

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER-GREEN HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743	
(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  F 226 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 10/14-16/14. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p><b>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to implement written policies and procedures related to resident protection during investigations of allegations of mistreatment, neglect, and abuse of residents. The facility received an allegation of possible neglect on 10/14/14 and initiated an investigation. The alleged perpetrator who was working at the facility on 10/14/14 was allowed to complete the shift and was not suspended per facility policy until the following day on 10/15/14.</p> <p>The findings include:</p> <p>Review of the Abuse Policy (revision date 2013) revealed the Executive Director would be responsible to require the staff member to leave the property immediately and place the employee on immediate investigatory suspension while completing the investigation into the allegation of abuse or neglect.</p>	F 000  F 226	<p>Please See Attached</p> <p>Please See Attached word Document.</p>

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

TITLE

(X5) DATE

*[Signature]*

Interim Executive Director 11/24/14

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 226	Continued From page 1  Review of the medical record revealed Resident #7 was admitted to the facility on 05/28/14 with diagnoses including Esophageal Reflux, Mitral Valve Disorder, Renal Disease, Cerebrovascular Disease, and Anxiety. Review of the quarterly MDS assessment dated 08/22/14 revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate impairment with cognition.  Interview with Resident #7 on 10/14/14, at 11:40 AM (ET) during the initial facility tour revealed the resident stated he/she got "choked" while eating a piece of pie in his/her room on 10/13/14. Resident #7 stated he/she used the call light to call for help and a Certified Nurse Aide (CNA) responded. Resident #7 stated he/she told the CNA about the choking episode and that he/she was having trouble catching his/her breath. The resident also asked the CNA if he/she could go back to bed. Resident #7 stated the CNA stated she could not put the resident to bed without help, would have to go get someone to assist her, and would be back. However, the resident stated approximately 30 minutes elapsed before anyone came back to the room to help the resident. The resident stated he/she had been able to cough and call out for help during the episode, but experienced pain in the chest from where the pie was "lodged." In addition, the resident stated he/she had not reported the incident to anyone in Administration.  Interview with the facility Administrator on 10/14/14, at 1:00 PM, revealed she was not aware of the incident involving Resident #7. The Administrator stated an investigation would be	F 226		

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F 226 Continued From page 2  
initiated immediately into the allegation.

Further interview with the facility Administrator and the Assistant Director of Nursing (ADON) on 10/15/14, at 11:30 AM, revealed the facility had conducted an investigation and identified CNA #2 as the staff person who responded to Resident #7 on 10/13/14. According to the ADON, CNA #2 was working the day shift on 10/14/14 and was allowed to complete the shift after the incident was reported to the Administrator. The ADON stated the CNA would have been working the day shift on 10/15/14, but was already scheduled off. The Administrator and ADON stated they had not suspended the alleged perpetrator since the investigation had not been completed. The ADON stated after she had realized the incident could be considered neglect the CNA should have been immediately suspended.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED  
SS=E PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and facility policy review, the facility failed to provide services in accordance with the written plan of care for four (4) of twenty-one (21) sampled residents (Residents #1, #2, #16, and #18). Residents #1, #2, #16, and #18 required the use of an indwelling catheter and had care plan interventions to secure the catheter tubing to

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*Please see Attached word Document*

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prevent trauma or injury. However, observation during catheter care revealed the catheter tubing was not secured for Residents #1, #2, #16, and #18. In addition, Residents #1 and #16 had care plan interventions to provide catheter care per facility policy; however, observations revealed the facility staff failed to clean the catheter tubing prior to cleaning the perineal area.

The findings include:

Review of the Care Plan policy (no date) revealed the Certified Nurse Aides (CNAs) and nurses would be responsible for carrying out the interventions for the plan of care. The policy noted the CNAs would be responsible to review the CNA care plan (the green sheet) to identify specific care needs for their assigned residents. In addition, the policy noted the nurses would be responsible to monitor the CNAs by doing regular rounds every two hours.

Review of the Peri/Catheter Care policy (dated 2013) revealed the leg strap would be applied to secure the catheter tubing and the catheter tubing would be washed prior to cleaning the perineal area.

1. Review of the medical record for Resident #2 revealed the facility admitted the resident on 07/16/13 with diagnoses that included Stage III Chronic Kidney Disease, Hypertension, Chronic Ischemic Heart Disease, Depressive Disorder, and Diabetes Mellitus.

Review of the annual MDS assessment dated 07/10/14 revealed the resident required extensive assistance with toileting and required an indwelling catheter. Care plan interventions

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included providing catheter care as ordered, changing the catheter bag every month and as needed, and reporting any signs/symptoms of urinary tract infections to the physician as needed.

Observations of catheter care for Resident #2 on 10/15/14 revealed the catheter care was performed per policy; however, the tubing was not secured to the resident's thigh.

Interview conducted with CNA #1 on 10/16/14, at 4:00 PM, revealed she had been trained to secure the catheter tubing to prevent possible injury or trauma to the resident. However, CNA #1 stated the tubing was not secured to the resident if the resident was not out of bed most of the time.

2. Review of the medical record revealed Resident #18 was readmitted to the facility on 03/28/14 with diagnoses to include Chronic Kidney Disease, Anorexia, Hypertension, Benign Prostrate Hypertrophy, Urinary Tract Infection, and Advanced Alzheimer's Disease. Review of the admission MDS assessment dated 04/07/14 revealed the resident was assessed to require extensive assistance with toileting and to require and indwelling catheter. Care Plan interventions included providing catheter care every shift and as needed, to report and signs/symptoms of urinary tract infections, and to secure the catheter and tubing appropriately.

Catheter care was observed to be performed by facility staff for Resident #18 on 10/16/14, at 3:45 PM. Facility staff provided catheter care per policy; however, the tubing was not secured to the resident's thigh.

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Interview conducted with CNA #1 on 10/16/14, at 4:00 PM, revealed she had received training on catheter care and had been trained to secure the catheter tubing to prevent pulling on the tubing. CNA #1 stated the tubing was not secured to the resident's thigh unless the resident was out of bed and mobile.

3. Review of the medical record revealed Resident #1 was readmitted to the facility on 02/08/10 with Osteoporosis, Neurogenic Bladder, Depressive Disorder, Anemia, and Arterial Embolism. A review of the MDS assessment dated 08/13/14 revealed the resident was assessed to require extensive assistance with toileting. Further review of the medical record revealed a physician's order for a urinary catheter on 08/10/14 for declining condition, contractures, and to promote wound healing. Care plan interventions included providing catheter care every shift and as needed, to report any signs/symptoms of urinary tract infections, and to secure the catheter and tubing appropriately.

Catheter care was provided by CNA #5 for Resident #1 on 10/14/14, at 4:35 PM. Facility staff provided catheter care, washing the perineal area first and then using the same washcloth to wash the catheter tubing. The catheter tubing was not secured to the resident's thigh.

A phone interview conducted with CNA #5 on 10/16/14, at 5:20 PM, revealed she had received training on providing catheter care but couldn't remember if she had been trained to secure the tubing with a leg strap to prevent pulling on the tubing.

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4. Review of the medical record revealed the facility admitted Resident #16 on 08/31/14 with diagnoses of Congested Heart Failure, Anemia, Hypertension, Depression, and Digestive Disorder. A review of the MDS assessment dated 09/07/14 revealed the resident was assessed to require extensive assistance with toileting. Further review of the medical record revealed a 09/04/14 physician's order for a urinary catheter for urinary retention. Care plan interventions included providing catheter care every shift and as needed, to report any signs/symptoms of urinary tract infections, and to secure the catheter and tubing appropriately.

Catheter care was provided by CNA #3 for Resident #16 on 10/16/14, at 4:00 PM. Facility staff provided catheter care, washing the perineal area first and then using the same washcloth to wash the catheter tubing. The catheter tubing was not secured to the resident's thigh.

Interview conducted with CNA #3 on 10/16/14, at 4:20 PM, revealed she had received training on catheter care and to anchor the tubing with a leg strap but wasn't aware she was supposed to clean the catheter tubing first.

Interview with Registered Nurse (RN) #1 on 10/16/14, at 2:15 PM revealed she was the Director of Clinical Education for facility staff. RN #1 stated the nurses from each shift were responsible to attach a list that included care plan interventions to the daily shift report. This list was passed on to the oncoming nurses at the end of each shift. The nurses were responsible to check for compliance with implementation of the care plan interventions from that list. The nurse was then responsible to sign off on the CNA care plan

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to indicate that care plan interventions had been provided during that shift. RN #1 stated no problems had been identified.

Interview with the ADON on 10/16/14 at 7:50 PM, revealed catheter tubing was not generally secured for residents at the facility and stated she was not aware that it was the facility's policy. The ADON confirmed that nurses should sign off on the CNA care plan to indicate the care plan interventions had been provided for the residents during that shift. The ADON stated she was not aware of any problems related to care plan interventions not being provided.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
SS=D

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and facility policy review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) of twenty-one (21) sampled residents (Resident #7). Resident #7 had food to get "lodged" in his/her throat on

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*Please see Attached Word Document.*

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F 309	<p>Continued From page 8</p> <p>10/13/14 causing pain and some difficulty with breathing. The resident activated the call light to request staff assistance. Staff responded promptly, but left the resident unattended while going to get additional help from facility staff and failed to report the change in condition to the nurse.</p> <p>The findings include:</p> <p>Review of the notification of change in resident condition policy (no date) revealed the following would be considered a change in a resident's condition: an accident, acute illness, or a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly, a decision to transfer or discharge the resident, and expected or unexpected death.</p> <p>Review of the medical record revealed Resident #7 was admitted to the facility on 05/28/14 with diagnoses that included Esophageal Reflux, Mitral Valve Disorder, Renal Disease, Cerebrovascular Disease, and Anxiety. Review of the quarterly MDS assessment dated 08/22/14 revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate impairment with cognition. Further review revealed the resident was also assessed to require extensive assistance of two staff persons for transfers and ambulation.</p> <p>Review of the comprehensive care plan for Resident #7 revealed the facility addressed the mobility deficit for the resident with an intervention to provide transfer assistance and encourage the resident to come from a lying position to sitting</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>position and then to stand and pivot self into a chair with minimal assistance of two staff persons.</p> <p>Resident #7 was observed on 10/14/14, at 11:30 AM to be lying in bed with the head of the bed raised. The resident was neat and clean and was talking with a visitor.</p> <p>Interview with Resident #7 on 10/14/14, at 11:40 AM (ET) during the initial facility tour revealed the resident stated he/she got "choked" while eating a piece of pie in his/her room on 10/13/14. Resident #7 stated he/she used the call light to call for help and a CNA responded. Resident #7 stated he/she told the CNA about the choking episode and that he/she was having pain in his/her chest and trouble catching his/her breath. The resident also asked the CNA if he/she could go back to bed. Resident #7 stated the CNA stated she could not put the resident to bed without help, would have to go get someone to assist her, and would be back. However, the resident stated approximately 30 minutes elapsed before anyone came back to the room to help the resident. The resident stated he/she had been able to cough and call out for help during the episode, but experienced pain in the chest from where the pie was "lodged." In addition, the resident stated he/she had not reported the incident to anyone in Administration. The resident stated he/she could not recall the CNA's name and did not know who assisted him/her to bed on 10/13/14.</p> <p>Interview with CNA #2 on 10/14/14, at 4:15 PM, revealed she had been assigned to Resident #7 on 10/13/14 during the 7:00 AM to 3:00 PM shift. CNA #2 stated she answered the resident's call</p>	F 309		

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F 309	<p>Continued From page 10</p> <p>light sometime between 1:00 PM and 1:30 PM on 10/13/14. The CNA stated Resident #7 reported he/she was choking and the CNA asked if the resident needed a drink. The CNA stated the resident then stated, "I'll be all right, but I would like to lay down." CNA #2 stated she told the resident she would have to get another CNA to help her and asked the resident if he/she would be okay. CNA #2 stated the resident replied, "Yes." However, the CNA stated she was unable to immediately find a staff person to help her and went back to the resident's room to tell the resident it would be a few more minutes. CNA #2 stated the resident was still saying he/she still felt like "I need to catch my breath and lay down." The CNA stated she told the resident she was still trying to find help and left the resident's room. The CNA stated after approximately 15 minutes she and another CNA went to the resident's room and the resident was in bed at that time and the nurse was in the room with the resident. CNA #2 stated she did not report the change in condition to the nurse because she did not feel the resident was choking and she had not been trained to report that "type of change" in condition.</p> <p>Interview with RN #4 on 10/14/14, at 4:30 PM revealed she was the nurse on duty on 10/13/14. RN #4 stated a CNA came to the nurses' station at approximately 2:00 PM and reported Resident #7 was short of breath. The RN stated she could not recall the CNA's name. The RN also stated no one reported the resident had been choked or had food stuck in his/her throat. The RN stated she assessed the resident and found the resident in bed with his/her head down. RN #2 stated the resident's oxygen cannula was lying on the floor and the resident's oxygen saturation level was 89 to 90 percent and she started oxygen per nasal</p>	F 309	

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F 309	Continued From page 11  cannula and the oxygen level came up to 97 percent. The RN stated the resident routinely used oxygen but frequently removed the oxygen. RN #4 stated the CNA should have reported the choking episode immediately to a nurse.  Interview with the ADON on 10/14/14, at 2:00 PM, revealed staff was trained to identify a change in condition for residents. The ADON also stated staff was trained to report any change in condition immediately to the nurse or physician.	F 309		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide appropriate treatment and services to prevent urinary tract infections and/or trauma for four (4) of twenty-one (21) sampled residents (Residents #1, #2, #16, and #18). Observations during catheter care revealed facility staff failed to secure the catheter tubing to prevent trauma and/or infections for Residents #1, #2, #16, and #18. In addition, facility staff failed to clean the	F 315	Please See Attached word document.	

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F 315	<p>Continued From page 12</p> <p>catheter tubing per facility policy during catheter care for Residents #1 and #16.</p> <p>The findings include:</p> <p>Review of the Peri/Catheter Care policy (dated 2013) revealed the leg strap would be applied to secure the catheter tubing and the catheter tubing would be washed prior to cleaning the perineal area.</p> <p>1. Review of the medical record for Resident #2 revealed the facility admitted the resident on 07/16/13 with diagnoses that included Stage III Chronic Kidney Disease, Hypertension, Chronic Ischemic Heart Disease, Depressive Disorder, and Diabetes Mellitus.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated 07/10/14 revealed the resident required extensive assistance with toileting and required an indwelling catheter. Care plan interventions included providing catheter care as ordered, changing the catheter bag every month and as needed, and reporting any signs/symptoms of urinary tract infections to the physician as needed.</p> <p>Observations of catheter care conducted for Resident #2 on 10/15/14 revealed the catheter care was performed per policy; however, the tubing was not secured to the resident's thigh.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #1 on 10/16/14, at 4:00 PM, revealed she had been trained to secure the catheter tubing to prevent possible injury or trauma to the resident. However, CNA #1 stated the tubing was not secured to the resident unless the resident was</p>	F 315		

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F 315 Continued From page 13  
out of bed most of the time. F 315

2. Review of the medical record revealed Resident #18 was readmitted to the facility on 03/28/14 with diagnoses that included Chronic Kidney Disease, Anorexia, Hypertension, Benign Prostrate Hypertrophy, Urinary Tract Infection, and Advanced Alzheimer's Disease. Review of the admission MDS assessment dated 04/07/14 revealed the resident was assessed to require extensive assistance with toileting and to require an indwelling catheter. Review of the care plan revealed interventions included to provide catheter care every shift and as needed, to report signs/symptoms of urinary tract infections, and to secure the catheter and tubing appropriately.

Facility staff was observed to provide catheter care for Resident #18 on 10/16/14, at 3:45 PM. Facility staff provided catheter care per policy; however, the tubing was not secured to the resident's thigh.

Interview conducted with CNA #1 on 10/16/14, at 4:00 PM, revealed she had received training on catheter care and had been trained to secure the catheter tubing to prevent pulling on the tubing. CNA #1 stated the tubing was not secured to the resident's thigh unless the resident was out of bed and mobile.

3. Review of the medical record revealed Resident #1 was readmitted to the facility on 02/08/10 with Osteoporosis, Neurogenic Bladder, Depressive Disorder, Anemia, and Arterial Embolism. A review of the MDS assessment dated 08/13/14 revealed the resident was assessed to require extensive assistance with toileting. Further review of the medical record

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F 315	<p>Continued From page 14</p> <p>revealed a physician's order for a urinary catheter on 08/10/14 for declining condition, contractures, and to promote wound healing. Review of the care plan revealed the resident was at high risk for urinary tract infections and interventions included providing catheter care every shift and as needed, to report any signs/symptoms of urinary tract infections, and to secure the catheter and tubing appropriately.</p> <p>Catheter care was provided by CNA #5 for Resident #1 on 10/14/14, at 4:35 PM. Facility staff provided catheter care, washing the perineal area first and then using the same washcloth to wash the catheter tubing. The catheter tubing was not secured to the resident's thigh.</p> <p>Phone interview conducted with CNA #5 on 10/16/14, at 5:20 PM, revealed she had received training on providing catheter care however, she couldn't remember if she had been trained to secure the tubing with a leg strap to prevent pulling on the tubing.</p> <p>4. Review of the medical record revealed the facility admitted Resident #16 on 08/31/14 with diagnoses of Congested Heart Failure, Anemia, Hypertension, Depression, and Digestive Disorder. A review of the MDS assessment dated 09/07/14 revealed the resident was assessed to require extensive assistance with toileting. Further review of the medical record revealed a 09/04/14 physician's order for a urinary catheter for urinary retention. Review of the care plan revealed the resident was at risk for urinary tract infections and having an indwelling catheter. Interventions included providing catheter care every shift and as needed, to report any signs/symptoms of urinary tract infections, and to</p>	F 315		

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F 315	<p>Continued From page 15</p> <p>secure the catheter and tubing appropriately.</p> <p>Catheter care was provided by CNA #3 for Resident #16 on 10/16/14, at 4:00 PM. Facility staff provided catheter care, washing the perineal area first and then using the same washcloth to wash the catheter tubing. The catheter tubing was not secured to the resident's thigh.</p> <p>Interview conducted with CNA #3 on 10/16/14, at 4:20 PM, revealed she had received training on catheter care and to anchor the tubing with a leg strap; however, she wasn't aware she was supposed to clean the catheter tubing first.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 10/16/14, at 7:50 AM, revealed the CNAs were trained at least annually on catheter care and an annual competency evaluation was performed to ensure the CNA was performing catheter care per facility policy. The ADON stated it was not "general practice" to secure the catheter to the resident's thigh and she was not familiar with the policy. After reviewing the policy, the ADON stated the catheter tubing should be secured as written in the policy.</p>	F 315		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>	F 329	<p>Please See Attached Word Document.</p>	

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F 329 Continued From page 16

F 329

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure two (2) of twenty-one (21) sampled residents (Residents #13 and #16) were free from unnecessary medications. Resident #13 received Zoloft routinely; however, there was no gradual dose reduction (GDR) since February 2013. Resident #16 was identified with a drug allergy/intolerance to Oxycontin upon admission, and there was no clarification of the allergy prior to administering the medication to the resident.

The findings include:

A review of the facility's policies titled "Medication Administration Competency Guideline," with a revision date of January 2011, and "Medication Monitoring," with a revision date of November 2011, revealed the facility will demonstrate correct procedures for administering and documenting

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F 329	<p>Continued From page 17</p> <p>medications. Antipsychotic medications would be reviewed for a gradual dose reduction (GDR) within the first year, unless clinically contraindicated.</p> <p>1. Review of the medical record revealed the facility admitted Resident #16 on 08/31/14 with diagnoses of Congested Heart Failure, Anemia, Hypertension, Depression, and Digestive Disorder. Review of the admission Minimum Data Set (MDS) assessment, dated 09/07/14, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was moderately impaired cognitively.</p> <p>Review of the admission physician's orders dated 08/31/14, revealed Resident #16 was admitted with orders to receive Oxycodone (opiate analgesic) 5 milligrams every six hours as needed for pain. Further review of the physician's orders and review of the Medication Administration Record (MAR) revealed Resident #16 had a drug allergy to Oxycontin.</p> <p>Interview on 10/16/14 at 6:00 PM with Resident #16's physician revealed Resident #16 had been taking Oxycodone since August 2014 while in the hospital and had tolerated the medicine just fine. He further stated, "I believe she has a intolerance to the medicine instead of an allergy."</p> <p>Interview on 10/16/14 at 6:15 PM with Registered Nurse (RN) #2 revealed staff was responsible upon admission to check all medicines ordered against the resident's allergy list and the staff administering the medicines is also responsible for checking all medicines against the allergy list. She further stated, "I don't know if anybody called</p>	F 329		

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F 329	<p>Continued From page 18</p> <p>and checked the allergy against the medicines given but it was put in the computer as an intolerance instead of an allergy." However, there was no documented evidence that facility medical staff had validated the resident's tolerance to the medicine (Oxycodone).</p> <p>2. Review of the medical record revealed Resident #13 was admitted to the facility on 09/03/11 with diagnoses of Hypertension, Depression, Anemia, Dementia, Renal Failure, and Anxiety. Review of the current physician's orders revealed the physician had prescribed Zoloft 25 mg (antidepressant) daily to be administered to Resident #13.</p> <p>Review of the quarterly MDS assessment dated 07/31/14 revealed the resident was assessed to have a depression score of 1, which indicates minimal depression.</p> <p>Review of the "Psychoactive Medication Gradual Dose Reduction/Review," dated 02/20/13, revealed a dosage change/reduction was referred to the physician for review and no changes were recommended. Further review of the monthly pharmacy medication regimen review summary dated from 11/27/13 through 09/20/14 revealed there was no evidence a gradual dose reduction (GDR) evaluation had been conducted for the Zoloft since the 02/20/13 date.</p> <p>Interview conducted with the interim consulting pharmacist on 10/16/14, at 5:00 PM, revealed a GDR should be done two times a year when an antidepressant is initiated and then annually. The pharmacist stated she had only filled in at the facility for a couple of months and had not made a referral for the Zoloft because she believed it</p>	F 329		

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F 329 Continued From page 19  
had been addressed by the previous pharmacist.

F 431 483.60(b), (d), (e) DRUG RECORDS,  
SS=D LABEL/STORE DRUGS & BIOLOGICALS

F 329

F 431 *Please See Attached  
word Document.*

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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F 431	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's policies, it was determined the facility failed to ensure safe and secure storage of one (1) unsampled resident's medication (Resident D). In addition, a tablet identified as Carbidopa (medication used to treat Parkinson's Disease) was found lying underneath the heating and air conditioner unit in the South Wing dining area on 10/14/14.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, "Medication Administration Competency Guideline," dated revised January 2011, revealed new hires successfully complete the Medication Competency Testing prior to independently passing medications. Further review of the Medication Administration Competency Checklist for Oral Medication dated 09/21/10, revealed staff was to observe the resident swallow the medications and document their initials after administration of the medication.</p> <p>Observation on 10/14/14 at 11:00 AM, revealed six medicines were in the medicine cup on Resident D's bedside table. Facility staff was not observed in the resident's room and the medication had been left unattended.</p> <p>Interview with Resident D on 10/14/14 at 11:05 AM, revealed he/she had not taken the medication yet because a cold drink was not available.</p> <p>Interview with LPN #1 on 10/14/14 at 2:21 PM, revealed it was the policy of the facility to ensure</p>	F 431		

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F 431 Continued From page 21 F 431

medicines are placed in the mouth for the resident to swallow. Nursing staff was then to check the resident's mouth for any medicine that might be left behind. The LPN stated, "I left the medicine in one hand and Shasta cola in the other hand and I left the room." "I left the room for a lady in the next room to do a mini nebulizer treatment for pneumonia; my mistake."

Interview on 10/16/14 at 7:51 PM, with the Assistant Director of Nursing (ADON) revealed all nursing staff receives medication administration training upon hire during orientation and annually. Nursing staff is to remain with the resident while they swallow their medicine, "each and every pill," to make sure there is no problem and the resident is okay. The ADON stated medicines should absolutely not be left unattended or at the resident's bedside. The ADON further revealed she was responsible for conducting random medication pass evaluations, and had not identified any problems.

2. Review of the facility's policy titled "4.1 Storage of Medication," dated December 2008, revealed medications and biologicals were to be stored properly, following manufacturer's recommendations or those of the supplier.

Observation on 10/14/14 at 1:25 PM, of the South Wing dining area revealed a medication tablet was lying on the floor underneath the heating and air unit. Facility staff identified the medication tablet as Carbidopa (25 mg - 100 mg). Carbidopa is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms.

Interview on 10/16/14 at 7:51 PM, with the ADON

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F 431	Continued From page 22 revealed if nurses are doing medication pass and drop a pill they are to find and dispose of the medication.	F 431		

**Green Hill - Plan of Correction  
Annual State Survey 10.16.14  
11.24.14**

**2567 F-Tags**

**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**

**F 226 Develop/Implement Abuse/Neglect, Etc. Policies**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

On 10/15/14, the Certified Nursing Aide #2 (CNA #2) was placed on immediate investigatory suspension regarding the failure to report the change in condition of Resident #7 based on the alleged allegation of possible neglect.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

All residents have the potential to be affected. In the event of an employee, resident, friend, visitor, or family member who reports an alleged violation regarding potential abuse, neglect, injuries of unknown source, and/or misappropriations of resident property, the nursing home administrator (NHA), per the Abuse Policy (revision date 2013), will place the suspected perpetrator on immediate investigatory suspension while the NHA completes the investigation of the alleged abuse or neglect. The NHA will have the suspected perpetrator leave the property immediately for the protection of the resident.

In order to ensure there were no other unreported allegations of abuse, on 10/15/14 department managers interviewed all residents with a BIM score greater than eight, focusing on how they were treated by staff. As a result of the interviews, no issues were found. There were no other resident's identified to have unreported abuse.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

On 10/15/14, the NHA and Assistant Director of Nursing (ADON) were re-educated on the Abuse Policy (revision date 2013) regarding resident protection by the Field Services Clinical Director (FSCD) when an alleged violation has been reported and the direct responsibilities of the NHA to remove the suspected perpetrator from the property immediately. The Director of Clinical Education immediately initiated re-education to all other nursing staff on abuse/neglect and prompt reporting. All nursing employees were mandated to have the abuse re-education and successfully complete a written test to prove competency in the topic. Employee's are to be placed on immediate investigatory suspension while completing the investigation.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

To ensure the protection of the resident during investigations of allegations of mistreatment, neglect, and abuse of residents, as of 10/16/14, the Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) will discuss and review with the NHA the requirements, per the Abuse Policy (revision date 2013), regarding the immediate investigatory suspension for the alleged perpetrator to ensure it meets the qualifications for immediate employee suspension.

All residents to be monitored for any signs of abuse including but not limited to unexplained bruising and/or injuries as well as residents showing fear of staff or visitors. If any allegations of abuse are recognized, all residents will again be interviewed to determine if the abuse issue is contained or widespread.

The DON and/or ADON will bring the investigation summaries of the allegations to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further investigation summaries for employee suspension are needed to be reviewed and discussed by the NHA with the DON and/or ADON at the time of the allegation.

**Completion date 10/26/2014.**

#### **F 282 Services By Qualified Person/Per Care Plan**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

On 10/30/14, Resident #1, #2, #16, and #18 care plans were updated to include the indwelling catheter tubing to be secured with a leg strap at all times. On 10/30/14, Resident #1, #2, #16, and #18 orders were changed to include securing the indwelling catheter with the leg strap at all times on the TAR and the ADL sheets. On 10/16/14, the Director of Clinical Education (DCE) began in-service education for the hands-on nursing staff, Certified Nursing Aides (CNA's), on the Peri/Catheter Care policy dated 2013, for securing the indwelling catheter tubing with a leg strap and indwelling catheter tubing care with perineal care. The in-service education training for the CNA staff was completed 10/20/14.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

All residents with an indwelling catheter have the potential to be affected by the alleged deficient practice. New orders entered into the computer each day are reviewed in the Enhanced clinical start-up each morning. All new orders for residents that include an indwelling catheter will be reviewed by the interdisciplinary team (IDT) to ensure leg band orders are in place in the care plan, the TAR, and the ADL sheets for those specific residents. Enhanced clinical start-up occurs five days a week. All new nursing staff will be educated during their initial orientation on the Peri/catheter Care policy and procedure for indwelling catheter and perineal care. Nursing staff currently employed will be required to have a peri-audit done witnessed by the DCE in order to recognize any problems and correct immediately to ensure proper care is done. Peri-audits were started on 10/17/14.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

All Certified Nursing Aides (CNA's) will demonstrate the proper technique when providing indwelling catheter and perineal care by following the Peri/Catheter Care Policy (dated 2013). Director of Clinical Education (DCE) or a licensed nurse will observe each CNA providing catheter care by 11/16/14. After completion of the check-offs by the DCE or licensed nurse, the DCE will verify five CNA's per week for correct techniques for a total of four weeks, then bi-weekly for four weeks, then monthly for four months to ensure staff compliance with policy. Audits will be turned into the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON). Audits started on 10/17/14.

All nursing staff are required to perform a annual competency test for both indwelling catheter care and perineal care monitored by the Director of Clinical Education (DCE). If the staff member is not in compliance, re-education will be administrated at that time by the DCE.

DNS, DCE, MDS, and Charge Nurses will review residents plan of care to ensure compliance. Any issues noted will be immediately addressed and corrected.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

The DON and/or ADON will bring the results of the weekly/monthly audits to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits if needed. Annual competency test for indwelling catheter care and perineal care will be given to the CNA and nursing staff by the DCE. Competency tests were started on 10/17/14. All new CNA and nursing staff will also be educated during their initial orientation on the proper techniques of indwelling catheter care and perineal care per the Peri/Catheter Care Policy (dated 2013).

**Completion date 10/26/2014.**

### **F 309 Provide Care/Services for Highest Well Being**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

On 10/15/14, the Certified Nursing Aide #2 (CNA #2) was placed on immediate investigatory suspension regarding the failure to report the change in condition of Resident #7 based on the alleged allegation of possible neglect. The resident was given a thorough assessment by nursing staff to determine if the resident had any adverse effects. Resident found to have no issues and no long term effects from the change of condition.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

All residents have the potential to be affect by the alleged deficient practice. All Certified Nursing Aides (CNA's) were re-educated on the Change in Resident Condition policy through an in-service by the Director of Clinical Education (DCE) on the specifics of how to recognize a change in resident condition and how to immediately report any change in resident condition to the licensed nurse. The re-education process began on 10/16/14. The in-service education is based on the company Change in Resident Condition policy (no date).

Nursing staff was interviewed by ADON, DCE, and Nurses on the floor to ensure there were no other change of conditions or issues that they did not report to nurses. No issues found. Residents assessed throughout the shift and found to have no problems noted.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

On 10/20/14, all the Certified Nursing Aides (CNA's) staff were re-educated through an in-service on the definition of the change in resident condition by the Director of Clinical Education (DCE). Following the re-education of the change in condition, the DCE had each member of the CNA staff to verbalize the understanding of the definition of a change in resident condition. The Stop and Watch tool is located at each nurses station for changes noted that are not life threatening. For other changes in resident condition the CNA staff members are instructed think about their A-B-C's: (Airway, Breathing, and Circulation). For the CNA - shortness of air, trouble breathing, chest pain, signs of choking, and changes in the color of skin and to immediately report these changes in resident condition to the licensed nurse. The DCE will audit five CNA's per week, starting on 10/20/14, for their knowledge and understanding of the change in resident condition for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure the CNA's complete understanding of the change in resident condition. The audits will be turned into the Director of Nursing (DON) and/or Assistant Director of Nursing (ADON).

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

The DON and/or ADON will bring the results of the weekly/monthly audits to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and

determine the continued time schedule for further audits. Annually, the DCE will audit the CNA staff for a complete knowledge and understanding of the definition and signs of a change in resident condition and when to immediately report to a licensed nurse.

The STOP and WATCH forms that are to be filled out by the CNA's, will be turned in to the nurse, who will follow up and sign. The ADON/DON will review all change in conditions to ensure there was a timely response when a change of condition occurred.

**Completion date 10/26/2014.**

#### **F 315 No Catheter, Prevent UTI, Restore Bladder**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

On 10/30/14, Resident #1, #2, #16, and #18 care plans were updated to include the indwelling catheter tubing to be secured with a leg strap at all times. On 10/30/14, Resident #1, #2, #16, and #18 orders were changed to include securing the indwelling catheter with the leg strap at all times on the TAR and the ADL sheets. On 10/16/14, the Director of Clinical Education (DCE) began in-service education for the hands-on nursing staff, Certified Nursing Aides (CNA's), on the Peri/Catheter Care policy dated 2013, on the proper technique of peri care with and without an indwelling catheter.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

All residents have the potential to be affected by the alleged deficient practice. On 10/16/2014, the DCE began re-training the staff on providing perineal care with and without indwelling Foley catheters, using correct technique as stated in the facility policy. All CNA's will be observed on an one on one basis, by either the DCE or a licensed nurse, ensuring proper techniques are used, including securing the tubing with a leg band if applicable, while providing perineal care. This will be completed by 11/15/2014.

All residents who currently have urinary catheters had care plans reviewed and were assessed at bedside to ensure compliance with regulatory practice. Any new residents or current residents with new orders for a catheter will be reviewed by the DON/ADON to ensure proper compliance with care.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

All current nursing staff re-educated on the facility's catheter care policy. Staff demonstrated and verbalized understanding of the catheter care policy. Staff re-education began on 10/17/14.

The DCE or a licensed nurse will observe a minimum of 5 CNA's per week providing perineal care using proper technique x4 weeks. Then, bi-weekly x4 weeks. Then, monthly x 4 months to ensure staff compliance with policy. Audits will be turned into the DON and/or ADON.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

The DON, ADON, DCE, and MDS will audit to ensure compliance with resident's plan of care.

The DON and/or ADON will bring the results of the weekly/monthly audits to the QAPI committee for 2 quarterly meetings. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits if needed. Annual competencies for providing perineal care with and without indwelling catheter will be given to the CNA's by the DCE. All newly hired CNA's will be trained during their initial orientation on providing proper perineal care per the Peri/Catheter Care Policy (dated 2013).

**Completion date 10/26/2014.**

## **F 329 Drug Regimen is Free From Unnecessary Drugs**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

Resident # 16 was identified with a drug allergy/ intolerance, Oxycontin, upon admission. Resident was receiving Oxycodone 5mg p.o. every 6 hours as needed for pain. The MD was contacted for clarification to the listing. MD stated the medication was an intolerance, not an allergy. MD instructed nursing staff to remove the medication from the resident's allergy list related to absence of adverse reactions.

On a review of resident #13's current medications, it was noted that Zoloft 25 mg p.o. daily was ordered. Review of the quarterly MDS dated 7-31-14 revealed the resident was assessed to have a depression score of 1, which indicates minimal depression. Review of the monthly pharmacists' recommendations revealed there was no evidence of a gradual dose reduction since 2-20-13. The interim consulting pharmacist agreed a GDR should be done twice a year when an antidepressant is initiated, then annually. The pharmacist stated she had only filled in at the facility for a couple of months, and had not made a referral for the Zoloft because she believed it has been done by the previous pharmacist.

The pharmacist and MD were contacted regarding the Zoloft. As a result of a review of the medication, the medication was discontinued. Resident monitored for any adverse reactions as a result of the discontinuation and none were found.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

Any resident that has an allergy to any medication or is receiving an antidepressant or antipsychotic medication has the potential to be affected by the alleged deficient practice.

The Social Service worker and the restorative Nurse conducted an audit of all resident's on 10/20/14 regarding residents on anti-psychotic medication and anti-depressants to determine last dose reduction attempt. Any that were found to be out of compliance were given to the MD to review.

Pharmacist will review anti-psychotic medications and anti-depressants to determine if a dose reduction needs to be attempted. Those recommendations will then be given to the MD for review. Charge nurse will follow up on recommendations given to MD.

All medication orders for each resident will be cross checked against listed allergies. Any discrepancies found will be addressed immediately with the MD. This audit will be completed by the unit manager for each resident by 11/10/14.

New orders entered into the computer each day are classified by category such as 'antidepressant' or 'antipsychotic' and are reviewed by the IDT team in enhanced clinical start up each morning. The restorative nurse and the social services worker review all pharmacy recommendations monthly to ensure GDR's are completed in a timely manner. Parkview Psychiatric Services also makes recommendations every six weeks, those recommendations are also reviewed by the restorative nurse and social services worker. A monthly behavior meeting is held with the IDT team to further review antidepressant, antipsychotic, and hypnotic medications.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

A new medication/behavior review form has been initiated as of 11-01-14. Any resident who has been ordered an antidepressant, antipsychotic, and/or hypnotic medication is entered into this tracking form. This form includes the date of review, the drug order including date ordered, any moods/behaviors, any care plans in place, the last psych evaluation and recommendations and if they were followed. It also tracks the last AIMS assessment and identifies any problems, recommendations for dosage adjustment, and any follow up needed. The review will be conducted by the Social Service Worker and the DNS.

All newly admitting residents medication orders will be checked and signed by two licensed nurses verifying they have cross checked medications ordered with allergies listed. All nurses re-educated by the DCE on proper procedure for verifying allergies against medications ordered.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

The social services worker and the restorative LPN were both re-educated on how to complete the medication/behavior reviews by the Field Services Clinical Director (FSCD). The social services worker will bring the results from the medication/behavior reviews to the QAPI committee meeting for 2 quarterly meetings. The QAPI committee will determine if any further actions need to be taken to ensure GDR's are addressed in a timely manner.

The DON and/or ADON will review all newly admitted resident's orders to ensure two licensed nurses are cross checking medications against listed allergies and also ensuring any resident admitted with an antidepressant, antipsychotic, and hypnotic medication is entered into the medication/behavior review form. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits.

**Completion date 11/21/2014.**

#### **F 431 Drug Records, Label/Store Drugs & Biologicals**

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

LPN #1, on 10/14/2014, left medications on the bedside table of Resident # D. LPN #1 was re-educated by the DCE on the facility's policy regarding medication administration competency guideline dated (January 2011) on 10/14/14.

Further review of the medication competency checklist for oral medication states staff is to observe the resident swallow the medications, then document their initials after administration of medication. LPN #1 stated she was aware of the policy and acknowledged she had made a mistake.

Also observation on 10/14/2014, of the south wing dining area revealed a medication tablet was lying on the floor underneath the heating and air unit. The DCE instructed all nursing staff to immediately pick up any medication found on floor and dispose of properly.

All resident's immediately assessed by ADON and DCE to ensure no medications were left unattended in resident's rooms. All medication carts also audited to verify that medications were properly locked securely.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

Any residents who have orders for oral medications have the potential to be affected by the alleged deficient practice.

The DON, ADON, and DCE will do audits when medication pass is occurring to ensure this practice does not occur again and that all medications are secure.

Medication administration by licensed nursing staff will be monitored on a select number of residents for compliance with the facilities policy regarding oral medications.

Licensed nursing staff have also been instructed to locate and discard any medication that falls into the floor immediately.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

All nurses were re-educated on proper medication administration. Demonstration and verbalization of understanding was verified on each nurse by the DCE. Re-education began on 10/16/14.

The DCE or ADON will observe a minimum of 5 licensed nurses per week x 4 weeks, during medication administration to ensure the facility policy for medication administration is correctly followed. Then, bi-weekly x 4 weeks, and then monthly x 4 months to ensure staff compliance with medication administration competency checklist for oral medication guidelines continue to be followed. Audits will be turned into the DON and/or ADON.

**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

The DCE and ADON will complete audits weekly for four weeks, then biweekly for four weeks, and then monthly for four months. The DCE will bring audit results to two quarterly QAPI meetings.

Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken, and determine the continued time schedule for further audits.

**Completion date 11/10/2014**