, and failed to report Resident #1's refusal of morning medications to the charge nurse. The charge nurse later found the medications in the trash on the morning of 01/07/12. Additionally, CMT #1 disposed of Residents #2, #5 and #6's medication in the trash on 12/11/10, and the charge nurse later found the medications in the trash on that same day. Facility staff neglected to provide Resident #1 his/her medication on	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 2-17-12

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

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F 224 Continued From page 1  
01/07/12, as well as Residents #2, #5 and #6's medication on 12/11/10, when CMT #1 threw the residents' medication in the trash.

The findings include:

A review of the facility's policy/procedure "Abuse, Neglect, or Exploitation," revised 04/12/10, revealed it was essential for all staff, volunteers, and visitors to be responsible for the health, safety, and welfare of all individuals receiving support. Employees were prohibited to exploit, neglect, or abuse residents served. "Neglect" was defined in the policy as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

1. A record review revealed Resident #1 was admitted to the facility on 05/08/07 with diagnoses to include Paranoid Schizophrenia, Anxiety and Diabetes Mellitus-Type II. A review of the quarterly Minimum Data Set (MDS), dated 01/09/12 revealed he/she had a Brief Interview of Mental Status (BIMS) score of "11." The facility assessed the resident to be moderately cognitively impaired.

A review of the Medication Administration Record (MAR), dated 01/01/12 through 01/31/12, revealed, on 01/07/12, CMT #1 circled her initials which indicated the resident refused all 8:00 AM and 9:00 AM medications, and did not inform the charge nurse. These medications included Levothyroxine Sodium 50 micrograms (mcg), Mobic 15 milligrams (mg), Potassium Chloride 20 milliequivalents (meq), a Multiple Vitamin tablet, Depakote Sprinkles 1000 mg, Effexor 150 mg, Geodon 80 mg, Mefformin 1000 mg, Haldol 10

F 224 All licensed staff and CMT'S were inserviced on the revised policy by 2-13-12 by the DON. See Exhibit #2 Inservice

Licensed staff inserviced on the daily (nightly, as the review is completed on the night shift) chart review process for physician orders, using the revised Physician Order Policy from 2-7-12 thru 2-13-12 by the DON.

2. ID of Others at risk:

All resident MAR's reviewed by the facility DON and Compliance Nurses on 2-6-12 through 2-7-12 and compared with medications on cart with no problems noted. No medications were found in trash on random check on carts during review.

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F 224	<p>Continued From page 2</p> <p>mg, Alivan 2 mg, and Two Cal 90 milliliters (ml).</p> <p>An interview with Registered Nurse (RN) #1, 01/17/12 at 1:05 PM and 8:22 PM, revealed she was the nurse who found the medications in the trash on 01/07/12. She reviewed Resident #1's MAR and saw CMT #1 initiated the MAR to indicate the resident had refused his/her medications. CMT #1 did not notify RN #1 regarding the resident's refusal of medications. She checked the resident's MAR and found all medications for the entire day were initiated by CMT #1. Further review of the MARs for Hall 1 revealed CMT #1 initiated all the residents' medication for the entire day. She observed pills lying on the top of the trash can and removed the trash bag only to find that multiple pills were in the trash. She asked CMT #1 about the pills in the trash and was told she found them loose in the medication cart. She revealed there was a similar incident which happened a long time ago. The pills of three residents were found unopened in the trash of the medication cart. CMT #1 explained to her she got the medications mixed up with her trash and threw the pills away. RN #1 revealed CMT #1 had initiated the residents' MARs as if the medications were administered in both incidents. She stated "this second incident on 01/07/12, I do not think she had intent to hurt the residents. We just could not have this happen again. Something had to be done about it." She notified the Director of Nursing (DON), and informed her of what happened. She received direction to suspend CMT #1 for three days and administration would address the issue.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 12/07/92 and</p>	F 224	<p><b>3. Prevention Measures:</b> All licensed staff inserviced On revised Abuse, Neglect, and Exploitation Policy 2-6-12 thru 2-13-12.</p> <p>All residents refusing medications or not receiving a medication for any reason are to be reported to the Charge Nurse and assessed. (Inservice for all licensed staff and CMT's concluding on 2-13-12 included this information.) If the Charge Nurse suspects a problem with The medication aide or another nurse, she is to report this immediately to the DON or Administrator. The employee is to be suspended and an investigation will follow.</p> <p>If abuse, neglect or mis-appropriation is suspected, facility policy for reporting to OIG and other agencies will be followed.</p>	
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F 224	<p>Continued From page 3</p> <p>re-admitted to the facility on 04/11/12 with diagnoses to include Cardiac Dysrhythmias, Dementia with Behavior Disturbance and Congeslve Heart Failure. Further review revealed Resident #2 expired at the facility on 08/30/11.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on the record were initialed by CMT #1 as being administered; however, a review of the facility's investigative worksheet revealed he/she did not receive any of the 9:00 AM scheduled medications.</p> <p>3. A record review revealed Resident #5 was admitted to the facility on 09/10/10 with diagnoses to include Hypertension, Intermittent Explosive Disorder, Diabetes Mellitus-Type II and Cerebrovascular Disease. A review of the quarterly MDS, dated 11/28/11, revealed he/she had a Brief Interview of Mental Status (BIMS) score of "3." The facility assessed the resident to be severely cognitively impaired.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on the record were initialed by CMT #1 as being administered; however, a review of the facility's investigative worksheet revealed he/she did not receive any of the 9:00 AM scheduled medications.</p> <p>4. A record review revealed Resident #6 was admitted to the facility on 09/20/10 with diagnoses to include Alzheimer's Disease, Dementia, Hypertension and Cardiovascular Disease. A review of the quarterly MDS, dated 01/12/12,</p>	F 224	<p><b>4. Monitor:</b></p> <p>The Administrator will report all Abuse Investigations using the existing CQI tool for investigations to the Corporate office for one month for review. If no problems, the reporting will be reviewed monthly by the Corporate Compliance Nurse for three months and then quarterly. All information will be reported in the monthly CQI meeting. <b>See Exhibit #3 CQI Tool</b></p> <p><b>2. Date Corrected:</b></p>	2-14-12
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F 224	<p>Continued From page 4</p> <p>revealed he/she had a BIMS score of "3." The facility assessed the resident to be severely cognitively impaired.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on the record were initiated by CMT #1 as being administered; however, a review of the facility's investigative worksheet, dated 12/11/10 at 12:00 PM, revealed Resident #6 did not receive any of his/her 9:00 AM scheduled medications.</p> <p>Attempts to interview CMT #1, on 01/17/12 at 4:07 PM, 4:09 PM and 6:06 PM, were unsuccessful.</p> <p>An interview with the DON, on 01/17/12 at 10:00 AM, revealed she expected the nurses to administer the medications as ordered, and if the resident refused his/her medications, then the CMTs were to inform the charge nurse. The charge nurse then attempted to get the resident to take his/her medications and if unsuccessful, they would document the refusal as well as to contact the physician. She stated there was a similar incident with medications being thrown in the trash awhile back which involved three residents (Residents #2, #5 and #6), as well as the incident involving Resident #1. CMT #1's actions were not thought of as neglectful, and the errors she made in the past were dealt with through re-education and re-training, but did not help.</p> <p>An interview with the Administrator, on 01/17/12 at 3:45 PM, revealed during the investigation, neglect was not suspected related to CMT #1. It was identified she did not complete her duties</p>	F 224		
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F 224	Continued From page 5 after she was provided re-training and re-education. Following the second incident related to throwing the residents' medications in the trash, the decision was made to end CMT #1's employment with the facility.  A phone interview with the attending physician, on 01/18/12 at 12:40 PM, revealed the facility staff did make her aware of the incident on 01/07/12, and she could not recall the 12/10 incident. She revealed she expected the staff to administer the medication as ordered. Additionally, the staff were to notify her if the residents refused medications and if the staff find any pills thrown away.	F 224		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure written policies and procedures were implemented that prohibit abuse, neglect and exploitation of four residents (#1, #2, #5 and #6), in the selected sample of six residents. On 01/07/12, Certified Medication Technician (CMT) #1 threw Resident #1's medications in the trash can. Additionally, on 12/11/10, CMT #1 threw Residents #2, #5 and #6's medications in the trash. The facility investigated the employee's conduct on 01/09/12,	F 226	<p><b>F226</b></p> <p><b>1. Corrective Action:</b></p> <p>Res #1, 2, 5, 6 Residents #1, 2, 5, and 6 are being provided medications and services daily as ordered and any refusals are referred to the Charge Nurse for follow up.</p> <p>Each resident is being monitored daily by the evening shift licensed staff at the end of the day to assure medications and services are being provided correctly.</p>	

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F 226	Continued From page 6 and determined CMT #1 did not carry out her duties. CMT #1 was terminated on 01/09/12; however, the facility did not address an issue of neglect due to CMT #1 throwing the residents' medications in the trash. The facility did not identify CMT #1's behavior to be neglectful until after State Survey Agency review.  The findings include:  A review of the facility's policy and procedure, "Resident Abuse, Neglect and Exploitation," dated 04/12/10, revealed "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Any incidents of suspected abuse, neglect or exploitation involving staff toward a resident shall be immediately reported to the employee's immediate supervisor and the Administrator and/or designee, at which time an investigation will begin. The Administrator and/or designee will follow the facility protocols for reportable incidents. In cases of alleged abuse involving an employee against a resident, that employee shall be suspended immediately pending further investigation by the Administrator and/or designee. The Division of Long-Term care is to be notified immediately or if after hours can be notified the next business day after the allegation. The Administrator and/or designee will conduct an investigation of the allegation and report the results of the investigation within five (5) working days to the Division of Long-Term Care. Failure to report an allegation of abuse, neglect or exploitation by an employee may be cause for dismissal.  1. A record review revealed Resident #1 was	F 226	Policy on Abuse, Neglect, or Exploitation was reviewed and revised by the Concord Health Systems Policy Committee on 2-7-12.  See Exhibit #1  The revised policy was reviewed with the Administrator and Director of Nursing by the Corporate Compliance Nurse on 2-7-12 in an effort to assure that multiple drug omissions are to be interpreted as neglect in the facility definition of neglect which defines neglect as the provision of goods and services necessary to avoid physical harm, mental anguish, or mental illness.  Corporate disciplinary action administered by Corporate Compliance Nurse in the form of verbal re-education for Administrator and DON on	

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F 226	<p>Continued From page 7</p> <p>admitted to the facility on 05/08/07 with diagnoses to include Paranoid Schizophrenia, Anxiety and Diabetes Mellitus-Type II. A review of the quarterly Minimum Data Set (MDS), dated 01/09/12, revealed he/she had a Brief Interview of Mental Status (BIMS) score of "11." The facility assessed the resident to be moderately cognitively impaired.</p> <p>A review of Resident #1's Medication Administration Record (MAR), dated 01/01/12 through 01/31/12, revealed, on 01/07/12, CMT #1 circled her initials which indicated the resident refused all 8:00 AM and 9:00 AM medications. These medications included Levothyroxine Sodium 50 micrograms (mcg), Mobic 15 milligrams (mg), Potassium Chloride 20 milliequivalents (meq), a Multiple Vitamin tablet, Depakote Sprinkles 1000 mg, Effexor 150 mg, Geodon 80 mg, Mefformin 1000 mg, Haldol 10 mg, Ativan 2 mg, and Two Cal 80 milliliters (ml).</p> <p>Further review of the MARs for Hall 1, revealed, on 01/07/12, CMT #1 initialed all of the residents' MARs for the entire day. Hall 1's medication administration times were 9:00 AM for daily medications, 9:00 AM and 9:00 PM for twice a day (BID) medications, 9:00 AM, 3:30 PM and 9:00 PM for three times a day (TID) medications, 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM for four times a day (QID) medications, and 9:00 PM for hour of sleep medications.</p> <p>An interview with the MDS Coordinator, on 01/17/12 at 12:35 PM, revealed there was an issue with CMT #1's work performance during the weekend of 01/07/12. She stated Resident #1 was upset on the morning of 01/07/12, and</p>	F 226	<p>2-7-12 regarding investigations and the determination of neglect or potential neglect as well as reporting requirements.</p> <p>All licensed staff and CMT'S were inservice on the same revised policy, Abuse, Neglect or Exploitation, by 2-13-12 by the DON.</p> <p><b>See Exhibit #2 Inservice</b></p> <p><b>2. ID of Others at risk:</b></p> <p>Corporate Compliance Nurse Reviewed all Administrative investigations from 2011 on 2-7-12. No reporting problems were identified.</p> <p><b>3. Prevention Measures:</b></p> <p>Administrator and DON were re-educated by Corporate Compliance Nurse on 2-7-12</p>	

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F 226	<p>Continued From page 8</p> <p>Registered Nurse (RN) #1 checked the MAR to see if the resident's medications were administered. RN #1 reviewed the MAR to find CMT #1 had circled her initials on the resident's morning medications, which would indicate refusal of medications. RN #1 continued to review Resident #1's MAR and found CMT #1 initiated Resident #1's medications for the entire day, as well as all the other residents residing on Hall 1 of the facility (total of thirty-three residents). RN #1 observed medications in the bag of the medication cart's trash can. She then removed it to find multiple pills in the bottom of the trash bag. CMT #1 informed them she found all of those loose pills in the medication cart and threw them away. The CMTs were to make the charge nurse aware if a resident refused his/her medications, and CMT #1 did not let anyone know about Resident #1's refusal. She further stated a similar incident happened several months prior to that, when she and another nurse found Residents #2, #5 and #6's (9:00 AM) medications in the pill packs in the trash. CMT #1 explained she got the medications mixed up with the trash that she had on top of the cart and threw all of the medications in the trash.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 12/07/92 and re-admitted to the facility on 04/11/12 with diagnoses to include Cardiac Dysrhythmias, Dementia with Behavior Disturbance and Congestive Heart Failure. Further review revealed Resident #2 expired at the facility on 08/30/11.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on</p>	F 226	<p>regarding investigating and reporting abuse, neglect or exploitation.</p> <p>All licensed staff inserviced on revised Abuse, Neglect, and Exploitation Policy 2-7-12 thru 2-13-12 by the DON.</p> <p>All residents refusing medications or not receiving a medication for any reason are to be reported to the Charge Nurse and assessed. Inservice for all licensed staff and CMT's concluding on 2-13-12 included this information. If the Charge Nurse suspects a problem with the medication aide or another employee, she is to report this immediately to the DON or Administrator. The employee is to be suspended and an investigation will follow.</p>		

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F 226	<p>Continued From page 9</p> <p>the record were initiated by CMT #1 as being administered; however, a review of the facility's investigative worksheet revealed he/she did not receive any of the 9:00 AM scheduled medications.</p> <p>3. A record review revealed Resident #5 was admitted to the facility on 09/10/10 with diagnoses to include Hypertension, Intermittent Explosive Disorder, Diabetes Mellitus-Type II and Cerebrovascular Disease. A review of the quarterly MDS, dated 11/28/11, revealed he/she had a Brief Interview of Mental Status (BIMS) score of "3." The facility assessed the resident to be severely cognitively impaired.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on the record were initiated by CMT #1 as being administered; however, a review of the facility's investigative worksheet revealed he/she did not receive any of the 9:00 AM scheduled medications.</p> <p>4. A record review revealed Resident #6 was admitted to the facility on 09/20/10 with diagnoses to include Alzheimer's Disease, Dementia, Hypertension and Cardiovascular Disease. A review of the quarterly MDS, dated 01/12/12, revealed he/she had a BIMS score of "3." The facility assessed the resident to be severely cognitively impaired.</p> <p>A review of the MAR, dated December 2010, revealed, on 12/11/10 at 9:00 AM, medications on the record were initiated by CMT #1 as being administered; however, a review of the facility's investigative worksheet, dated 12/11/10 at 12:00</p>	F 226	<p>If abuse, neglect or mis-appropriation is suspected, facility policy for reporting to OIG and other agencies will be followed.</p> <p><b>4. Monitor:</b></p> <p>The Administrator will report all investigations using the existing CQI tool for investigations to the Corporate office for one month for review. If no problems, the reporting will be reviewed monthly by the Corporate Compliance Nurse for three months and then quarterly. All information will be reported in the monthly CQI meeting. <b>See Exhibit #3 CQI Tool</b></p> <p><b>5. Date Corrected:</b></p>	2-14-12
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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F 226	<p>Continued From page 10</p> <p>PM, revealed Resident #6 did not receive any of his/her 9:00 AM scheduled medications.</p> <p>A review of personnel records revealed CMT #1 received disciplinary action, on 12/11/10, related to multiple residents who did not receive his/her 9:00 AM medications. On 03/29/11, CMT #1 received re-education due to not administering a Medrol dose pack and antibiotic eye drops to a resident, on 03/26/11 and 03/27/11. Additionally, on 03/29/11, CMT #1 received re-education for not administering Coumadin as ordered. On 05/13/11, the employee received disciplinary action related to not passing residents their snacks on the weekend, dated 05/07/11 through 05/08/11. On 07/08/11, the employee received disciplinary action for not administering Potassium Chloride to a resident, on 07/02/11 and 07/03/11. Additionally, on 01/07/12, the employee received disciplinary action due to not reporting a resident's medication refusal.</p> <p>An interview with RN #1, on 01/17/12 at 1:05 PM, revealed she was the day shift nurse who worked on 01/07/12. She revealed there was an incident a long time ago with CMT #1 related to not administering Resident #2's medication. She noticed Resident #2's medications (still in the pill packs) were in the medication cart trash along with two other residents' medications. CMT #1 reported she got the medications mixed up with the trash on top of the cart, and threw all of the packs in the trash. After that incident, CMT #1 received re-education from the compliance nurse and the DON completed disciplinary action. On 01/07/12, Resident #1 was upset and she checked the MAR to see if the resident received his/her medications. A review of the MAR</p>	F 226		
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F 226	<p>Continued From page 11</p> <p>revealed CMT #1 circled her initials, which indicated Resident #1 refused his/her medications. CMT #1 did not inform her the resident had refused his/her medications. Further review of the MARs revealed CMT #1 initialed all the residents' MARs on Hall 1 for the entire day. Additionally, she noticed pills in the trash can and pulled the bag out to find multiple pills in the bottom of the trash bag. She notified the DON and made her aware of the incident. The DON directed her to write it up and place the CMT on a three-day suspension. RN #1 revealed she did not count the pills nor could she identify who the medication belonged to. The CMT informed her the medications were loose in the bottom of the medication cart, so she just threw them away.</p> <p>Attempts to interview CMT #1, on 01/17/12 at 4:07 PM, 4:09 PM and 6:06 PM, were unsuccessful.</p> <p>An interview with the DON, on 01/17/12 at 4:54 PM, revealed, on 01/07/12, she received a call from RN #1 in regard to CMT #1 marking Resident #1 as refusing his/her medications, the multiple medications found in the trash, and the MARs being signed for the entire day. She instructed the staff to write the situation up and send CMT #1 home on a three-day suspension. Upon returning to work on 01/09/12, the DON and the Administrator discussed the issue and determined CMT #1 already made errors with verbal warnings. CMT #1 had re-training and she continued to make errors. CMT #1 was terminated on 01/09/12 related to poor work performance. She stated she did not think of the situation as being neglectful until State Survey</p>	F 226			

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F 226	Continued From page 12 Agency review. The DON stated she had not reported the incident to the State Survey Agency, in accordance with the facility's policy/procedure.	F 226	<b>F333</b> <b>1. Corrective Action</b> <b>Resident # 4</b>	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.	F 333	Medication Administration Record for resident #4 was reviewed by the DON and compared with physician orders 1-18-12 with no discrepancies noted.	
	This REQUIREMENT is not met as evidenced by:		A new on-line resident mgt system has been implemented in January 2012 to provide a more efficient process that automatically processes changes and generates the MAR. The Review of Physicians's order Policy was completed on 2-7-12, inserviced and implemented on 2-13-12.	
	Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#4), in the selected sample of six residents, was free from significant medication errors. On 07/07/11, the physician increased Resident #4's Levimar; however, the order was not transcribed to the Medication Administration Record (MAR) until 07/11/11. Resident #4 went five (5) days without receiving the increased dose of his/her medications.		Licensed staff inserviced on the daily (nightly, as the review is completed on the night shift) chart review process for physician orders, using the revised Physician Order Policy from 2-7-12 thru 2-13-12 by the DON. <b>See Exhibit # 4</b>	
	The findings include:			
	A review of the facility's policy/procedure, "Prescriber Medication Orders," undated, revealed "each medication order is documented in the patient's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet or the telephone order sheet/Interim Order form if it is a verbal order, on the Medication Administration Record (MAR)." Additionally, a review of the facility's policy/procedure, "Review of Physician's Order Policy," undated, revealed "all residents charts will be checked nightly to			

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F 333	<p>Continued From page 13</p> <p>assure all physician's order have been transcribed correctly. The charge nurse will sign her name and date in red on each of the physician's order sheet to verify that physician's orders were checked and found to be correct or corrected."</p> <p>A record review revealed Resident #4 was admitted to the facility on 05/06/11 with diagnoses to include Schizophrenia, Mental Retardation and Diabetes Mellitus.</p> <p>A review of the physician's orders, dated 07/07/11, revealed orders for discontinuation of Metformin and Janument 50/500 1 tablet by mouth (po) twice daily (BID), and to increase Levimar 30 units at hour of sleep (HS). Further review of the MAR, dated July 2011, revealed the order for the Metformin and Janument were transcribed to the MAR on 07/07/11, but the change to the Levimar was not transcribed to the MAR. Resident #4 received Levimar injection 20 units for five consecutive days, from 07/07/11 through 07/11/11, instead of the Levimar injection 30 units (a 10 unit increase).</p> <p>An interview with the Minimum Data Set (MDS) Coordinator, on 01/18/12 at 12:40 PM, revealed she took the orders off on 07/07/11. She stated she missed the order for the increase in the Levimar and received discipline related to the omission.</p> <p>An interview with Registered Nurse (RN) #1, on 01/17/12 at 1:05 PM, revealed she worked the night of 07/07/11. She revealed she did not complete the 24 hour check on the orders. RN #1 revealed she received discipline for not</p>	F 333	<p><b>2. ID of Others at Risk:</b></p> <p>All MARs reviewed by Compliance Nurses and DON for accuracy on 2-6-12 and 2-7-12 with no problems identified.</p> <p><b>3. Prevention:</b></p> <p>The new on-line system implemented in January 2012 to provide a more efficient process for generating the MAR.</p> <p>Licensed staff inserviced on the daily (nightly) chart review process using the revised Physician Order Policy from 2-7-12 thru 2-13-12 by the DON.</p> <p><b>4. Monitor:</b></p> <p>The Review of Medication Pass CQI Tool will be utilized</p>	

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F 333	<p>Continued From page 14 completing the check and for not catching the increase in the Levimar.</p> <p>An interview with the Compliance Nurse, on 01/17/12 at 4:20 PM, revealed RN #1 was not the nurse transcribing the order on 07/07/11, but she was the nurse responsible for completing the 24 hour check on the chart. The facility protocol for checking medication orders was the responsibility of the third shift nurse, who was to ensure all the new orders from the day before were transcribed to the MAR. RN #1 did not complete the 24 hour check and the order was not discovered until five days later, which resulted in a medication error.</p> <p>An interview with the Director of Nursing (DON), on 01/18/12 at 2:30 PM, revealed RN #1 stayed over and worked on 07/07/11 to help out and the order for the increase in the medication was overlooked. The staff were expected to take the orders off when received from the physician. The staff on the 6:00 PM to 6:00 AM shift were responsible for completing the 24 hour check and RN #1 was not used to working that shift. We determined she did not complete the check and that was how the order got missed. Even if she completed the 24 hour check later in the shift, the resident might have only missed the first dose of the increase in medication, instead of missing five days without the increase in medication.</p>	F 333	<p>weekly x one month and then monthly x three months and resume quarterly. All information will be reported in the monthly CQI Meeting. See Exhibit # 5</p> <p>5. Date Corrected:</p>	2-14-12
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