

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

L-NO. 1040100 P. 4/1/200
PRINTED: 08/26/2011
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 226	<p>Continued From page 1</p> <p>the Protection Procedures revealed, in order to protect the residents, an employee involved in an abuse investigation would be suspended until the investigation process was completed and corrective action would be taken to protect the alleged victim and any potential victims.</p> <p>Record review revealed the facility admitted Resident #2 on 06/14/11 with diagnoses which included Diabetes, Calcaneus Fracture, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Anxiety, Neuropathy and Peripheral Vascular Disease.</p> <p>Review of the Nurses Notes revealed, on 07/03/11 at 3:00, Resident #2 accused Registered Nurse (RN) #1 of taking another resident's medication. It was alleged the resident saw the nurse take the medication during Medication Pass on 07/03/11. The nurse notified the House Supervisor (RN #2) of the allegation.</p> <p>Interview, on 08/25/11 at 8:25 PM, with RN #1 revealed the resident accused her of taking another resident's medications, on 07/03/11, and the nurse reported the accusation to the House Supervisor.</p> <p>Interview, on 08/25/11 at 10:40 AM, with the House Supervisor revealed the nurse reported the resident had accused her of taking another resident's medication. He stated he went to see the resident to assure him/her that that they were safe, no one was out to get him/her. Further interview revealed the House Supervisor did not remove RN #1 from the floor, he did not think the allegation was true, and the resident was not in danger at that moment. He stated the nurse did</p>	F 226	<p>Policies and Procedures, including Misappropriation of Property. A reminder notification was placed in the Nurse Supervisor's book to immediately call Administrator, Director of Nursing, and/or Social Services any time an allegation or suspected abuse, neglect, or misappropriation of property was reported. Staff was educated according to the facility's policies and procedures that dictates that any employee named in an allegation of abuse/neglect is to be suspended immediately pending the completion of an investigation.</p> <p><i>Monitoring</i> The Administrator, Director of Nursing, and Social Services Director will review all abuse investigations and will ensure policy and procedure compliance for the next six (6) months and as needed thereafter. Post-testing of employees will be completed following the in-services to all employees and all results of the post testing will be referred to the Quality Assurance (QA) committee for recommendations and follow-up.</p>	9-30-11
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F 226	Continued From page 2 not appear to be inebriated and he did not feel there was a need to test the nurse for drugs. He stated he could not remember if he reported the incident to anyone. Interview, on 08/25/11 at 5:50 PM, with the Director of Nursing (DON) revealed when she came to work on 07/05/11 she was told the resident was confused and was sent to the hospital. She stated RN #1 was not suspended or tested for drugs. Further interview revealed if she had felt like the allegation was true she would have taken the nurse to be tested. She stated there was no documentation that the facility followed the policy. Interview, on 08/25/11 at 4:00 PM, with the Administrator revealed she was unaware when the facility became aware of the incident, she was not the Administrator at that time. She stated the facility should always follow their policies. Interview, on 08/26/11 at 6:15 PM, with the Administrator revealed RN #1 should have been suspended until the investigation was completed.	F 226		
F 333 SS=D	489.26(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Medication Administration General Guidelines Policy it was determined the facility failed to ensure residents were free of any	F 333	<u>F 333 (D) Residents Free of Significant Med Errors</u> <i>Targeted Residents</i> Resident #2 is no longer a resident of the facility. The licensed nurse involved in this allegation was counseled regarding ensuring that she has a current physician order prior to administering medication on 9-4-11 by the Director of Nursing. <i>Identification of Other Residents</i> The Quality Assurance (QA) nurse compared the physician orders to the Medication Administration Record (MAR) of all facility residents to ensure that	

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F 333	<p>Continued From page 3</p> <p>significant medication errors, for one (1) of six (6) sampled residents, (Resident #2). Review of the Medication Administration Record (MAR) revealed documentation that Lortab 5/325 mg was administered, on 08/27/11 at 3:00 AM, to Resident #2 without a Physician's Order.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #2 on 08/14/11 with diagnoses which included Diabetes, Calcaneus Fracture, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Anxiety, Neuropathy and Peripheral Vascular Disease.</p> <p>Review of the facility's Medication Administration General Guidelines Policy, undated, revealed medications were to be administered in accordance with written orders of the attending Physician.</p> <p>Review of the June 2011 Physician's Orders revealed an order, dated 08/23/11, to change Lortab 10/325 mg to every 6 hours scheduled. Review of the June 2011 MAR for Resident #2 revealed Lortab 10/325 mg every 6 hours was added and Lortab 10/325 mg every 6 hours as needed (PRN) was discontinued on 08/23/11. Further review of the MAR revealed the Lortab 10/325 mg was to be given at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM.</p> <p>Review of the June 2011 Pain Assessment Observation Profile Form and the June 2011 MAR for Resident #2 revealed Lortab 5/325 mg was given to Resident #2 on 08/27/11 at 3:00 AM.</p>	F 333	<p>medications were administered per the physician orders on 8-30-11. No further issues were identified in this area; therefore, no further corrective action was necessary at this time.</p> <p><i>Systemic Changes</i> Staff Development Coordinator in-serviced all licensed nurses on 9-8-11 of the facility's policies and ensuring a physician order is present prior to administration of all medications. The Quality Assurance (QA) nurse conducts daily audits (Monday through Friday) to compare physician orders to the MAR.</p> <p><i>Monitoring</i> The audits (comparing physician orders to the MAR) completed by the Quality Assurance (QA) nurse will be reviewed by the Quality Assurance (QA) committee that meets monthly for recommendations and follow-up.</p>	9-30-11

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F 333	<p>Continued From page 4</p> <p>Interview, on 08/26/11 at 4:15 PM, with the Director of Nursing (DON) revealed the Lortab was to be given at the time on the MAR, as per the Physician's Orders. She stated if the Lortab was given at 3:00 AM it would be a medication error.</p> <p>Interview, on 08/26/11 at 5:30 PM, with the Administrator revealed if the Physician's Order was not followed it was a medication error.</p>	F 333		