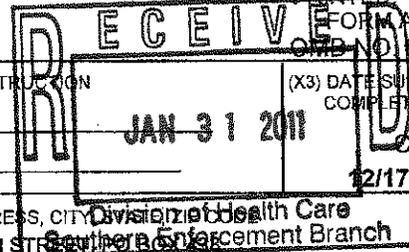


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second SOD

PRINTED: 01/27/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2010
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP 301 S MAIN STREET BURKESVILLE, KY 42717
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(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
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F 000	INITIAL COMMENTS A standard health survey and abbreviated standard survey (KY15671) was initiated on December 6, 2010, and concluded on December 17, 2010. The allegation was substantiated. Immediate Jeopardy related to KY15671 was identified on December 7, 2010, and was determined to exist on November 27, 2010. The facility was notified of the Immediate Jeopardy on December 7, 2010. An extended survey was conducted on December 17, 2010. Deficiencies were cited at 483.10 Resident Rights (F157), 483.13 Resident Behavior and Facility Practices (F225), 483.25 Quality of Care (F309), and 483.60 Pharmacy Services (F425), at a scope/severity of 'K.' Deficiencies were cited at 483.75 Administration (F490 and F520) at a scope/severity of 'L.' Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. **An acceptable allegation of compliance was submitted on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010. The scope/severity for F157, F225, F309, and F425 was lowered to 'E' and F490 and F520 lowered to 'F.'	F 000	Cumberland Valley Manor Federal & State Plan of Correction Standard Survey 12/6 – 12/17/2010 Preparation and execution of this 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 deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157	F 157 Physician Notification A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X9) DATE 01-28-2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately inform the resident, the resident's physician, and the resident's legal representative, as per facility policy, when there was an accident/incident involving the resident which had the potential for requiring physician intervention for ten (10) of twenty (20) sampled residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16).</p> <p>On November 27, 2010, staff found that the</p>	F 157	<p>psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).</p> <p>Criteria 1 and 2:</p> <p>The Director of Nursing began an internal investigation of the narcotic medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e., evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>-The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing.</p> <p>-As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on</p>	

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F 157	<p>Continued From page 2</p> <p>narcotic medication packages (Lortab and Vicodin) for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16 had been tampered with and the narcotic medications had been replaced with other medications (Theophylline, Naproxen, Robaxin) which were similar in color, shape, and size. The facility failed to inform the residents, physicians, and responsible parties of this incident.</p> <p>The facility's failure to notify the residents, physicians, and responsible parties of these ten (10) residents regarding the discrepancies in the resident medication placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>Review of the facility policy regarding resident incident/accident reports dated December 6, 2010, revealed the licensed nurse was required to notify the attending physician immediately when a resident was involved in an incident/accident. According to the policy, the nurse was required to document the physician's recommendations/decisions on the incident/accident report and in the resident's medical record for the shift in which the incident/accident occurred. Further, the licensed nurse was required by facility policy to promptly notify the family or guardian when a resident was involved in an incident/accident.</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010, at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7,</p>	F 157	<p>12/8/10 for medication administration staff who had direct access to each of the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p> <p>-Residents who had documented administration of medication from one of the 10 identified packages with discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes 11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p>		

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F 157	<p>Continued From page 3</p> <p>2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed on November 27, 2010, the facility became aware of discrepancies in residents' medications. According to the interviews, staff discovered the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, and Robaxin medications.</p> <p>Interviews with the Pharmacist on December 8, 2010, at 9:30 a.m., the Medical Director on December 9, 2010, at 4:09 p.m., and an attending physician on December 8, 2010, at 9:50 a.m., revealed the medications Theophylline, Naproxen, and Robaxin could be dangerous/harmful if administered to residents for whom they were not prescribed. According to the Medical Director, the medication Theophylline could cause a resident to have nausea/vomiting, arrhythmias, and Theophylline toxicity, and the medication Naproxen could cause a resident to suffer from gastrointestinal bleeding. The attending physician stated Theophylline could cause a resident with a diagnosis of Heart Disease to have an elevated heart rate.</p> <p>Review of the medical records for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16, revealed no documentation that the physician or responsible party was contacted concerning the narcotics discrepancy and the possibility that these ten residents may have received medications that were not prescribed for them.</p>	F 157	<p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time an are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10- 12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p>		

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F 157	<p>Continued From page 4</p> <p>Interviews with the Director of Nursing (DON) and the Nurse Consultant on December 7, 2010, at 9:30 a.m., confirmed the facility did not notify the residents, attending physicians, and responsible parties of the narcotics discrepancy and the possibility that these ten residents received the wrong medications.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Upon notification by facility staff on November 27, 2010, the facility Director of Nursing (DON) began an internal investigation of the narcotic medication discrepancies.</p> <p>The local law enforcement agency was contacted by the DON on November 27, 2010.</p> <p>The attending physician and responsible parties for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16 were notified of the narcotic medication discrepancies by the DON/ADON/Medical Records Nurse on December 8, 2010, with follow-up interventions implemented as ordered.</p> <p>All registered Nurses, Licensed Practical Nurses, and Certified Medication technicians received in-service education beginning December 1,</p>	F 157	<p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications have been reviewed/revised to include the following:</p> <ol style="list-style-type: none"> 1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of shift and with any change in the possession of the medication cart keys. 2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies. 3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10. <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as</p>	

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F 157	<p>Continued From page 5</p> <p>2010, and completed on December 8, 2010, on notification of resident's physician and responsible party. In addition any new employee will be in-serviced upon hire and employees who were off work will be in-serviced upon returning to work.</p> <p>According to the allegation of compliance a Continuous Quality Improvement (CQI) indicator for auditing notification of change would be utilized on five medical records monthly for two months, then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>Record reviews for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16 on December 8, 2010, revealed the attending physician and responsible party were notified of the narcotic medication discrepancies, with follow-up interventions as ordered.</p> <p>Interviews conducted with RNs #4 and #7, LPNs #1, #6, and #7, the DON, and the Administrator on December 17, 2010, revealed in-services related to notification of the physician and responsible party were completed from December 1-8, 2010. Interviews conducted with nurses revealed they were knowledgeable of the information received in the in-services related to notification of the physician/responsible party. Further interview with the Administrator revealed that new hires would be in-serviced upon employment and staff that was off work would be in-serviced upon return to work.</p> <p>Additional review of residents #21, #22, #23, and</p>	F 157	<p>misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to DCBS, the OIG, and local law enforcement. The Nurse Consultant received in-service education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term Care Regulations/Consultant to the Kentucky Association of Health Care Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p> <p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person</p>		

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F 157	Continued From page 6 #24 revealed no concerns related to notification of physician and responsible party. Interview with the Administrator and review of the facility record on December 17, 2010, revealed a Continuous Quality Improvement (CQI) indicator auditing tool was completed on December 16, 2010, for five resident records related to physician/responsible party notification with no concerns noted. Based on the above findings, it was determined the Immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "E" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for notification of resident's physician/responsible party.	F 157	responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures .-The licensed nurse identified in the specific complaint provided to DCBS has been suspended pending the conclusion of the investigation by local law enforcement. -RNs, LPNs, and CMTs will have a witness to verify pain relief from administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation. See Insert Pages 7A, and 7B	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	F 164 Privacy and Confidentiality The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.(1)Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require that the facility provide a private room for each resident.	

F157

Criteria 4:

- The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures.
- The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.
- The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.
- The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

F157

-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

Criteria 5:

January 24, 2011

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F 164	<p>Continued From page 7</p> <p>and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide personal privacy for one (1) of twenty-six (26) sampled residents (resident #5). On December 7, 2010, at 10:37 a.m., facility staff failed to ensure visual privacy for resident #5 who was observed during a skin assessment, without clothing, sitting in the wheelchair with no privacy curtain pulled to provide privacy.</p> <p>The findings include:</p> <p>Review of resident #5's medical record revealed the resident was admitted to the facility on September 14, 2007. Resident #5 had a diagnosis of Mental Retardation, Hypertension, Psychosis, Bipolar Maniac, Joint Contractures, and Urinary Incontinence. Review of the resident's care plan dated August 9, 2010, revealed the resident required limited to extensive assistance with transfers and bed mobility. Furthermore, the resident required extensive assistance with personal hygiene, dressing, and bathing. Further review revealed resident #5 ambulated with assistance and required the use</p>	F 164	<p>Criteria 1: Resident #5 is provided privacy during care including but not limited to completely pulling the privacy curtain around the bed.</p> <p>Criteria 2: All residents requiring assistance with ADL care have the potential for being affected. Weekly Administrative Nursing Compliance Rounds are determining that residents are provided privacy during care including but not limited to completely pulling the privacy curtain around the bed.</p> <p>Criteria 3: Facility nursing staff have received in-service education on the need to provide privacy during care including but not limited to completely closing the privacy curtain around the bed, as provided by the DON and Training Coordinator on 1/13/11-1/17/11.</p> <p>Criteria 4: The CQI indicator for the monitoring of resident privacy during care will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Social Services.</p> <p>Criteria 5:</p> <p style="text-align: right;">January 24, 2011</p>		

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F 164	Continued From page 8 of a wheelchair. Review of resident #5's Minimum Data Set (MDS) dated October 20, 2010, revealed resident #5 required extensive assistance of two staff persons for transfer, dressing, toilet use, and personal hygiene. Observation on December 7, 2010, at 10:37 a.m., revealed during a skin assessment Registered Nurse (RN) #1 and Certified Nursing Assistant #1 did not pull the privacy curtain to allow privacy for resident #5. Interview with CNA #1 on December 7, 2010, at 10:37 a.m., revealed the privacy curtain should have been pulled to protect the resident from being seen when the door was opened. Interview with RN #4 on December 7, 2010, at 10:37 a.m., revealed the privacy curtain should have been pulled around the resident to allow privacy from people opening the door.	F 164		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	F 225 Abuse Staff Treatment of Residents The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	

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F 225	<p>Continued From page 9</p> <p>including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure all violations involving misappropriation of resident property were immediately reported to the appropriate state agencies. The facility failed to thoroughly investigate violations of misappropriation of resident property and failed to take action to prevent further potential abuse while the investigation was in progress for eleven (11) of twenty-six (26) sampled residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16). In addition, resident #17's pain medication patch was found with an altered date when the resident was transferred to the local hospital for uncontrolled pain/discomfort on November 26,</p>	F 225	<p>Criteria 1 and 2</p> <p>-Resident #17 is demonstrating effective pain management with the Fentanyl patch.</p> <p>-The Director of Nursing began an internal investigation of the narcotic medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e., evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>-The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing.</p> <p>-As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on 12/8/10 for medication administration staff who had direct access to each of</p>

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F 225	<p>Continued From page 10</p> <p>2010. The facility failed to follow the "Abuse/Neglect/Misappropriation of Resident property" policy and procedure.</p> <p>On November 27, 2010, staff found that the narcotic medication packages (Lortab and Vicodin) for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and the narcotic medications had been replaced with other medications (Theophylline, Naproxen, Robaxin) which were similar in color, shape, and size. The facility failed to immediately notify the appropriate state agencies and failed to thoroughly investigate this incident. The facility became aware of the name of an alleged perpetrator on December 3, 2010, but failed to protect the residents from further potential harm by failing to remove the alleged perpetrator from direct resident care in accordance with facility policy. The alleged perpetrator was observed providing direct resident care on December 7 and 9, 2010.</p> <p>The facility's failure to immediately report this incident to the appropriate state agencies, failure to thoroughly investigate the incident, and failure to protect these ten residents from further potential harm during the investigation regarding discrepancies in the residents' medications placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>1. Review of the facility policy regarding Abuse/Neglect/Misappropriation of Resident Property (policy not dated) revealed the facility Administrator was responsible to immediately notify State agencies of all alleged incidents of</p>	F 225	<p>the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p> <p>-Residents who had documented administration of medication from one of the 10 identified packages with discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes 11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p> <p>-All residents with Fentanyl patch medication orders have Q shift verification and documentation that the patch is in place and is effective in relieving the resident's pain.</p>		

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F 225	<p>Continued From page 11</p> <p>abuse, to include misappropriation of resident property. The facility policy defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy further stated if the incident involved an employee, the employee would immediately be placed on suspension until the facility investigation had been completed, but the policy did not address the steps the facility would complete to thoroughly investigate the incident.</p> <p>Review of an Abuse/Neglect/Misappropriation Checklist (document not dated) revealed the facility was required to obtain a statement from the residents affected, witnesses to the incident, and the staff involved when an allegation/incident occurred.</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010, at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed that on November 27, 2010, the facility became aware of discrepancies in resident medications. According to the interviews, staff discovered the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, and</p>	F 225	<p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time an are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10- 12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p>		

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F 225	<p>Continued From page 12 Robaxin medications.</p> <p>Interviews with the Pharmacist on December 8, 2010, at 9:30 a.m., the Medical Director on December 9, 2010, at 4:09 p.m., and an attending physician on December 8, 2010, at 9:50 a.m., revealed the medications Theophylline, Naproxen and Robaxin could be dangerous/harmful if administered to residents for whom they were not prescribed. According to the Medical Director, the medication Theophylline could cause a resident to have nausea/vomiting, arrhythmias, and Theophylline toxicity, and the medication Naproxen could cause a resident to suffer from gastrointestinal bleeding. The attending physician stated Theophylline could cause a resident with a diagnosis of Heart Disease to have an elevated heart rate.</p> <p>Review of the medical records for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16, and review of the accident/incident reports revealed no evidence the facility had immediately reported the misappropriation of resident property/discrepancies in the resident's narcotics to the appropriate state agencies. In addition, resident #17 was sent to the local hospital for examination on November 26, 2010. The attending physician for resident #17 notified the nursing facility that the narcotic Fentanyl Patch for resident #17 appeared to have been tampered with/re-used. The Emergency Room physician reported the findings to the facility administrative staff. There was no evidence the facility investigated the incident or notified the state regulatory agencies regarding the incident.</p> <p>Interviews with the Director of Nursing (DON) on December 7, 2010, at 2:20 p.m. and December 8,</p>	F 225	<p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications have been reviewed/revise to include the following:</p> <ol style="list-style-type: none"> 1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of shift and with any change in the possession of the medication cart keys. 2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies. 3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10. <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as</p>	
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F 225	<p>Continued From page 13</p> <p>2010, at 10:30 a.m., revealed the DON reported the discrepancies in the residents' narcotics to the Administrator and the Nurse Consultant on November 27, 2010. According to the DON, he/she was instructed by the Nurse Consultant to notify the local police department regarding the missing narcotics but the Nurse Consultant informed the DON it was not necessary to notify the State Agency, because the incident was a criminal matter. The DON further stated a formal investigation regarding the residents' missing narcotics was not completed and incident reports/medication error reports were not completed because the facility did not know if the residents had received any of the medications used to replace the narcotics. According to the DON, no statements were obtained from staff regarding the discrepancies in resident medications and the alleged perpetrator was allowed to continue to provide resident care and administer resident medications after November 27, 2010. The DON stated the facility could not determine who had tampered with the resident medications and therefore no employees were suspended.</p> <p>Interview with the Administrator on December 7, 2010, at 5:30 p.m., revealed the Administrator was informed of discrepancies in the residents' narcotic medications by the DON. The Administrator instructed the DON to conduct drug screenings of all employees who had access to medications on November 27, 2010, to contact the local police regarding the medication discrepancies, and to notify the Nurse Consultant of the incident. The Administrator informed the DON to review the security cameras in the facility in an effort to determine which staff was involved; however, the cameras were not functioning on</p>	F 225	<p>misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to DCBS, the OIG, and local law enforcement. The Nurse Consultant received in-service education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term Care Regulations/Consultant to the Kentucky Association of Health Care Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p> <p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person</p>		

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F 225	<p>Continued From page 14</p> <p>November 26-27, 2010. The Administrator became aware RN #1 was named as an alleged perpetrator regarding the missing narcotics on December 3, 2010, but did not suspend the alleged perpetrator from direct resident care and administering resident medications because the facility had no proof the alleged perpetrator was guilty. The Administrator stated he/she was aware the facility policy required that an alleged perpetrator be suspended from employment regarding allegations of misappropriation of resident property but the facility considered this incident a criminal matter and not misappropriation. According to the Administrator, the facility did not have comprehensive documentation of the events surrounding the missing narcotics.</p> <p>Interview with the Nurse Consultant on December 7, 2010, at 4:40 p.m., revealed the Nurse Consultant was made aware of the incident on November 27, 2010, by the DON but determined the incident was of a criminal nature and was not required to be immediately reported to the State Agency. The Nurse Consultant stated because the facility had replaced the resident's narcotic medications without cost to the residents, the incident was not considered misappropriation of resident property, and a formal investigation was not required.</p> <p>Interviews with LPN #1 on December 6, 2010, at 5:29 p.m., RN #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., RN #1 on December 7, 2010, at 10:00 a.m., and LPN #4 on December 7, 2010, at 12:20 p.m., revealed these staff persons had access and/or administered resident medications on November 26-27, 2010, but had never been interviewed by</p>	F 225	<p>responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures.</p> <p>-The licensed nurse identified in the specific complaint provided to DCBS has been suspended pending the conclusion of the investigation by local law enforcement</p> <p>-RNs, LPNs, and CMTs will have a witness to verify pain relief from administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation.</p> <p>Criteria 4:</p> <p>-The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures.</p> <p>-The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic</p>		

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F 225	<p>Continued From page 15</p> <p>administrative staff as part of a facility investigation.</p> <p>Review of the staffing schedules for November and December 2010 revealed RN #1 was scheduled to work and provide direct resident care on November 26 and 30, 2010, and again on December 1, 4, 7, 8, and 9, 2010. The staffing schedule further revealed RN #1 was "on call" (to work if needed) for the facility on December 3, 2010, and had called in sick on December 5, 2010. RN #1's regularly scheduled days off were November 27, 28, and 29, 2010 and December 2 and 6, 2010, according to the staffing schedule. Review of "Hours Worked Detail Report" for RN #1 revealed this RN worked, providing direct resident care, for 16.50 hours on December 8, 2010. On December 7 and 9, 2010, RN #1 was observed in the facility hallway, at the nursing station, and was scheduled to provide direct resident care. At 9:45 a.m. on December 7, 2010, RN #1 was observed at the nursing station obtaining physician's orders via telephone for resident #11. On December 9, 2010, at 7:40 p.m., RN #1 was observed at nursing station #1 documenting in a resident's medical record. Review of the medical records for residents #4 and #7 revealed RN #1 had worked at the facility and provided direct care for both residents on December 4, 2010, and had provided care for residents #14 and #15 on December 7, 2010.</p> <p>Interview with the local police officer on December 9, 2010, at 5:45 p.m., and with LPN #1 on December 6, 2010, at 5:29 p.m., revealed according to the medication records RN #1 had signed out (signed as administered) more narcotics for residents than any other staff member.</p>	F 225	<p>count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.</p> <p>-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.</p> <p>-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.</p> <p>-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the</p>	

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F 225	Continued From page 16 2. Review of a hospital medical record and incident report for resident #17 dated November 26, 2010, at 7:43 p.m., revealed the resident was transferred to the hospital via ambulance with a complaint of increased pain. The resident had a Fentanyl patch attached to the resident's skin with two dates noted on the patch. According to the hospital records, the date of November 24, 2010, appeared to be written over the date of November 21, 2010, on the patch and the patch appeared to be very dirty and old in appearance. The hospital records stated that resident #17 was in severe pain and was yelling. Interview with the Medical Director on December 9, 2010, at 4:00 p.m., revealed resident #17 presented to the Emergency Room on November 26, 2010, due to the resident's pain. The Medical Director stated this resident had physician's orders for a Fentanyl patch to be applied to the resident's skin every three days. According to the Medical Director, when the resident arrived at the hospital, the Fentanyl patch on the resident's skin appeared to have had the date altered from November 21, 2010, with a mark across the numeral 1 to make the date appear to be November 24, 2010. The Medical Director, who was present in the Emergency Room at the time resident #17 presented, stated the resident was screaming with intense pain. The Medical Director explained that the old pain patch was removed, a new Fentanyl patch was applied to the resident's skin and 30 minutes later the resident was calm and in less pain. The Medical Director was concerned about this incident and contacted the DON of the nursing facility to report the incident. The Medical Director requested that the Administrator and DON come to the hospital	F 225	established CQI calendar under the supervision of the DON. -The CQI indicator for the monitoring of Abuse and Neglect investigation and reporting will be utilized monthly as per the established CQI calendar under the supervision of the Administrator. Criteria 5: January 24, 2011	

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F 225	<p>Continued From page 17</p> <p>to evaluate the resident regarding the resident's medical condition.</p> <p>Interview with the Administrator on December 8, 2010, at 5:30 p.m., revealed the facility did not report this incident of neglect to the appropriate state agencies. The Administrator stated the caregiver was neglectful of the resident but the facility had not neglected the resident and therefore the allegation was not immediately reported to state agencies.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Upon notification by facility staff on November 27, 2010, the facility Director of Nursing (DON) began an internal investigation of the narcotic medication discrepancies.</p> <p>The local law enforcement agency was contacted by the DON on November 27, 2010.</p> <p>Drug testing was conducted on medication administration staff that had direct access to each of the medication carts containing the narcotic medication packages with in the 24 hours prior to the identification of the narcotics discrepancies on November 27, 2010, December 3, 2010, and December 8, 2010.</p>	F 225		

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F 225	<p>Continued From page 18</p> <p>The alleged perpetrator, RN #1, was suspended on December 9, 2010.</p> <p>The Nurse Consultant received in-service education on the abuse/neglect/misappropriation of resident property by an expert in long-term care regulations on December 10, 2010.</p> <p>The Administrator and DON were in-serviced by the Nurse Consultant on December 9, 2010, on the need to consider any identified missing medications as misappropriation of resident property and to follow the facility policy and procedure for the reporting of the misappropriation to the correct state agencies.</p> <p>The facility staff received in-service education on the abuse/neglect/misappropriation of resident property policy and procedures on December 10, 2010.</p> <p>Twenty-four hour monitoring by administrative licensed nursing staff and/Nurse Consultants was implemented on December 11, 2010, to observe medication preparation and administration.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>Interview with the DON, Nurse Consultant, and Administrator on December 6-9, 2010, revealed an internal investigation began on November 27, 2010, with the local law enforcement being contacted. In addition, drug testing of all nursing staff present in the building was conducted on November 27, 2010, December 3, 2010, and December 8, 2010, and narcotic medications were inspected to identify discrepancies for all</p>	F 225			

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F 225	<p>Continued From page 19</p> <p>residents. Ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) were identified as having narcotics replaced with non-prescribed medications.</p> <p>Interview with the local law enforcement on December 9, 2010, revealed an investigation was initiated on November 27, 2010, and was ongoing.</p> <p>An interview with the Administrator and review of the employee change of status form on December 9, 2010, revealed the alleged perpetrator was suspended on that date pending the outcome of the investigation.</p> <p>An interview with the Administrator, DON, and Nurse Consultant, and review of facility records, on December 17, 2010, revealed that an in-service was conducted for the Administrator, DON, ADON, and Social Worker on December 9, 2010, by the Nurse Consultant regarding the need to consider any identified missing medications as misappropriation of residents' property, and to report misappropriation of resident property to the appropriate state agencies. Further interview and record review revealed on December 10, 2010, the expert in Long-Term Care regulations (consultant to the Kentucky Association of Health Care Facilities) reviewed and verified the accuracy of the in-service information provided by the Nurse Consultant.</p> <p>Interview with the Administrator, DON, Nurse Consultant, CMTs #3 and #5, LPNs #1, #6, and #7, and RNs #4, #5, #6, and #7, and review of facility in-service records revealed facility staff received in-service education regarding abuse, neglect, and misappropriation of property on</p>	F 225		

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F 225	Continued From page 20 December 10, 2010. Interviews with CMTs #3 and #5, LPNs #1, #6, and #7, and RNs #4, #5, #6, and #7 on December 17, 2010, confirmed the staff attended the in-service, and was knowledgeable of the information received in the in-service. Further interview with the Administrator revealed that new hires would be in-serviced upon employment and staff that was off work would be in-serviced upon return to work. An interview with the Administrator and DON and review of facility records on December 17, 2010, revealed continuous monitoring of all medication passes by Registered Nurses was implemented on December 11, 2010, and was ongoing. Observations on December 17, 2010, revealed continuous monitoring was in progress. Interview with Registered Nurses performing continuous monitoring on December 17, 2010, revealed nurses were knowledgeable of monitoring of medication preparation and administration. Based on the above findings, it was determined the Immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "E" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for investigating allegations, protecting residents, and notifying appropriate state agencies of misappropriation of property.	F 225			
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	F 309 Provide Care/Services Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		

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F 309	<p>Continued From page 21 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct physical assessments, per their policy and procedure, for ten (10) residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) after the facility discovered on November 27, 2010, that narcotic medications (Lortab and Vicodin) had been replaced with other medications of similar color, shape, and size (Theophylline, Naproxen, and Robaxin). Interviews with the Medical Director, the Pharmacist, and an attending physician revealed these medications could be dangerous/harmful if administered to residents for whom they were not prescribed.</p> <p>In addition, resident #11 was not assessed for the effectiveness of the resident's pain medication.</p> <p>The failure of the facility to conduct physical assessments placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>Review of the facility policy regarding Abuse/Neglect/Misappropriation of Resident Property (policy not dated) revealed when an allegation of alleged abuse/misappropriation of resident property was received the facility was required to conduct a thorough examination of the resident to determine if any injury occurred as a result of the incident.</p>	F 309	<p>Criteria 1 and 2:</p> <ul style="list-style-type: none"> -Resident #11 has had review of pain management orders by the attending physician, with orders changed to include new orders for routine and prn pain medications.. -The Director of Nursing began an internal investigation of the narcotic medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e., evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed. -The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing. -As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on 12/8/10 for medication administration 	

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F 309	<p>Continued From page 22</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010, at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed on November 27, 2010, the facility became aware of discrepancies in resident medications. According to the interviews, staff discovered the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, and Robaxin medications.</p> <p>Interviews with the Pharmacist on December 8, 2010, at 9:30 a.m., the Medical Director on December 9, 2010, at 4:09 p.m., and an attending physician on December 8, 2010, at 9:50 a.m., revealed the medications Theophylline, Naproxen, and Robaxin could be dangerous/harmful if administered to residents for whom they were not prescribed. According to the Medical Director, the medication Theophylline could cause a resident to have nausea/vomiting, arrhythmias, and Theophylline toxicity, and the medication Naproxen could cause a resident to suffer from gastrointestinal bleeding. The attending physician stated Theophylline could cause a resident with a diagnosis of Heart Disease to have an elevated heart rate.</p> <p>Review of the medical records for residents #1,</p>	F 309	<p>staff who had direct access to each of the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p> <p>-Residents who had documented administration of medication from one of the 10 identified packages with discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes 11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14,15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p> <p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit</p>		

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F 309	<p>Continued From page 23</p> <p>#2, #3, #5, #6, #11, #13, #14, #15, and #16, and review of the accident/incident reports revealed no evidence the facility conducted physical assessments of these residents to determine if the residents had sustained injury/harm as a result of the incident. The medical records revealed residents #1, #3, #4, #6, #13, #14, #15, and #16 had diagnoses to include Congestive Heart Failure, Heart Disease, Hypertension, Atrial Fibrillation, and/or Orthostatic Hypotension (blood pressure falls after resident changes position, from sitting to standing).</p> <p>Interview with resident #11 on December 9, 2010, at 9:30 a.m., revealed the resident had physician's orders for Lortab 7.5 milligrams to be administered before meals and at bedtime. According to the resident, the pain medication was prescribed for abdominal pain and the medication had been administered at times which did not relieve the resident's pain (five of resident #11's Lortab 7.5 milligrams were found to have been replaced with Theophylline on November 27, 2010). Although the resident had physician's orders for pain medications to be administered for "break through" pain (Lortab 7.5 milligrams 1/2 tablet), this medication had not been administered to the resident in October, November, or December 2010 according to the medication administration records.</p> <p>Interview with the Director of Nursing on December 7, 2010, at 2:20 p.m., revealed after the narcotic medications were found to be replaced with other medications the DON instructed staff to monitor residents for changes in physical condition; however, no physical assessments of the residents were conducted. According to the DON, total physical</p>	F 309	<p>Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time and are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10-12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p> <p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications</p>	

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F 309	<p>Continued From page 24</p> <p>assessments of these residents were not completed until December 7, 2010, after surveyors entered the facility.</p> <p>Interview with the Nurse Consultant on December 7, 2010, at 12:40 p.m., revealed physical assessments were not conducted for residents as the facility could not determine, and did not believe, the residents had received the unprescribed replacement medications (Theophylline, Naproxen, and Robaxin).</p> <p>Interview with LPN #4 on December 7, 2010, at 12:20 p.m., revealed no resident assessments were conducted on November 27, 2010, after the facility discovered the narcotics had been replaced with other medications.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16, who had identified narcotic medication discrepancies, had documented assessments of their status and/or interview by the DON as to their status per the nursing notes on November 27, 2010. In addition a complete assessment for these residents was conducted by the MDS Coordinator, Training Coordinator, and 3-11 Supervisor on December 7, 2010.</p>	F 309	<p>have been reviewed/ revised to include the following:</p> <ol style="list-style-type: none"> 1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of shift and with any change in the possession of the medication cart keys. 2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies. 3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10. <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the</p>		

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F 309	<p>Continued From page 25</p> <p>RNs and LPNs received in-service education beginning on December 1, 2010, and completed on December 8, 2010, related to conducting resident assessments as provided by the DON/ADON/3-11 Supervisor.</p> <p>Twenty-four hour monitoring by the licensed nursing staff and or nursing consultants was implemented on December 11, 2010, to ensure residents were being assessed and to monitor staff's response to changes in residents' status.</p> <p>A Continuous Quality Improvement indicator for auditing notification of change will be utilized on five medical records monthly for two months, and then quarterly as per established CQI calendar under the supervision of the DON which included assessments of the resident.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>An interview with the DON and Nurse Consultant on December 6-9, 2010, revealed assessments for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16 were conducted on December 7, 2010, with interventions implemented as ordered. A review of the physical assessment forms completed on December 7, 2010, revealed the assessments were completed and no concerns were identified.</p> <p>An interview with the DON and Nurse Consultant and review of facility records on December 17, 2010, revealed in-services for nursing staff were completed on December 9, 2010, regarding resident assessments related to change in status and pain management. Interviews with nursing</p>	F 309	<p>misappropriation to DCBS, the OIG, and local law enforcement. The Nurse Consultant received in-service education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term Care Regulations/Consultant to the Kentucky Association of Health Care Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p> <p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by</p>	

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F 309	<p>Continued From page 26</p> <p>staff on December 17, 2010, revealed the nursing staff attended the in-services and was knowledgeable of the information received. Further interview with the Administrator revealed that new hires would be in-serviced upon employment and staff that was off work would be in-serviced upon return to work.</p> <p>An interview with the DON, Administrator, and Nurse Consultant, and review of facility records on December 17, 2010, revealed continuous monitoring of resident assessments for pain and changes of status by licensed nursing staff and/or Nurse Consultants were implemented on December 11, 2010, and were ongoing. Observations on December 17, 2010, revealed continuous monitoring was in progress with no concerns. Interview with RNs #5 and #6 who performed continuous monitoring on December 17, 2010, revealed the consultants were knowledgeable of monitoring of resident assessments for pain management and changes of condition.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "E" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for assessments of residents related to pain management and change in condition.</p>	F 309	<p>the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures.</p> <p>-The licensed nurse identified in the specific complaint provided to DCBS has been suspended pending the conclusion of the investigation by local law enforcement.-RNs, LPNs, and CMTs will have a witness to verify pain relief from administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation.</p> <p>Criteria 4:</p> <p>-The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures. See Insert Page 27 A and 27B</p>	
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332	<p>F 332 Medication errors</p> <p>The facility must ensure that it is free of medication error rates of 5 percent or greater.</p>	

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-The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.

-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.

-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

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-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10-12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10-12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.

Criteria 5:

January 24, 2011

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F 332	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free of medication error rates of five (5) percent or greater. Observations of the December 6, 2010, 5:00 p.m. medication pass, and the December 9, 2010, 9:00 a.m. medication pass revealed three (3) medication errors (residents #12, #20, and #26) with forty-three (43) opportunities for error, resulting in an error rate of 6.9 percent.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of a medication administration conducted for resident #12 on December 6, 2010, at 5:30 p.m., revealed the Licensed Practical Nurse (LPN) prepared 5 milliliters (ml) of liquid Megace from a bottle labeled 40 mg per milliliter for a total dose of 200 mg. <p>A review of the liquid Megace bottle revealed a date opened of November 24, 2010.</p> <p>A review of resident #12's electronic Medication Administration Record and the physician's order revealed the resident was ordered to receive Megace 625 mg two times daily.</p> <p>An interview conducted with the LPN on December 6, 2010, revealed the LPN had not noticed the discrepancy on the label of the liquid medication, and did not identify that resident #12 was not receiving the medication as ordered.</p> <p>An interview conducted with the Director of</p>	F 332	<p>Criteria 1:</p> <ul style="list-style-type: none"> -The Megace orders for resident #12 were clarified to reflect the correct dosage to be administered. -The Symbicort medication for resident #20 has been available and administered as ordered. -The Miralax ordered for resident #26 is administered as ordered. <p>Criteria 2:</p> <ul style="list-style-type: none"> -All residents receiving medication have the potential to be effected. -Med Pass observations were completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant. -Medications are administered to residents with less than a 5% error rate. -Medications are available and administered to residents as ordered, unless the MD has been contacted for circumstances in which a medication is not able to be provided, to obtain further orders. <p>Criteria 3:</p> <ul style="list-style-type: none"> Medication administration staff received inservice education by the DON, MDS Coordinators, Unit 	

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F 332	<p>Continued From page 28</p> <p>Nursing on December 7, 2010, at 2:20 p.m., revealed the pharmacist had filled the medication and labeled the bottle with an incorrect dose. Further interview revealed staff had not noticed the discrepancy and the DON was not aware of the medication being administered at an incorrect dose.</p> <p>2. A review of resident #20's medical record revealed physician's orders for Symbicort 160 4.5-mcg inhaler one puff twice daily. Further review of resident #20's diagnoses revealed Chronic Obstructive Pulmonary Disease.</p> <p>Observation of the December 6, 2010, 5:30 p.m. medication pass revealed the Symbicort 160 4.5-mcg inhaler was not available for the resident as the medication had not been sent from the pharmacy. The resident did not receive the inhaler on December 6, 2010, for the 5:00 p.m. dose or the December 7, 2010, 9:00 a.m. dose.</p> <p>An interview with the Certified Medication Technician (CMT) giving medications to resident #20 on December 6, 2010, at 5:30 p.m., revealed the inhaler was not in the medication cart. The CMT contacted the nurse to have the medication ordered from the pharmacy.</p> <p>An interview with LPN #6 on December 7, 2010, at 12:20 p.m., revealed the Symbicort medication for resident #20 had been ordered last week from the local pharmacy; however, the medication had run out and resident #20 missed two doses. The LPN reported the medication was available for use on December 7, 2010, at the 5:00 p.m. dose.</p> <p>3. A review of resident #26's medical record revealed physician's orders for Miralax 24 grams</p>	F 332	<p>Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time and are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.</p> <p>Criteria 4:</p> <p>-The CQI indicator for the completion of MedPass observations will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p>	
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F 332	Continued From page 29 by mouth twice daily. Further review of the medical record revealed a diagnosis of Constipation. Observation of the medication administration pass at 5:30 p.m. on December 6, 2010, revealed Miralax 24 grams was mixed with eight ounces of water and given to resident #26 to drink after receiving other medications whole in applesauce. Resident #26 drank a portion of the Miralax/water mixture but sat the cup down and the CMT threw the remainder of the Miralax/water mixture in the garbage can. An interview with the Certified Medication Technician (CMT) on December 6, 2010, at 5:30 p.m., revealed the entire cup of Miralax/water mixture should have been given to resident #26. According to the CMT resident #26 did not refuse medications and usually drank the Miralax/water mixture as prescribed.	F 332	-The Pharmacy Consultant will perform random MedPass observations on 1-2 medication administration staff with monthly visits. Criteria 5: January 24, 2011		
F 425 SS=K	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425	F 425 Pharmacy Services The facility must provide routine and emergency drugs and biological to its residents to obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. Criteria 1 and 2: -The Director of Nursing began an internal investigation of the narcotic		

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F 425	<p>Continued From page 30</p> <p>a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate administration of all drugs to meet the needs of each resident. On November 27, 2010, staff found that the narcotic medication packages (Lortab and Vicodin) for ten (10) residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and the narcotic medications had been replaced with other medications (Theophylline, Naproxen, and Robaxin) which were similar in color, shape, and size. The facility was aware narcotic medication packages were being taped to hold medications in place; however, the facility failed to have an effective system to ensure the medications were not being tampered with and replaced with other non-prescribed medications.</p> <p>The facility's failure to provide pharmaceutical services to ensure the accurate administration of drugs to residents placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010,</p>	F 425	<p>medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e., evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>-The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing.</p> <p>-As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on 12/8/10 for medication administration staff who had direct access to each of the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p> <p>-Residents who had documented administration of medication from one of the 10 identified packages with</p>	

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F 425	<p>Continued From page 31</p> <p>at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed on November 27, 2010, the facility became aware of discrepancies in resident medications. According to the interviews, staff discovered the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, and Robaxin medications.</p> <p>A review of resident #1's medical record revealed the resident had a physician's order for Lortab 7.5/500 mg to be administered every four hours as needed for pain. According to the facility's investigation and observations of the medication packages on December 7, 2010, at 4:40 p.m., resident #1 had ten Lortab 7.5/500 mg tablets that had been replaced with Theophylline medication and the package had been taped on the back, across the foil backing.</p> <p>A review of resident #2's medical record revealed the resident had a physician's order for Lortab 5/500 mg to be administered every six hours as needed for pain. According to the facility's investigation and observations of resident #2's medication packages on December 7, 2010, at 4:40 p.m., the resident had 11 Lortab tablets replaced with Robaxin. According to the facility's investigation, resident #2's Lortab (60 tablets) was delivered to the facility on July 13, 2010.</p> <p>Resident #3 had physician's orders for</p>	F 425	<p>discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes 11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p> <p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for</p>		

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F 425	<p>Continued From page 32</p> <p>Hydrocodone 5/500 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed two of the resident's Hydrocodone had been replaced with Theophylline and the medication package had been taped on the back of the package. According to the facility's investigation, resident #3's Hydrocodone was delivered to the facility on November 8, 2010.</p> <p>The medical record for resident #5 revealed the resident had physician's orders for Hydrocodone 5/500 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed six of the resident's Hydrocodone had been replaced with Robaxin and the medication package had been taped on the back. According to the facility's investigation, resident #5's Hydrocodone was delivered to the facility on September 20, 2010.</p> <p>Resident #6 had physician's orders for Lortab 5/500 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed 11 of the resident's Hydrocodone had been replaced with Robaxin and the medication package had been taped on the back. According to the facility's investigation, resident #6's Hydrocodone was delivered to the facility on November 5, 2010.</p> <p>A review of resident #11's medical record revealed the resident had physician's orders for Hydrocodone 7.5/500 mg scheduled before meals and at bedtime, and half of a tablet as needed for pain. The facility's investigation and</p>	F 425	<p>administration; the requirement that medications are never to be prepared for more than one resident at a time are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10- 12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p> <p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications have been reviewed/ revised to include the following:</p> <p>1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of shift and with any change in the possession of the medication cart keys.</p>		

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F 425	<p>Continued From page 33</p> <p>observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed five of the resident's Hydrocodone had been replaced with Theophylline and the medication package had been taped on the back. According to the facility's investigation, resident #11's Hydrocodone was delivered to the facility on November 26, 2010.</p> <p>Resident #13 had physician's orders for Hydrocodone 5/325 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed two of the resident's Hydrocodone had been replaced with Naproxen 500 mg and the medication package had been taped on the back of the package. According to the facility's investigation, resident #11's Hydrocodone was delivered to the facility on May 27, 2010.</p> <p>A review of resident #14's physician's orders revealed an order for Hydrocodone 7.5/500 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed five of the resident's Hydrocodone had been replaced with Theophylline and the medication package had been taped on the back. According to the facility's investigation, resident #14's Hydrocodone was delivered to the facility on November 1, 2010.</p> <p>Resident #15 had physician's orders for Vicodin 5/500 mg every four hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed two packages of the resident's Hydrocodone had been tampered with</p>	F 425	<p>2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies.</p> <p>3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10.</p> <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to DCBS, the OIG, and local law enforcement. The Nurse Consultant received in-service education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term Care Regulations/Consultant to the Kentucky Association of Health Care</p>		

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F 425	<p>Continued From page 34</p> <p>and twenty-three Vicodin had been replaced with Robaxin and the medication package had been taped on the back. According to the facility's investigation, resident #15's Hydrocodone was delivered to the facility on September 12, 2010.</p> <p>A review of resident #16's medical record revealed physician's orders for Hydrocodone 7.5/500 mg every six hours as needed for pain. The facility's investigation and observation of the medication packages on December 7, 2010, at 4:40 p.m., revealed two of the resident's Hydrocodone had been replaced with Theophylline and the medication package had been taped on the back. According to the facility's investigation, resident #3's Hydrocodone was delivered to the facility on November 8, 2010.</p> <p>Further review of physician's orders for residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16 revealed the residents did not have orders for Theophylline, Robaxin, or Naproxen.</p> <p>A review of Medications Administration Policy revised July 16, 2000, revealed drugs "shall be kept and stored in the labeled dispensing container. Drugs may not be transferred from one container to another. This may be done only by a pharmacist."</p> <p>A review of the Facility Agreement with the Consultant Pharmacist signed on August 27, 2010, revealed the consultant's responsibilities included preparing a monthly summary report for the Administrator and pharmacy and a quarterly report on the status of the facility's pharmaceutical services and staff performance. In addition, the Consultant Pharmacist was responsible for meeting "all other responsibilities</p>	F 425	<p>Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p> <p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures.</p> <p>-The licensed nurse identified in the specific complaint provided to DCBS</p>	

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F 425	<p>Continued From page 35</p> <p>required of a consultant pharmacist as set forth in federal, state, and local laws, regulations, or rules."</p> <p>An interview with the Consultant Pharmacist on December 8, 2010, at 9:30 a.m., revealed the consultant had been providing services for the facility since September 1, 2010. The pharmacist stated he had visited the facility three times and had conducted random narcotics counts and drug regimen reviews. According to the consultant pharmacist, he/she had not identified narcotic medication packages were being taped on the back of the package, and had not observed a discrepancy in resident medications.</p> <p>Interview with a local police officer on December 9, 2010, at 5:45 p.m., and with LPN #1 on December 6, 2010, at 5:29 p.m., revealed according to the medication records, RN #1 had signed out more narcotics for residents than any other staff member. Interview with RN #2 on December 6, 2010, at 6:20 p.m., revealed that RN #2 had suspected and reported to the Assistant Director of Nursing (ADON) that residents were not receiving pain medications when RN #1 was on duty.</p> <p>In addition interviews with the night shift supervisor on December 8, 2010, at 5:20 p.m., and the ADON on December 9, 2010, at 2:24 p.m., revealed they had reviewed Medication Administration Records (MARs) and Narcotic Sign Out Logs after receiving complaints related to RN #1's medication practices. According to LPN #3 and the ADON, RN #1 signed out more narcotic pain medication for residents who did not normally require pain medication than any other nurse.</p>	F 425	<p>has been suspended pending the conclusion of the investigation by local law enforcement.</p> <p>-RNs, LPNs, and CMTs will have a witness to verify pain relief from administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation.</p> <p>Criteria 4:</p> <p>-The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures.</p> <p>-The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.</p> <p>-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and</p>		

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F 425	<p>Continued From page 36</p> <p>An interview with the Director of Nursing (DON) on December 7, 2010, at 2:20 p.m., revealed administrative staff conducted periodic random narcotics counts for resident medications to ensure the appropriate number of medications were present in the package and coincided with the narcotics sign-out sheet. The DON stated he/she was aware narcotics packages were being taped with surgical tape by staff because the packages were fragile. However, according to the DON, the facility did not monitor the packages to ensure the narcotics had not been replaced nor did the facility have a system to reconcile narcotic medications including the frequency they were administered and who was administering the medications.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>Ten residents were identified with evidence of discrepancies in their narcotic medication packages (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) on November 27, 2010.</p> <p>All narcotic medication packages were inspected by the DON on November 27, 2010, and again by the MDS Coordinators/DON/ADON/Training Coordinator, and 3-11 Supervisor on December</p>	F 425	<p>will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.</p> <p>-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.</p> <p>-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: January 24, 2011</p>		

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F 425	<p>Continued From page 37</p> <p>7, 2010, and any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications were reviewed/ revised to include the following revisions: three medication administration staff persons were required to visually observe all narcotic medications at the change of shift and with transfer of medication keys from staff member to staff member. In addition the use of any type of tape on medication packaging was prohibited.</p> <p>Tamper-evident packaging was obtained for all narcotic medications packaging on December 10, 2010.</p> <p>The medication administration staff was in-serviced by the DON, ADON, Training Coordinator, and 3-11 Supervisor on the revised facility medication policies and procedures on December 8, 2010.</p> <p>Twenty-four hour monitoring to observe medication preparation and administration of medications by administrative licensed nursing staff and/or Nurse Consultants was implemented on December 11, 2010.</p> <p>The DON, ADON, MDS Coordinator, Training Coordinator, Restorative Coordinator, Medical Records Nurse, or 3-11 Supervisor would conduct reviews of narcotic medication packages, narcotics count sheets, and narcotics administration logs for two medication carts daily for two weeks, weekly for four weeks, then monthly thereafter to determine compliance with</p>	F 425		

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F 425	<p>Continued From page 38 the revised medication policies and procedures.</p> <p>The pharmacy consultant will include reviews of two medication carts of narcotic medication packages, narcotics count sheets, and narcotics administration logs weekly for one month, then bi-weekly for one month, and then monthly. The pharmacy consultant will also conduct complete medication cart audits monthly for three months, and then as indicated by monthly observations.</p> <p>The nursing consultant will review narcotics count and administration log documentation for two medication carts monthly, and will review the monthly pharmacy consultant reports to identify any follow-up interventions necessary.</p> <p>The Continuous Quality Improvement indicator for auditing of the medication room/carts will be utilized on each of the two medication rooms and two medication carts monthly for two months, and then quarterly as per the established CQI calendar and monitored by the DON.</p> <p>The CQI indicator for the completion of medication pass observations was completed for all medication administration staff on December 13-15, 2010, by the DON, MDS Coordinator, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and the Nurse Consultant.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>A review of the consultant pharmacist's written statement of monitoring/audit of medication carts completed on December 16, 2010, revealed audit/monitoring was completed with no</p>	F 425		

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F 425	<p>Continued From page 39 discrepancies identified.</p> <p>An interview with the DON, Administrator, and Nurse Consultant, review of facility record, and observations on December 17, 2010, revealed 24-hour monitoring by administrative licensed nursing staff and or nursing consultants was implemented on December 11, 2010. Observations on December 17, 2010, revealed Nurse Consultants monitoring all medication preparation and administration (including narcotics).</p> <p>A review of the facility policy for medication storage in the facility dated December 7, 2010, revealed the following revisions: three medication administration staff persons will be required to visually observe all narcotic medications at the change of shift, with transfer of medication keys from staff member to staff member, and the use of any type of tape on medication packaging will be prohibited.</p> <p>Interviews with the DON, Administrator, Nurse Consultant, CMAs #3 and #5, LPNs #1, #6, and #7, and RNs #4, #5, #6, and #7 on December 17, 2010, revealed in-services regarding policy revision and medication administration were conducted for all medication staff on December 8-11, 2010. Interviews with facility nurses and CMTs on December 17, 2010, revealed all facility medication staff attended the in-services and was knowledgeable of the subject matter.</p> <p>Observations of medication rooms and medication carts on December 17, 2010, revealed no concerns with accountability of narcotic medications. Tamper-proof packaging for narcotics was observed to be in place for the</p>	F 425		

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F 425	Continued From page 40 facility. Interview with the DON and the Nurse Consultant, and review of facility documents on December 17, 2010, revealed narcotics audits by administrative staff were initiated on December 11, 2010, and were ongoing with no concerns identified. A review of the Continuous Quality Improvement (CQI) tool on December 17, 2010, revealed each medical staff person working at the facility had a competency check completed by December 15, 2010, regarding medication administration. Based on the above findings, it was determined the Immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "E" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for notification of administration and accountability of resident medications.	F 425			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	F 431 Drug Records, Label/Store Drugs & Biologicals Criteria 1: All expired drugs/biologicals (Lactated Ringers IV solution, vial of Phenergan, Glucagon injectable, Valium tablets, vial of normal saline, bottle of sterile eye irrigation solution, vials of Ativan, vial of Chlorpormazine, Ativan tablets) were removed and/or destroyed and replaced as indicated. Criteria 2: The medication rooms and EDK boxes were inspected by the Pharmacy consultants with any identified expired drugs/biological removed and/or destroyed and replaced as indicated.		

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F 431	<p>Continued From page 41</p> <p>instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional principles to include an expiration date when applicable. Expired medications and medications that were opened and not labeled were observed to be stored in side 1 and side 2 medication rooms.</p> <p>The findings include:</p> <p>Observations of the side 2 medication room conducted on December 9, 2010, at 2:30 p.m., revealed the following drugs and biologicals were expired and available for resident use in the</p>	F 431	<p>Criteria 3: Facility licensed nursing staff have received inservice education by the DON on the proper storage and labeling of drugs and biological included but not limited to: the need to remove expired/out-dated drugs/biologicals upon identification; the need to date all multi-use medications with the date opened/accessed; the need to verify that multi-use medications are within the acceptable time frame for use based on the date of opening/access, as provided on 1/13 – 1/17/2011.</p> <p>Criteria 4: The CQI indicator for the monitoring of storage and labeling of drugs and biological will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>Criteria 5: January 24, 2011</p>

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F 431	<p>Continued From page 42</p> <p>emergency drug box: Lactated Ringers 1,000 milliliters (ml) intravenous (IV) solution with an expiration date of July 2008, Phenergan 1 ml injectable vial with an expiration date of September 2010, and Glucagon 1 mg injectable with an expiration date of November 2010. In addition observations of the emergency drug boxes revealed two Valium 5 mg tablets were stored in an unsealed envelope in the emergency box. Further observations of the side 2 medication room revealed a 30 ml vial of normal saline opened and not dated as to when opened, and a 16-oz bottle of sterile eye irrigation solution with an expiration date of October 2010 available for use.</p> <p>Observation of the side 1 medication room on December 9, 2010, at 3:15 p.m., revealed two Ativan 2 ml vials opened and not dated to indicate when the medication had been opened. The emergency box contained Chlorpromazine 1 ml injectable vial with an expiration date of October 2010 that was available for use. In addition two Ativan 1 mg tablets and two Valium 5 mg tablets were stored in an unsealed envelope in the emergency box.</p> <p>An interview conducted with the facility Pharmacy Technician on December 9, 2010, at 2:30 p.m., revealed the emergency box was checked by the pharmacy when a medication was replaced in the box. The Pharmacy Technician stated the expired drugs and biologicals must have been missed when the emergency box was restocked.</p> <p>An interview conducted with a Licensed Practical Nurse (LPN) on December 9, 2010, at 3:15 p.m., revealed Nursing was responsible for checking for expired drugs and biologicals weekly.</p>	F 431		

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F 431	Continued From page 43 However, the LPN was not aware of when the medication room had been checked for expired drugs and biologicals.	F 431		
F 441 SS=D	A review of the facility policy titled Medication Expiration Dating and Storing with a revision date of September 2004 did not clearly address how a medication was to be labeled when opened. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F 441 Infection Control, Prevent Spread, Linens The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Criteria 1: The nebulizer tubing and mouth piece equipment was replaced for resident #2. Criteria 2: Nebulizer tubing and mouth piece equipment were replaced for all residents utilizing these devices. Criteria 3: Licensed nursing staff have received inservice education on the replacement of nebulizer tubing and mouth piece equipment weekly and prn, and the need to cleanse the mouthpiece equipment with water after each use and with any visible signs of debris, as provided by the DON, Training Coordinator, or 3-11 Supervisor on 1/13 - 1/17/2011.	

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F 441	<p>Continued From page 44 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain an effective infection control program and infection control practices during a medication pass on December 6, 2010, for one (1) of twenty-six (26) sampled residents (resident #26). Resident #26 received a nebulizer treatment on December 6, 2010, with a soiled mouthpiece.</p> <p>The findings include:</p> <p>Observation of the medication administration pass on December 6, 2010, revealed a nebulizer treatment was administered to resident #26 with a soiled mouthpiece. The mouthpiece was covered in a pinkish brown substance. The medication was placed in the nebulizer, and the nebulizer turned on. The soiled mouthpiece was placed in the resident's mouth. The nebulizer treatment was interrupted for the mouthpiece to be cleansed at the surveyor's request. The CMT ran water over the mouthpiece to remove the pinkish brown substance, and the nebulizer treatment was then continued as ordered.</p> <p>Interview on December 6, 2010, at 5:30 p.m., with</p>	F 441	<p>Criteria 4: Nebulizer equipment will be inspected weekly by the 3-11 Supervisor to determine that there are no visible signs of debris and that the tubing and mouth pieces have been changed each week.</p> <p>Criteria 5: January 24, 2011</p>	

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F 441	Continued From page 45 the Certified Medication Technician (CMT) administering resident #26's medications revealed the nebulizer mouthpiece should have been cleansed prior to administration of the nebulizer treatment. Interview with the Director of Nursing on December 17, 2010, at 6:15 p.m., revealed the nebulizer tubing and mouthpieces should be clean prior to any nebulizer treatment. The DON stated extra tubing and mouthpieces were kept at the facility for replacements as needed. The DON further stated the Respiratory Department replaced the tubing/mouthpieces for nebulizers on a weekly basis. Review of the policy for respiratory care services, undated, revealed tubing/mouthpieces for nebulizer treatments were to be replaced every seven days and as needed, and when nebulizer equipment was not in use the tubing/mouthpiece should be kept in a plastic setup bag.	F 441		
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility Administrator failed to administer the facility in a manner that enabled the facility to use resources effectively and efficiently to attain or maintain the highest	F 490	<p>F 490 Administration 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>Criteria 1 and 2: -The Director of Nursing began an internal investigation of the narcotic medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e.,</p>	

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F 490	<p>Continued From page 46</p> <p>practicable physical well-being of residents.</p> <p>On November 27, 2010, ten (10) of twenty (20) sampled residents' (residents #1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) narcotic medication packages had been tampered with and the narcotic medications had been replaced with other medications (Theophylline, Naproxen, and Robaxin) which were similar in color, shape, and size. The facility Administrator failed to ensure residents' physicians and responsible parties were notified of the incident, failed to ensure residents were assessed for complications and/or changes in condition, failed to have a system for reconciling narcotic medications, and failed to thoroughly investigate and report allegations of misappropriation of property. In addition, the facility Administrator failed to protect residents by not removing the alleged perpetrator(s) (refer to F157, F225, F309, F425, and F520).</p> <p>The facility Administrator's failure to administer the facility, thoroughly investigate and report allegations of misappropriation of resident property, and protect facility residents placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010, at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed on November 27,</p>	F 490	<p>evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>-The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing.</p> <p>-As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on 12/8/10 for medication administration staff who had direct access to each of the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p> <p>-Residents who had documented administration of medication from one of the 10 identified packages with discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes</p>	

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F 490	<p>Continued From page 47</p> <p>2010, the facility became aware of discrepancies in resident medications. According to the interviews, staff discovered the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, or Robaxin medications.</p> <p>Interviews with the Pharmacist on December 8, 2010, at 9:30 a.m., the Medical Director on December 9, 2010, at 4:09 p.m., and an attending physician on December 8, 2010, at 9:50 a.m., revealed the medications Theophylline, Naproxen, and Robaxin could be dangerous/harmful if administered to residents for whom they were not prescribed. According to the Medical Director, the medication Theophylline could cause a resident to have nausea/vomiting, arrhythmias, and Theophylline toxicity, and the medication Naproxen could cause a resident to suffer from gastrointestinal bleeding. The attending physician stated Theophylline could cause a resident with a diagnosis of Heart Disease to have an elevated heart rate.</p> <p>Interviews with the Director of Nursing (DON) on December 7, 2010, at 2:20 p.m. and December 8, 2010, at 10:30 a.m., revealed the DON reported the discrepancies in the residents' narcotics to the Administrator and the Nurse Consultant on November 27, 2010. According to the DON, the DON was instructed by the Nurse Consultant to notify the local police department regarding the missing narcotics but the Nurse Consultant informed the DON it was not necessary to notify the State Agency because the incident was a</p>	F 490	<p>11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p> <p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures including but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time and are to be given immediately upon preparation; the requirement that</p>	

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F 490	<p>Continued From page 48</p> <p>criminal matter. The DON further stated a formal investigation regarding the residents' missing narcotics was not completed and incident reports/medication error reports were not completed because the facility did not know if the residents had received any of the medications that were used to replace the narcotics. According to the DON, no statements were obtained from staff regarding the discrepancies in resident medications and the alleged perpetrator was allowed to continue to provide resident care and administer resident medications after November 27, 2010. The DON stated the facility could not determine who had tampered with the resident medications and therefore no employees were suspended.</p> <p>In addition, the Director of Nursing (DON) stated administrative staff conducted periodic random narcotics counts for residents' medications to ensure the appropriate number of medications were present in the package and coincided with the narcotics sign-out sheet. The DON stated he/she was aware narcotics packages were being taped, on the foil backing, with surgical tape because the packages were fragile. However, according to the DON, the facility did not monitor the packages to ensure the narcotics had not been tampered with nor did the facility have a system to reconcile narcotic medications including the frequency they were administered and who was administering the medications.</p> <p>Interview with the Administrator on December 7, 2010, at 5:30 p.m., revealed the Administrator was informed of the discrepancies in the residents' narcotic medications by the DON. The Administrator instructed the DON to conduct drug screenings of all employees who had access to</p>	F 490	<p>residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10- 12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p> <p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications have been reviewed/ revised to include the following:</p> <ol style="list-style-type: none"> 1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of shift and with any change in the possession of the medication cart keys. 2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies. 	

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F 490	<p>Continued From page 49</p> <p>medications on November 27, 2010, to contact the local police regarding the medication discrepancies, and to notify the Nurse Consultant of the incident. The Administrator explained the facility became aware RN #1 was named as an alleged perpetrator regarding the missing narcotics on December 3, 2010; however, the facility did not suspend the alleged perpetrator from direct resident care and administering resident medications because the facility had no proof the alleged perpetrator was guilty. The Administrator stated he/she was aware the facility policy required that an alleged perpetrator be suspended from employment regarding allegations of misappropriation of resident property but the facility considered this incident a criminal matter and not misappropriation. According to the Administrator, the facility did not have comprehensive documentation of the events surrounding the missing narcotics.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>The Administrator suspended the alleged perpetrator on December 9, 2010.</p> <p>Internal investigation findings were reviewed by the Administrator with the conclusion that the person for narcotics discrepancies could not be</p>	F 490	<p>3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10.</p> <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to DCBS, the OIG, and local law enforcement.</p> <p>The Nurse Consultant received inservice education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term Care Regulations/Consultant to the Kentucky Association of Health Care Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p>	

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F 490	<p>Continued From page 50 determined.</p> <p>Disciplinary action was taken for medication administration staff that was identified during the investigation process as not complying with facility narcotics administration documentation policies and procedures.</p> <p>The Administrator was provided in-service education by the Nurse Consultant on December 9, 2010, on the need to consider any identified missing medications misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to appropriate state agencies.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>An interview with the Administrator and review of facility documentation, on December 17, 2010, revealed the Administrator was in-serviced on December 9, 2010, regarding the need to consider any identified missing medications as misappropriation of resident property and follow the facility policy and procedure for reporting allegations of misappropriation of resident property to the appropriate state agencies, and to protect residents from abuse, neglect, and misappropriation of property.</p> <p>A review of the facility policy for medication storage in the facility dated December 7, 2010, revealed the following revisions: three medication administration staff persons will be required to visually observe all narcotic medications at the change of shift; and with transfer of medication keys from staff member to staff member; and the use of any type of tape on medication packaging</p>	F 490	<p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures.</p> <p>-The licensed nurse identified in the specific complaint provided to DCBS has been suspended pending the conclusion of the investigation by local law enforcement.</p> <p>-RNs, LPNs, and CMTs will have a witness to verify pain relief from</p>	

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F 490	Continued From page 51 will be prohibited. Based on the above findings, it was determined the immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "F" based on the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for administration regarding the following: investigating, reporting, protection of residents from abuse, neglect, misappropriation of resident property; resident assessments for changes of condition and pain management; notification of physician and responsible party and accountability of resident medications.	F 490	administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation. Criteria 4: -The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures. See Insert Pages 52A and 52B	
F 520 SS=L	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.	F 520	F 520 Quality Assessment and Assurance A facility must maintain a quality assessment and assurance committee consisting of i) The director of nursing services; ii) A physician designated by the facility; and iii) At least 3 other members of the facility's staff. The quality assessment and assurance committee i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.	

F490

-The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.

-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.

-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

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-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The facility Corporate Compliance Officer will review allegations of abuse, neglect and misappropriation of resident property with the Administrator to determine that notification of all State agencies has been conducted and documentation is complete.

Criteria 5:

January 24, 2011

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F 520	<p>Continued From page 52</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to identify issues for which quality assessment and assurance activities were necessary, and failed to develop and implement appropriate plans of action to correct identified quality deficiencies. There was no evidence the facility Quality Assurance Committee identified that narcotic medication packaging had been tampered with and replaced with non-prescribed medications. In addition, the quality assurance committee failed to identify that incidents of misappropriation of resident property were not being investigated, reported to appropriate state agencies, and residents were not being protected per facility policy (refer to F157, F225, F309, F425, and F520).</p> <p>The facility's failure to ensure a Quality Assurance Committee was in place that identified quality concerns in the facility, and implemented action plans to correct the concerns placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>A review of the facility Continuous Quality Improvement Program (not dated) revealed the facility would have a systematic, structured, and documented CQI process in place that would focus on continually improving the delivery of care/services to residents. The policy revealed</p>	F 520	<p>Criteria 1 and 2:</p> <p>-The Director of Nursing began an internal investigation of the narcotic medication discrepancies immediately upon notification on 11/27/10, with interviews of medication administration staff. All narcotic medication packages were inspected to identify any discrepancies (i.e., evidence of the presence of tape on the packaging, punctures in the packaging, discrepancies in the appearance of the medications) by the DON on 11/27/10, and again by the DON/ADON/MDS Coordinators/RAI Coordinator, Training Coordinator, and 3-11 Supervisor on 12/7/10. There were no discrepancies identified other than those with the original 10 residents. Any medications identified with evidence of tape present on the packaging were destroyed.</p> <p>-The local law enforcement agency was contacted by the DON immediately on 11/27/10, and the officer conducted an on-site investigation at that time, which is still ongoing.</p> <p>-As part of the internal investigation, drug testing was conducted on 11/27/10, 12/3/10, and the final on 12/8/10 for medication administration staff who had direct access to each of the carts containing the narcotic medication packages within the 24 hours prior to the identification of the discrepancies.</p>		

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717		
(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 520	<p>Continued From page 53</p> <p>the CQI Committee met monthly and reviewed and analyzed data gathered by the interdisciplinary action teams. According to the policy, if data analysis showed a problem and/or potential problem the CQI Committee charged the interdisciplinary action team with correction, or appointed a special project team.</p> <p>Interviews with the Administrator on December 7, 2010, at 5:41 p.m., the Director of Nursing Services (DON) on December 7, 2010, at 2:43 p.m., Registered Nurse #1 on December 7, 2010, at 10:09 a.m., Registered Nurse #2 on December 6, 2010, at 6:20 p.m., CMA #2 on December 7, 2010, at 9:49 a.m., LPN #1 on December 6, 2010, at 5:29 p.m., and LPN #3 on December 8, 2010, at 5:20 p.m., revealed that on November 27, 2010, the facility became aware of discrepancies in resident medications. According to the interviews, staff discovered that the narcotic medications for ten residents (residents #1, #2, #3, #5, #6, #11, #13, #14, #15, and #16) had been tampered with and replaced with other medications with similar color, shape, and size. The narcotic medications (Lortab and Vicodin) were replaced with Theophylline, Naproxen, and Robaxin medications.</p> <p>Interviews with the Pharmacist on December 8, 2010, at 9:30 a.m., the Medical Director on December 9, 2010, at 4:09 p.m., and an attending physician on December 8, 2010, at 9:50 a.m., revealed the medications Theophylline, Naproxen, and Robaxin could be dangerous/harmful if administered to residents for whom they were not prescribed. According to the Medical Director, the medication Theophylline could cause a resident to have nausea/vomiting, arrhythmias, and Theophylline toxicity, and the</p>	F 520	<p>-Residents who had documented administration of medication from one of the 10 identified packages with discrepancies within 24 hours of the identification of the discrepancies, had documented assessments of their status and/or interview by the DON as to their status as per the nursing notes 11/27/10 and the DON interviews conducted on 11/27/10.</p> <p>-Complete vital signs and nursing systems assessments were performed by the MDS Coordinators, Training Coordinator, and 3-11 Supervisor on 12/7/10, with findings documented on the physical assessment form for this purpose.</p> <p>-The attending physician and responsible party were notified of the investigation circumstances and resident assessment findings for each of the 10 residents (#1, 2, 3, 5, 6, 11, 13, 14, 15, and 16) with identified narcotic medication discrepancies, by the DON/ADON/Medical Records Nurse on 12/8/10, with follow-up interventions implemented as ordered.</p> <p>Criteria 3:</p> <p>-Medication administration staff received inservice education by the DON, MDS Coordinators, Unit Supervisors, Training Coordinator, 3-11 Supervisor, Restorative Coordinator, and Medical Records Nurse on 12/11/10 and 12/12/10, on medication administration procedures</p>	

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F 520	<p>Continued From page 54</p> <p>medication Naproxen could cause a resident to suffer from gastrointestinal bleeding. The attending physician stated Theophylline could cause a resident with a diagnosis of Heart Disease to have an elevated heart rate.</p> <p>On December 9, 2010, at 4:00 p.m., an interview was conducted with the Compliance staff, which was responsible for the facility's CQI program. The Compliance staff member stated the facility identified quality concerns through resident council, complaints from residents/staff, and the standardized CQI monitoring tools. The Compliance staff stated the facility monitored abuse and neglect allegations to ensure appropriate action was taken; however, the facility had not identified misappropriation as a concern and did not monitor misappropriation of resident property as a part of the CQI process. In addition, the Compliance staff member explained the facility monitored medication carts as a part of the CQI process to ensure medications were labeled properly, stored appropriately, and expired medication and discontinued medications were removed. According to the CQI staff member, the facility did address narcotic medications as part of the CQI program.</p> <p>**An acceptable allegation of compliance related to the Immediate Jeopardy was submitted by the facility on December 14, 2010, which alleged removal of Immediate Jeopardy on December 16, 2010. An extended survey was conducted on December 17, 2010, which determined the Immediate Jeopardy was removed on December 16, 2010.</p> <p>A review of the allegation of compliance revealed the following:</p>	F 520	<p>but not limited to: the need to keep the medications locked at all times when not being accessed for administration; the requirement that medications are never to be prepared for more than one resident at a time an are to be given immediately upon preparation; the requirement that residents are to be observed swallowing all of their medications.</p> <p>-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10- 12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10 – 12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to the present. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.</p> <p>-The facility policies and procedures for the delivery, monitoring, and documentation of narcotic medications have been reviewed/ revised to include the following:</p> <p>1. Three (3) medication administration staff (RN, LPN, or CMT) will be required to visually observe all narcotic medications at the change of</p>	

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F 520	<p>Continued From page 55</p> <p>Twenty-four hour monitoring by administrative licensed nursing staff and or Nurse Consultants was implemented on December 11, 2010. This monitoring includes continuous rounds of the facility to observe medication preparation and administration, reassessing of residents for pain relief after pain medication administration, and reassessing residents and monitoring staff's response to changes in resident status.</p> <p>The DON, ADON, MDS Coordinator, Training Coordinator, Restorative Coordinator, Medical Records Nurse, or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotics sheets and administration logs for two medication carts daily for two weeks, weekly for four weeks, and then monthly thereafter to determine compliance with the revised medication policies and procedures.</p> <p>The Pharmacy consultant will include reviews of two medication carts of the narcotic medication packages, narcotics count sheets, and narcotics administration logs weekly for one month, then bi-weekly for one month, and then monthly in the pharmacy visit report. The pharmacy consultant will also conduct complete medication audits monthly for three months and then as indicated by monthly observations.</p> <p>The nursing consultant will review narcotics count and administration log documentation for two medication carts monthly, and will review the monthly pharmacy consultant reports to identify any follow-up interventions necessary.</p> <p>The CQI indicator for auditing of medication room/carts will be utilized on each of the two</p>	F 520	<p>shift and with any change in the possession of the medication cart keys.</p> <p>2. The use of any type of tape on medication packaging is prohibited, and staff are to immediately report to the DON or ADON the identification of the presence of any tape or other medication packaging discrepancies.</p> <p>3. The medication administration staff have received inservice education by the DON/ADON/Training Coordinator/3-11 Supervisor on the revised facility medication policies and procedures on 12/8/10.</p> <p>-RNs, LPNs and CMTs have received inservice education beginning at the nursing meeting on 12/1/10 and completed on 12/8/10, on resident change in status, including but not limited to: resident assessment, documentation of findings, and notification of MD/RP, as provided by the DON/ADON/3-11 Supervisor.</p> <p>-The Administrator and Director of Nursing were provided inservice education by the Nurse Consultant on 12/9/10 on the need to consider any identified missing medications as misappropriation of resident property, and to follow the facility policy and procedure for the reporting of the misappropriation to DCBS, the OIG, and local law enforcement. The Nurse Consultant received in-service education on the abuse, neglect and misappropriation of resident property regulations by an expert in Long Term</p>	

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F 520	<p>Continued From page 56</p> <p>medication rooms and two medication carts monthly for two months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>The CQI indicator for auditing the notification of change will be utilized on five medical records monthly for two months, and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>The CQI indicator for the completion of medication pass observations was completed on all medication administration staff on December 13-15, 2010, to determine that all staff administered medications with less than 5 percent error rate, as conducted by the DON, MDS Coordinator, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisor, Medical Records Nurse, and Nurse Consultant.</p> <p>The survey team validated the corrective actions taken by the facility as follows:</p> <p>An interview with the DON and Nurse Consultant and review of facility documentation on December 17, 2010, revealed Continuous Quality Improvement (CQI) tools were reviewed and revised to include the following: auditing of medication room carts, medication pass observations, notification of physician/responsible party, and resident change in condition assessments.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed on December 16, 2010. Noncompliance continued with scope and severity lowered to "F" based on</p>	F 520	<p>Care Regulations/Consultant to the Kentucky Association of Health Care Facilities, provided on 12/10/10. This expert also reviewed and verified the accuracy of the inservice information provided for the Administrator and DON by the Nurse Consultant.</p> <p>-The facility staff received inservice education on the abuse, neglect and misappropriation of resident property policy and procedures, including but not limited to: review of medication diversion/replacement as misappropriation, and failure to address resident change in status with assessment/MD & RP notification and follow up as neglect, as provided by the Administrator, Social Services Coordinator, DON, ADON, Training Coordinator, Dietary Manager, Environmental Manager, or 3-11 Supervisor on 12/10/10.</p> <p>-The internal investigation findings were reviewed by the Administrator and Director of Nursing with the investigating DCBS staff, the Medical Director, and the Pharmacy Consultant, with the conclusion that the person responsible for the narcotic discrepancies could not be determined. Disciplinary actions were conducted by the DON for medication administration staff who were identified during the investigation process as not complying with facility narcotic administration documentation policies and procedures.</p>		

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F 520	Continued From page 57 the facility's need to evaluate the effectiveness of CQI activities related to the implementation of policies and procedures for administration regarding the following: investigating, reporting, protection of residents from abuse, neglect, misappropriation of resident property; resident assessments for changes of condition and pain management; notification of physician and responsible party; and accountability of resident medications.	F 520	-The licensed nurse identified in the specific complaint provided to DCBS has been suspended pending the conclusion of the investigation by local law enforcement. -RNs, LPNs, and CMTs will have a witness to verify pain relief from administered narcotic medication, and will document the observation of the witness (a staff member that did not administer the pain medication to the resident) in the nursing documentation. Criteria 4: -The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures. -The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations See Insert Page 58 A		

F520

-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.

-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the monitoring of the QA process will be utilized quarterly X2 quarters and then every six months under the supervision of the facility Corporate Compliance Officer.

Criteria 5:

January 24, 2011

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on December 8, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "D" level.	K 000	Cumberland Valley Manor Federal & State Plan of Correction Standard Survey 12/6 - 12/17/2010	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were able to resist	K 018	Preparation and execution of this 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 deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. K018 NFPA 101 Life Safety Code Standard Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door	

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

TITLE

Administrator

(X5) DATE

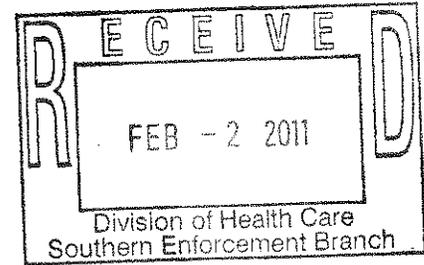
01/04/11

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

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K 018	<p>Continued From page 1</p> <p>the passage of smoke. This deficient practice affected one (1) of seven (7) smoke compartments, staff, and seven (7) residents. The facility has the capacity for 92 beds with a census of 85 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on December 8, 2010, at 10:55 a.m., with the Director of Maintenance (DOM), observation revealed resident room 223 was observed to have an approximate 1/2-inch gap at the top of the doors. Resident rooms 231 and 230 were also observed to have an excessive gap at the top of the doors. In addition the door to resident room 219's door was observed not to latch as required. These doors must be able to resist the passage of smoke in a fire situation.</p> <p>An interview with the DOM on December 8, 2010, at 10:55 a.m., revealed the DOM was not aware of the gaps at the top of the doors or that resident room 219's door would not latch.</p>	K 018	<p>closed. Dutch doors meeting 19.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Criteria 1: The doors of resident rooms 223, 231 and 230 have been adapted to be in compliance with the Life Safety Code, eliminating the gap at the top of the doors.</p> <p>The door latch of room 219 was repaired on 1/11/11.</p> <p>Criteria 2: All resident room doors have been inspected by the Maintenance Director to verify that they meet life safety code.</p> <p>Criteria 3: The Administrator in-serviced maintenance staff to monitor resident room doors for excessive gaps as well as monitoring doors for proper functioning of door latch.</p> <p>Criteria 4: CQI tool ES3 will be used per the CQI schedule to continue monitoring for gaps in resident room doors and proper latch functioning.</p> <p>Criteria 5: Completion date: January 17, 2011</p>		

ADDENDUM**F309****Criteria 4:**

-The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures.

-The Pharmacy Consultants will include reviews of 2 carts of the narcotic medication packages, narcotic count sheets and administration logs weekly X 1 month, then bi-weekly X 1 month, and then monthly in the pharmacy visit and report. The pharmacy consultant will also conduct complete med cart audits monthly X 3 months and then as indicated by monthly observations.

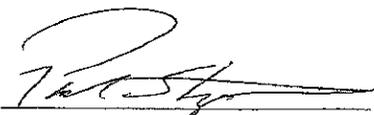
-The nursing consultant will review narcotic count and administration log documentation for 2 carts monthly X 3 months and quarterly thereafter, and will review the monthly Pharmacy Consultant reports to identify any follow up interventions necessary.

-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-24 hour monitoring by administrative licensed nursing staff and/or nurse consultants was conducted from 12/11/10-12/19/10, then 8 hour monitoring daily on alternating shifts by administrative licensed nursing staff was conducted 12/20/10-12/31/10, then 8 hour monitoring 2 days per week on alternating shifts is being conducted from 1/1/11 to 03/01/11 and monthly thereafter. This monitoring includes rounds of the facility to observe medication preparation and administration, re-assessing of residents for pain relief after pain medication administration, and re-assessing of residents and monitoring of staff response for resident changes in status.

Signature: Date: February 2, 2011

F490

Criteria 4:

The DON/ADON, MDS Coordinators, Training Coordinator, Restorative Coordinator, Medical Records Nurse or 3-11 Supervisor will conduct reviews of narcotic medication packages, narcotic count sheets and administration logs for 2 carts daily X 2 weeks, weekly X 4 weeks, and then monthly thereafter to determine compliance with the revised facility medication policies and procedures.

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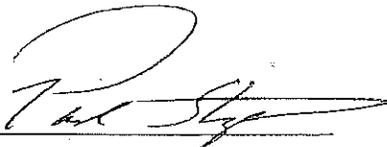
-The CQI indicator for auditing of the medication room/carts will be utilized on each of the 2 medication rooms and 2 med carts monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the completion of Med Pass observations was completed on all medication administration staff on 12/13/10, 12/14/10, and 12/15/10 to determine that all staff passed medications with less than a 5% error rate, as conducted by the DON, MDS Coordinators, 3-11 Supervisor, Restorative Coordinator, Training Coordinator, Unit Supervisors, Medical Records Nurse, and Nurse Consultant.

-The CQI indicator for auditing Notification of Change will be utilized on 5 medical records monthly X 2 months, and then quarterly as per the established CQI calendar under the supervision of the DON.

-The facility Corporate Compliance Officer will review allegations of abuse, neglect and misappropriation of resident property with the Administrator to determine that notification of all State agencies has been conducted and documentation is complete X 6 months and quarterly thereafter.

Signature:



Date: February 2, 2011