

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

PRINTED: 07/26/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

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07/14/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2012
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP+4 CODE 200 NORFOLK DRIVE SOMERSET, KY 42501
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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	F 000		
F 224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation, it was determined the facility failed to implement policies and procedures that prohibited misappropriation of resident property for one of eight sampled residents (Resident #8). The facility deliberately utilized Resident #8's medication for four days (eleven capsules) for administration to Resident #5 without Resident #8's consent.</p> <p>The findings include: A review of the facility's policy/procedure for prohibiting mistreatment, neglect, and abuse of residents (undated) revealed the facility prohibited misappropriation of resident property by anyone including staff. The facility defined misappropriation to include use of a resident's property without the resident's consent.</p>	F 224	<p>F224</p> <p>R8's medication has been replaced at no cost to the resident. The Medical Director was notified by the Director of Nursing (DON) on 7/14/12 that the medication was borrowed and replaced at no cost to the resident. No new orders were noted. Each licensed nurse that was identified was suspended and this incident was reported to the Office of Inspector General and the local police on 7/12/12 by the Administrator.</p> <p>The DON, the Education and Training Director(ETD), the Unit Managers (UM) and the Restorative Nurse will complete a one time audit by 8/21/12 of all residents Medication Administration Record (MAR) to ensure all medications listed are in the facility by comparing the MAR to the actual medication. Any issues identified will by corrected immediately. The Social Service Director (SSD) will interview all cognitive residents by 8/21/12 to identify any resident who might have missing items, or has any issues with staff care or treatment. Any issues that are identified will be immediately reported to the appropriate agencies.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gill Spurgeon</i>	TITLE <i>Adm.</i>	(X8) DATE <i>8/4/12</i>
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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.

Received Time Aug. 5. 2012 1:36PM No. 9918

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F 224	<p>Continued From page 1</p> <p>Observation of a medication administration pass on 07/13/12, at 10:15 AM, and review of a facility investigation dated 07/13/12, revealed facility nurses had deliberately used Resident #8's medication for administration to Resident #5 on four days, totaling eleven capsules.</p> <p>Interview with Resident #8 on 07/14/12, at 3:20 PM, revealed the facility at no time had ever asked or obtained the resident's consent to utilize his/her medication for any other facility resident.</p> <p>Interviews on 07/13/12, with Licensed Practical Nurse (LPN) #2 at 4:14 PM, and LPN #3 at 4:35 PM, revealed each of the nurses had used Resident #8's medication on four separate occasions from 07/09/12 to 07/12/12, to administer to Resident #5 without obtaining Resident #8's consent. The nurses stated during the interview they had never documented/informed Administration of the deliberate use of Resident #8's property for another resident, and had no intentions of replacing the medication or compensating Resident #8. Further interview with the nurses revealed both denied having knowledge of or being trained by the facility that "borrowing" medication from one resident for administration to another resident without consent would be considered misappropriation of the resident's property.</p> <p>Interview with the Director of Nursing (DON) and Regional Nurse Consultant on 07/13/12, at 2:00 PM, revealed individual resident medications were not to be utilized for any resident other than the resident the medication was prescribed for. The DON and Regional Nurse Consultant went</p>	F 224	<p>The ETD re-educated all licensed nurses regarding the policy and procedures that prohibit mistreatment, neglect and abuse of a resident, and misappropriation of resident property on 8/3/12. The SSD will interview 5 cognitive residents weekly x 4 weeks regarding abuse neglect or misappropriation of property, to include borrowing medication, starting 8/20/12</p> <p>The facility Quality Assurance Committee,(QA) consisting of at least the ADM, DON, ETD, UM, SSD, & Medical Director will meet at least monthly until all issues are resolved beginning the week of 8/20/12, to review audit findings and revise plan as needed.</p> <p>Date of Completion 8/24/12</p>	

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F 224	Continued From page 2 on to say that all staff had been trained that any use of resident property without the resident's consent would be considered misappropriation of property, which would include resident medications.	F 224		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based observations, interviews, record review, and facility policy review, it was determined the facility failed to follow physician's orders for one of eight sampled residents (Resident #2). Resident #2 had physician's orders to utilize no straws. However, observations on 07/13/12 revealed Resident #2 had a straw in his/her bedside water pitcher. The findings include: A review of the facility's written procedure (undated) for swallowing/aspiration precautions submitted by the Corporate Nurse on 07/13/12, revealed the facility had no specific policy in place, and each intervention would be resident specific and per physician's order. The facility readmitted Resident #2 on 06/22/12, after an acute hospital stay for pneumonia. A review of Resident #2's admitting physician's orders dated 06/22/12, revealed the resident was to receive a dysphagia level 3 diet (soft diet), and use no straws. Additionally, Resident #2's	F 281	F281 Resident #2 had no change in condition related to using a straw. The resident's physician as notified by the DON on 7/13/12 with no new orders. No other residents were identified. A one time audit of all physicians orders will be completed by 8/20/12 by the DON, UM, and ETD to identify any diet order that states "no straws", and to ensure all residents are receiving the correct diet, consistency, and assistive devices. Any issues identified will be immediately corrected. A one time audit of all CNA sheets and care plans will be completed by the DON, UM, and ETD by 8/15/12 to identify any areas of inconsistency to ensure correct assistive devices, diet consistencies, and correct diet is on the CNA sheets.	

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F 281	<p>Continued From page 3</p> <p>physician's orders dated July 2012 revealed the physician's order was continued for "no straws."</p> <p>A review of Resident #2's Minimum Data Set (MDS) assessment dated 07/05/12, revealed the facility had assessed Resident #2 to require assistance with eating, and the resident's Nursing Assistant Assignment Worksheet dated 07/13/12, revealed Resident #2 was to have "no straws."</p> <p>Observations of Resident #2 on 07/13/12, at 11:19 AM, 11:50 AM, 12:28 PM, 12:40 PM, and 12:57 PM, revealed the resident to be in bed with a straw in the bedside water pitcher. Interview with Resident #2 on 07/13/12, at 12:42 PM, revealed the resident always utilized a straw in the water pitcher, and had never been told by staff that the physician did not want him/her to use straws.</p> <p>Observations on 07/13/12, at 12:40 PM, revealed the Director of Nursing (DON) in Resident #2's room conversing with the resident regarding lunch, but failing to mention or acknowledge Resident #2 having a straw in the water pitcher. At 12:57 PM, Resident #2's lunch tray was delivered to the resident's room by Licensed Practical Nurse (LPN) #6, who was caring for the resident. LPN #6 was observed to provide tray setup assistance for Resident #2, including placing the water pitcher with the straw on the resident's food tray prior to exiting the room. LPN #6 failed to acknowledge the straw in the water pitcher. Observation of Resident #2's food tray revealed a dietary slip in full view stating "no straws."</p> <p>Interviews on 07/13/12, at 3:12 PM, with LPN #6,</p>	F 281	<p>The Regional Nurse Consultant (RNC) re-educated the ETD, UM, and DON on 8/3/12 regarding the policy regarding physician orders and following CNA sheets to ensure each resident is served the correct diets, correct consistency, and assistive devices.</p> <p>ETD to audit 5 trays weekly x 4 weeks to ensure that tray card reflects the correct diet, correct consistency, and assistive devices and that the care plan and CNA sheets are correct. The DON/UM will audit 10 residents weekly x 4 weeks to ensure that all care is provided per physician order.</p> <p>The facility QA committee will meet at least monthly until all issues are resolved, beginning 8/20/12, to review all audit findings and revise plan as needed.</p> <p>Date of completion: 8/24/12</p>		

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F 281	Continued From page 4 at 7:15 PM, with the DON, at 2:45 PM, with Certified Nursing Assistant (CNA) #6, and at 2:52 PM, with CNA #7 who both cared for Resident #2 on 07/13/12, revealed they all stated they were unaware that Resident #2 was not to utilize straws per physician's order. Although LPN #6 acknowledged she usually compared the tray card with what was on the resident's tray, which was system utilized by the facility to ensure each resident was receiving the correct diet, diet consistency, and assistive devices, LPN #6 stated she did not look at Resident #2's tray card when providing tray setup for the resident. CNAs #6 and #7 both reportedly "looked" at the CNA assignment sheet for Resident #2 on 07/13/12, but failed to "see" the entry for "no straws."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure services were provided in accordance with the resident's plan of care for one of eight sampled residents (Resident #6). On 07/13/12, facility staff failed to ensure Resident #6 was provided assistance with meals in accordance with the resident's plan of care. The findings include:	F 282	F282 Resident #6 was immediately fed by staff on 7/13/12 p.m. meal. R#6 has experienced no weight loss and the physician was notified of him not being fed immediately by staff. DON, UM, and ETD to audit at least 10 meals by 8/20/12 to identify any resident eating in the hallway, and any residents that	

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F 282	<p>Continued From page 5</p> <p>A review of the facility Plan of Care Policy (undated) revealed care was to be provided or arranged, consistent with each resident's care plan.</p> <p>A review of the medical record for Resident #6 revealed the facility admitted the resident on 09/21/04, and the resident has diagnoses that included Dementia and Cerebral Vascular Accident.</p> <p>A review of the comprehensive plan of care dated 03/09/12, revealed staff was to provide Resident #6 physical assistance during meals. The most recent quarterly Minimum Data Set (MDS) assessment completed on 05/31/12, for Resident #6 revealed the facility had assessed the resident to require extensive assistance of one person with eating. The MDS also revealed Resident #6 had limitations in range of motion in both upper extremities.</p> <p>Resident #6's Nursing Assistant Assignment Worksheet dated 07/13/12, revealed the resident was a "feed."</p> <p>Observation of Resident #6 on 07/13/12, at 6:15 PM, revealed the resident was sitting in the hallway in a geri-chair with a full tray attached, attempting to feed him/herself without staff assistance or without staff being present in any part of the hallway. Resident #6 was observed to be attempting to eat a hamburger by lifting it up to his/her mouth and attempting to bite the top of the bun without success. Ground meat was observed to fall from between the bun onto the tray during the resident's attempts to eat the hamburger. The observation revealed Resident</p>	F 282	<p>have been assessed as needing assistance with feeding are receiving assistance according to their plan of care. Any issue identified will be corrected immediately. DON, UM, and ETD will audit all care plans by 8/20/12 to identify if the CNA sheets and care plan both are consistent with the specific individual needs of the resident and are correct. Any issues identified will be corrected immediately.</p> <p>Regional Nurse Consultant re-educated the DON, UM, and ETD on 8/3/12 regarding ensuring all residents receive care according to their plan of care, including assistance with eating. The ETD will re-educate all nursing staff by 8/20/12 regarding ensuring all residents receive care according to their plan of care, including assistance with eating, 8/5/12. DON/UM will monitor 10 residents at meals at least weekly for 4 weeks to ensure residents' CNA sheet, tray card, and physician order is correct, diet consistency is correct, and any needed assistance with meals is correct according to the plan of care. Charge nurses will monitor each meal every day x 10 days, beginning 8/20/12, to ensure that residents are assisted per their plan of care and are not fed in the hallway.</p> <p>The Facility QA committee will meet at least monthly, beginning 8/20/12 until all issues are resolved, to review audit finding and revise plan as needed.</p> <p>Date of Completion: 8/24/12</p>		

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F 282	Continued From page 6 #6 was unable to effectively feed him/herself. An interview conducted on 07/14/12, at 2:40 PM, with Certified Nursing Assistant (CNA) #9 revealed she had been assigned to provide care/assistance for Resident #6 on 07/13/12, during the evening meal. The CNA stated a family member had requested the resident be seated in the hall to eat because the resident "choked," but also stated the family member wanted Resident #6 to feed him/herself. CNA #9 stated she was doing what Resident #6's family had requested by not assisting the resident to eat. CNA #9 stated it had been approved by all the "nurses," including the Director of Nursing (DON) for Resident #6 to sit in the hallway to eat and allow the resident to feed him/herself. CNA #9 stated she did not know why the resident's Nursing Assistant Assignment Sheet dated 07/13/12, still directed staff to "feed" the resident. Interview with the DON and Regional Nurse Consultant conducted on 07/14/12, at 1:45 PM, revealed the nursing assistant should have provided care in accordance with Resident #6's plan of care. The DON stated she was not aware staff was leaving Resident #6 out in the hallway for the evening meal and failing to provide the required meal assistance.	F 282			
F 309 SS=D	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 accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care for one of eight sampled residents (Resident #3). Resident #3's dietary tray card contained instructions for the resident to have no straws, however, staff failed to clarify or ensure the intervention was not applicable prior to providing the resident straws on 07/13/12. The findings include: Interviews with the facility's Regional Nurse Consultant and Director of Nursing (DON) on 07/13/12, at 7:15 PM, and 07/14/12, at 1:45 PM, revealed the facility had no specific written policy regarding staff utilizing dietary tray cards. However, they stated that the staff had been trained and was expected to compare the dietary tray card with what was on the resident's tray to ensure instructions on the tray card regarding dietary restrictions/interventions were being provided to the resident. The facility admitted Resident #3 on 05/05/06. A review of Resident #3's tray card on 07/13/12, revealed the resident was to have "no straws" and be provided a two-handed sippy cup. Observation of Resident #3 being assisted with the noon meal on 07/13 12, revealed staff placed	F 309	F309 Resident #3 had no Physician order for "no straws". Tray card was corrected on 7/14/12. Physician was notified with no new orders and resident R #3 continues to use straws. DON/UM/ETD and Dietary Manager to complete a one time audit by 8/20/12 of physician orders to verify correct diet consistency, correct assistive device, and correct diet is reflected on each tray card and nursing care plan and CNA sheet. Any issue identified will be corrected immediately. RNC re-educated DON, UM, ETD and Dietary Manager regarding following physician orders, maintaining tray card accuracy, and ensuring correct diet, consistency, and assistive devices to maintain the highest practicable physical well-being is followed. The ETD is to re-educate the nursing staff on following physician orders, maintaining tray card accuracy, ensuring correct diet, consistency, and the use of assistive devices to maintain the highest practicable level of well being. The Dietary Manager (DM) will audit 5 tray cards weekly x 4 weeks to ensure tray cards match the physician orders and those 5 residents are receiving correct diets, consistency, and assistive devices if ordered. The Facility QA committee will meet at least monthly, beginning 8/20/12 until all issues are resolved, to review audit finding and revise plan as needed.		

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F 309	<p>Continued From page 8</p> <p>a straw in the resident's fluids, and then assisted the resident to drink by positioning the straw to the resident's mouth to facilitate fluid intake. The observation further revealed Resident #3's dietary tray card to be in full view stating "no straws."</p> <p>An interview was conducted on 07/13/12, at 2:45 PM, with Certified Nursing Assistant (CNA) #7 who assisted Resident #3 with the noon meal on 07/13/12. CNA #7 stated he was aware the resident was not supposed to utilize straws, however, the resident's daughter had provided staff "a case" of straws to keep in the resident's closet, and instructed staff to use the straws when providing fluids to Resident #3. CNA #7 stated, "I don't pay any attention to the dietary tray card," continuing, "it comes out the same every day."</p> <p>Interview with the Dietary Manager (DM) on 07/13/12, at 5:30 PM, revealed she had been employed at the facility since 05/25/12, and had conducted no audit of the dietary tray cards to ensure all the cards were accurate and appropriate.</p> <p>Interviews with the DON and Regional Nurse Consultant conducted on 07/13/12, at 7:15 PM, and 07/14/12, at 1:45 PM, revealed staff was to utilize the dietary tray cards to ensure residents were receiving the proper diet, proper consistency, and assistive devices. The interviews revealed the facility was unaware of when the instruction for "no straws" was added to the resident's tray card, or if the intervention was still desirable. However, the DON and Regional Nurse Consultant stated the staff should not have provided the straw to Resident #3 before</p>	F 309			

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F 309 F 323 SS=D	Continued From page 9 clarifying if the tray card was accurate. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, it was determined the facility failed to provide adequate supervision to prevent accidents for one of eight sampled residents (Resident #7). Resident #7 was assessed to require a dysphagia level 1 diet (pureed consistency including bread); however, on 07/13/12, Resident #7 was unsupervised during the evening meal and removed the top portion of another resident's hamburger bun off the resident's food tray, stuffing the entire bun into his/her mouth prior to staff intervention. The findings include: Review of the Resident Supervision Procedure (undated) revealed the appropriate level of supervision to ensure an immediate and optimal level of safety would be provided to each resident. Residents were to be continually evaluated through assessment and observation of the resident's cognitive, behavioral, medical, or	F 309 F 323	F323 Resident #7 experienced no change of condition related to eating a portion of the "bun". Resident #7 is one on one during all meals and has been since 7/14/12. Physician was notified immediately on 7/13/12, by the DON and no new orders were noted. Resident #6 was fed by staff in his room at the dinner meal on 7/13/12 and that continues. Administrator will complete a one time audit of the environment by 8/20/12 to identify any environmental hazards. Any issues will be immediately corrected. DON/UM/ETD will complete a one time record review by 8/20/12 to identify if adequate supervision is being provided, if assistance level is adequate and if Care plans and CNA sheets reflect the appropriate amount of supervision. Any issues will be corrected immediately. The UM and ETD will audit 10 meals by 8/20/12 to identify any resident that may require more supervision with meals. Any issues identified will be addressed immediately and corrected. The facility ETD will re-educate all nursing		

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F 323	<p>Continued From page 10 other conditions that placed the resident at risk to self and others.</p> <p>The facility admitted Resident #7 on 02/27/86. Resident #7's diagnoses include Profound Mental Retardation, Seizure Disorder, and Esophageal Strictures (narrowing of the swallowing tube).</p> <p>Review of the medical record for Resident #7 revealed staff had assessed the resident to have chewing and swallowing difficulties and to exhibit behaviors including grabbing food. On 02/24/12, Daily Clinical Review documentation revealed Resident #7 was continually ambulating to the dining room because the resident "knew there was bread being served." The entry further explained Resident #7 "wants bread but cannot safely eat it" Resident #1 was to be redirected away from the dining room "for [his/her] safety." Review of Resident #1's annual Minimum Data Set (MDS) dated 04/20/12, revealed Resident #7 required the extensive assistance of one staff person with eating. Interventions listed on Resident #7's Comprehensive Care Plan for mood/behavioral symptoms dated 06/25/12, revealed staff would assess Resident #7's needs and redirect as needed.</p> <p>An observation on 07/13/12, at 6:15 PM, revealed Resident #7 was seated in the hallway without staff supervision. Resident #6 was also observed seated in the hallway (one door away), in a geri-chair with a tray attached, eating his/her evening meal. Resident #7 was observed to get up from the chair, go toward Resident #6, look intently at the food tray, and then "quickly grab" the top portion of Resident #6's hamburger bun from the meal tray and force the entire bun into</p>	F 323	<p>staff by 8/20/12 regarding ensuring that each resident's environment remains free of hazards, as is possible, and each resident receives adequate supervision and assistance to prevent accidents. The facility Interdisciplinary Team consisting of the Adm. DON, Life Enrichment Coordinator Social Service Director and the Unit Managers, will evaluate at least 5 records weekly beginning 8/20/12 x 4 weeks to ensure appropriate supervision and if the CNA sheets are correct according to the resident individual needs. Any issues identified will be immediately addressed and corrected. All Department Managers will audit 5 meals weekly x 4 weeks beginning 8/20/12 to ensure each resident is being adequately supervised, is receiving the correct diet, consistency, and adequate supervision and assistance with intake per their Plan of care.</p> <p>The Facility QA committee will meet at least monthly, beginning 8/20/12 until all issues are resolved, to review audit finding and revise plan as needed.</p> <p>Date of Completion: 8/24/12</p>	
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F-323	<p>Continued From page 11 his/her (Resident 7's) mouth.</p> <p>Interview with Certified Nursing Assistant (CNA) #12 on 07/13/12, at 6:20 PM, revealed she had been on the other unit serving as the "hall monitor" and was unable to reach Resident #7 in time to prevent the resident from "grabbing" the bread and "stuffing" it into his/her mouth. CNA #12 stated, "I knew [Resident #7] was going to do that, but I couldn't get to [the resident] in time." CNA #12 stated Resident #7 "loved bread" and tries to "steal it." Although CNA #12 was functioning as the hall monitor, she stated she had been provided no special instructions regarding Resident #7's supervision during meals stating, "We just try to watch [Resident #7]."</p> <p>An interview conducted on 07/14/12, at 2:40 PM, with CNA #9 who was caring for Resident #7 on 07/13/12, revealed Resident #7 "loves bread" and has to be frequently redirected from the kitchen due to trying to "snatch" bread. CNA #9 stated the resident was not required to have any special supervision to her knowledge stating, "We just try to redirect [Resident #7] when we see [him/her]."</p> <p>Interviews with the Director of Nursing (DON) and Regional Nurse Consultant conducted on 07/13/12, at 7:15 PM, and 07/14/12, at 1:45 PM, revealed the DON was aware that Resident #7 "loved bread" and tried to "steal it." The DON further stated, "We know [Resident #7] can't go to the dining room, because he steals bread and shoves it in." However, according to the DON, Resident #7 had been provided no increased level of supervision during meals to ensure the resident's safety stating, "We have to watch him as best we can."</p>	F 323			

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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>The facility must employ or obtain the services of 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, record review, and review of facility policy, it was determined the facility failed to provide pharmaceutical services to meet the needs of one of eight sampled residents. Resident #5 had a physician's order to receive Micro Potassium 10 milliequivalents (meq) three times daily; however, the medication was not available for administration on 07/13/12. The physician's order for the medication was received for Resident #5 on 07/09/12. However, according to the pharmacy, the facility failed to provide the pharmacy with the order for the</p>	F 425	<p>F425</p> <p>Resident #5 received Micro Potassium 10 megs from the Pharmacy on 7/13/12. R#5's physician was notified by the DON on 7/13/12, that Micro Potassium 10 megs was not delivered on 7/9/12 when ordered with no new orders noted. The facility Medical Director was made aware on 7/13/12 that the Micro Potassium 10 megs was not received from the pharmacy on 7/9/12 when ordered, with no new orders received.</p> <p>The facility DON, UM, ETD, and/or the Restorative Nurse will complete a one time audit by 8/20/12 of all residents Medication Administration Records (MAR's) to ensure all medications listed are in the facility by comparing the MAR to the actual medication. Any issues identified will by corrected immediately.</p> <p>The facility ETD will re-educate all licensed nurses by 8/20/12 regarding calling pharmacy and verbally notifying pharmacy of new orders via phone and stating when it</p>	

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F 425	<p>Continued From page 13 . medication; therefore, the medication had never been supplied to Resident #5.</p> <p>The findings include:</p> <p>A review of the facility's Pharmacy Services and Procedures Manual (dated May 2010) revealed all new orders for non-controlled substances needed before the next scheduled delivery were to be verbally communicated to the pharmacy pharmacist via phone stating the exact time by which the medication was needed. The pharmacist was to be asked to read the order back to assure accuracy, and the telephone order was to be confirmed by sending a faxed copy to the pharmacy.</p> <p>Observation of medication administration on 07/13/12, at 10:15 AM, revealed Registered Nurse (RN) #1 was unable to administer Resident #5's Micro Potassium 10 meq as ordered by the physician because the medication was not available for administration. A review of Resident #5's Medication Administration Record and physician's orders revealed the medication had been ordered on 07/09/12, at 6:45 AM, by Resident #5's physician.</p> <p>An interview on 07/13/12, at 3:45 PM, with the pharmacist revealed the facility had failed to notify the pharmacy of the physician's order for Micro Potassium until 07/13/12, at approximately 11:00 AM. The pharmacist was able to confirm that no telephone call had been made to the pharmacy and no faxed order had been sent to the pharmacy regarding Micro Potassium for Resident #5 prior to 07/13/12.</p>	F 425	<p>is needed, faxing new orders and the verifying pharmacy received the fax. Unit Managers will verify via phone that pharmacy was notified of all medication orders and that medication is delivered within 48 hours of orders for 60 , beginning 7/14/12. Any medication not called or sent to pharmacy by the charge nurse will result in a one on one re-education by the UM.</p> <p>The Facility QA committee will meet at least monthly, beginning 8/20/12 until all issues are resolved, to review audit finding and revise plan as needed.</p> <p>Date of Completion: 8/24/12</p>		

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F 425	<p>Continued From page 14</p> <p>In interview on 07/13/12, at 5:50 PM, Licensed Practical Nurse (LPN) #13, who wrote the order on 07/09/12, stated she faxed the order to the pharmacy on 07/09/12, but "did not have time" to wait for a confirmation that the fax was successfully transmitted. LPN #13 stated she did not call the pharmacy per the facility policy/procedure stating, "I faxed it like I was supposed to," denying having any other responsibility to ensure the medication would be supplied to Resident #5.</p> <p>A review of Resident #5's Medication Administration Record (MAR) from 07/09/12, at 8:00 AM through 07/12/12, at 8:00 PM, revealed staff had signed each scheduled dose (11 doses) of the Micro Potassium 10 meq medication indicating the medication had been administered to Resident #5 as ordered. Interviews with LPN #2 on 07/13/12, at 4:14 PM, and LPN #3 on 07/13/12, at 4:35 PM, who documented Resident #5's Micro Potassium was administered from 07/09/12 thru 07/12/12, revealed the staff had "borrowed" the medication from another facility resident and administered it to Resident #5.</p> <p>Interviews with the Director of Nursing (DON) and Regional Nurse Consultant conducted on 07/13/12, at 7:15 PM, and 07/14/12, at 1:45 PM, revealed when reviewing a resident's MARS, if a medication was initiated that it had been administered, then it had always been assumed the medication being administered had been obtained per facility protocol from the pharmacy. The DON and Regional Nurse Consultant stated the facility had no other system in place to ensure new medications ordered for a resident were obtained from the pharmacy.</p>	F 425			

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