

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

*Acceptable
POC
10/21/14*

PRINTED: 10/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2014
NAME OF PROVIDER OR SUPPLIER ELLIOTT NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE RT 32 EAST, HOWARD CREEK RD SANDY HOOK, KY 41171	

(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

An Abbreviated Survey investigating KY00022199 was initiated on 09/16/14 and concluded on 09/18/14. KY00022199 was substantiated with deficiencies cited with the highest Scope and Severity of a "D".

F 157 SS=D 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 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).

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.

The facility must record and periodically update the address and phone number of the resident's

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Elliott Nursing or Rehabilitation Center strives to ensure that the resident's physician, and if known, the resident's legal representative is notified of any 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 psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.

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The medication for resident #3 was delivered by pharmacy on 9/3/2014 and administered on 9/3/2014. The DON spoke with the resident regarding the medications on 9/3/2014. She detected no adverse reaction to the incident that occurred on 9/2/2014. The LPN charge nurse conducted an assessment of resident #3 on 9/6/2014. No changes were identified from the previous assessment. The physician had no additional orders for resident #3 on 9/18/2014 when she was notified of the medication omission. The DON will review the Medical Record Administration sheets for each current resident for the last 30 days no later than 10/15/2014 to ensure that medications have been provided as directed by the physician. Any omission will be relayed to the physician for follow up. All licensed staff and CMT's received additional education by the DON on 9/24/2014 regarding the importance of notifying the physician when a change in condition occurs. This included notification regarding omission of resident medications or treatments.

The Health Information Management Coordinator will perform MAR audits each week for 12 weeks to ensure that medications are being administered as ordered by the physician. Any omissions will be reported to the DON or RN Supervisor for further investigation. The findings will also be shared with the physician. Additionally, the RN Supervisor will complete a weekly medication cart audit for at least 12 weeks to ensure that all medications ordered by the MD are present in the cart and that an ample supply remains in the cart for the following week. The RN Supervisor will ensure that meds are re-ordered in a timely manner if the supply is

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alan Reeves</i>	TITLE <i>administrator in training</i>	(X6) DATE <i>10/20/14</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.

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F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>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 the Physician was notified for one (1) of three (3) sampled residents (Resident #3) when the resident missed three (3) scheduled doses of his/her Klonopin (anti-anxiety medication) medication because it was not reordered timely.</p> <p>The findings include: Interview with the Director of Nursing (DON) on 09/18/14 at 1:10 PM, revealed she indicated the facility's expectation would be for the Physician to be notified when a resident missed scheduled doses of medications. Record review revealed the facility admitted Resident #3 on 06/20/14, with diagnoses which included Depression and Anxiety. Review of the 06/30/14 Admission Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #3 as being cognitively intact. Review of Resident #3's Comprehensive Care Plan, 06/20/14, revealed a care plan which stated Resident #3 was at risk for side effects from his/her psychoactive medications related to the diagnoses of Anxiety and Depression. Continued review of the care plan revealed interventions which included administering medications as ordered by the Physician. Review of the June 2014 monthly Physician's Orders revealed an order for Klonopin 1 milligram (mg), three (3) times daily for the diagnosis of Anxiety.</p>	F 157	<p>not adequate.</p> <p>The results of these audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance. At the end of three months, the QAPI Committee members will determine how much additional monitoring is required based on the information contained in the weekly audits. The facility QAPI members are AIT, DON, Social Services, MDS Coordinator, Med Records, Dietary, Activities, Therapy Coordinator, Environmental Services, Medical Director and Pharmacy.</p>		

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F 157	<p>Continued From page 2</p> <p>Additionally, review of the Physician's Orders revealed an order for Klonopin 1 mg once daily PRN (as needed) for Anxiety.</p> <p>Interview, on 09/17/14 at 1:05 PM, with Resident #3 revealed on 09/02/14, he/she had not received his/her three (3) scheduled doses of Klonopin medication, and this had made him/her very anxious as he/she felt he/she really needed the medication.</p> <p>Review of the September 2014 electronic Medication Administration Record (E-MAR) revealed Resident #3's Klonopin 1 mg was documented as "N" at 11:30 AM, 4:30 PM and 9:30 PM, which according to the key indicated the medication was not administered as ordered.</p> <p>Further review of Resident #3's medical record revealed no documented evidence of the facility's nurses had notified Resident #3's Physician of the three (3) scheduled Klonopin doses had not been administered on 9/02/14.</p> <p>Interview with Certified Medication Technician (CMT) #1 on 09/17/14 at 3:30 PM and on 09/18/14 at 11:55 AM, who worked the 3:00 PM to 11:00 PM shift on 09/02/14, and with CMT #2 on 09/18/14 at 10:10 AM, who had worked the 7:00 AM to 3:00 PM shift on 09/02/14, revealed there had not been any Klonopin 1 mg medication available to administer on 09/02/14. Both CMTs indicated they could not recall whether they had told the nurse or not about there being no Klonopin available.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 09/18/14 at 10:40 AM, revealed CMTs administered most of residents' medications, and</p>	F 157			

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F 157	Continued From page 3 the nurses depended on them to tell them if a resident missed their medications for any reason. She stated if Resident #3 missed three (3) doses of his/her Klonopin then the nurse should have notified the resident's Physician of the resident missing the scheduled doses of Klonopin on 09/02/14. However, indicated she did not know whether the Physician was notified of this information or not. Interview, on 09/18/14 at 12:35 PM, with Resident #3's Physician revealed she expected to be notified by facility staff regarding residents missing doses of their scheduled medications. Continued interview, on 09/18/14 at 1:10 PM, with the DON revealed she was not aware of a specific facility policy regarding notification of Physicians; however, she regarded notifying the Physician of missed medications as good nursing practice. She stated the nurse should also document the Physician notification in the resident's medical record.	F 157			
F 225 SS=D	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.	F 225	It is the policy of Elliott Nursing and Rehabilitation that all residents are free from abuse, neglect and misappropriations of funds. On 9/2/2014, resident #3 and resident # 7 reported to facility staff that each had \$5 missing on 9/1/2014. Upon Interview with the Administrator and Social Services Director, the residents declined to have facility staff search for their missing money. Both residents claimed that another resident of the facility had been in their rooms and the residents felt sure that this resident, who was confused, had taken their \$5. The confused resident had been noted to be in both resident rooms during the AM when the money disappeared. Interview with the residents revealed that neither resident wanted the confused resident's room searched nor did they want their money back from the resident. They considered the confused resident a "friend" and didn't	10/21/14	

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F 225	Continued From page 4 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. 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 all residents' allegations of misappropriation were reported to the appropriate State Agencies for two (2) of seven (7) sampled residents (Residents #3 and #7). Resident #3 and Resident #7 voiced allegations of missing money to facility staff; however, the missing money allegations were not reported to the State Agencies. The findings include:	F 225	want anyone's feelings hurt. They only ask that the resident not be permitted back in their room while they were not in attendance. In order to respect resident's rights and personal wishes, the facility completed a Complaint/Concern Form regarding the missing money and reminded all staff to assist wandering residents out of other resident rooms. The Administrator and Social Services Director will review the Complaint/Concern Log and Incident Reports for the last 60 days by 10/8/14 to ensure that no incidents have occurred that require law enforcement. No incidents requiring additional notification were identified. An investigation was completed on 9/2/2014 when the incident occurred. Staff members caring for the residents were interviewed by the previous administrator on 9/2/2014. No staff member had any knowledge of the resident money other than the reports that a confused resident had been seen in each resident's room. The alert and oriented residents (BIMS of 8 or higher) on the 200 hall were interviewed by the Social Services Director on 9/2/2014 to ensure that no other residents were affected. Additional interviews with alert and oriented residents (BIMS 8 or higher) were conducted by the Social Services Director on 10/1-2/2014. No resident was noted to have items missing. The Regional Director of Clinical Operations reviewed the Guidelines for Abuse Reporting with the Administrator on 9/18/2014. She has since transferred to other employment. The Regional DCO reviewed the Guidelines for Abuse Reporting with the current AIT on October 8, 2014. The AIT will provide education to all staff by 10/17/14 regarding the Guidelines for Abuse Reporting. All allegations of misappropriation, among other things, will be immediately reported to the AIT for further investigation and appropriate reporting. All resident concern forms, incident reports, nursing reports and Manager on Duty Reports will be reviewed daily (M-F) in morning meeting to ensure that appropriate notification to outside agencies has occurred as directed per facility protocols and Federal Regulations.		

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F 225	Continued From page 5 Review of the facility's, "Abuse Policy", dated 03/01/14, revealed alleged violations of Federal and State Law involving mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident's property would be reported to the State Agencies and law enforcement in accordance with existing state law. The Abuse Policy revealed the Administrator would direct a thorough investigation of each alleged violation and would be responsible for reporting the results of all investigations to the State Agencies as required by state and federal laws. 1. Review of Resident #3's medical record revealed the facility admitted the resident on 06/20/14, with diagnoses which included Chronic Airway Obstruction, Chronic Pain Syndrome, Anxiety and Asthma. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/30/14 revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating no cognitive impairment. Interview with Resident #3 on 09/18/14 at 8:35 AM, revealed he/she informed the "nurses at the nursing station" he/she was missing five (5) dollars and also told "the person" at the receptionist desk, "there's a thief in here". Continued interview revealed Resident #3 did not report this incident to any specific person but was making general comments while passing through those areas of the facility. Resident #3 indicated he/she could not recall the exact date but stated "about two (2) weeks ago" was when the money went missing. Resident #3 denied anyone in the facility had discussed his/her allegations with	F 225	These reviews will be forwarded to the monthly QAPI meeting for the next three months for further monitoring and continued compliance. At the end of three months, members of the QAPI committee will determine, based on the information available in the audits, if additional monitoring should occur. The facility QAPI members are AIT, DON, Social Services, MDS Coordinator, Med Records, Dietary, Activities, Therapy Coordinator, Environmental Services, Medical Director and Pharmacy.		

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F 225	Continued From page 6 him/her. 2. Record review revealed the facility admitted Resident #7 on 08/12/11, with diagnoses which included Anemia, Chronic Airway Obstruction, Chronic Kidney Disease, Heart Failure, Anxiety, and Depression. Review of the Quarterly MDS Assessment dated 08/03/14 revealed the facility assessed Resident #7 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating no cognitive impairment. Interview with Resident #7 on 09/18/14 at 9:05 AM, revealed the resident informed State Registered Nursing Assistant (SRNA) #1 "about two (2) weeks ago" of five (5) dollars missing out of his/her room, and also told SRNA #1 Resident #3 was missing five (5) dollars as well. Resident #7 stated the allegations were discussed with the Social Worker (SW) but "nothing was done." Interview with SRNA #1 on 09/18/14 at 9:50 AM, revealed she had worked at the facility for fourteen (14) years and had training on abuse and misappropriation of property. SRNA #1 stated Resident #7 reported to her he/she had placed two (2) five (5) dollar bills into a bottle on the night stand but now was missing one (1) of the five (5) dollar bills. SRNA #1 stated Resident #7 had a locked drawer which he/she kept other valuables in. SRNA #1 also stated Resident #3 was present at the time, and was encouraging Resident #7 to report the missing money as he/she was also missing five (5) dollars. SRNA #1 revealed she reported Resident #3's and Resident #7's missing money to Licensed Practical Nurse (LPN) #1. Interview with LPN #1 on 09/18/14 at 10:25 AM,	F 225			

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F 225	Continued From page 7 revealed she had received training on abuse and misappropriation of property, and stated she would report any allegations to either the Administrator or the SW. LPN #1 stated all residents had locked drawers in their rooms, and she did not remember any allegations regarding Resident #3 and Resident #7 missing money being reported to her by SRNA #1. Interview with the Administrator and SW on 09/18/14 at 11:10 AM, revealed on the morning of 09/02/14, as the Administrator was arriving at the facility both Resident #3 and Resident #7 were sitting on the front porch of the facility and reported to the Administrator the allegations of missing money. The Administrator stated she then went to the SW to determine if the allegations had been reported to her. The SW denied having knowledge of the allegations; and the SW stated she and the Administrator went to the front porch to discuss the allegations with Resident #3 and Resident #7. The Administrator stated the residents reported they suspected another resident took the money, as he/she was seen in both of their rooms prior to the money being missing. According to the Administrator, Resident #3 and Resident #7 stated they both did not want an "investigation" due to the fact both residents considered the suspected resident a "friend". The Administrator revealed both residents just wanted staff to inform that resident not to go into other residents' rooms unless the residents were in their rooms. The Administrator further stated both residents were aware of their locked drawers and were encouraged to use them. The Administrator stated these allegations were not reported to State Agencies and law enforcement as per facility policy, as the residents had not wanted the facility to conduct	F 225			

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F 225	Continued From page 8 an investigation and an investigation was not conducted per their request.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to thoroughly investigate allegations of misappropriation of property for two (2) of seven (7) sampled residents (Residents #3 and #7). Resident #3 and Resident #7 both reported allegations of missing money to facility staff; however, the facility did not conduct an investigation into the missing money. The findings include: Review of the facility's, "Abuse Policy", dated 03/01/14, revealed allegations involving mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property would be reported to State Agencies and law enforcement in accordance with existing state law. The Policy revealed the Administrator would direct a thorough investigation of each allegation and had the responsibility of reporting the results of all investigations of allegations to the State Agencies as required by state and federal laws.	F 226	On 9/2/2014, resident #3 and resident #7 reported to facility staff that each had \$5 missing on 9/1/2014. Upon interview with the Administrator and Social Services Director, the residents declined to have facility staff search for their missing money. Both residents claimed that another resident of the facility had been in their rooms and the residents felt sure that this resident, who was confused, had taken their \$5. The confused resident had been noted to be in both resident rooms during the AM when the money disappeared. Interview with the residents revealed that neither resident wanted the confused resident's room searched nor did they want their money back from the resident. They considered the confused resident a "friend" and didn't want anyone's feelings hurt. They only ask that the resident not be permitted back in their room while they were not in attendance. In order to respect resident's rights and personal wishes, the facility completed a Complaint/Concern Form regarding the missing money and reminded all staff to assist wandering residents out of other resident rooms. An investigation was completed on 9/2/2014 when the incident occurred. Staff members caring for the residents were interviewed by the previous administrator on 9/2/2014. No staff member had any knowledge of the resident money other than the reports that a confused resident had been seen in each resident's room. The alert and oriented residents (BIMS of 8 or higher) on the 200 hall were interviewed by the Social Services Director on 9/2/2014 to ensure that no other residents were affected. Additional interviews with alert and oriented residents (BIMS 8 or higher) were conducted by the Social Services Director on 10/1-2/2014. No resident was noted to have items missing. The currently guidelines were reviewed by the facility by the DCO and no changes were made. The Administrator and Social Services Director will review the Complaint/Concern Log and Incident Reports for the last 60 days by 10/8/14 to ensure that no incidents have occurred that require additional notification of State Agencies, APS, or local law enforcement.	10/21/14	

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F 226	Continued From page 9 1. Medical record review revealed the facility admitted Resident #3 on 06/20/14, with diagnoses which included Anxiety, Chronic Airway Obstruction, Chronic Pain Syndrome, Depression and Diabetes. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/30/14, revealed the facility assessed Resident #3 to be cognitively intact and interviewable. Interview, on 09/18/14 at 8:35 AM, with Resident #3 revealed he/she told nurses who were sitting at the nurse's station he/she had five (5) dollars missing. Resident #3 stated he/she also told "the person" who sitting at the receptionist desk there was a "thief" in the facility. Resident #3 stated he/she could not recall the exact date; however, indicated it was approximately "two (2) weeks ago". Per interview, the resident indicated he/she had made the comments while passing through the areas, and had not reported specific information regarding the missing money to a particular person. Resident #3 denied any facility staff person had ever discussed with him/her the allegations of missing money. 2. Medical record review revealed the facility admitted Resident #7 on 08/12/11, with diagnoses which included Anxiety, Heart Failure, Hypertension and Depression. Review of the Quarterly MDS Assessment dated 08/03/14, revealed the facility assessed Resident #7 to be cognitively intact and interviewable. Interview, on 09/18/14 at 9:05 AM, with Resident #7 revealed the resident told State Registered Nursing Assistant (SRNA) #1 he/she was missing five (5) dollars out of his/her room. According to Resident #7, he/she also informed SRNA #1 Resident #3 had five (5) dollars missing too.	F 226	No incidents requiring additional notification were identified. The Regional Director of Clinical Operations reviewed the Guidelines for Abuse Reporting with the Administrator on 9/18/2014. She has since transferred to other employment. The Regional DCO reviewed the Guidelines for Abuse Reporting with the current AIT on October 8, 2014. The AIT will provide education to all staff by 10/17/14 regarding the Guidelines for Abuse Reporting. All allegations of misappropriation, among other things, will be immediately reported to the AIT for further investigation and appropriate reporting. All resident concern forms, incident reports, nursing reports and Manager on Duty Reports will be reviewed daily (M-F) in morning meeting to ensure that appropriate notification to outside agencies has occurred as directed per facility protocols and Federal Regulations. These reviews will be forwarded to the monthly QAPI meeting for the next three months for further monitoring and continued compliance. At the end of three months, members of the QAPI committee will determine, based on the information available in the audits, if additional monitoring should occur. The facility QAPI members are AIT, DON, Social Services, MDS Coordinator, Med Records, Dietary, Activities, Therapy Coordinator, Environmental Services, Medical Director and Pharmacy.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 10</p> <p>Resident #7 reported the missing money allegations were discussed with the Social Worker (SW); however, "nothing" had been "done".</p> <p>Interview, on 09/18/14 at 9:50 AM, with SRNA #1 revealed Resident #7 told her about placing two (2) five (5) dollar bills in a bottle on his/her night stand, and five (5) dollars was now missing. SRNA #1 revealed Resident #7 had a locked drawer which other valuables were kept for safeguarding. According to SRNA #1, Resident #3 was present during her conversation with Resident #7, and had encouraged Resident #7 to report his/her missing money as he/she was missing five (5) dollars also. Per interview, the SRNA reported Resident #3's and Resident #7's allegations of missing money to Licensed Practical Nurse (LPN) #1. SRNA #1 stated she had had worked for the facility for fourteen (14) years and had received training regarding abuse and misappropriation of property.</p> <p>Interview, on 09/18/14 at 10:25 AM, with LPN #1 revealed all facility residents had locked drawers in their rooms to store their valuables in. LPN #1 stated she did not recall being informed of any allegations of Resident #3 and Resident #7 missing money. Continued interview revealed she had received training on abuse and misappropriation of property and if she received allegations she would report them to either the SW or Administrator.</p> <p>Interview, on 09/18/14 at 11:10 AM, with the Administrator and Social Worker revealed on 09/02/14, during the morning Residents #3 and Resident #7 reported their allegations of missing money to the Administrator. The Administrator</p>	F 226			

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F 226	Continued From page 11 revealed going to the SW to determine if the allegations had been reported to her; however, the SW denied knowing about the resident's missing money allegations. According to the SW, she and the Administrator returned to were the residents were sitting on the front porch and discussed Resident #3's and Resident #7's missing money allegations with them. The Administrator stated both residents revealed suspicion regarding a resident who had been seen in both of their rooms prior to finding their money missing. Per interview, the Administrator revealed Resident #3 and Resident #7 both stated they did not want an investigation conducted by the facility, as they considered the suspected resident as a "friend". Continued interview with the Administrator revealed both residents just wanted the staff to inform this resident not to go into other residents' if they were not in their rooms. The Administrator stated both residents had locked drawers in their rooms and were encouraged to use them to store valuables in. Further interview with the Administrator revealed Resident #3's and Resident #7's allegations regarding their missing money was not reported to State Agencies and law enforcement. Additionally, the Administrator stated the facility did not conduct an investigation, as per facility policy, due to Resident #3 and Resident #7 not wanting the facility to perform any further actions.	F 226			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	Elliott Nursing or Rehabilitation Center strives to ensure that residents are free of any significant medication errors. The medication for resident #3 was delivered by pharmacy on 9/3/2014 and administered on 9/3/2014. The DON spoke with the resident on 9/3/2014 and did not note any alteration in the resident's demeanor or physical status. The LPN charge nurse conducted an assessment of resident #3 on 9/6/2014. No changes were identified from the previous assessment. The physician had no additional orders for resident #3 on 9/18/2014 when she was notified of the medication omission.	10/21/14	

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F 333	Continued From page 12 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 one (1) of three (3) sampled residents (Resident #3) had Klonopin (anti-anxiety medication) on hand to administer the physician ordered doses. The findings include: Review of the facility's policy titled, "IC 3: Ordering and Receiving Medications from the Dispensing Pharmacy", undated, revealed staff were to reorder medication three (3) to four (4) days in advance to ensure an adequate supply was "on hand". Review of the facility policy titled, "IC 5 a: Emergency Pharmacy Services", undated, revealed emergency pharmacy service was available on a twenty-four (24) hour basis. Continued review of the Policy revealed staff were to use the after hours pharmacy emergency number when medications were unavailable for administration. Review of Resident #3's medical record revealed the facility admitted him/her on 06/20/14, with diagnoses which included Anxiety and Depression. Review of the Admission Minimum Data Set (MDS) Assessment dated 06/30/14, revealed the facility assessed Resident #3 to have a mood severity score of three (3) which indicated minimal depression, and to have a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, which indicated no cognitive	F 333	The DON will review the Medical Record Administration sheets for each current resident for the last 30 days no later than 10/15/2014 to ensure that medications have been provided as directed by the physician. Any omission will be relayed to the physician for follow up. All licensed staff and CMT's received additional education by the DON on 9/24/2014 regarding the importance of administering medications as ordered by the physician. This included the six rights of medication administration. Additional education was provided related to ordering and receiving medications from the pharmacy. The numbers for the pharmacy were posted prominently in the nursing station area and the procedures for ordering medications during the weekends, holidays and off hours were reviewed with all nurses and CMTs. The Health Information Management Coordinator will perform MAR audits each week for 12 weeks to ensure that medications are being administered as ordered by the physician. Any omissions will be reported to the DON or RN Supervisor for further investigation. The findings will also be shared with the physician. Additionally, the RN Supervisor will complete a weekly medication cart audit for at least 12 weeks to ensure that all medications ordered by the MD are present in the cart and that an ample supply remains in the cart for the following week. The RN Supervisor will ensure that meds are re-ordered in a timely manner if the supply is not adequate. The results of these audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance. At the end of three months, the QAPI Committee members will determine how much additional monitoring is required based on the information contained in the weekly audits. The facility QAPI members are AIT, DON, Social Services, MDS Coordinator, Med Records, Dietary, Activities, Therapy Coordinator, Environmental Services, Medical Director and Pharmacy.	

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F 333	<p>Continued From page 13</p> <p>impairment. Review of Resident #3's Comprehensive Care Plan, 06/20/14, revealed the resident was care planned as at risk for side effects from his/her psychoactive medications related to the diagnoses of Anxiety and Depression, with interventions which included administering his/her medications as ordered by the Physician. Continued record review revealed the monthly Physician's Orders dated June 2014 revealed an order for Klonopin 1 milligram (mg), three (3) times daily, upon rising, supper and at bedtime daily for the diagnosis of Anxiety. Further review of the monthly June 2014 Physician's Orders revealed an order for Klonopin 1 mg once daily PRN (as needed) for Anxiety.</p> <p>Interview with Resident #3, on 09/17/14 at 1:05 PM, revealed he/she had not received his/her three (3) scheduled doses of Klonopin medication on 09/02/14. Resident #3 stated she was very anxious that day and felt she really needed his/her medicine.</p> <p>Review of the electronic Medication Administration Record (E-MAR) for September 2014 revealed no documented evidence Resident #3 received the three (3) scheduled doses of Klonopin 1 mg on 09/02/14 as ordered upon rising, at supper and bedtime. Further review of the E-MAR revealed the staff administering medications on 09/02/14 documented Resident #3's scheduled Klonopin doses, which were timed at 11:30 AM, 4:30 PM and 9:30 PM, as "N" which indicated the medication was not administered.</p> <p>Further review of Resident #3's medical record revealed no documented evidence of why the resident did not receive his/her scheduled Klonopin doses on 09/02/14. Additionally, record</p>	F 333			

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F 333	<p>Continued From page 14</p> <p>review revealed no documented evidence nursing staff notified Resident #3's Physician of the three (3) missed doses of scheduled Klonopin on 09/02/14. Review of facility's "Refill Request Sheets" revealed no evidence the pharmacy was notified Resident #'s Klonopin 1 mg needed to be refilled prior to 09/02/14.</p> <p>Review of the Pharmacy's order "Fill History" document, dated 09/18/14, for Resident #3's Klonopin 1 mg medication revealed it was re-ordered on 08/22/14, with a seven (7) day supply dispensed at that time, and not filled again until 09/03/14 when a seven (7) day supply was dispensed, twelve (12) days after the previous order. Review of the Pharmacy emergency call log for the week of 09/01/14 through 09/07/14 revealed no documented evidence of calls to the pharmacy requesting an emergency run for Resident #3's Klonopin 1 mg for 09/02/14, due to there being no Klonopin 1 mg medication for the resident available for administration.</p> <p>Interview with Certified Medication Technician (CMT) #1 on 09/17/14 at 3:30 PM and on 09/18/14 at 11:55 AM, who worked the 3:00 PM to 11:00 PM shift on 09/02/14, revealed the medication cards which residents' medications were encased in and the medication sign out sheet both have "reorder stickers" for staff to use to adhere to a pharmacy "Refill Request Sheets" form. CMT #1 stated staff then faxed the "Refill Request Sheets" document to the pharmacy to ensure there was always enough medication for administration. She stated the pharmacy was closed on Sundays and holidays. CMT #1 reported she could not recall if she faxed a reorder request to the pharmacy for Resident #'s Klonopin medication. Continued interview</p>	F 333		

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F 333	<p>Continued From page 15</p> <p>revealed it was the staff person passing medication's responsibility to let the Charge Nurse know if reordered medication had not been received in a timely fashion to ensure an adequate supply of medication was on hand to administer. CMT #1 revealed if a "N" was recorded on the E-MAR on 09/02/14, that indicated the medication was not given. According to CMT #1, the documented reason for not administering the two (2) doses of Klonopin on her shift was "pending pharmacy" which meant the medication was unavailable and waiting on delivery. Further interview revealed she was unable to remember if she notified the Charge Nurse or who the nurse was. CMT #1 indicated there had been two (2) missed opportunities for Resident #1's Klonopin 1 mg to be reordered prior to 09/02/14, so the resident would not miss a dose.</p> <p>Interview with CMT #3 on 09/17/14 at 3:50 PM, revealed she verified CMT #1's description of the facility's medication reorder process for faxing requests to the pharmacy. She stated she usually followed up the next day to ensure the requested medication reordered had been received, and if not, she would reorder it. Continued interview revealed she tried to "look ahead" and make sure residents had enough medication to get through Sundays and holidays, as the pharmacy was closed then. She stated it was staff's responsibility to make sure residents had enough medications so they wouldn't miss any doses. Further interview revealed she didn't remember re-ordering Resident #3's Klonopin on 08/27/14, or why she didn't "look ahead" to ensure there would be an adequate supply of the medication for administration over the holiday, 09/01/14.</p>	F 333		

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F 333	Continued From page 16 Interview with CMT #2 on 09/18/14 at 10:10 AM, revealed she knew the facility's reorder process for medications. CMT #2 stated she worked 7:00 AM to 3:00 PM on 09/02/14, and Resident #3 had no Klonopin 1 mg available for administration, therefore, she documented an "N" on the E-MAR which indicated the medication was not administered. She stated, however she was unsure if she had notified the Charge Nurse of Resident #3's Klonopin being out, but stated she should have done that. Interview with Licensed Practical Nurse (LPN) #1 on 09/18/14 at 10:40 AM, revealed the facility process for ordering needed or missing doses of medication after hours or on holidays was to call the on-call pharmacy number. LPN #1 remembered calling the on call pharmacy number on 09/02/14 for medication; however, could not recall what the medication was or which resident it was for. Interview with the facility Pharmacy Consultant on 09/18/14 at 12:00 PM, revealed the "bottom line" was Resident #3 ran out of the medication, Klonopin 1 mg, and there was "no documentation" the facility attempted to notify the pharmacy. The Pharmacy Consultant stated there was an emergency pharmacy number the facility could have used to notify pharmacy personnel regarding the medication and arranged for delivery of it prior to 09/02/14; however, there was no documentation anyone had attempted to do that either. Interview with Resident #3's Physician on 09/18/14 at 12:35 PM, revealed it was her expectation the facility would notify her in the	F 333			

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F 333	<p>Continued From page 17</p> <p>event of missed medication doses.</p> <p>Interview with the Director of Nursing (DON) on 09/18/14 at 1:10 PM, revealed it was her expectation for staff to have notified the pharmacy regarding Resident #3's missing medication by using the emergency after hours number as per facility policy. The DON stated the expectation was for facility policies to be followed at all times. Continued interview revealed she was unaware if the facility had a specific policy in regard to Physician notification of missed medication doses, however, she would consider it good nursing practice to notify the Physician and to also document the notification.</p>	F 333		