STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	507529	A. BUILDING: _____ B. WING _____	06/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAVENDER FIELDS ASSISTED LIVING	150 WATER STREET Beverly, WV 26253

(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) COMPLETE DATE
E 112	64CSR14-5.2.f. The Licensee The licensee shall report major incidents, as defined in Subsection 3.23, to the office of health facility licensure and certification as soon as possible, and no later than the next business day. (Class III) DEFICIENT PRACTICE and FINDINGS: Complaint #4996 Based on interview on June 8, 2009 the administrator has failed to report a major incident to the licensing agency as required by this regulation. 1. During interview the Administrator stated an aide working the 11:00 p.m. to 7:00 a.m. shift on May 8, 2009 had taken, from the facility, twenty-two (22) Morphine pills belonging to Resident #1. The administrator had notified the police who arrested the employee on the morning of May 9, 2009 but neglected to notify the licensing agency as required by this regulation.	E 112	Directed Plan of Correction: The administrator will notify the licensing agency (OHFLAC) of any major incident which occurs at the facility as outlined in this regulation. If the police are notified, the licensing agency must be notified This notification must be done as soon as possible and no later than the next business day. Completion date: Immediately	
E 004	Complaint Investigation #4996 June 8, 2009 Census: 9 #5002 June 15, 2009 Census: 9	E 004	Directed Plan of Correction: The administrator will notify the licensing agency (OHFLAC) of any major incident which occurs at the facility as outlined in this regulation. If the police are notified, the licensing agency must be notified This notification must be done as soon	

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	Surveyors: Jane Cost, RN HFNS II Louise Hall, RN HFNS II		as possible and no later than the next business day. Completion date: Immediately	
E 206	64CSR14-7.4.g. Health Care Standards The licensee shall keep medications in a locked room, cabinet or other storage receptacle, accessible only to the staff responsible for medications. If a resident is capable of self administration of medication, the licensee shall provide him or her resources to store medications in a manner to be inaccessible to other residents. (CLASS I) DEFICIENT PRACTICE and FINDINGS: CI# 4996 Based on observation and interview on June 8, 2009, the administrator and supervising registered nurse have failed to assure all resident medications remain locked and accessible only to those individuals responsible for medication administration. 1. Observation at approximately 10:00 a.m., revealed the medication cart, located in the hallway between the kitchen and the laundry room, was unlocked and unattended. 2. Observation revealed six (6) of the current residents were either in the dining area or the living area of the home, which is a large open room at the entrance of the home and directly	E 206	CI# 4996 The supervising registered nurse must conduct an inservice with all Approved Medication Assistive Personnel (AMAP) regarding the following: * Basic medication administration by AMAP. * The requirements for locking the medication cart and safely maintaining resident medications. * The requirements for double locking Schedule II medications. (Double locked with two separate keys to access.) This inservice should be presented as a classroom type inservice. An outline of information presented should be maintained on file and available for surveyor review. Each AMAP must provide their dated signature to verify their receipt of the inservice.	07/13/09

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	adjacent to the hallway and the medication cart, leaving the medications accessible to residents and visitors alike. 3. During interview, PK, Aide/Cook, who was working in the kitchen at the time, stated the Approved Medication Administration Personnel (AMAP) was "down the hall" providing personal care to a resident. 4. During interview, the supervising registered nurse and the administrator both acknowledged leaving the medication cart unlocked was unacceptable and stated BL, AMAP, "knew better.".			
E 209	64CSR14-7.4.j. Health Care Standards If Schedule II drugs of the Uniform Controlled Substances Act W. Va. Code §60 A -1-101 et seq. are administered, a copy of the written prescription signed by the physician shall be in the resident's record and a proof of use record shall be maintained. Schedule II drugs shall be stored in a manner so that they are securely protected by two (2) locks. The key to the separately locked Schedule II drugs shall not be the same key that is used to gain access to non-scheduled drugs. (CLASS I) DEFICIENT PRACTICE and FINDINGS: CI# 4996 Based on observation, review and interview on June 8, 2009, the administrator and supervising	E 209	CI# 4996 The supervising registered nurse must conduct an inservice with all Approved Medication Assistive Personnel (AMAP) regarding the following: * Basic medication administration by AMAP. * The requirements for locking the medication cart and safely maintaining resident medications. * The requirements for double locking Schedule II medications. (Double locked with two separate keys to access.) This inservice should be presented as a classroom type inservice. An outline of information presented should be maintained on file and available for surveyor review.	07/13/09

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	registered nurse have failed to assure all Schedule II medications are maintained and protected by two (2) separate locks. 1. Observation at approximately 10:00 a.m., revealed the medication cart, located in the hallway between the kitchen and the laundry room, was unlocked and unattended. Therefore, the narcotic drawer located within the medication cart was maintained by only one (1) lock on the drawer and not by two (2) locks as required. 2. Review of patient ordered medications revealed Resident #1 has the following Schedule II medication order: Morphine Sulfate 15mg. One (1) p.o., qd at 8:00 p.m. Observation revealed Resident #1 had Morphine available in both pill form and in liquid form. 3. Observation revealed six (6) of the current residents were either in the dining area or the living area of the home, which is a large open room at the entrance of the home and directly adjacent to the hallway and the medication cart, leaving the medications accessible to residents and visitors alike. 4. During interview, PK, Aide/Cook, who was working in the kitchen at the time, stated the Approved Medication Administration Personnel (AMAP) was "down the hall" providing personal care to a resident. 5. During interview, the supervising registered nurse and the administrator both acknowledged leaving the medication cart unlocked was unacceptable and stated BL, AMAP, "knew better."		Each AMAP must provide their dated signature to verify their receipt of the inservice.	