

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

PRINTED: 03/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/19/2014
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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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 281 SS=D	<p>An Abbreviated Survey was conducted on February 18-19, 2014 to investigate KY 21332. The Division of Health Care substantiated the allegation with deficiencies cited.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and Lippincott (ninth edition) manual, it was determined the facility failed to ensure services provided met professional standards. The facility failed to administer medications to one (1) of five (5) sampled residents as prescribed by the physician. Resident #1 was to receive Zyprexa 7.5 mg daily. However, there was no documented evidence the resident received the medication for eight days, December 1-8, 2013. There was no documented harm to the resident.</p> <p>The findings include: Review of the facility's policy titled Medication Administration-Administering Medications, effective date of December 2010, revealed all medications were to be administered only as ordered by the physician. The policy detailed the guidelines and procedures for administering medications. The policy stated to record the medication given on the medication record.</p>	F 281	<p>1. Resident #1 is receiving medication per MD order. Resident #1 was assessed by nursing on 12/10/13 and no signs or symptoms of physical distress were identified. The Assistant Director of Nursing completed an audit of med cart, physician orders, and Medication Administration Records of resident #1 to ensure resident's medications were available and listed on the Medication Administration Record per Physician Orders. A medication discrepancy report was completed on the 12/09/13 incident. The incident was discussed in Quality Assurance Meeting on 02/20/14 with the Medical Director present.</p> <p>2. 02/18/14 and 02/19/14, the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Restorative Coordinator conducted an audit for all residents of physician orders and Medication Administration Records to ensure residents' medications were listed on the Medication Administration Record per Physician Orders. No other issues were</p>	3/21/14 3/31/14

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

TITLE

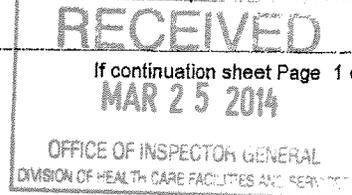
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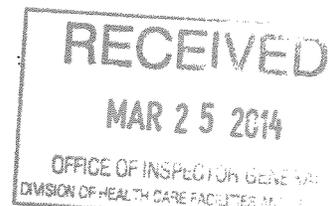
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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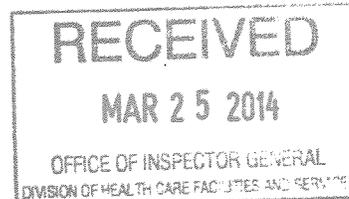
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F 281	Continued From page 1 Review of the facility's policy regarding Medication Discrepancies, effective December 2010, revealed medication discrepancies would also include omission of any medication due to a prescribing, dispensing, or administering error. A medication discrepancy/error/incident report would be completed. Medication/error/incident reports are reviewed on a regular basis by the Performance Improvement Committee (Quality Assurance) and acted upon as appropriate. Interview with the Director of Nursing (DON), on 02/19/14 at 12:45 PM, revealed the facility used the Lippincott (ninth edition) Manual as a reference for standards of practice. Review of the manual revealed medications were administered according to physician orders. Review of the clinical record for Resident #1 revealed the resident had resided at the nursing facility since December 2010. The most current diagnoses included Major Depression with Psychosis, Parkinson's, Senile Dementia, and Diabetes. The comprehensive assessment conducted, on 10/08/13, revealed the resident had a severe cognition impairment with a Brief Interview Mental Status (BIMS) score of a six (6) of a possible fifteen (15). Continued review of the clinical record revealed the resident had a history of lengthy psychiatric admissions to a Psychiatric Hospital for Major Depression and remains under the care of a Psychiatrist. The record revealed the resident was admitted to a local acute hospital on 06/11/13 in a mute and catatonic condition and was found to be lethargic and unresponsive. The acute hospital documentation revealed the resident had been off the medication Zyrprexa for a couple of	F 281	identified. Medical Records Clerk, MDS Nurse, Nurse, and Admissions Nurse are completing an audit by 03/18/14 to ensure residents' medications were listed on the Medication Administration Record per Physician Orders and available in medication. The Director of Nursing completed an audit of last 30 days Medication Discrepancy Reports to ensure investigations were completed thoroughly and any reports were discussed in Quality Assurance Meeting on 02/20/14. 3. The Vice President of Operations reeducated the Administrator, Director of Nursing, and Assistant Directors of Nursing on 2/18/14 on completing a thorough investigation. The Signature Care Consultant reeducated the Director of Nursing and Assistant Directors of Nursing on completing thorough investigations on medication errors, on completing month end change over and ensuring all Medication and Administration Records match the Physician Orders. Education was completed on 3/13/14. The Staff Development Coordinator reeducated licensed nursing staff on ensuring medications are available and given per physician orders and documented on the Medication Administration Record.	3/31/14	



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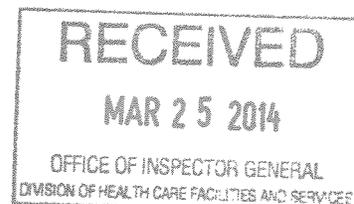
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F 281	<p>Continued From page 2</p> <p>days and noted every time the resident was off this medication, the resident developed a flat affect and became mute. The resident was placed back on the medication, given IV fluids and antibiotic treatment for a Urinary Tract Infection with much improvement. He/She was discharged back to the nursing facility on 06/17/13.</p> <p>Review of the most current Plan of Care, dated 08/07/13, revealed an approach to administer medications as prescribed by the physician and monitor for effectiveness. Review of the physician orders for December 1-31, 2013 revealed the medication Zyprexa 7.5 mg (1) tablet was ordered to be administered daily at bedtime. Review of the November Medication Administration Record (MAR) revealed the resident received Zyprexa 7.5 mg (1) at bedtime. The MAR revealed the resident refused the medication on 11/02/13 and 11/25/13. Review of the December 2013 MAR revealed the medication sheet with the Zyprexa 7.5 mg was not included. On 12/09/13, Zyprexa SL 5 mg daily at bedtime was hand written on the December 2013 MAR. However, there was no documented evidence that the Zyprexa had been given as ordered by the physician from December 1-8, 2013.</p> <p>Interview with the Administrator and DON, on 02/18/14 at 2:32 PM, revealed a staff nurse reported on 12/09/13 that Resident #1 had not received the medication Zyprexa 7.5 mg daily from December 1-8, 2013. The medication had not been placed on the December MAR. The DON stated she began an investigation that included an inspection of the medication cart and she found the Zyprexa tablets thirteen (13) total in the medication cart. Review of the pharmacy</p>	F 281	<p>Reeducation will be completed by 3/31/14.</p> <p>4. The Assistant Directors of Nursing will audit five residents per neighborhood, including resident #1, weekly times eight weeks then monthly times four months. This audit will include review of physician orders to Medication Administration Record to medications available in the medication cart.</p> <p>The Assistant Directors of Nursing will forward these audits for review to the Quality Assurance Committee for further recommendations monthly or more frequently if deficient practices have been identified.</p> <p>Completion Date: March 31, 2014</p>	3/31/14 <i>per Crystal Hamilton</i> <i>By PB 3-27-14</i>



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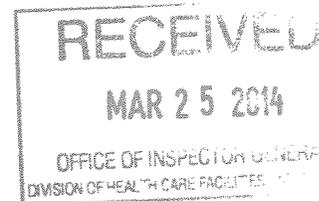
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F 281	<p>Continued From page 3</p> <p>manifest sheet revealed on 11/28/13, fifteen (15) tablets of Zyprexa 7.5 mg had been delivered to the facility. The DON stated when she reviewed the December MAR for Resident #1, on 12/09/13, she found a page was missing from the MAR that would have included the medication Zyprexa. She searched the medication cart, nurses' station, room behind the nurses' station, and the physician's book and did not find the missing MAR. She interviewed the Assistant Director of Nursing (who had completed the MAR check and placed the December MAR in the binder for change over night) and she told the DON she recalled the December MAR did include the medication Zyprexa. The DON stated she requested the Medical Record staff to pull the resident's profile and when she did, the Zyprexa was on the resident's profile and would have been printed onto the December MAR. She made the determination the page with the Zyprexa medication was missing from the December MAR. The DON indicated she could not determine if the resident received the medication or not. The DON indicated she had conducted an audit of all residents' medications and compared them to the December MAR. She stated she found no additional problems.</p> <p>Continued interview with the Administrator on 02/18/14 revealed she could not find the investigation she had conducted regarding the missing MAR. She stated she received a call from the Regional Nurse Consultant on 12/10/13 and she explained the situation to her. The consultant came to the facility on 12/11/13 and she conducted interviews with the nurses who were responsible for administering the medication, Zyprexa from December 1-8, 2013. The Administrator did not have those interviews</p>	F 281			



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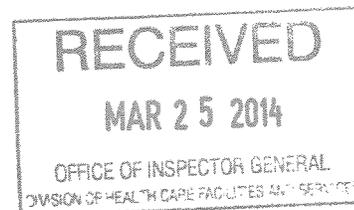
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F 281	<p>Continued From page 4</p> <p>nor were there any written statements from those nurses. Neither the Administrator or DON was present during those interviews and did not know what the nurses had said. She thought the Regional Consultant may have them. She could not confirm if the nurses gave the medication or not. She could not provide evidence a medication error/incident report was completed according to the facility's policy. The Administrator stated she had met with the resident's daughter on 12/11/13 and told her the December MAR with the Zyprexa was missing and she could not determine if the resident received the medication or not. She stated the resident's primary physician had been contacted on 12/10/13 but did not know if the Psychiatrist had been notified.</p> <p>Interview with the Assistant Director of Nursing, on 02/18/14 at 3:03 PM, revealed she was the person who had checked the December MAR and placed them in a binder. The nurses would take that binder with the December MAR and administer medications from that MAR on the first of the month. She stated she made sure the Zyprexa was on the December MAR because the resident's daughter was very particular about the resident's medications. She stated she double checked and was sure the Zyprexa was present on the December MAR. She did not know how the MAR that had the Zyprexa medication printed on it came up missing. She revealed she did not check the resident's MAR after she had placed it in the binder. Therefore, she could not say the MAR sheet that contained Zyprexa was present on any of the days December 1-8, 2013. She could not validated the resident received the medication Zyprexa 7.5 mg during those days.</p>	F 281		



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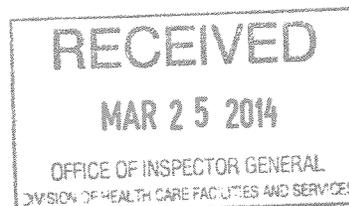
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F 281	<p>Continued From page 5</p> <p>Another interview with the administrator, on 02/18/14 at 4:38 PM, revealed she had called the Regional Consultant and she did not have the investigation nor the interviews with the nurses.</p> <p>On 02/19/13 at 8:44 AM, interview with the Administrator, DON, and ADON was conducted. The Administrator stated she had looked, but could not find the investigation. The Administrator revealed she and the consultant could not determine if the resident had received the medication or not. She had searched, but did not find any evidence a medication error/incident report had been completed. The administrator stated this would have been considered a medication omission.</p> <p>Interview with the Administrator and DON, on 02/19/14 at 9:45 AM, revealed no changes had been made to the process of reviewing the MARS since the incident. No additional checks had been implemented and no monitoring of Resident #1's MAR to ensure the resident received medications according to the physician's orders. The Administrator revealed the staff used the same method as before. She did indicate the nurse consultant re-educate the ADONs on the process to ensure they were following policy. However, the rest of the staff received no training regarding the Mars.</p> <p>Review of the December 2013 MAR, in the presence of the Administrator and DON, during the above interview, revealed Zyprexa SL 5 mg was placed on the MAR to be given at 8:00 PM on 12/09/13. However, the MAR had no staff initials to indicate the medication had been given on December 13, 16, 19, and 27 th. Closer review revealed no documentation that the resident</p>	F 281			



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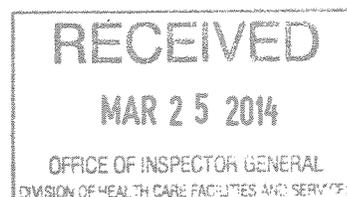
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F 281	<p>Continued From page 6</p> <p>refused the medication and the staff initialed the resident took all other medications ordered on those dates.</p> <p>Continued interview with the Administrator and DON, on 02/19/14 at 9:45 AM, revealed they were not aware of the blanks on the December 2013 MAR. They revealed there had been no monitoring of Resident #1's December MAR after the incident to ensure the resident received medications as ordered by the physician. The DON stated if the MAR had no staff's initials indicating the medication was given, the nurse following should have called the staff and asked if they had given the medication. She said no staff had informed her there were blanks on the December MAR and could not say the resident received the medication, Zyprexa 5 mg SL, as ordered by the resident's physician on those days the MAR was blank. The Administrator and the DON revealed there had been no oversight of staff or the MAR to ensure the residents received their medications.</p> <p>Interview with the Psych Nurse Practitioner (NP), on 02/19/14 at 11:12 AM, revealed she conducted a routine visit to see Resident #1 on 12/09/13 because the daughter had asked for the route of the Zyprexa to be changed from pill form to liquid. She stated the dose 7.5 mg did not come in a liquid form so she changed the dose to 5 mg. She stated when she went to check the MAR, she did not find Zyprexa listed on the December MAR. She stated the nurse looked in the medication cart and found a box of Zyprexa 7.5 mg. That was when the nurse discovered the omission. The NP stated Zyprexa was very important for this resident and if he/she did not receive the medication for several days, it could cause major</p>	F 281			



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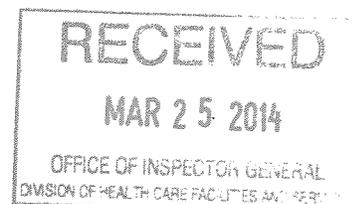
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F 514	<p>Continued From page 8</p> <p>Refer to F-281.</p> <p>The findings include:</p> <p>The facility did not provide a policy for documenting in the clinical record. The facility provided a learning guide on documentation that they utilized for training purposes. Review of the learning guide, dated 2004, revealed the guide included information on the what, where, why, when, and how of documentation. The usual rule was; if it wasn't documented, it wasn't done. The guide instructed the reader to document when they assist a resident with medications on the medication record. In addition, a resident's response to medicines were to be documented in the record.</p> <p>Review of the December 2013 MAR, in the presence of the Administrator and Director of Nursing, on 02/19/14 at 9:45 AM, revealed Zyprexa SL 5 mg was placed on the MAR to be given at 8:00 PM on 12/09/13. However, the MAR had no staff initials to indicate the medication had been given on December 13, 16, 19, and the 27th. Closer review revealed no documentation that the resident refused the medication and the staff initialed the resident took all other medications ordered on those dates.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 02/19/14 at 9:45 AM, revealed they were not aware of the blanks on the December 2013 MAR. They revealed there had been no monitoring of Resident #1's December MAR after the incident to ensure the resident received medications as ordered by the physician. The DON stated if the MAR had no</p>	F 514	<p>On 3/13/14, the Signature Care Consultant reeducated the Director of Nursing and both Assistant Directors of Nursing on monitoring holes in the medication records.</p> <p>Medication Administration Record pages will be individually labeled at month end changeover from March to April and ongoing to identify total number of pages that should be present in Medication Administration Records.</p> <p>4. The Assistant Director of Nursing is reviewing the documentation weekly to ensure Resident #1 is receiving medications per physician order and this is documented on the MAR including any refusals. This will be completed weekly x 4 weeks, then monthly x 3 months.</p> <p>The Assistant Directors of Nursing are auditing 15 residents per neighborhood weekly times twelve weeks then monthly times three months to ensure proper documentation on the Medication Administration Records to include holes and refusals.</p> <p>The Assistant Directors of Nursing will forward these audits for review to the Quality Assurance Committee for further recommendations monthly or more frequently if deficient practices have been identified.</p> <p>Completion Date: <i>March 4 2014</i></p>	3/31/14



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F 514	Continued From page 9 staff's initials indicating the medication was given, the nurse following should have called the staff and asked if they had given the medication. She said no staff had informed her there were blanks on the December 2013 MAR and could not say the resident received the medication, Zyprexa 5 mg SL, as ordered by the resident's physician on those days. The Administrator and DON revealed there had been no oversight of staff or the MAR to ensure Resident #1 received the medications as ordered by the physician. In addition, there was no evidence the nurses who administered medications those days had been called to ensure Resident #1 had received the medication. Continued interview with the Administrator and DON revealed no changes had been made to the process of reviewing the MARS since the incident. No additional checks had been implemented and no monitoring of Resident #1's MAR to ensure the resident received medications according to the physician's orders. The Administrator stated a training regarding proper documentation for nurses and Medication Tech's was conducted on 02/07/14. Review of the training records validated the training regarding documentation in the medical record was held on 02/07/14 with twenty-one (21) nurses in attendance. However, that did not include two of the nurses that administered Resident #1's medications in December 2013.	F 514			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520 F 520	1. The physician was notified on 12/11/13 that there is no record that Resident #1 received the medication Zyprexa for eight days. The	4/01/14	



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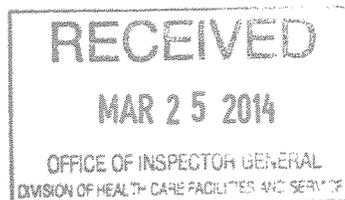
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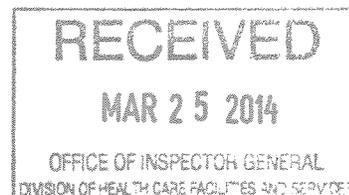
F 520	Continued From page 10 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review for Performance Improvement, it was determined the facility failed to have an effective Quality Assurance (QA) committee that would identify and correct quality deficiencies. The facility was informed of Resident #1's missing Medication Administration Record (MAR) for December 2013 that indicated Resident #1 did not receive all medications as ordered by the physician from December 1-8, 2013. The facility could not provide evidence appropriate plans of actions were implemented to correct deficiencies and ensure all residents received medications according to physician orders for one of five	F 520	family was notified and there were no negative outcomes for the resident. A new order was obtained for Zyprexa to be restarted on 12/09/13 and was added to the MAR on 12/09/13 by Director of Nursing. The medication discrepancy involving resident #1 was discussed in the Quality Assurance Meeting held on 02/20/14, with the Medical Director present. 2. The medication discrepancies for the months of January and February were reviewed to ensure that to ensure that each discrepancy was addressed to include physician and family notification. All medication discrepancies were discussed in the Quality Assurance Meeting held on 02/20/14, with the Medical Director present. The plan to monitor Residents' medications, medication administration record, and physician orders to ensure everything is in place and being followed, was reviewed in this meeting. 3. Going forward, all medication discrepancies will be reviewed by the nursing administration team with a process improvement approach. This will include a	4/6/14 4/6/14
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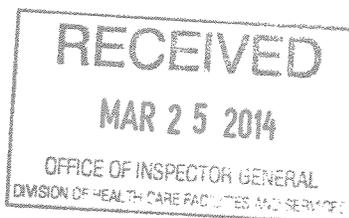
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2014
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F 520	Continued From page 11 sampled Residents. (Resident #1) Review of the December 2013 MAR revealed there was no documented evidence Resident #1 received the medication Zyprexa on December 13, 16, 19, and 27th. Refer to F-281. The findings include: Review of the Performance Improvement Plan with Abaqis, not dated, provided by the facility as their policy for Quality Assurance, revealed this plan was synonymous with the Center for Medicare/Medicaid (CMS) regulatory QA requirements. Under the section Standard of Practice, the policy stated the facility was to conduct an on-going performance improvement (PI) program to systematically monitor, evaluate, and improve the quality and appropriateness of resident care. The facility would exam both outcomes and processes relevant to these outcomes with the objective of improving overall performance. The facility would identify areas for Performance Improvement monitoring and resources to be used. These monitoring activities should focus on processes that significantly affect resident outcomes. Interview with the Administrator and Director of Nursing (DON), on 02/18/14 at 2:32 PM, revealed a staff nurse reported on 12/09/13 that Resident #1 had not received the medication Zyprexa 7.5 mg daily from December 1-8, 2013 because the medication had not been placed on the December MAR. The DON stated she inspected the medication cart and found the Zyprexa tablets thirteen (13) total in the medication cart. Review of the pharmacy manifest sheet revealed on	F 520	PI to address what was done for the affected resident but also include what will be done for all other residents with the potential to be affected. All medication discrepancies will be brought to the monthly QA meeting by the Director of Nursing to include discussion on any noted trends. The Vice President of Operations reeducated the Administrator, Director of Nursing, and Assistant Directors of Nursing on 2/18/14 on completing a thorough investigation. On 3-13-14, the Signature Care Consultant reeducated the Director of Nursing and Assistant Directors of Nursing on completing a medication discrepancy investigation, completing month end change over and ensuring all Medication and Administration Records match the Physician Orders. The Staff Development Coordinator reeducated licensed nursing staff on ensuring medications are given per physician orders and documented on the Medication Administration Record. The Administrator reeducated administrative staff including the Assistant		



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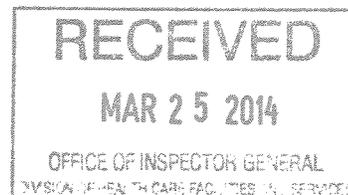
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F 520	<p>Continued From page 12</p> <p>11/28/13, fifteen (15) tablets of Zyprexa 7.5 mg had been delivered to the facility. The DON stated when she reviewed Resident #1's December 2013 MAR, she found a page was missing that would have included the medication Zyprexa. She searched but did not find the MAR that included the Zyprexa. When she interviewed the Assistant Director of Nursing (who had completed the check and placed the December MAR in the binder for change over night) she told the DON she recalled the December MAR did include the medication Zyprexa. The DON stated she requested the Medical Record staff to pull the resident's profile and when she did, the Zyprexa was on the resident's profile and would have been printed onto the December 2013 MAR. The DON indicated she could not determine if the resident received the medication or not. The DON stated she had conducted an audit of all residents' medications and compared the medications to the December MAR. She stated she found no additional problems.</p> <p>Continued interview with the Administrator revealed she could not find the investigation she had conducted regarding the missing MAR. She stated she received a call from the Regional Nurse Consultant on 12/10/13 and she explained the situation to her. The consultant came to the facility on 12/11/13 and she conducted the interviews with the nurses who were responsible for administering the Zyprexa from December 1-8, 2013. The Administrator does not have those interviews nor were there any written statements from those nurses. Neither the Administrator nor the DON was present during those interviews and did not know what the nurses had said. She thought the Regional Consultant may have them. She could not confirm if the nurses gave the</p>	F 520	<p>Directors of Nursing, Staff Development Coordinator, Restorative Coordinator, MDS Coordinator, Business Office Manager, Dietary Services Manager, Quality of Life Director, Environmental Services Director, Social Services Director, Medical Records Clerk, and Admissions Director on our Quality Assurance Policy and Procedure.</p> <p>Quality Assurance Referral forms are available at each nurses work station, kitchen, Housekeeping office, and administrative work/copy machine room so staff may make referrals on issues that require review by the Quality Assurance team. The Staff Development Coordinator, Housekeeping Supervisor, Dietary Services Manager, Rehab Services Manager, Administrator, Director of Nursing, and Assistant Directors of Nursing have reeducated all staff on Quality Assurance Referral forms and their use to identify and correct issues at the facility.</p> <p>On 3/20/14, the Signature Care Consultant reeducated the Administrator, Assistant Directors of Nursing, Dietary Manager, Quality of Life Director, Chaplain, Business Office Manager, Staff Development Coordinator, Admissions Director, and Social Services Director on the Quality Assurance Process Improvement and audit tools and systems</p>	



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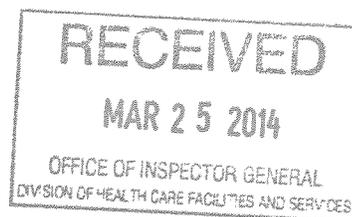
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F 520	Continued From page 13 medication or not. She could not provide evidence a medication error/incident report was completed according to facility policy. The Administrator stated she had met with the resident's daughter on 12/11/13 and told her the December MAR with the Zyprexa was missing and she could not determine if the resident received the medication or not. Another interview with the Administrator, on 02/18/14 at 4:38 PM, revealed she had called the Regional Consultant and she did not have the investigation nor the interviews with the nurses. On 02/19/13 at 8:44 AM, interview with the Administrator, DON, and ADON was conducted. The Administrator stated she had looked, but could not find the investigation. In addition, the Administrator said she had searched, but did not find any evidence a medication error/incident report had been completed. The administrator stated this would have been considered a medication omission. Interview with the Administrator and DON, on 02/19/14 at 9:45 AM, revealed no changes had been made to the process of reviewing the MARS since the incident. No additional checks had been implemented and no monitoring of Resident #1's MAR to ensure the resident received medications according to the physician's orders. The Administrator revealed the staff used the same method as before. Review of the December MAR, in the presence of the Administrator and DON, during the above interview, revealed Zyprexa SL 5 mg was placed on the MAR to be given at 8:00 PM on 12/09/13. However, the MAR had no staff initials to indicate	F 520	to use to identify areas that need improvement and utilize the QAPI process. The Signature Care Consultant provided them with a calendar to use to assure all audits are completed timely. The Director of Nursing received training on QAPI at DON School Training at the home office the week of 3/17/14. 4. An audit will be completed weekly for 4 weeks and then monthly by 3 months, by the administrator, to ensure that a complete investigation is completed with each medication discrepancy and to ensure that the we have completed a PI to indicate what was done for the affected resident and what was done for all other residents who have the potential to be affected. The administrator will ensure that medication errors are discussed monthly in the QA meeting. The Administrator and Director of Nursing created a calendar for staff responsible for auditing related to the Plan of Correction and will review all audits as they are turned in per the calendar schedule. Any concerns identified by the audits will be reviewed in a Quality Assurance Meeting and corrective actions will be taken.	4/01/14	



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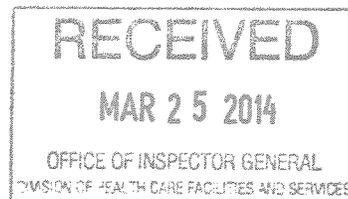
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F 520	<p>Continued From page 14</p> <p>the medication had been given on December 13, 16, 19, and 27. Closer review revealed no documentation that the resident refused the medication and the staff initialed the resident took all other medications ordered on those dates.</p> <p>Continued interview with the Administrator and DON, on 02/19/14 at 9:45 AM, revealed they were not aware of the blanks on the December MAR. They revealed there had been no monitoring of Resident #1's December MAR after the incident to ensure the resident received medications as ordered by the physician. The DON stated if the MAR had no staff's initials indicating the medication was given, the nurse following should have called the staff and asked if they had given the medication. She said no staff had informed her there were blanks on the December MAR and could not say the resident received the medication, Zyprexa 5 mg SL, as ordered by the resident's physician on those days the MAR was blank. The Administrator and the DON revealed there had been no oversight of staff or audits conducted to ensure the residents received their medications as ordered.</p> <p>Additional interview with the Administrator revealed she had not conducted a PI meeting (QA) regarding the incident. The Administrator stated the regular scheduled QA meeting had been held, but the incident had not been discussed and there was no action plans developed or any monitoring conducted since the incident. The Administrator said she considered the incident to be an isolated event and did not think it involved processes. She indicated since the facility could not determine if the resident received the medications or not, and the resident had no negative outcome, it was considered</p>	F 520	<p>The Signature Care Consultant provided them with a calendar to use to assure all routine QAPI audits are completed timely. Performance Improvement Audits will be distributed monthly by the Administrator to assigned department heads.</p> <p>5. Completion Date: April 1, 2014</p>	



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F 520	Continued From page 15 isolated. She revealed the Medical Director was informed of the incident, but not during a QA meeting. She confirmed no audits were conducted on any resident's MAR and since the medication error/incident was not found, it was not discussed in QA or with Pharmacy.	F 520			



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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/01/2014 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.