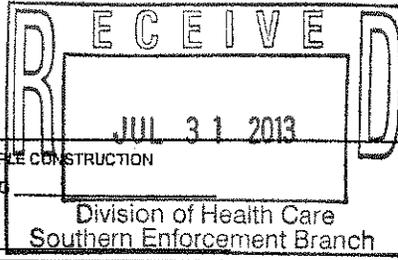


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 07/10/2013
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NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 21048 US HWY 421 SOUTH HYDEN, KY 41749
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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 An abbreviated standard survey (KY20405) was conducted on 07/10/13. The complaint was substantiated with deficient practice identified at "D" level.	F 000		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, it was determined the facility failed to provide pharmaceutical services to ensure periodic reconciliation of controlled medications, which included frequency, method, by whom, and pertinent documentation, was	F 425	Attached	7/31/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melissa Sparto* TITLE: *Administrator* (X6) DATE: *7-31-13*

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 425	<p>Continued From page 1</p> <p>conducted for three of four sampled residents (Residents #1, #2, and #4). A review of the Medication Administration Records (MARs) for Resident #1, Resident #2, and Resident #4 revealed a significant increase in the amount of narcotic (pain) medication the residents required. A review of the Resident's MARs revealed the change occurred in April 2013, May 2013, and June 2013, for Residents #1 and #2, and in May 2013 and June 2013 for Resident #4. An interview with Licensed Practical Nurse (LPN) #1 confirmed she had signed out narcotics for Residents #1, #2 and #4. However, the LPN stated medications were never administered to the residents as documented in the resident's records. LPN #1 continued to state she had given the narcotics to LPN #2. An interview with the facility Pharmacist on 07/10/13 revealed he had conducted medication reviews in April, May, and June of 2013 for the residents. However, the pharmacist stated he had not identified any concerns when the medication records were reviewed.</p> <p>The findings include:</p> <p>A review of the facility policy titled Medication Regimen Review, dated May 2007, revealed the policy failed to address how the facility would ensure controlled medications were periodically reconciled as required.</p> <p>1. A review of the medical record on 07/10/13, for Resident #1 revealed the resident had a physician's order which was obtained on 01/17/13 for Hydrocodone/APAP 7.5/650 milligrams (mg) (medication to relieve pain), to be administered every six hours as needed for pain. Further</p>	F 425		

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F 425	<p>Continued From page 2</p> <p>review of the medical record revealed the order remained current on 07/01/13.</p> <p>A review of Resident #1's MAR revealed facility staff administered one dose of Hydrocodone/APAP 7.5/650 mg during the month of January 2013. The MAR further revealed facility staff had not administered Hydrocodone/APAP 7.5/650 mg during the month of February 2013 and had administered three doses of the medication to the resident in March 2013. However, a review of Resident #1's April 2013 MAR revealed facility staff had administered 37 doses of Hydrocodone/APAP 7.5/650 mg to Resident #1 (27 doses of the medication were documented as being administered by LPN #1). A review of Resident #1's May 2013 MAR revealed 47 doses of Hydrocodone/APAP 7.5/650 mg were administered to the resident (40 doses of the medication were administered by LPN #1). The resident's June 2013 MAR revealed facility staff administered 41 doses of Hydrocodone/APAP 7.5/650 mg to the resident (37 doses were administered by LPN #1).</p> <p>2. A review of the medical record on 07/10/13 for Resident #2 revealed the resident had a physician's order for 7.5/650 mg of Hydrocodone/APAP, to be administered every six hours as needed for pain. Further review of the medical record revealed the order was current on 07/01/13; however, no original order date was obtained.</p> <p>A review of Resident #2's MAR revealed staff had administered two doses of Hydrocodone/APAP 7.5/650 mg during the month of January 2013. The MAR further revealed facility staff had not</p>	F 425			

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F 425	<p>Continued From page 3</p> <p>administered Hydrocodone/APAP 7.5/650 mg during the month of February or March 2013. A review of Resident #2's April 2013 MAR revealed facility staff had administered 39 doses of Hydrocodone/APAP 7.5/650 mg to Resident #2 (28 doses of the medication were documented to be administered by LPN #1). A review of the resident's May 2013 MAR revealed 48 doses of Hydrocodone/APAP 7.5/650 mg were administered to the resident (40 doses of the medication was administered by LPN #1). The resident's June 2013 MAR revealed facility staff administered 35 doses of Hydrocodone/APAP 7.5/650 mg to the resident (33 doses were administered by LPN #1).</p> <p>3. A review of Resident #4's medical record on 07/10/13 revealed a physician's order dated 05/06/13 for 7.5/650 mg of Hydrocodone/APAP (medication to relieve pain) to be administered every six hours, as needed, for pain.</p> <p>A review of Resident #4's MAR revealed the resident had received 17 doses of Hydrocodone/APAP 7.5/650 mg in May 2013 (16 doses were administered by LPN #1). A review of the resident's MAR for June 2013 revealed staff administered 20 doses of Hydrocodone/APAP 7.5/650 mg for the month of June (18 doses were documented to be administered by LPN #1).</p> <p>LPN #1 stated during an interview on 07/10/13 at 1:20 PM that she had signed out Hydrocodone/APAP 7.5/650 mg for Residents #1, #2 and #3 (unable to recall how many times or when she began to sign them out) with the intent to divert the medications to her supervisor, LPN #2. LPN #1 stated that although she had not</p>	F 425		

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F 425	<p>Continued From page 4</p> <p>observed the residents to be in pain, she had indicated on each resident's MAR that she had administered the medication to the residents. LPN #1 stated she gave the controlled medications to LPN #2 as a "favor." LPN #1 stated LPN #2 had told her that a "sick" family member with a terminal diagnosis needed the medication. LPN #1 continued to state she knew the diversion of controlled medications was wrong, "There's no excuse for what I have done; I have done a horrible thing."</p> <p>LPN #2 was unable to be reached for an interview during the investigation.</p> <p>An interview with the facility Pharmacist on 07/10/13 at 3:45 PM revealed he had conducted medication regimen reviews for Residents #1, #2, and #4 for the months of February, March, April, May, and June 2013, and had not identified any concerns. The pharmacist further stated he reconciled controlled medications in the facility by observing narcotic storage drawers and reviewing narcotic count sheets for accuracy. The pharmacist stated he checked each resident's MAR for frequent usage of medication only if the computer system "kicks out something for frequent use." Otherwise, the pharmacist stated he would not have a reason to check medication records for frequency of use.</p> <p>An interview with the Director of Nursing (DON) on 07/10/13 at 5:00 PM revealed she had not identified any concerns with the residents' medication frequencies or whom the medications were administered by until an allegation was reported to her on 07/01/13. The DON stated that prior to this incident each Clinical Coordinator</p>	F 425			

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F 425	Continued From page 5 was responsible to review all residents' MARs monthly for accuracy. According to the DON, prior to this incident she had asked the Clinical Coordinators each month if they had conducted the monthly medication reviews to ensure the MARs were accurate. The DON stated the previous Clinical Coordinator, LPN #2, would have conducted the monthly medication reviews, and stated since LPN #2 had been reported to have been involved in the medication diversion, she would not have notified her (the DON) of the concerns related to the documented administration of the controlled medications.	F 425		

Hyden Health and Rehabilitation Center

F 425

1. Residents #1, #2, and #4 were assessed for pain and any changes in pain per Administrative Nursing Staff. The medication regimens were reviewed per MD, FNP, and Pharmacist to ensure medications were warranted and dose reduction attempted and discontinued when appropriate. Residents #1, #2, and #4 received pharmaceutical services that ensured reconciliation of controlled medications including frequency, method, by whom and pertinent documentation. LPN #1 and LPN #2 were suspended immediately and employment was terminated on July 2, 2013.
2. All residents with pain medication were assessed for signs and symptoms of pain. The MARS and MD orders were reviewed by CQI consultant staff, facility administrative nursing staff, and the consultant pharmacist to ensure that residents were receiving medications as ordered, to observe for any identified areas of concern, and that all residents were receiving pharmaceutical services.
3. All licensed nursing staff received in-service education by the Administrative Nursing Staff on 7/01/2013 in regard to proper medication administration, narcotic documentation and assessing residents for pain. The Consultant Pharmacist reviewed regulation and made additional checks part of his monthly review including but not limited to reconciliation of Narcotics that required checks for method, frequency, signature, by whom and other pertinent documentation.
4. CQI committee designees will conduct weekly reviews of 5 residents per medication cart for proper signatures, frequency, correct count, and route of administration of controlled medications. These reviews will be conducted weekly for one month and then monthly. Any irregularities will be corrected immediately and reported to the CQI Committee for review and follow-up. Clinical coordinators of each unit will now review the MARS for the other unit and in addition all completed narcotic sheets will be reviewed by the Director of Nursing for any signature discrepancies, frequency, and pertinent documentation. The Consultant Pharmacist will conduct a random audit of residents on PRN medication.
5. Completion Date : 7/08/2013

Melissa Sparks
Administrator