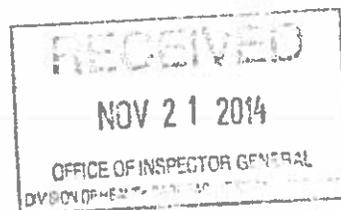


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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
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 75</p> <p>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 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 1:28 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>	F 431			



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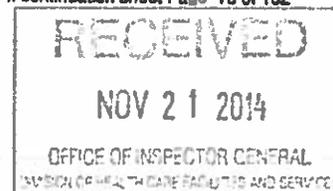
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F 431	Continued From page 78 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the 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 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. 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	F 431			

Continuation sheet Page 77 of 153
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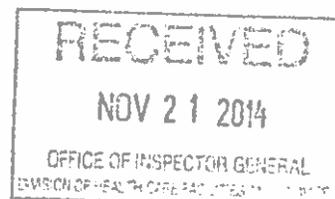
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F 431	Continued From page 77 were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole shift on 10/10/14 without being educated. Review of the 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 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 10/06/14 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	F 431			



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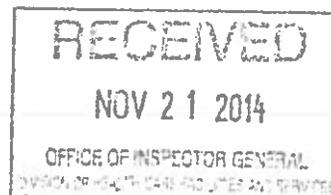
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F 431	<p>Continued From page 78</p> <p>correction of the deficiency. Interview with the Regional Director of Operations, on 10/10/14 at 2:21 PM, revealed staff was not to work unless they had been educated. He stated he was not aware LPN #3 was on 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 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 Ins 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</p>	F 431			



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F 431	<p>Continued From page 79</p> <p>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-serviced on PRN medication management and ensuring an assessment was completed on all residents 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</p>	F 431			



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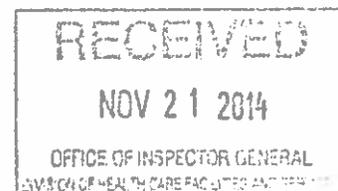
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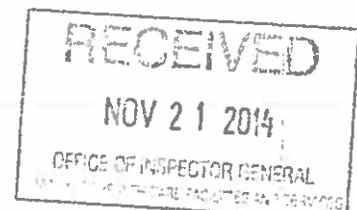
F 431	<p>Continued From page 80</p> <p>09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs were educated on abuse, misappropriation and the importance of notifying the DON and Administrator as soon as abuse was observed. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 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> <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</p>	F 431		
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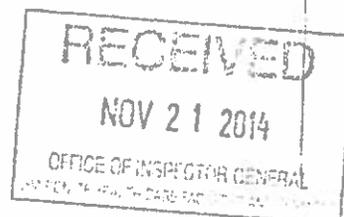
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F 431	<p>Continued From page 81</p> <p>10/07/14 through 10/10/14. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #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, 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 DCN, 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 2:26 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 1:26 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>	F 431			



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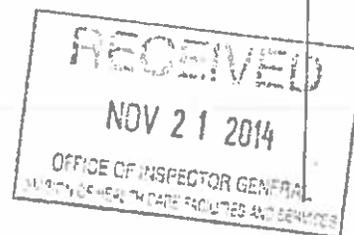
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F 431	Continued From page 82 16. Review of the Pharmacy consults, dated 10/03/14, revealed the MARs were verified to match the pharmacy delivery tickets, and, matched the labels. All counts, and all tablets were verified to be accurate and no signs 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 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	F 431			



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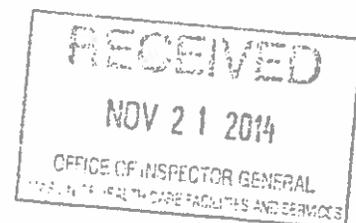
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F 431	Continued From page 83	F 431			
F 490 SS=K	<p>contacted them to report the allegation of drug diversion. Review of the signature section of the policies and procedures revealed they were reviewed by the DON and ADON on 10/06/14 with no changes to the policies and procedures.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies and the Administrator's job description it was determined the Administrator failed to use available resources to ensure an effective system was in place to ensure staff was knowledgeable of the facility's policies and procedures for narcotic and medication administration and to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #8); and, two (2) of two (2) unsampled residents (Unsampled Residents A and B). The Administrator failed to ensure medications and narcotics were administered, reconciled, and monitored. (Refer to F224, F431, F514 and F520)</p> <p>The Administrator had a concern with reordering medications in June and July of 2014; this was</p>	F 490	<p>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.</p> <p>F490 Completion Date: 11/05/2014 SS=E 483.75 Effective Administration/Resident Well-Being</p> <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</p>		



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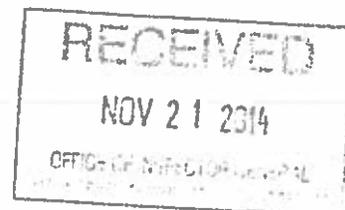
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F 490	<p>Continued From page 84</p> <p>taken to Quality Assurance (QA) and considered resolved as of 07/28/14. This was the last QA meeting on record. However, it was never identified by QA that narcotics were being diverted during this time. The Administrator was not made aware on 08/31/14 of the narcotic blister packs, that were identified by Licensed Practical Nurse (LPN) #2, #3 and #8, as having been tampered and taped. She became aware of this on 09/08/14, by the Director of Nursing and initiated audits to determine how many residents were effected. The audits determined twenty-five (25) additional residents were effected; however, this was never taken to QA for review, monitoring or resolution.</p> <p>Although the Administrator contacted the pharmacy for assistance, the Administrator never reviewed the audits for 09/09/14 and 09/15/14 to ensure it covered the suspected medication cart on Lincoln Lane. In addition, the Administrator did not make sure all of the licensed staff was educated on the facility's policy and procedures for reconciling and documenting narcotic counts. The Administrator did not ensure the Abuse education provided to staff after 09/08/14, clarified that theft/diversion of resident drugs was defined as misappropriation of resident property and should be reported immediately, per the facility's policy.</p> <p>The failure of the Administrator to effectively use available resources to detect misappropriation/diversion of medications and narcotics, ensure the Quality Assurance Committee developed action plans and monitored the reconciliation of narcotics, and administration of medications placed residents at risk in a situation that has caused or was likely to cause</p>	F 490	<p>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 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-</p>	



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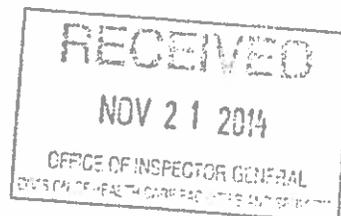
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F 490	<p>Continued From page 85</p> <p>serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/09/14 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 493.75 Administration (F490) 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 job description for the Administrator, not dated or signed, revealed the purpose of the position was to direct the day to day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern nursing facilities. The essential function of the position was: compliance management; to ensure excellent care for residents is maintained by overseeing and monitoring patient care services delivered; works with and supervises personnel to ensure complete understanding of responsibilities; and, to ensure maintenance of accurate medical records for billing, auditing, and regulatory compliance.</p> <p>Review of the Inventory Control of Controlled Substances Policy, revised 01/01/13, revealed the facility representative should regularly check the inventory records to reconcile inventory. The Facility should regularly reconcile Current and discontinued inventory of controlled substances</p>	F 490	<p>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's" 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 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</p>		



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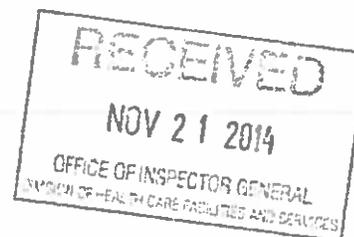
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F 490	<p>Continued From page 86</p> <p>to the log used in the facility's controlled medication inventory system: Current inventory to the controlled medication declining inventory record and to the residents' Medication Administration Record (MAR) and unused controlled substances held in storage destruction to the declining inventory record.</p> <p>Review of the Loss and Theft Policy, effective 12/01/07, revealed 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 controlled substance discrepancies and if such discrepancies are not reconciled, notifying the appropriate law enforcement agencies according to applicable law and facility policy.</p> <p>Review of the facility's policy, "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, "Documentation of Medication Administration", revised April 2007, revealed a nurse or Certified Medication Aide would document all medications administered on each resident's Medication Administration Record (MAR). Administration of medication must be documented immediately after (never before) it was given.</p>	F 490	<p>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 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 discharged 7/26/2014. This medication issue was not</p>		



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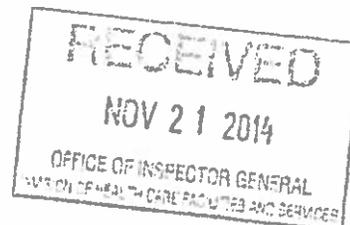
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F 490	<p>Continued From page 87</p> <p>Review of the facility's policy, "Medical Records", revised August 2006, revealed a medical/clinical record was maintained for each resident admitted to the facility. All data contained in the resident's chart maintained at the nurse's station reflects the medical history of the resident.</p> <p>Review of the facility's policy regarding Adverse Consequences and Medication Error, revised February 2014, revealed the interdisciplinary team reviews the resident's medication regimen for efficiency and actual or potential medication-related problems on an ongoing basis. The QA Committee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective in reducing errors.</p> <p>Review of the training records revealed licensed staff borrowing medications was not included in either training conducted on 06/04/14 or 06/10/14. Education provided on 09/17/14 after the drug diversion was suspected did not cover misappropriation of resident property. Review of the computer education regarding Abuse revealed it did not cover drug diversion as misappropriation of resident property. (Refer to F224)</p> <p>The Administrator did not ensure education provided on 06/04/14, 06/10/14, and 09/17/14 addressed identification of diversion of medications/narcotics, monitoring narcotics, reporting suspicion of diversion of drugs, or following the facility policies. (Refer to F431)</p>	F 490	<p>discovered until this complaint investigation.</p> <p>The licensed nurse in question was immediately suspended pending investigation by the Director of Nursing (Director of Nursing) on 9.8.14 for suspected narcotic misappropriation and law enforcement contacted.</p> <p>On 9.8.14 The Director of Nursing started a full investigation of licensed staff and residents receiving narcotics for any misappropriation or tampering with medication cards. The Director of Nursing and facility Administrator, in good faith, reported the possible misappropriation to the Kentucky State Agency (OIG), the Kentucky Board of Nursing (KBN) and Adult Protective Services (APS). In addition, any medication found to be missing or tampered with was reordered for those residents at the facility's cost.</p> <p>The Administrator and the Director of Nursing advised both the Regional Director of Operations and the Regional Nurse Consultant as well as the Divisional Nurse Consultant were contacted via conference call on 9/8/2014. Regional and Division team members advised the Administrator and Director of Nursing to immediately secure the narcotics, narcotic worksheets, notify the physician/family, Medical</p>		



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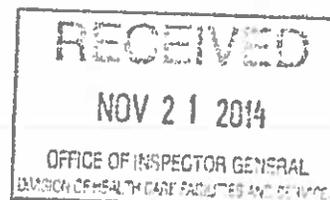
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F 490	Continued From page 88 The Administrator did not ensure narcotic count sheets were monitored for irregularities or inaccurate documentation. The Administrator did not ensure Pharmacy was reviewing the narcotic count sheets for accuracy. The Administrator did not ensure education provided on 06/04/14, 06/10/14 and 09/17/14 addressed monitoring the accuracy of the medication/narcotic documentation. (Refer to 514) Interview, on 09/25/14 at 4:06 PM, with the Administrator, revealed the facility did not monitor, reconcile and/or destroy medications according to policy. Interview with the Director of Nursing (DON), on 09/24/14 at 3:48 PM, revealed she destroyed evidence (narcotic blister packs and liquids) when diversion of drugs was suspected and continued to destroy evidence once law enforcement had initiated an active case. From 09/15/14 until 10/13/14 twenty-five (25) additional residents were identified as possible victims of the drug diversion. The Administrator failed to ensure a QA meeting was held to develop a plan of action and monitor the investigation process after she was notified of the suspected diversion of drugs on 09/08/14. (Refer to 520) Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed she was made aware of the diversion on 09/08/14 by the DON. She stated there was no QA meeting held after 09/08/14 to address the magnitude of the diversion of drugs; however, there was a QA meeting scheduled for the week after 09/25/14. In addition, she did not make contact with the pharmacy consultant about the information discovered on 09/08/14 due to the pharmacist had been working with the DON.	F 490	Director, do a clinical assessment of the resident, contact the GM of the Pharmacy, replace any missing medications, etc. Also requested preparation of first report to OIG, notify local police department, and DCBS. Also advised to suspend employee under investigation immediately. The Regional team has worked with facility management regarding pharmacy intervention and follow through. We have been on site evaluating the work completed, to assure compliance. The Regional Nurse Consultants have been on site in the facility: 9/16/2014, 9/17/2014, 9/18/2014, 9/23/2014, 9/24/2014, 9/25/2014, 10/14/2014, 10/15/2014, 10/16/2014, 10/20/2014, 10/21/2014, 10/22/2014, 10/23/2014, 10/24/2014, 10/27/2014, 10/28/2014, 11/03/2014, 11/04/2014, and 11/05/2014. The Regional Director of Operations has been on site in the facility: 10/5/2014, 10/6/2014, 10/7/2014, 10/8/2014, 10/9/2014, 10/10/2014, 10/11/2014, 10/12/2014, 10/13/2014, 10/14/2014, 10/20/2014, 10/21/2014, 10/27/2014, and 10/28/2014. The administrator in her role made appropriate and timely contacts with the Regional Team. She asked for and took direction as to the steps to follow. She		



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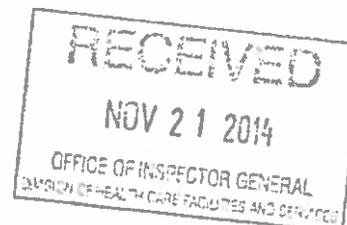
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F 490	<p>Continued From page 89</p> <p>Continued interview with the Administrator, on 10/01/14 at 3:01 PM, revealed she was alerted to medication errors before and they were addressed. As of now and looking at them today and knowing what has happened, she would look at the medication errors differently. The Administrator stated she was not aware the DON was not looking at the narcotic sheets or the empty blister packs. She stated she was aware there were some concerns with pharmacy and the delay of medications, but she felt the facility was at fault because the time lines in which medications were given.</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"> 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. 	F 490	<p>organized with the Director of Nursing, the collection of narcotics, inventory control sheets, etc. She directed the auditing and worked with QA to make sure all processes were in place to assure not only abatement but continued compliance on a go forward basis. She has been in contact with local law enforcement, providing information as necessary. (9/8/2014, 9/15/2014, 9/16/2014, and 9/24/2014)</p> <p>The administrator has reviewed all policies and procedures from 9/8/14 forward, been involved in the auditing process, assuring compliance on a daily basis. Policies reviewed included: Abuse and Neglect 9/8/2014, Misappropriation and Diversion of Narcotics 9/8/2014, Conditions of Participation regarding Abuse, 9/8/2014, Destruction of Narcotics 9/8/2014, Notification to Administration and Pharmacy 9/8/2014, Physician Notification, 9/8/2014. Administrator has been in regular contact with Regional Staff on the improvements being made and compliance on a daily basis.</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</p>		



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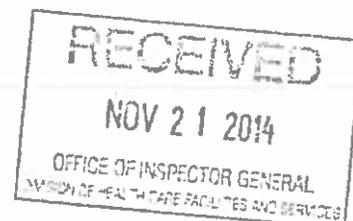
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F 490	<p>Continued From page 90</p> <p>4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14.</p> <p>5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident 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 starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs,</p>	F 490	<p>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 Administrator worked with the Director of Nursing, to provide daily oversight and follow-up to assure timely completion and full compliance by the staff on the education provided to them.</p> <p>The Director of Nursing and facility administration have conducted 100% audit of narcotic orders (beginning 9/8/14 and on-going) and reconciliation sheets for any discrepancies that may indicate diversion narcotic count records, administration sheets. Since 9/4/14 there has been no breach of narcotic medication administration, documentation, reconciliation and/or tampering of packaging system.</p> <p>The Regional Nurse Consultant reviewed and educated the Administrator and the Director of Nursing on policies and standards of practice nursing that included the following: Abuse, Neglect, and Misappropriation; Documentation of Pain</p>	



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F 490	<p>Continued From page 91</p> <p>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 Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training</p>	F 490	<p>Management, including with medication administration sheets (MARs) and Narcotic Reconciliation Records; and Identifying and Reporting Suspicious Activity related to Drug Diversion to Local Law Enforcement, Pharmacy Consultant and/or General Manager, immediately. This was completed on 9/12/2014.</p> <p>In addition, education provided to the nursing staff by the Director of Nursing included misappropriation a form of stealing resident property and inability to provide goods and services as ordered by the physician and to notify the Director of Nursing, nurse on call and/or the Administrator immediately if suspicious activity was noted regarding misappropriation of medications, tampering of medication packaging, or appearance of falsification of narcotic records.</p> <p>The Director of Nursing educated the nursing staff beginning on 9/17/2014 and concluding on 9/22/2014.</p> <p>The facility supplemented in-service education provided by the Pharmacy Consultant Nursing Staff. Education was provided on 10/7/2014.</p> <p>Pharmacy Consultant Manager from Omnicare Pharmacy (facility contract) came</p>		



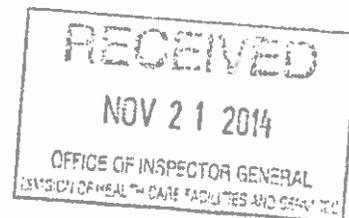
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2014
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NAME 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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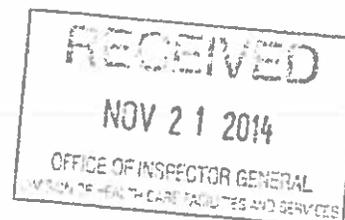
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F 490	<p>Continued From page 92 was completed by all nursing staff on the computer program SilverChair by 09/28/14.</p> <p>13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the 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> <p>16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list</p>	F 490	<p>to facility on 10.3.14 to review and analyze narcotic medications dispensed and being administered for any discrepancies or tampered packaging, documentation of narcotic sheets and medication administration records for reconciliation. No issues or concerns were discovered.</p> <p>Whenever/If any concerns are identified immediate action will be take in regards to disciplinary action, education and/or notification to proper authorities and an immediate investigation will be implemented and immediately taken to QA Committee.</p> <p>Any suspicious activity will be immediately reported to the Administrator and/or Director of Nursing and appropriate action will be taken within the facility and reported to outside agencies per law.</p> <p>In addition the facility consulting pharmacist made her monthly visit on 10/22/2014, did her auditing and reviews as was done on 10/3/2014 and her reporting and exit interview with facility administration did not undercover any concerns with narcotics in any area.</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>	



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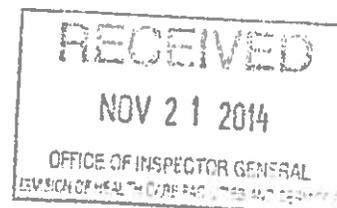
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F 490	<p>Continued From page 93</p> <p>of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure 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 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</p>	F 490	<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, then on 10/22/14, 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. These visits included a detailed review of the narcotic EDK as well.</p> <p>The Administrator working with the Director of Nursing, daily oversaw and followed-up to assure timely completion and full compliance by the staff on the education provided to them. Review of in-services completed, audits completed, and speaking with the medical director with updates (no concerns from MD noted), policy reviews, and communication with Regional Nurse Consultant and/or Regional Director of Operations, as needed, and assuring for</p>		



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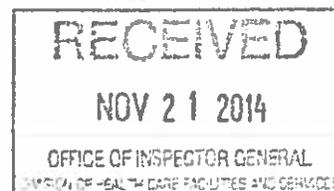
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F 490	<p>Continued From page 94</p> <p>notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14.</p> <p>3. Review of the facility's charges from the 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 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>	F 490	<p>Pharmacy compliance with obligations. This has been on-going since 9/8/2014.</p> <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 included a detailed review of the narcotic EDK, as well. No problems noted on visit of 10/22/2014.</p> <p>Destruction medication records for narcotics will be reviewed by the consultant pharmacists at each consulting visit. The facility utilizes its internal policy entitled "Discarding or Destruction of Medication." There were no problems noted on 10/22/2014 visit by consulting pharmacist. The Licensed Nursing (RN and LPN, Unit Manager, ADON, and DON) staff were in-serviced and/or re-in-serviced on this Policy on 10/7/2014 by the Pharmacy Nursing Services.</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 completed on 10/3/2014 and 10/22/2014.</p>		



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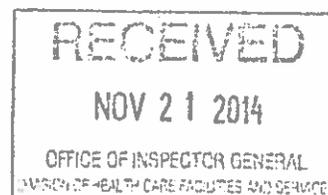
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F 490	<p>Continued From page 95</p> <p>6. Review of Resident #5's Morphine and Lorazepam narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed Morphine and Lorazepam on 09/16/14.</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 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 Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards.</p>	F 490	<p>Facility Abuse and Neglect Policy was reviewed by the QA Committee and no changes were identified to the policy. This was done on October 6, 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.</p> <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 on 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, 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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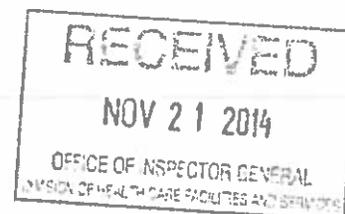
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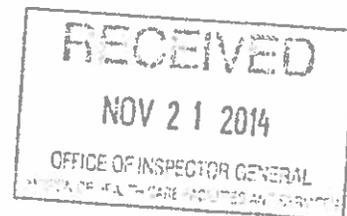
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F 490	Continued From page 97 Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on 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. 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 Nurse Clinician for pharmacy, revealed she completed a quick training with the staff because she was told the staff had already been	F 490	the pharmacy. Any error, omission or issue will be addressed through the Quality Assurance Committee. Corrective action will be as documented through the QA Committee report with QA recommendations, as appropriate. The results are reported to QA daily through 11/30/2014 (five days per week week) starting 10/6/2014. The reporting will continue weekly thereafter. Aberrations are reported to Pharmacy for their review and audit and if necessary to outside agencies including the OIG, DCBS, the Kentucky Board of Nursing and if necessary the local police department, as deemed appropriate. The Consulting Pharmacist will do a 100% review of all active residents in the facility during their monthly visit (which was done on 10/22/2014). The Consulting Pharmacist will review Medication Administration Records, Narcotic Balance Sheets, and the EDK book to assure that all medications are available, given as noted, reconciled appropriately and disposed in accordance to approved pharmaceutical standards. There were no issues reported. Each Consultant visit will end with an "Exit" interview with the Administrator or their designee in their absence, and the Director of Nursing or designee in their absence (Assistant Director of Nursing). The must provide a summary of Pharmacy		



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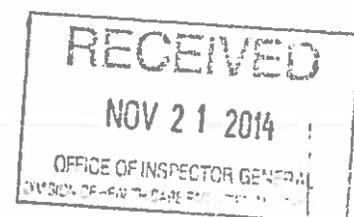
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F 490	Continued From page 98 In-serviced. The training was supposed to be a quick reference tool. She stated she observed a shift to shift narcotic count. The Regional Nurse Clinician stated she wanted to ensure the nurses, when counting narcotics, 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 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	F 490	recommendations at that time. An extensive review will be available through the OMNIVIEW facility website which the Administrator and Director of Nursing have access. The exit report must have evidence of audit review and summary, and other findings. Implementation of this process with reporting occurred on October 22, 2014. The Regional Director of Operations or the Regional Nurse Consultant for Preferred Care Partners Management Group will provide oversight support weekly or PRN as needed through November 30, 2014, then Monthly or PRN as needed thereafter. The Regional Director of operations has been in constant contact with the facility regarding the investigation as has the Regional Nurse Consultant. Both have provided input, reviewed the production and completion of the POC, and assured complete compliance of the processes within this POC.		



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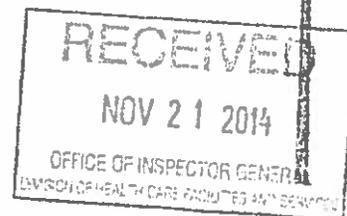
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F 490	<p>Continued From page 99 educated on 10/10/14 by the DON.</p> <p>12. Review of the Pain Assessment and Management training provided from 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on pain medications. 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 Ins 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 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</p>	F 490	<p>The Regional Nurse Consultant has been to the building, completed training and education, reviewed the medical records, and provides counseling and support as needed or deemed necessary. This involves all aspects of the daily clinical operations of the facility.</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 (who is the Director of the QA Committee and also the Abuse and Neglect Coordinator), Director of Nursing, Unit Managers, Social Services, Activities Director, and the Dietary Director. 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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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 490	<p>Continued From page 100</p> <p>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> <p>Review of the training on the Pharmacy Training Guide, EDK Process and KAR's Controlled</p>	F*490		



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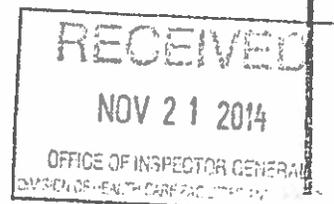
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F 490	<p>Continued From page 101</p> <p>Subs:ance Notification, provided on 09/17/14, revealed nine (9) LPN's and five (5) RN's were educated and two LPN's were educated on a later date. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 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, 10/09/14 and 10/10/14, revealed the Administrator, DON, Unit Manger, Medical Director, Consulting Pharmacist and Regional</p>	F 490			

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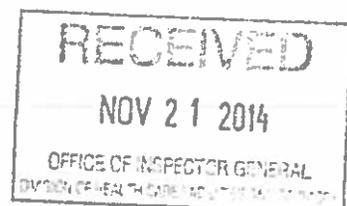
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F 490	<p>Continued From page 102</p> <p>Director of Operations had attended daily meetings Monday through Friday. Interview with the DON, on 10/13/14 at 10:29 AM, revealed there was a QA meeting every morning. Review of the Controlled Substance Audit, 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 1:26 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 control substance orders, made sure the directions matched the narcotic pinks sheets. She conducted an inventory of what narcotics were</p>	F 490			



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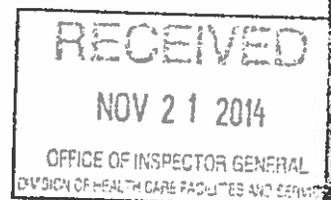
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F 490	Continued From page 103 available, with the nursing staff. Interview with the Pharmacy Regional Manager, on 10/13/14 at 9:31 AM, revealed to his understanding the new Consultant Pharmacist would be completing 100% audits, looking at narcotic 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 10/08/14 with no changes to the policies and procedures.	F 490		
F 514 SS=K	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible, and systematically organized.	F 514	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	



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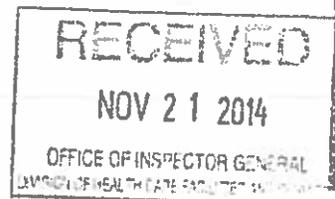
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F 514	<p>Continued From page 104</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>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 maintain accurate clinical records and have an effective system in place for monitoring narcotics sheets and monitoring Medication Administration Records (MARs) for four (4) of nine (9) sampled residents (Residents #1, #2, #3 and #6); and two (2) of two (2) unsampled residents (Residents A and B). (Refer to F431)</p> <p>RN #1 altered narcotic count sheets to make the balance appear accurate on paper although the actual narcotic tablets had been removed from the blister packs and substituted with an unknown medication. In addition, RN #1 did not sign for the narcotics as they were removed from the blister pack, she would complete the documentation as the shift to shift count occurred. RN #1 made changes on the narcotic count sheets by obliterating her signature, date and time, without a witness or supervisor review. RN #1 documented the removal of narcotic tablets for the same date and time on two (2) separate count sheets. The Medication Administration Records (MARS) did not reflect the administration</p>	F 514	<p>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.</p> <p>F514 Completion Date: 11/05/2014 SS=E 483.75(I)(1) Resident Records Complete/Accurate/Accessible</p> <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 reoccurrence 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>		



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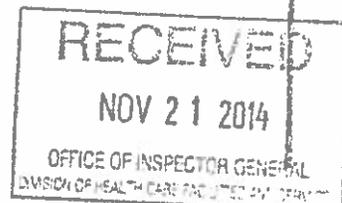
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F 514	<p>Continued From page 105</p> <p>of the narcotics removed by RN #1. The MAR reflected missing doses or medications that were not available. There was no documented evidence of follow up with the pharmacy for the missing medications. The narcotic count sheets were filed in medical records when completed without any review by the Director of Nursing, Assistant Director of Nursing, Administrator, Medical Records Director or Pharmacy.</p> <p>The facility's failure to have an effective system in place to ensure narcotic and medication administration records were accurately documented 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 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 483.75 Administration (F514) with the 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, Inventory Control of Controlled Substances, revised 01/01/13, revealed the facility's representative would regularly check the inventory records to reconcile inventory. The facility would regularly reconcile current and discontinued inventory of controlled substances against the log used in facility's</p>	F 514	<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 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 thro" 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>	



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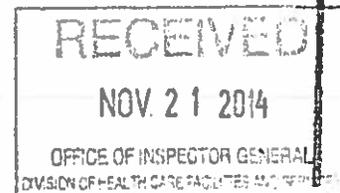
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F 514	<p>Continued From page 106</p> <p>controlled medication inventory system; current inventory against the controlled medication declining inventory record; and, to the residents' Medication Administration Record (MAR) and unused controlled substances held in storage destruction to the declining inventory record.</p> <p>Review of the facility's policy, "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 Medical Records, revised August 2006, revealed a medical/clinical record was maintained for each resident admitted to the facility. All data contained in the resident's chart maintained at the Nurses's Station should reflect the medical history of the resident.</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 blisters number twenty-four (24) through thirty (30) were empty and blister number twenty-one (21) was empty, blisters 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, on 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>	F 514	<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 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</p>		



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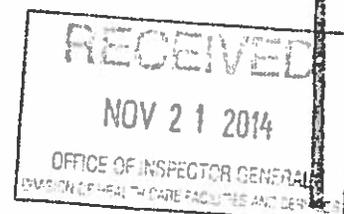
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 514	Continued From page 107 Review of the Morphine Sulfate IR, 15 mg, from the untampered narcotic card, dated 09/04/14, revealed Resident #1 received medication at 10:00 AM, 2:00 PM and 6:00 PM all by RN #1 when there was eighteen (18) tablets available on the first narcotic sheet of Morphine Sulfate IR, 15 mg. Interview with LPN #6, on 09/26/14 at 2:33 PM, revealed she was informed to always use up all the medication on the first narcotic card and then move to the second narcotic card. This would be keeping an accurate clinical record. If she had seen where the nurse was pulling from one narcotic sheet and then pulling from another when narcotics were available on the first sheet, she would have notified her supervisor. 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. So when LPN #3 reviewed the narcotic count sheet it revealed RN #1 had pulled three (3) doses of Morphine 15 mg all on 09/04/14 at 10:00 AM, 2:00 PM and 6:00 PM while utilizing a new medication card for Resident #1. LPN #3 stated this was really odd for Resident #1 to receive three (3) doses in one day. She stated this was not reported to the supervisor on duty, she just made a copy placed it under the DON's door for review on Monday. 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 pain to the right leg. Resident #1 stated he/she had five (5) surgeries to his/her leg. Resident #1's right leg was observed to be lying to the right	F 514	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. 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. During record review and investigation, it was discovered on 9.30.14 that the pharmacy consultant failed to notify the facility administration and Director of Nursing of scratched through licensed signatures for Resident # 1, 2, 3, 5, 6, and unsampled residents A & B. Narcotic count sheets, medications allegedly not given and circled, narcotic reconciliation sheets not		



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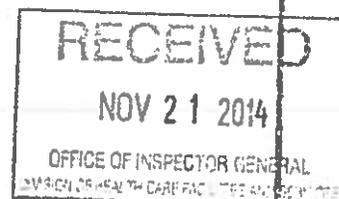
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
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F 514	<p>Continued From page 108</p> <p>severely and contracted. 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>2. Review of Resident #2's Oxycodone, 2.5 mg, every eight (8) hours as needed revealed out of a total of thirty (30) tablets, #13 and #4 tablets were removed from the medication card, with no signature as to what happened to the medications. Signature space for #28 had one (1) line through the error with one signature and it was not witnessed by two (2) nurses. Further review of the narcotic count sheet revealed the dates of removal were out of order. Tablet #5 was removed at 6:30 AM on 08/28/14 with a balance of 4, tablet #4 was noted as empty with a balance of 3, and tablet #3 was removed on 08/27/14 at 10:30 AM, after it was documented tablet #5 was removed on 08/28/14.</p> <p>Interview with the DON, on 09/25/14 at 6:00 PM, revealed she had a concern with the tape on the blister packs; however, she did not have any concerns with narcotic counts because she had not reviewed the narcotic count sheets and had focused on pharmacy from 09/01/14 through 09/08/14 as the source of the tape being on the back of the blister packs. On 09/05/14, she received a copy of a second set of narcotic count sheets with a note from LPN #3. The narcotic count sheet revealed three (3) doses were removed on 09/04/14 by RN #1; however, the note stated Resident #1 never takes three (3) doses in one day.</p> <p>3. Review of Resident #3's Lorazepam, 0.5 mg, by mouth three (3) times a day as needed, dated from 05/27/14 through 08/29/14, revealed tablets</p>	F 514	<p>matching the medication administration sheets for some PRN narcotic medications; when the consultant pharmacist was in the facility reviewing said system/documents which may have allowed for misappropriation of medications in the facility. In addition the pain flow sheets were not documented (by licensed nursing staff) in accordance with policy for narcotic pain medication administration. No residents appeared to have negative outcome from the alleged deficient practice.</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> <p>On 9/8/2014, the Director of Nursing, through her investigation, discovered that the administration and documentation of narcotic pain management medications did not match facility protocol documentation requirements of the pain flow sheet, narcotic reconciliation record, and the medication administration record. Thus, Director of Nursing and facility administration have</p>		



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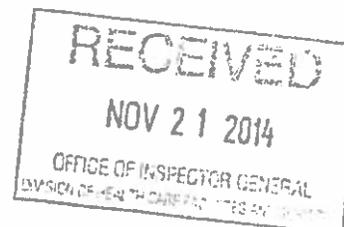
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F 514	<p>Continued From page 109</p> <p>#11, #13, two (2) #22's, and #23 were scribbled through with multiple lines. Tablet #23, two #22's and #11 were observed to have been scribbled through by RN #1. "Error" was documented on signature line for tablets #11 and #13. Review also revealed there was no documentation of two (2) nurses to witness the error, as per policy.</p> <p>Review of Resident #3's Hydromorphone 2 milligrams (mg) every four (4) hours as needed for pain, narcotic sheet, revealed there were two (2) narcotic cards, one for the month of June dated 06/15/14 through 06/20/14; and, a second narcotic dated 06/19/14 through 06/25/14. The first sheet had multiple lines going through 06/17/14 over RN #1's name, date and time of medication. There was no "error" documented above RN #1's name, nor an initial to document the error.</p> <p>Interview with the DON, on 09/26/14 at 3:18 PM, revealed nurses were to draw a line through the error, write "error" above the line and initial with a witness.</p> <p>Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed the poor documentation on the narcotic count sheets had become routine and acceptable over time. He further stated he was not aware of the procedure for correcting the narcotic count sheets.</p> <p>Interview with LPN #3, on 10/01/14 at 2:02 PM, revealed when she would do the shift to shift count of narcotics, she did not recognize the scratching out of the signatures as a concern.</p> <p>Review of Resident #3's Physician's Orders, dated 04/14/14, revealed an order for</p>	F 514	<p>conducted 100% audit of narcotic reconciliation records, medication administration records and pain</p> <p>flow sheets since 9/8/2014 and on-going at present time. No further incidents of diversion, misappropriation or tampering have been discovered.</p> <p>On 9/8/14 the Director of Nursing immediately began planning and implementation of education for the licensed nurses in regards to accurate narcotic count reconciliation each shift with 2 licensed nurses signing, PRN narcotic medications are documented on the medication administration record in addition to the narcotic reconciliation sheet. When a PRN pain medication is given there needs to be a pain assessment documented on the pain flow sheet as well. This education with licensed nursing staff was all completed by 10/10/2014.</p> <p>Pharmacy Consultant Manager from Omnicare Pharmacy (facility contract) came to facility on 10/3/14 to review and analyze narcotic medications dispensed and being administered for any discrepancies of narcotic sheets and medication administration records for reconciliation. The Consultant did not find any incidents of diversion, misappropriation, or tampering. In addition, our consulting pharmacist did</p>		



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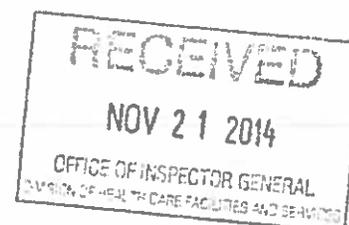
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F 514	<p>Continued From page 110</p> <p>Hydromorphone, 2 mg, one (1) tablet every four (4) hours as needed. Review of the first narcotic sheet, dated 08/01/14, and a second narcotic sheet dated 08/08/14, revealed RN #1 removed three (3) narcotics on 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.</p> <p>Interview with Resident #3, on 09/23/14 at 8:57 AM, revealed the facility ran out of multiple medications before, such as his/her pain medications and Ativan. Resident #3 stated it had occurred ever since he/she got out of the hospital in December 2013. Resident #3 stated he/she suffered from pain all the time.</p> <p>Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed a lot of times when he and RN #1 would count the narcotic sheets and blister packs, RN #1 would have to either sign the narcotic sheet to balance the total tablets or she would scribble her signature due to signing on the wrong line of the narcotic sheet. LPN #2 stated when a nurse passes out a narcotic medication they should sign the narcotic out immediately. LPN #2 stated RN #1 would have to correct the narcotic sheets frequently and he did not suspect anything was wrong at the time; although he was aware the narcotic was to be signed for when removing the tablet.</p> <p>Interview with the DON, on 09/25/14 at 6:00 PM, revealed she pulled narcotic count sheets and focused on RN #1's documentation and she identified through her audits that RN #1 had given medications too close, there were transcription errors noted, and narcotics were given at the</p>	F 514	<p>another review of the above on her monthly visit to the facility on 10/22/2014, and again did not find any incidents of diversion, misappropriation, or tampering.</p> <p>If at anytime any concerns are identified with medications related to diversion, misappropriation, and tampering the facility administration will take immediate action in regards to disciplinary action, education and/or notification to proper authorities and immediately take the concerns to the QA Committee.</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</p>	



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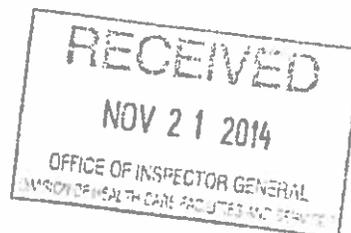
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F 514	<p>Continued From page 111 same line.</p> <p>Additional interview with the DON, on 09/26/14 at 3:18 PM, revealed when the nurse had an error, the nurse was to document a line through the narcotic sheet and then write error above the line and sign with an initial. The nurse was to also have a nurse witness the error and notify her of any errors or inconsistencies in documentation.</p> <p>4. 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, 05/06/14, 05/07/14, 05/08/14, 05/09/14, 05/10/14, 05/13/14, 05/15/14, 05/16/14, 05/24/14, 05/29/14 and, days 05/04/14, and 05/29/14 had no initial in the day provided. There was no documentation for the reason the medication was not given, except for 05/10/14, 05/14/14, 05/24/14, it was documented the medication was not available; and, on 05/06/14, 05/07/14 and 05/24/14 it was documented the resident refused the medication.</p> <p>Review of Resident #6's Nurses Notes, dated 05/06/14, revealed Resident #6 had refused to take the Primidone, and no other documentation was provided.</p> <p>Review of Resident #6's pharmacy Work Order Fills form, 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, which meant the medications were available for use.</p> <p>Review of Resident #6's, MAR for the month of June 2014, revealed Resident #6's Primidone, 50 mg, were not given on 06/07/14, 06/11/14, 06/14/14, 06/15/14, 06/16/14, 06/17/14, 06/18/14,</p>	F 514	<p>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> <p>Destruction medication records for narcotics will be reviewed by the consultant pharmacists at each consulting visit. This was completed on the 10/22/2014 monthly visit to the facility.</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 and medication documentation. This was completed on the 10/22/2014 monthly visit to the facility.</p> <p>From 9/8/14 and to current, the Director of Nursing and nursing administration have conducted daily audits of the above outlined system. During follow up audits, no further incidents of diversion, misappropriation or tampering have been discovered. Education and/or disciplinary action has been applied if the protocol was not followed by licensed nurses and will continue ongoing.</p>		



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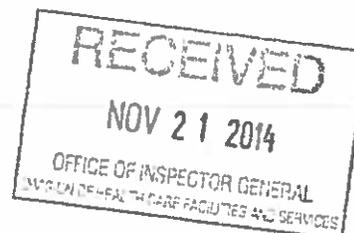
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F 514	<p>Continued From page 112</p> <p>06/19/14, 06/20/14, 06/21/14, 06/22/14, 06/24/14. There was no documentation to indicate why the medications were circled for the days of the 05/07/14, 05/19/14, 05/21/14, and 05/24/14. The dates of 05/11/14 and 05/14/14 were blank with no initials or documentation as why the boxes were left blank.</p> <p>Review of Resident #6's Nurses Notes, dated 06/05/14, revealed Resident #6 had refused all medications for the day. No other documentation was provided as to why the medication was refused.</p> <p>Review of Resident #6's pharmacy Work Order Fills form, for the month of June 2014, revealed the Pharmacy sent a total of thirty (30) Primidone tablets on 06/24/14.</p> <p>Review of Resident #6's, MAR for the month of July 2014, revealed Resident #6's Primidone, 50 mg, were circled as 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.</p> <p>Interview with LPN #6, on 09/26/14 at 2:33 PM, revealed she received counseling for circling the Primidone because she had circled for a couple of days in a row and then some days her initials did not have circles. LPN #6 stated she would call pharmacy and would be notified that it was too early to reorder. Further interview with LPN #6, on 09/30/14 at 3:17 PM, revealed she could remember at one point the medication had come in and then she would come in at a later date and</p>	F 514	<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 spoke with the Regional Manager for Kentucky with Omnicare as verbally advised him on October 3, 2014 of these requirements which were acknowledged and agreed upon. This was implemented on 10/3/2014 by the Pharmacy Consultant Visit and for the monthly visit of 10/22/2014 — and will continue.</p> <p>The Director of Nursing and the 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, and 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. This Education included: Destruction and Disposal of Controlled Substances; Security of the Medication Cart;</p>	



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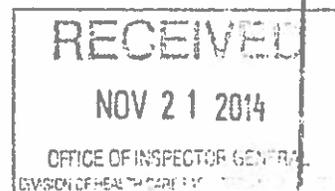
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F 514	<p>Continued From page 113</p> <p>see that the medication was being circled again. LPN #6 stated this had occurred for a long time. LPN #6 stated she did not know why she did not inform the DON of this occurrence.</p> <p>Interview with the DON, on 10/01/14 at 12:30 PM, revealed not one nurse had ever talked to her about the medication coming up missing. The DON stated she talked to the nurses and informed them that someone was stealing the medication and was not sure if this concern had went to QA.</p> <p>5. Review of Unsampled Resident A's Oxycodone, 5/325 mg, revealed it was ordered two (2) tablets every six (6) hours for pain. Review of the narcotic count sheet for 09/04/14 at 12:00 PM revealed two (2) tablets had been removed by RN #1. Two (2) more tablets were then given at 8:00 PM on 09/04/14, which was the last pill on the narcotic sheet. On a new narcotic sheet, RN #1 then removed two (2) more medications on 09/04/14 at 8:00 PM. Thus RN #1 appeared to have administered four (4) tablets at 8:00 PM which was not how the medication was ordered.</p> <p>6. Review of Unsampled Resident B's Oxycodone, 5 mg, revealed it was ordered one (1) to two (2) tablet every four (4) hours as needed for pain. Review of the narcotic count sheet for 07/26/14 at 7:30 PM revealed RN #1 had removed the last one (1) tablet and finished the narcotic sheet. On a new sheet, same medication, RN #1 then removed two (2) tablets at the same time.</p> <p>Interview with the DON, on 09/25/14 at 6:00 PM, revealed she recognized RN #1 had given medication too close and there were transcription</p>	F 514	<p>Documentation; Medication Administration; Administering Medications; Accepting Delivery of Medication; Controlled Substances; and Destroying Medications. This was attended by 14 licensed nursing staff (7 RNs, 7 LPNs, DON, and Unit Manager).</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, DCBS, local Police, and in certain situations, the Kentucky Board of Nursing. This notification practice was done on</p>	



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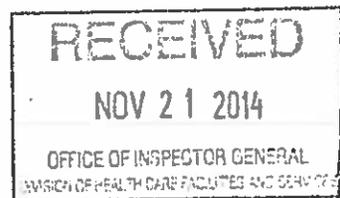
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F 514	<p>Continued From page 114 errors noted when she completed her audits.</p> <p>Further interview with the DON, on 10/02/14 at 4:58 PM, revealed there were improvements needed for the nurses at this time in regards to making the nurses document changes in the Nurses Notes. The DON stated she always strived to have an accurate clinical record. In reviewing of the narcotic sheets, she recognized the nurses were documenting times to close, documenting giving medications at the same time and appearing to double dose the resident. She stated she was not sure if the staff was stealing or giving the wrong medications. The DON stated scribbling on the narcotic sheets was not appropriate as well and she could not understand how anyone could miss it.</p> <p>Interview with the Administrator, on 10/01/14 at 3:01 PM, revealed she was alerted to medication errors before and they were addressed. As of now and looking at them today and knowing what has happened, she would look at the medication errors differently. The Administrator stated she was not aware the DON was not looking at the narcotic sheets or the empty blister packs. The Administrator stated she was aware there were some concerns with pharmacy and the delay of medications, but felt the facility was at fault because the time lines in which medications were given.</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</p>	F 514	<p>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 and /or Administrator will notify the appropriate law enforcement agencies according to applicable Law and Facility Policy. 		



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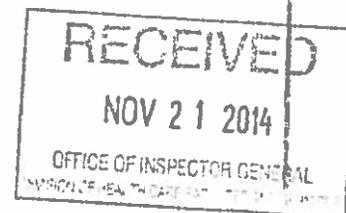
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
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F 514	<p>Continued From page 115 Immediate Jeopardy.</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 	F 514	<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 as per the monitoring protocol noted above. Regional Management will review for pharmacy related issues specific to diversion, misappropriation or tampering. This was started on 10/6/2014 and will continue for 60 days or two months, and then will be PRN.</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> <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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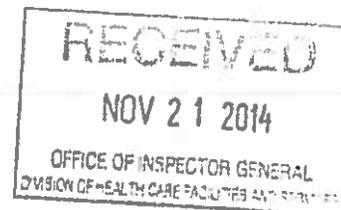
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F 514	<p>Continued From page 116</p> <p>complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages.</p> <p>8. The Consultant Manager from the pharmacy (facility 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 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</p>	F 514			



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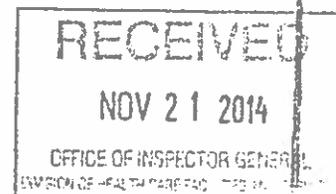
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F 514	<p>Continued From page 117</p> <p>fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th.</p> <p>12. All Registered 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 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</p>	F 514			



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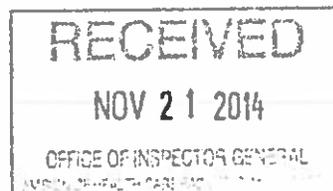
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F 514	<p>Continued From page 118</p> <p>narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police 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> <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</p>	F 514			



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F 514	<p>Continued From page 119</p> <p>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 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,</p>	F 514			



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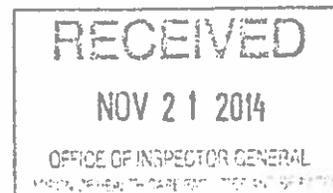
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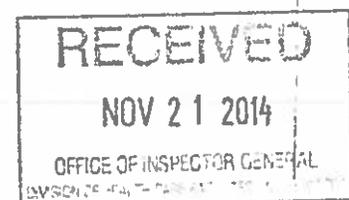
F 514	Continued From page 120 revealed she destroyed any medications that appeared tampered. 5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) morphine narcotic cards, which were in police custody at the Police 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. 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. 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. 8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14,	F 514		
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F 514	<p>Continued From page 121</p> <p>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 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 1:28 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</p>	F 514			



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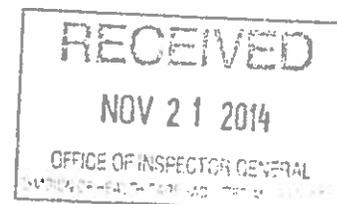
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F 514	Continued From page 122 report to the DON or Administrator immediately. 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, 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 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. 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	F 514		
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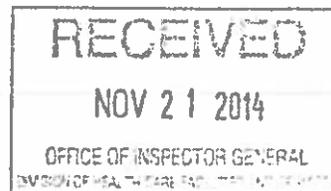
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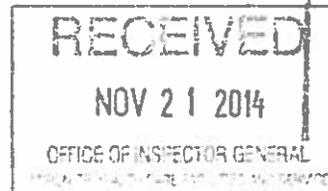
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F 514	<p>Continued From page 123</p> <p>10/08/14 in which the Consulting Pharmacists were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole 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 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</p>	F 514		



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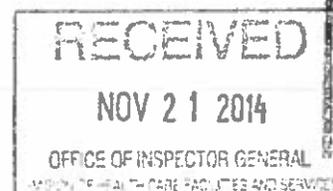
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2014
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 514	<p>Continued From page 124</p> <p>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 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 1:28 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 Ins 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</p>	F 514			



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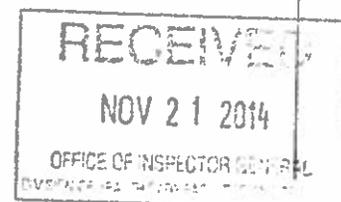
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F 514	<p>Continued From page 125</p> <p>10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of accurate documentation of the MAR's and narcotic 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-serviced on PRN medication management and ensuring an assessment was completed on all residents 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 DCN 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</p>	F 514			



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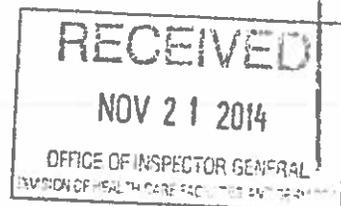
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F 514	<p>Continued From page 126</p> <p>and Reporting Resident Abuse, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs were educated on abuse, misappropriation and the importance of notifying the DON and Administrator 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> <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)</p>	F 514			



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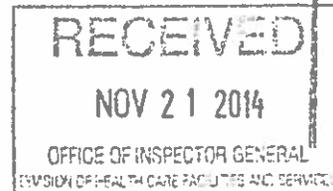
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F 514	<p>Continued From page 127</p> <p>LPNs and five (5) RNs were inserviced from 10/07/14 through 10/10/14. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 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 10/08/14, 10/07/14, 10/08/14, 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 1:26 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</p>	F 514			



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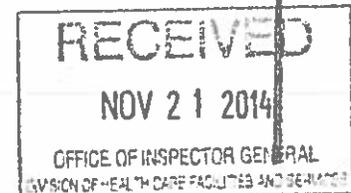
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F 514	Continued From page 128 medication card. 16. Review of the Pharmacy consults, dated 10/03/14, revealed the MARs were verified to match the pharmacy delivery tickets; and, matched the labels. All counts, and all tablets were verified to be accurate 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 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 QIA 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,	F 514			



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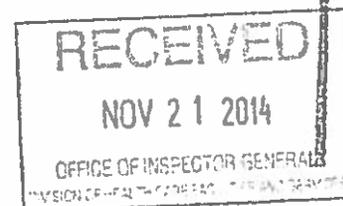
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F 514	Continued From page 129 09/22/14 at 3:23 PM, revealed the facility had contacted them to report the allegation of drug diversion. Review of the signature section of the policies and procedures revealed they were reviewed by the DON and ADON on 10/06/14 with no changes to the policies and procedures.	F 514			
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	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. F520 Completion Date: 11/05/2014 SS=E 483.75(o)(1) QAA Committee-Members/Meet Quarterly/Plans 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		



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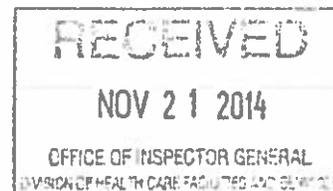
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F 520	<p>Continued From page 130</p> <p>Based on observation, interview, record review and review of the facility's policies and job descriptions, it was determined the facility failed to have an effective Quality Assurance Committee (QA) to ensure the identification of quality deficiencies, implementation of plans of action, and monitoring of the plans of action to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances, for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #8); and, two (2) of two (2) unsampled residents (Residents A and B). The facility failed to identify and report diversion of medications/narcotics when staff found tape on the back side of narcotic cards. Narcotics were replaced with other medications, and staff borrowed resident medications for other residents' use. The facility failed to monitor, reconcile and destroy medications according to standards of practice. The facility failed to ensure the resident's clinical record was maintained in an accurate format to detail the care provided. The facility further failed to include Pharmacy in the QA Committee meetings to assist with the investigation of drug diversion. (Refer to F224, F431, F490 and F514)</p> <p>The facility staff identified suspicion of diversion of drugs; however, failed to report this to the Administrative staff. Once the Administrative staff was made aware of the suspicion of drug diversion they did not take this information to QA for review and possible plan of action. The staff continued to borrow medication from residents after education was provided by the Director of Nursing in June 2014, and the borrowing of medications was not reviewed by the QA Committee. Pharmacy provided the QA Committee with reports; however, they did not</p>	F 520	<p>identify, correct, and prevent further reoccurrence 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 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</p>		



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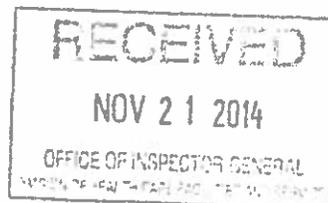
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F 520	<p>Continued From page 131</p> <p>Identify borrowing of medications or diversion of narcotics as a concern. The QA Committee did not review the narcotic reconciliation process to determine if the process met the facility's policy. The QA committee did not identify, monitor, or develop plans of action to ensure the accuracy of the medical record.</p> <p>The facility's failure to ensure an effective QA Committee was in place to identify quality deficiencies, develop action plans and monitor the effectiveness of the plans for narcotic reconciliation, monitoring of medication administration, and accurate documentation to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances placed residents at risk in a situation that has caused is 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 483.75 Administration (F520) with the 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, Adverse Consequences and Medication Error, revised February 2014, revealed the interdisciplinary team reviews the resident's medication regimen</p>	F 520	<p>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 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</p>		



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F 520	<p>Continued From page 132</p> <p>for efficiency and actual or potential medication-related problems on an ongoing basis. The QA Committee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective in reducing errors.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/25/14 at 9:28 AM, revealed such drugs as Primidone, Wellbutrin and Lasix were reordered too soon. The ADON stated she discovered it was easy to see on the Pharmacy System the drugs that needed to be reordered and the drugs the facility had to pay for reimbursement. The ADON stated she could not remember which residents were effected. She further stated she did not monitor anything, just the medications which needed to be reordered. The ADON stated the nurses had to be trained and the circumstance did not go to the QA Committee. The ADON stated it should have gone.</p> <p>Interview with the Director of Nursing (DON), on 09/24/14 at 3:48 PM, revealed she had repeatedly educated the staff about not borrowing medications and acknowledged she had educated the staff back in June 2014. The DON stated she began to complete medication checks, sometimes triple checks of the house drugs and was wondering why the facility was being charged for drugs. The DON stated she really did not know what to do with the information that was being presented to her. The DON stated she called a Pharmacy Representative and asked how could the facility be ordering multiple</p>	F 520	<p>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 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</p>		



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F 520	<p>Continued From page 133</p> <p>medications. However, post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed there was no conversation with the pharmacy on how the pharmacy would help resolve the reordering of medications. Per interview, the pharmacy always faxed over a "reorder to soon document" in which the DON or Administrator would have to sign to receive the medications. The DON stated no one from pharmacy called her to inform her about too many drugs being reordered by the facility.</p> <p>Interview with the Consulting Pharmacist, on 09/25/14 at 5:01 PM, revealed she had a phone conversation with the DON regarding the review of delivery tickets for Primidone by the DON, but could not recall the Buspirone (Buspar) and Escitalopram (Lexapro) (both are anti-depressants) being in the conversation.</p> <p>Continued interview with the DON on 09/24/14 at 3:48 PM, revealed the issue was taken to QA; however, she could not specify a date. The action plan instructed the DON to check the orders to see if they match what was on the narcotic cards. Also check to see if the amount of medication ordered balanced with the MARs.</p> <p>Further interview with the DON, on 09/25/14 at 2:37 PM, revealed she did not receive empty narcotic cards or narcotic sheets, as all of the narcotic sheets went to Medical Records to be filed; however, this was not reviewed in QA.</p> <p>Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed the DON had brought to her attention the facility had to replace medications which were coming up missing and this information was taken to the QA committee on</p>	F 520	<p>discovered until this complaint investigation.</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> <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</p>		

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F 520	<p>Continued From page 134</p> <p>06/06/14. The plan at that time was to monitor and triple check the nurses documentation of the MAR to ensure there was enough medications available. The Unit Manager was responsible to check the AHT (medical record in the computer system) to make sure the medication orders were placed on the MAR and AHT. The DON was responsible to update the care plans and educate the nursing staff on the importance of reviewing the five (5) rights and three (3) checks of the medication pass as well as the importance of ensuring the accuracy of the transcription of medication orders.</p> <p>Interview with the Medical Director, on 09/25/14 at 3:47 PM, revealed the facility had to reorder medications. The Medical Director stated there was a plan of action to get to the bottom of the problem on 06/06/14. He stated the QA talked about possible diversion of medication and foul play. The Medical Director stated he felt the action plan was consistent with the goals of the facility, but he could not specify the plan.</p> <p>Interview with the Consulting Pharmacist, on 09/25/14 at 5:01 PM, revealed she did not attend QA meetings; however, provided a QA report on what she had found quarterly. The Consulting Pharmacist stated she did not complete a 100% audit, but did complete a 10% spot check in which she did not identify any concerns with narcotics or control sheets. Based on the facility's census on 09/23/14, this would only be six (6) residents reviewed related to narcotics and control sheets.</p> <p>However, per the Consultant Pharmacist's job description, the Pharmacist would conduct a Medication Regimen Review on each resident in</p>	F 520	<p>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>Therefore, any suspicious activity will be immediately reported to the Administrator and/or Director of Nursing and appropriate action will be taken within the facility and reported to outside agencies per law</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>Members of the Quality Assurance Committee developed and implemented a process on 10/2/2014 to validate narcotic inventory to MAR and to Cart, validate label to Physician orders and that Countdown sheets were tamper free.</p> <p>In addition, education provided to the nursing staff by the Director of Nursing included misappropriation a form of stealing</p>	

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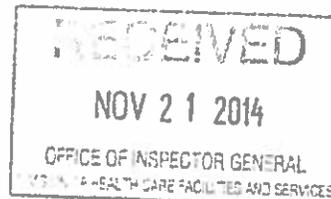
F 520	<p>Continued From page 135</p> <p>the facility monthly and would coordinate or perform review of controlled substance utilization, reconciliation and documentation. Although the Pharmacist's job description did not specify a measured quantity to review, it stated the Pharmacist should follow the regulations and per post survey interview with the Pharmacy General Manager, on 11/05/14 at 9:30 AM, the Pharmacist was to look at 100% of the 30 day reviews. The Pharmacy General Manager stated there was no rule that a Pharmacist had to look at ten (10) percent of the census for additional audits. They normally looked at enough residents to determine if there was a pattern to their concerns.</p> <p>Interview with the Administrator, on 09/25/14 at 4:08 PM, revealed she followed up on 08/30/14 in the QA meeting and what was reported was the in-service had been completed and the DON had worked individually with nurses who had issues with medication errors and there had been great improvements. Pharmacy came and checked their records to see if the nurses were reordering and comparing the information to the MARs. The Administrator stated she thought in July 2014, the Consulting Pharmacist stated to her the medications looked "really really good". The Administrator stated then on July 28th the QA Committee discontinued monitoring the reordering of medication concerns; however, never discussed the diversion of narcotics.</p> <p>Further interview with the Administrator, on 09/25/14 at 4:06 PM, revealed the DON reported the monitoring would continue and the licensed nursing staff would be educated as issues arose. No other QA meetings after the 07/28/14 meeting was provided; although diversion of narcotics was identified on 08/31/14.</p>	F 520	<p>resident property and inability to provide goods and services as ordered by the physician and to notify the Director of Nursing, nurse on call and/or the Administrator immediately if suspicious activity was noted regarding misappropriation of Medications, tampering of medication packaging, or appearance of falsification of narcotic records. This in-service was provided on 10/6/2014.</p> <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</p> <p>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>The Regional Manager of Omnicare for the State of Kentucky was advised by the Administrator, Director of Nursing, Regional Nurse Consultant, and the</p>	
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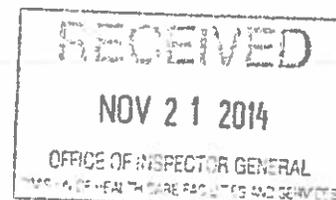
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F 520	Continued From page 138 Post survey interview with the Administrator, on 11/04/14 at 1:37 PM, revealed she talked to the Pharmacy when the reordering concern was brought to QA. The Administrator stated she talked to the pharmacy in regards to the new orders and the mix up on quantities of medications available. She stated she was trying to figure out what was sent and not sent for the residents. The Administrator stated she thought the problem was fixed when she asked the Pharmacy to send resident medications at their cost. She further stated the facility took on the responsibility to fix the reordering problem. Pharmacy was not identified as a source to help with the monitoring process or help the QA Committee find the root cause of the reordering concern. However, review of the Consultant Pharmacist's job description, effective 03/09/11, revealed the consultant pharmacist's key responsibilities included attending the facility's quarterly QA Committee meetings. Review of the pharmacy contract, effective 07/01/12, revealed the pharmacy would make a representative of pharmacy available for attendance at the facility's QA Committee meetings. Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed if there was any correspondence between the pharmacy and the facility regarding assistance with QA they would have come to him. However, review of his correspondences revealed there were none from the facility.	F 520	Regional Director of Operations verbally on October 3, 2014 of the expectations for Pharmacy Consultant visits, to review and advise of 100% narcotic review of label to MAR, inventory to MAR to Countdown worksheets, review of the weekly Narcotic Delivery Worksheet. Also it is a requirement to "Exit" and advice of any discrepancy as well as any systems change created and implemented by the pharmacy regarding the control, monitoring and auditing of Controlled Medication. The Regional Manager of Omnicare for the State of Kentucky acknowledged and agreed upon the above. Also, the consulting pharmacist supervisor, who came to the facility on 10/3/2014, was made aware of audit review expectations, which she performed and found no issues with narcotic medications regarding diversion nor any discrepancies of tampering with or documentation and reconciliation. 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		



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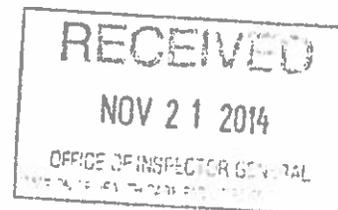
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F 520	<p>Continued From page 137</p> <p>Through facility audit reviews of narcotic sheets after 08/31/14, it was identified by the facility that twenty-five (25) additional residents were involved in the possible diversion of medications. However, the additional information was not discussed in the QA meetings, per interview with the Administrator, on 09/25/14, as there had been no QA meetings since 07/28/14.</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"> Residents #1, #2, #3, #5 and #8 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 	F 520	<p>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. The 10/3/2014 visit included a detailed review of the narcotic EDK as well.</p> <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 completed on the consulting pharmacist monthly visit of 10/22/2014. There were no issues.</p> <p>Destruction medication records for narcotics will be reviewed by the consultant pharmacists at each consulting visit. This was completed on the consulting pharmacist monthly visit on 10/22/2014. There were no issues.</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 completed on the consulting pharmacist</p>		



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F 520	<p>Continued From page 138</p> <p>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 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</p>	F 520	<p>monthly visit on 10/22/2014. There were no issues.</p> <p>Facility Abuse and Neglect Policy was reviewed by the QA Committee and no changes were identified to the policy. This was completed on October 6, 2014.</p> <p>The Director of Nursing and Administrator were educated by the Regional Nurse Consultant for Preferred Care Partners Management Group. The education included the following: Misappropriation and Diversion of Narcotics, Notification to Administration and Pharmacy, and Destruction of Narcotics, and Pain Assessments.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation:</p> <p>Members of the QA Committee developed a process on 9/15/2014 to validate that all resident narcotic sheets would be reviewed by the Nursing Administration (Director of Nursing or in his/her absence the Assistant Director of Nursing) prior to sending to Medical Records. Review of these sheets will ensure the narcotic count is correct, documentation by nursing staff is accurate, that there are no suspicious markings for potential errors, and that unused narcotic medication is disposed of properly and</p>		



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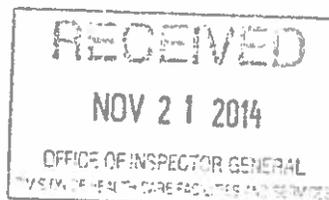
F 520	<p>Continued From page 139 (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator.</p> <p>10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 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 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</p>	F 520	<p>documented accordingly. This practice was implemented on 9/15/2014 and is ongoing. Any issue or issues identified are addressed and corrected immediately.</p> <p>Each week (started week of 10/6/2014) the Director of Nursing will review the delivered Pharmacy Narcotic Report and will verify that it reconciles to what narcotic medications have been delivered and what is in the facility Medication Carts for resident needs. Any noted error, omission, or issue will be addressed and corrected immediately with the pharmacy and reported to the Quality Assurance Committee. Any error, omission or issue will be addressed through the Quality Assurance Committee. This will be an on-going review and verification for Director of Nursing. Any necessary corrective action will be as described through a QA Committee Plan or Recommendation, as appropriate.</p> <p>The Consulting Pharmacist will do a 100% review of all active residents in the facility during their monthly visit. The Consulting Pharmacist will review Medication Administration Records, Narcotic Balance Sheets, and the EDK book to assure that all medications are available, given as noted, reconciled appropriately and disposed in accordance to approved pharmaceutical standards. This was done on 10/3/2014 and</p>	
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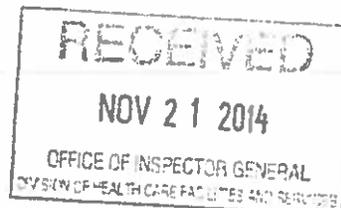
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F 520	<p>Continued From page 140</p> <p>Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; 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 10/06/14.</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> <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>	F 520	<p>10/22/2014 on consulting pharmacist visits to the facility and will be on-going monthly.</p> <p>Each Consultant visit will end with an "Exit" interview with the Administrator or their designee in their absence, and the Director of Nursing or designee in their absence (Assistant Director of Nursing). The must provide a summary of Pharmacy recommendations at that time. An extensive review will be available through the OMNIVIEW facility website which the Administrator and Director of Nursing have access. The exit report must have evidence of audit review and summary, and other findings. Implementation of this process with reporting occurred on October 3, 2014 and October 22, 2014.</p> <p>The Regional Director of Operations or the Regional Nurse Consultants for Preferred Care Partners Management Group will provide oversight support weekly or PRN as needed for 60 days, then Monthly or PRN as needed thereafter. This started on 10/5/2014.</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</p>		



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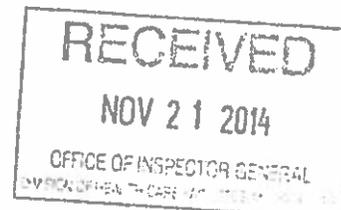
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F 520	Continued From page 141 17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions. 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. 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. 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. 3. Review of the facility's charges from the	F 520	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. 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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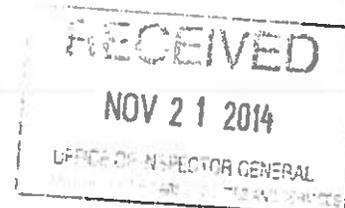
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F 520	<p>Continued From page 142</p> <p>Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview 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 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>	F 520			



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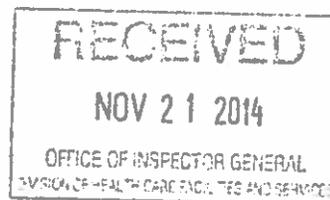
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F 520	Continued From page 143 7. Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 08/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit 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. 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 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	F 520			



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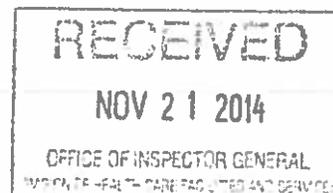
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F 520	Continued From page 144 with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14. 9. Review of the education content confirmed the 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 10:36 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately. 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 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	F 520			



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F 520	Continued From page 145 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. 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 10/06/14, 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 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	F 520			



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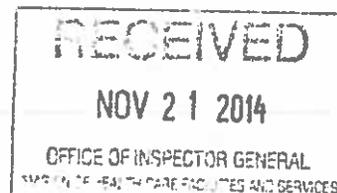
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F 520	<p>Continued From page 146</p> <p>ensure they matched. The DON stated she knew LPN #3 was not trained and was going to train LPN #3 at the end of her shift. The DON stated LPN #3, knew she had been trained on most of the information; however, 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 10/06/14 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 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</p>	F 520		

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F 520	<p>Continued From page 147</p> <p>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 Ins and Outs of Documentation, provided 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced 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-serviced on PRN medication management and ensuring an assessment was completed on all residents 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 09/28/14.</p>	F 520			



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F 520	Continued From page 148 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. 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 DCN 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. 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	F 520			

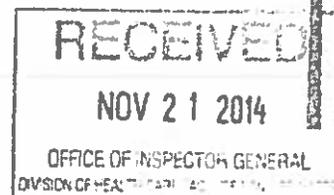
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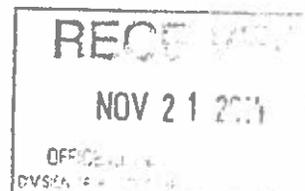
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F 520	<p>Continued From page 149</p> <p>PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the physician order process, EDK process, and reconciliation of narcotics. The training was completed 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, 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</p>	F 520		



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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186266	(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 520	<p>Continued From page 150</p> <p>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 1:26 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 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,</p>	F 520			



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F 520	Continued From page 151 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, 08/22/14 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 10/08/14 with no changes to the policies and procedures.	F 520			

