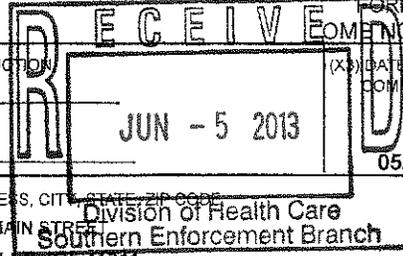


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2013

FORM APPROVED
NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2013
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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311
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F 000	INITIAL COMMENTS	F 000		
F 425 SS=E	<p>An abbreviated standard survey (KY20121 and KY20158) was initiated on 05/13/13 and concluded on 05/15/13. KY20121 was unsubstantiated with no deficient practice identified. KY20158 was substantiated with deficient practice identified at 42 CFR 483.60 Pharmacy Services, F0425, at "E" level.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation and policies, it was determined the facility failed to</p>	F 425	<p>F425</p> <p>1. Residents #4, and 10, were assessed for pain on May 8, resident #5 was assessed for pain on May 9, and residents 7, and 8, were assessed for pain on May 10 by the Director of Nursing, MDS Nurse, or Unit Manager with no signs/symptoms pain noted. Resident #9 was in the hospital at this time.</p> <p>Resident #6 was assessed for anxiety on May 10 with none noted.</p> <p>Residents' #4,5,6,7, 8 and 10 were all interviewed on May 9 or 10 by the Social Service Director, Director of Nursing or Unit Manager to ensure they are receiving their pain medications as scheduled and to ensure they are experiencing adequate pain relief. No issues were identified. All resident's bubble packs were reviewed by the Director of Nursing, Unit Manager or MDS nurse. All pills with tape over the backs were wasted appropriately by the Director</p>	6/4/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ed Hogan Administrator</i>	TITLE Administrator	(X6) DATE 6/5/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 425	<p>Continued From page 1</p> <p>ensure a system was in place for the receipt and disposition of narcotic medications for seven of ten sampled residents (Residents #4, #5, #6, #7, #8, #9, and #10). The facility identified discrepancies in the medication counts of the individual Narcotic Medication Cards (Narcotic Blister Packs) and the Individual Patient Narcotic Records (Narcotic Sign-out Sheets) and as a result discovered that Narcotic Blister Packs, as well as the corresponding Narcotic Sign-out Sheets, for Residents #4, #5, #6, #7, #8, #9, and #10 were missing from the facility.</p> <p>In addition, the facility failed to have an effective system in place to prevent loss or tampering with medications, and to define and monitor corrective actions for problems related to pharmaceutical services and medications for eight of eight unsampled residents (Residents A, B, C, D, E, F, G, and H). During inspection of the medication carts on 05/14/13, tape was observed to have been applied to the area of the packs utilized to access the specific medications for Residents A, B, C, D, E, F, G, and H. However, further observation of the packs revealed the medications in the Narcotic Blister Packs, that had been taped, did contain the correct medications.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Administration-Narcotic/Control Medication Accountability and Wasting of Controlled Meds," dated December 2010, revealed that at each shift change, or whenever cart keys were rendered, a physical inventory of all controlled medications should be conducted by two licensed nurses and</p>	F 425	<p>of Nursing, Unit Manager, MDS nurse and/or Staff Nurse.</p> <p>2. An audit was completed of all narcotic records for the month of April and May 2013 by the Regional Nurse Consultant, and Director of Nursing with no other issues identified.</p> <p>All inter-viewable residents were interviewed to ensure that they are receiving their pain medicine as ordered and are experiencing effective pain relief. All non-inter-viewable residents had clinical assessments to ensure adequate pain control.</p> <p>3. All NSG staff were in-serviced by the Director of Nursing/staff development co-ordinator/unit manager that upon completion of a narcotic package, the empty package will be stapled to the individual narcotic record and given to the DON and/or ADON and on not utilizing tape on any bubble pack. The individual narcotic record sheet will then be reconciled by the DON/ADON/Unit Manager to ensure accuracy.</p> <p>As of 06/04/13, two nurses will be required to sign in narcotics and place them in the cart.</p> <p>As of 06/04/13, The Unit Manager, ADON, Director of Nursing, MDS nurse,</p>		

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F 425	<p>Continued From page 2</p> <p>the inventory should be documented on the controlled substances accountability record. The policy further revealed that all controlled medications which had been prepared for administration, and later were contaminated or were unable to be administered, would be considered as wasted medications, and should be destroyed accordingly.</p> <p>1. Based on the facility's investigation, a review of the Controlled Substance Accountability Count, dated April 2013, revealed discrepancies in the counts of Narcotic Blister Packs and the Narcotic Sign-out Sheets. The facility's investigation revealed the medication cart should have had 6 Narcotic Medication Cards containing Hydrocodone (a narcotic analgesic), 30 tablets each, for Residents #4, #5, #7, #8, #9, and #10; however, based on the facility's report, the Narcotic Blister Packs and their corresponding Narcotic Sign-out Sheets were determined to be missing. Further review of the facility's investigative report revealed Resident #6's Narcotic Blister Pack for Diazepam (a controlled anxiolytic agent) which contained 30 tablets and its accompanying Narcotic Sign-out Sheet were both determined to be missing.</p> <p>Review of the Controlled Substance Accountability Count sheets (records reflecting the total number of Narcotic Sign-out Sheets and Narcotic Blister Packs) on 05/14/13 revealed the facility could account for all of its controlled substances (including narcotics).</p> <p>Interview on 05/14/13 at 12:05 PM, with Kentucky Medication Aide (KMA) #1 revealed staff performed narcotic (control substances) counts</p>	F 425	<p>or Staff Development coordinator will audit the "Controlled Substance Accountability Count" for accuracy and compare to the pharmacy manifest and the narcotics stored in the medication carts to ensure that all narcotics are accounted for weekly for 3 months. As of 6/04/13 The Unit Manager, ADON, Director of Nursing, MDS nurse, and/or Staff Development coordinator will audit all narcotic bubble packs once weekly for four weeks, then monthly for two months to ensure there is no tape on any bubble pack.</p> <p>4. Findings of the on-going audits to include time of any allegations and time of reporting allegations will be discussed in the June Quality Assurance Meeting and in the Quality Assurance Meeting for six months.</p>		

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F 425	Continued From page 3 by having two licensed staff persons count the narcotics at the beginning and at the end of each shift. KMA #1 further stated that offgoing staff used the narcotic book which contained the individual Narcotic Sign-out Sheets, to call off the name of the resident and the medication as the oncoming staff counted the number of pills in the Narcotic Blister Pack to ensure the count was accurate. Continued interview revealed the oncoming staff also counted the actual number of the Narcotic Blister Packs, while the offgoing licensed staff counted all the Narcotic Sign-out Sheets, thus ensuring that each blister pack had a corresponding sign-out sheet. The KMA denied there had been any problems with the narcotic counts and was not aware of any missing medications. Interview on 05/14/13 at 12:30 PM, with Licensed Practical Nurse (LPN) #1 revealed two licensed staff persons counted the narcotics at the beginning and end of each shift. LPN #1 stated the offgoing staff used the narcotic book which contained the individual Narcotic Sign-out Sheets and called off the name of the resident and the medication as the oncoming staff inventoried the pills remaining in the Narcotic Blister Pack to account for the accuracy of all pills. Continued interview with LPN #1 revealed the oncoming licensed staff also counted the actual number of Narcotic Blister Packs, while the offgoing licensed staff counted all the individual Narcotic Sign-out Sheets to ensure each blister pack had a corresponding sign-out sheet. The LPN denied there had been any problems with the narcotic counts and was unaware of any missing medications.	F 425			

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F 425	Continued From page 4 Interview on 05/14/13 at 1:04 PM with LPN #2 revealed at the beginning and end of each shift two licensed staff persons counted the narcotics. LPN #2 stated the offgoing staff used the narcotic book and called the name of the resident and the medication and the oncoming staff inventoried the number of pills remaining in the blister pack to make sure all medications were accurately counted. Continued interview revealed the oncoming staff should also count the actual number of Narcotic Blister Packs, while the offgoing licensed staff should conduct a count of all individual Narcotic Sign-out Sheets, thus ensuring each blister pack had a corresponding sign-out sheet. LPN #2 denied there had been any problems with the narcotic counts and was not aware of any missing medications. Interview on 05/14/13 at 1:45 PM with KMA #2 revealed two licensed staff persons counted the narcotics at the beginning and end of each shift. KMA #2 stated the offgoing staff used the narcotic book with all the individual Narcotic Sign-out Sheets and called off the name of the resident and the medication to the oncoming staff who counted the medication remaining in the Narcotic Blister Pack, ensuring an accurate accounting of all medications. Further interview revealed oncoming licensed staff should count the actual number of individual Narcotic Blister Packs, while the offgoing licensed staff was to count all individual Narcotic Sign-out Sheets to ensure there was the same number of blister packs as sign-out sheets. The KMA denied there had been any problems with the narcotic counts and was not aware of any missing medications.	F 425			

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F 425	Continued From page 5 Interview on 05/14/13 at 2:02 PM, with Registered Nurse (RN) #1, and on 05/14/13 at 3:02 PM with RN #2, revealed two licensed staff persons counted the narcotics at the beginning and end of each shift. Further interview with RN #1 and RN#2 revealed the offgoing staff used the narcotic book and called the resident's name and medication and the oncoming staff counted the number of pills remaining in the Narcotic Blister Pack for accuracy. Continued interview revealed the oncoming licensed staff also counted the total number of blister packs, and the offgoing licensed staff accounted for all individual sign-out sheets to ensure there were no discrepancies. The RNs denied there had been any problems with the narcotic counts and was not aware of any missing medications. Interview on 05/15/13 at 11:44 AM, with the Consultant Pharmacist revealed the pharmacist only conducted medication cart and narcotic audits if the facility requested the audit to be done. The Consultant Pharmacist stated the facility had not requested any audits of the medication carts or of the narcotic medications.	F 425			
	2. Additional observation of the Narcotic Blister Packs was conducted on 05/14/13. The observation revealed that although medications were intact within the blister packs, the seals to the area (slot) on the back of the blister packs that was to be used to access the medication had been broken and tape had been placed over the broken seals for the following medications and residents: - Hydrocodone 5/525 milligram (mg) (slot #8) for Resident A;				

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F 425	<p>Continued From page 6</p> <ul style="list-style-type: none"> - Lorazepam 0.5 mg (slot #28) for Resident B; - Hydrocodone 10/500 mg (slot #15) for Resident C; - Hydrocodone 5/500 mg (slot #26) for Resident D; - Hydrocodone 5/500 mg (slot #29) for Resident E; - Tramadol 50 mg (slot #20) for Resident F; - Hydrocodone 10/500 mg (slot #25) for Resident G; and - Tramadol (slots #18, #20, and #30) for Resident H. <p>Interview on 05/14/13 at 12:05 PM, with KMA #1 revealed the KMA did not know tape had been applied to the blister pack over the area used to access the medications. The interview further revealed medications removed from a blister pack but not administered should not be taped back into Narcotic Blister Packs but should be wasted in the presence of a witness.</p> <p>Interviews were conducted with both LPN #1 and LPN #2 on 05/14/13 at 12:30 PM and 1:04 PM respectively. LPN #1 and LPN #2 denied knowing that tape had been applied to the Narcotic Blister Packs over the area used to access the medications. Both staff members revealed medications should not be taped back into the blister pack but should be wasted in the presence of a witness.</p> <p>Interviews were conducted with KMA #2, RN #1, and RN #2 on 05/14/13 at 1:45 PM, 2:02 PM, and 3:02 PM respectively. All three staff persons denied knowledge that tape had been applied to the Narcotic Blister Packs over the area used to access the medications. All three staff members</p>	F 425		

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F 425	<p>Continued From page 7</p> <p>agreed that medications should not be taped back into the blister packs but should be wasted in the presence of a witness.</p> <p>Interview on 05/15/13 at 11:44 AM, with the Consultant Pharmacist revealed the Consultant Pharmacist was not aware the facility staff had applied tape to the backs of the Narcotic Blister Packs. The interview further revealed it was not good practice to tape the back of a blister pack, and if a medication was mistakenly taken out of a package staff should destroy the medication in the presence of a witness.</p> <p>Interview on 05/14/13 at 4:35 PM, with the Director of Nursing (DON) revealed to her knowledge administrative staff did not monitor the narcotic counts or the Controlled Substance Accountability Count unless there was a problem or discrepancy reported by staff. The interview further revealed the DON was made aware of the narcotics that were unaccounted for on 05/08/13 when the pharmacy informed a staff nurse that Resident #4 should have 20 to 30 pills remaining in the facility when the nurse attempted to reorder the Hydrocodone for Resident #4. The DON stated the facility began an investigation and discovered that in addition to Resident #4's medications that were unaccounted for there were narcotic medications missing for six additional residents (Residents #5, #6, #7, #8, #9, and #10). According to the interview with the DON, the facility reported the incident to the state agencies and the law enforcement agency. The interview further revealed the DON was unaware tape had been applied to the backs of the Narcotic Blister Packs because they had not inspected the backs of the cards during the</p>	F 425			

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F 425	Continued From page 8 review and were not aware why staff had taped the cards. The DON stated there was a possibility staff had mistakenly removed the medication from the Narcotic Medication Card and had taped the medication back into the cards; however, according to the DON, she would expect staff to waste a medication that had been taken out of a narcotic medication card and not used.	F 425			