

8/10/15  
ER

### SURVEYOR NOTES WORKSHEET

Facility Name: Madonna Manor

Surveyor Name: Marlene Abner, RN/NCI

Provider Number: 185241

Surveyor Number: 29137 Discipline: NSG

Observation Dates: From 08/10/15 To \_\_\_\_\_

| TAG/CONCERNS  | DOCUMENTATION  |
|---|--|
|   | Complaint Investigative Plan KY # 23655 A  |
| Allegations Category: staff to resident abuse   |  |
| Reg Tag:  |  |
| History of deficiencies R/T allegation:<br>(detail dates, reg, s/s if applicable)                 |  |
| Last survey highest s/s:  |  |
| Is the facility currently in compliance: Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| If no, detail tags out of compliance:   |  |
| Contacts Made: (Name, Date, Time)   |  |
| Complainant   | facility   |
| Ombudsman   | Bethany Breckel, 08/10/15, via e-mail, 2:19 PM   |
| DCBS  | NBSR.CI@ky.gov, 2:20 PM  |
| Other   |  |
| Observations to make pertinent to allegation: (detail partial tour)                               | staff to resident interactions<br><i>Staff re-directing Residents</i>  |
| Interviews to Get: (Name, Title, detail order & who may validate allegation)                      | all dayshift/evening shift staff to include nurses that worked 07/28/15 at change of shift on alleged victim's unit<br>maintenance men on unit at the time (2)<br>Admin, <i>Unit mgrs, DOW</i> |



8-10-15  
ER

### SURVEYOR NOTES WORKSHEET

Facility Name: Madonna Manor Surveyor Name: Marlene Abner, RN/NCI  
Provider Number: 185241 Surveyor Number: 29137 Discipline: NSG  
Observation Dates: From 08/10/15 To \_\_\_\_\_

| TAG/CONCERNS | DOCUMENTATION |
|--------------|---------------|
|--------------|---------------|

Complaint Investigative Plan KY # 23655 B

Allegations Category: improperly administered medication

Reg Tag: \_\_\_\_\_

History of deficiencies R/T allegation: \_\_\_\_\_

(detail dates, reg, s/s if applicable)

Last survey highest s/s: \_\_\_\_\_

Is the facility currently in compliance: Yes  No

If no, detail tags out of compliance: \_\_\_\_\_

Contacts Made: (Name, Date, Time)

Complainant facility

Ombudsman Bethany Breckel, 08/10/15, via e-mail, 2:19 PM

DCBS NBSR.CI@ky.gov, 2:20 PM

Other \_\_\_\_\_

Observations to make pertinent to allegation: (detail partial tour)

med pass

Interviews to Get: (Name, Title, detail order & who may validate allegation)

all dayshift staff to include nurses that worked 07/28/15 at change of shift on alleged victim's unit

Admin | Unit Manager, Dow  
licensed nurses



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

PRINTED: 10/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185241</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R-C</b><br><b>10/26/2015</b> |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD</b><br><b>VILLA HILLS, KY 41017</b> |
|--|---|

| (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 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the deficient practiced was deemed to be corrected on 10/23/15 as alleged.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE **10/13/2015**

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.

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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |
|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                  | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015   |
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |   |
| (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) |

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating complaint KY00023655 was initiated on 08/10/15 and concluded on 08/13/15. KY00023655 was substantiated with a related deficiency at a highest Scope and Severity of a "D".

F 425 483.60(a),(b) PHARMACEUTICAL SVC - SS=D 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 a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a nurse administered medications for one (1) of four (4) sampled residents (Resident #1).

F 000

The completion and submission of this plan of correction does not constitute that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law. The facility alleges compliance as of 10/23/2015.

F 425

F-425 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 a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

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

TITLE

(X6) DATE

*[Signature]* Executive Director 10/13/15

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.

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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |
|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                   | X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |   |
| 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 425 Continued From page 1

F 425

The findings include:

Review of the facility's policy titled, "General Dose Preparation and Medication Administration, revised December 2014, revealed medications were administered by a nurse. Continued review revealed medications were administered and monitored on an individual basis and records were to be adequately maintained. Further review revealed the nurse was to observe the resident consuming the medication and document the administration.

Review of the Registered Nurse (RN)/Licensed Practical Nurse (LPN) job description, undated, revealed it was the nurse's duty and responsibility to ensure all medications were administered and properly documented.

Review of the facility's "Nursing-Aide" job description, undated, revealed no documented evidence a "Nursing-Aide" was to administer resident's medications.

Review of Resident #1's medical record revealed the facility admitted him/her on 07/27/13, with diagnoses which included Alzheimer's Disease, Senile Dementia, Depression and other Symbolic Dysfunction. Review of the Quarterly Minimum Data Set (MDS) Assessments dated 05/27/15 and 08/10/15, revealed the facility assessed Resident #1 as moderately to severely cognitively impaired, indicating the resident was not interviewable. Review of the Physician's Orders revealed Resident #1 had an order for PRN (as necessary) Ativan (an anti-anxiety medication) ordered.

Surveyors Allegation: The requirement is not met as evidenced by the facility failed to ensure a nurse administered medications for one (1) of four (4) samples residents (Resident #1).

1. The alleged noncompliance was corrected for the resident affected by the deficient practice by educating the nurse and STNA directly involved in the noncompliance. The nurse and STNA were educated on the job descriptions and scope of practice respectively and included direction that medication administration is by nurses only.

Resident #1 experienced no adverse outcome per nurse assessment. The physician and POA were notified of the incident. No changes in the resident plan of care were indicated.

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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |
|---|---|

|                    |  |               |   |                      |
|--------------------|--|---------------|---|----------------------|
| (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 425 Continued From page 2

F 425

Interview with LPN #1 on 08/12/15 at 5:13 PM, revealed she was coming into work on the evening shift on 07/28/15, and noticed the unit was very "chaotic" due to the fire alarm having been engaged. Per interview, Resident #1 was holding the bar on the unit door down which had engaged the alarm. She stated in addition, a State Registered Nursing Assistant (SRNA) was being loud and disruptive. LPN #1 stated she clocked in for work and started getting report from the day shift nurse. Continued interview revealed she had gone to the medication cart to get Resident #1's PRN Ativan to crush and mixed the medication in ice cream. After obtaining Resident #1's PRN Ativan she observed another resident was about to fall. According to LPN #1, as she was closest to the other resident she responded and while doing so, SRNA #1 "grabbed" the ice cream with Resident #1's PRN Ativan in it out of her hand and gave the medicated ice cream to Resident #1. Further interview revealed she knew it was wrong for SRNA #1 to have administered the ice cream with Resident #1's PRN Ativan in it and had never done anything like that before. LPN #1 revealed however, as the nurse she should have stopped SRNA #1 from giving the medicated ice cream to Resident #1.

2. The facility will identify other residents/ patients having the potential to be affected by the same deficient practice by observing medication administration practice of the consistently assigned nurses on the same unit to ensure only nurses administer medications to a resident.
3. The facility will ensure that the deficient practice does not recur by conducting in-service training to all nurses and STNA and Certified Medication Technicians regarding job descriptions, and scope of practice with medication administration. The facility does not use Agency Staffing. The Director of Nursing and the Assistant Director of Nursing will oversee the in-servicing, which began 09/03/2015.

Interview with SRNA #1 on 08/13/15 at 10:45 AM, revealed she knew giving medications to residents was outside her scope of practice. She stated Resident #1's behaviors had become increasingly agitated by 3:00 PM, at shift change on 07/28/15. Per interview, Resident #1's agitation had increased to the point that re-direction with food, drink or an activity was no longer effective and the resident was requiring interventions such as one on one (1:1)

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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |
|---|---|

| (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 425 Continued From page 3 F 425

interactions of walking outside. SRNA #1 reported when outside though Resident #1 tried to get into cars and "go home" which staff could not allow and this increased his/her agitation also. Continued interview revealed the evening shift nurse was counting narcotics with the day shift nurse and asked SRNA #1 to get an ice cream to put something for Resident #1's agitation in as the least restrictive interventions had failed. She stated LPN #1 did crush Resident #1's Ativan and mix it in the ice cream, then sat the ice cream container on the medication cart while she continued to count narcotics with the day shift nurse. Per SRNA #1, it was at that point she became frustrated with the day shift and evening shift nurses and took the ice cream with the crushed Ativan medication in it and gave the ice cream to Resident #1. Further interview revealed she knew she wasn't supposed to give Resident #1's medicine, but felt if the nurses had intervened sooner, instead of giving report and counting drugs, the outcome might have been different.

Interviews on 08/13/15 at 1:17 PM with SRNA #2, at 1:26 PM with SRNA #3, at 1:47 PM with SRNA #4 and at 3:27 PM with SRNA #5 revealed they were all aware giving medication was outside their scope of practice and was not allowed per facility policy.

Interview with RN #1 revealed she was aware SRNA's were not allowed to pass medications because it was outside their scope of practice and she had never asked a SRNA to do so. She further stated she did not have any direct knowledge of the alleged incident involving Resident #1, LPN #1 and SRNA #1.

4. The facility plans to monitor its performance to ensure the solutions are sustained by conducting medication pass observations of two nurses per week for four weeks, then one nurse per week for four weeks, then two nurses per four weeks, then monitor at the direction of the Director of Nursing thereafter. The medication pass observations will be conducted by the Director of Nursing and the nursing management team as delegated. The results of the monitoring will be discussed as part of the Quality Management program ongoing.

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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |
|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185241   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                  | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015   |
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |   |
| (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 425 | Continued From page 4<br>Interview with the Human Resources (HR) Director on 08/13/15 at 3:39 PM, revealed SRNA's could not administer medication and all the involved staff had received re-education on their scopes of practice.<br><br>Interview on 08/13/15, with the Assistant Director of Nursing (ADON) at 4:12 PM and the Administrator at 4:20 PM, revealed they both confirmed the staff involved in the alleged medication incident were re-educated on their scopes of practice and had been disciplined. | F 425 |  |
|-------|--|-------|--|

Office of Inspector General

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>100268</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R-C</b><br><b>10/26/2015</b> |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD</b><br><b>VILLA HILLS, KY 41017</b> |
|--|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

{N 000} INITIAL COMMENTS

{N 000}

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the deficient practiced was deemed to be corrected on 10/23/15 as alleged.

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

TITLE

(X6) DATE

10/13/15

Office of Inspector General

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100268 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

NAME OF PROVIDER OR SUPPLIER  
**MADONNA MANOR**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2344 AMSTERDAM ROAD  
VILLA HILLS, KY 41017**

|                    |  |               |   |                    |
|--------------------|--|---------------|---|--------------------|
| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|

N 000 INITIAL COMMENTS

N 000

A Complaint Survey investigating complaint KY00023655 was initiated on 08/10/15 and concluded on 08/13/15. KY00023655 was substantiated with a related deficiency.

The completion and submission of this plan of correction does not constitute that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law. The facility alleges compliance as of 10/23/2015.

N 307 902 KAR 20:300-14(1)(b) Section 14. Pharmacy Services

N 307

(1) Procedures.  
(b) Administration of medications. All medications shall be administered by licensed medical or nursing personnel in accordance with the Medical Practice Act (KRS 311.530 to 311.620) and Nurse Practice Act (KRS Chapter 314) or by personnel who have completed a state approved training program from a state approved provider. The administration of oral and topical medicines by certified medicine technicians shall be under the supervision of licensed medical or nursing personnel. Intramuscular injections shall be administered by a licensed or registered nurse, or a physician. If intravenous injections are necessary they shall be administered by a licensed physician, registered nurse, or properly trained licensed practical nurse. Each dose administered shall be recorded in the medical record.

F-425 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.

This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a nurse administered medications for one (1) of four (4) sampled residents (Resident #1).

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 findings include:

Review of the facility's policy titled, "General Dose

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.

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

TITLE

(X6) DATE

STATE FORM

0099

ULMF11

If continuation sheet 1 of 5

*[Handwritten Signature]*

*Executive Director*

*10/13/15*

Office of Inspector General

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100268 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>VILLA HILLS, KY 41017</b> |
|--|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

N 307 Continued From page 1

N 307

Preparation and Medication Administration, revised December 2014, revealed medications were administered by a nurse. Continued review revealed medications were administered and monitored on an individual basis and records were to be adequately maintained. Further review revealed the nurse was to observe the resident consuming the medication and document the administration.

Review of the Registered Nurse (RN)/Licensed Practical Nurse (LPN) job description, undated, revealed it was the nurse's duty and responsibility to ensure all medications were administered and properly documented.

Review of the facility's "Nursing-Aide" job description, undated, revealed no documented evidence a "Nursing-Aide" was to administer resident's medications.

Review of Resident #1's medical record revealed the facility admitted him/her on 07/27/13, with diagnoses which included Alzheimer's Disease, Senile Dementia, Depression and other Symbolic Dysfunction. Review of the Quarterly Minimum Data Set (MDS) Assessments dated 05/27/15 and 08/10/15, revealed the facility assessed Resident #1 as moderately to severely cognitively impaired, indicating the resident was not interviewable. Review of the Physician's Orders revealed Resident #1 had an order for PRN (as necessary) Ativan (an anti-anxiety medication) ordered.

Interview with LPN #1 on 08/12/15 at 5:13 PM, revealed she was coming into work on the evening shift on 07/28/15, and noticed the unit was very "chaotic" due to the fire alarm having been engaged. Per interview, Resident #1 was

Surveyors Allegation: The requirement is not met as evidenced by the facility failed to ensure a nurse administered medications for one (1) of four (4) samples residents (Resident #1).

1. The alleged noncompliance was corrected for the resident affected by the deficient practice by educating the nurse and STNA directly involved in the noncompliance. The nurse and STNA were educated on the job descriptions and scope of practice respectively and included direction that medication administration is by nurses only.

Resident #1 experienced no adverse outcome per nurse assessment. The physician and POA were notified of the incident. No changes in the resident plan of care were indicated.

Office of Inspector General

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100268 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADONNA MANOR</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2344 AMSTERDAM ROAD<br/>VILLA HILLS, KY 41017</b> |
|--|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

N 307 Continued From page 2

N 307

holding the bar on the unit door down which had engaged the alarm. She stated in addition, a State Registered Nursing Assistant (SRNA) was being loud and disruptive. LPN #1 stated she clocked in for work and started getting report from the day shift nurse. Continued interview revealed she had gone to the medication cart to get Resident #1's PRN Ativan to crush and mixed the medication in ice cream. After obtaining Resident #1's PRN Ativan she observed another resident was about to fall. According to LPN #1, as she was closest to the other resident she responded and while doing so, SRNA #1 "grabbed" the ice cream with Resident #1's PRN Ativan in it out of her hand and gave the medicated ice cream to Resident #1. Further interview revealed she knew it was wrong for SRNA #1 to have administered the ice cream with Resident #1's PRN Ativan in it and had never done anything like that before. LPN #1 revealed however, as the nurse she should have stopped SRNA #1 from giving the medicated ice cream to Resident #1.

Interview with SRNA #1 on 08/13/15 at 10:45 AM, revealed she knew giving medications to residents was outside her scope of practice. She stated Resident #1's behaviors had become increasingly agitated by 3:00 PM, at shift change on 07/28/15. Per interview, Resident #1's agitation had increased to the point that re-direction with food, drink or an activity was no longer effective and the resident was requiring interventions such as one on one (1:1) interactions of walking outside. SRNA #1 reported when outside though Resident #1 tried to get into cars and "go home" which staff could not allow and this increased his/her agitation also. Continued interview revealed the evening shift nurse was counting narcotics with the day shift

2. The facility will identify other residents/patients having the potential to be affected by the same deficient practice by observing medication administration practice of the consistently assigned nurses on the same unit to ensure only nurses administer medications to a resident.
3. The facility will ensure that the deficient practice does not recur by conducting in-service training to all nurses and STNA and Certified Medication Technicians regarding job descriptions, and scope of practice with medication administration. The facility does not use Agency Staffing. The Director of Nursing and the Assistant Director of Nursing will oversee the in-servicing, which began 09/03/2015.

Office of Inspector General

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100268 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |
|---|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

N 307 Continued From page 3

N 307

nurse and asked SRNA #1 to get an ice cream to put something for Resident #1's agitation in as the least restrictive interventions had failed. She stated LPN #1 did crush Resident #1's Ativan and mix it in the ice cream, then sat the ice cream container on the medication cart while she continued to count narcotics with the day shift nurse. Per SRNA #1, it was at that point she became frustrated with the day shift and evening shift nurses and took the ice cream with the crushed Ativan medication in it and gave the ice cream to Resident #1. Further interview revealed she knew she wasn't supposed to give Resident #1's medicine, but felt if the nurses had intervened sooner, instead of giving report and counting drugs, the outcome might have been different.

Interviews on 08/13/15 at 1:17 PM with SRNA #2, at 1:26 PM with SRNA #3, at 1:47 PM with SRNA #4 and at 3:27 PM with SRNA #5 revealed they were all aware giving medication was outside their scope of practice and was not allowed per facility policy.

Interview with RN #1 revealed she was aware SRNA's were not allowed to pass medications because it was outside their scope of practice and she had never asked a SRNA to do so. She further stated she did not have any direct knowledge of the alleged incident involving Resident #1, LPN #1 and SRNA #1.

Interview with the Human Resources (HR) Director on 08/13/15 at 3:39 PM, revealed SRNA's could not administer medication and all the involved staff had received re-education on their scopes of practice.

Interview on 08/13/15, with the Assistant Director

- The facility plans to monitor its performance to ensure the solutions are sustained by conducting medication pass observations of two nurses per week for four weeks, then one nurse per week for four weeks, then two nurses per four weeks, then monitor at the direction of the Director of Nursing thereafter. The medication pass observations will be conducted by the Director of Nursing and the nursing management team as delegated. The results of the monitoring will be discussed as part of the Quality Management program ongoing.

Office of Inspector General

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>100268 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>08/13/2015 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MADONNA MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2344 AMSTERDAM ROAD<br>VILLA HILLS, KY 41017 |
|---|---|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

N 307 Continued From page 4  
of Nursing (ADON) at 4:12 PM and the Administrator at 4:20 PM, revealed they both confirmed the staff involved in the alleged medication incident were re-educated on their scopes of practice and had been disciplined.

N 307