

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

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/18/2012
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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064
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F 000	INITIAL COMMENTS	F 000	The statements contained in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedures it was determined the facility failed to ensure the residents' environment remained free from accident hazards for one resident (#2) in the selected sample of three (3) residents. The facility failed to secure a narcotic medication (Tylenol #3) which was left on top of a medication cart in a paper souffle cup during a medication pass while residents were wandering in the immediate area. The Certified Medication Technician (CMT) left the medication cart unsupervised and out of view for approximately three minutes to look for a medication which was missing from the resident's medication tray.	F 323	To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 08/13/2012. 1) No residents were affected by the deficient practice. 2) Wandering residents have the potential to be affected. 3) The Certified Medication Technician(CMT) was trained by the Director of Nursing(DON) on 7/19/12 on ensuring residents' environment remains free from	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jimmy Workman* TITLE *Administrator* (X6) DATE *9/21/12*

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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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42084		
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F 323	<p>Continued From page 1</p> <p>Findings include:</p> <p>A review of the facility's policy and procedures "Medication Administration" revealed during the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart, the cart must be clearly visible to the personnel administering medications when unlocked.</p> <p>A record review revealed the facility admitted Resident #2 on 06/20/12 with diagnoses to include Trigeminal Neuralgia, Osteoarthritis, and Chronic Obstructive Pulmonary Disease. Review of the resident's Physician Orders dated 07/05-31/12 revealed an order for the narcotic Tylenol #3, give one tablet by mouth every 8 hours for pain. Review of the Medication Administration Record (MAR) dated 07/05-31/12 revealed the resident was receiving Tylenol #3 every eight hour for pain.</p> <p>An observation of a medication pass on 07/17/12 at 9:50 AM revealed CMT #1 punching medications out of a pharmaceutical blister packet to administer Resident #2's medications. The CMT punched nine medications out of the blister packets and placed the medications in a single paper souffle cup. She then obtained the Tylenol #3 from the locked narcotic box and placed the tablet alone in an individual paper souffle cup. The CMT #1 placed the Tylenol #3 tablet in the paper souffle cup on top of the medication cart, which was unsupervised and unsecured by staff, with three unsupervised residents in the area of the medication cart. CMT #1 then left the medication cart to look for a</p>	F 323	<p>accident hazards; specifically when performing medication administration. Nurses and CMTs were trained by the DON to always secure medications, including during medication administration. Training was completed for nurses and CMTs prior to 8/13/12.</p> <p>4) DON and/or designee will observe medication pass once weekly times four weeks and then monthly times three months to ensure staff are securing medications during medication administration. All findings will be brought to AM clinical meeting for documentation. From there the facilities monthly CQI meeting will trend findings documented from AM clinical meetings.</p> <p>5) Date of compliance is 8/13/12.</p>	

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F 323	<p>Continued From page 2</p> <p>medication which was missing from the resident's medication tray. CMT #1 was gone from the medication cart for approximately three minutes, with the medication cart out of view. Observation revealed the Tylenol #3 sitting in the paper souffle cup unsecured on top of the medication cart.</p> <p>An Interview with CMT #1, on 07/17/12 at 10:15 AM, revealed she should have never left the Tylenol #3 sitting on top of the medication cart because the medication was a narcotic and was suppose to be locked up. Per interview, she did not have a visual of the unsecured drug when she left the area to look for another medication and there was opportunity for the unsupervised residents in the area of the medication cart to take the drug.</p> <p>An interview with Registered Nurse (RN) #1, on 07/12/12 at 11:30 AM, revealed she would have considered the Tylenol #3 tablet lying on top of the medication cart a risk for the cognitively impaired residents in the facility. Per interview, there were four residents in the facility who wander and have severe cognitive impairment. She further stated, the Tylenol #3 should have been locked up and not left on top of the medication cart which created a danger for those residents.</p> <p>A Interview with the Director of Nursing (DON), on 07/17/12 at 10:45 AM, revealed CMT #1 should have never left the narcotic, Tylenol #3 sitting on top of the medication cart unsecured and out of her field of vision and the fact there were unsupervised residents in the area made it a more serious situation. She further stated, the facility's polcny/procedures said medications were</p>	F 323		
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F 323	Continued From page 3 not to be left on top of the medication cart and narcotics were always to be secured in the medication cart. The residents with cognitive impairment and the facility's four wandering residents who have severe cognitive impairment were at greatest risk of harm due to the unsupervised medication.	F 323			