| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**185095** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**03/08/2014** |
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| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GOLDEN LIVINGCENTER - HILLCREEK** | **3116 BRECKINRIDGE LANE<br>LOUISVILLE, KY 40220** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **<b>Make sure services provided by the nursing facility meet professional standards of quality.</b>**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, and review of the facility's Investigation Report, Medication Administration Policy and the Licensed Practical Nursing Scope of Practice in Kentucky, it was determined the facility failed to have an effective system to ensure medications were administered according to professional standards for one (1) of ten (10) sampled residents (Resident #1). On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name. Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation.<br>Resident #1 was evaluated by the emergency room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), [MEDICAL CONDITION] and [MEDICAL CONDITION]. Resident #1 was hospitalized for [REDACTED].<br>(Refer to F333) In addition, interview and review of the facility's Nursing Competency revealed LPN #1's competency in medication administration had not been validated per the facility's policy. The facility's failure to ensure medication was administered according to the nursing standards of practice has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/14, and was determined to exist on 02/19/14.<br>The facility was notified of the Immediate Jeopardy on 02/28/14. An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a D while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's Licensed Practical Nursing Scope of Practice in Kentucky, dated July 2013, revealed the LPN was required to practice nursing with reasonable skill and safety. Even though the act may be within the scope, if the LPN did not have the training and skills, the act should not be done. Review of the facility's Nursing Competency Checklist revealed an assessment of clinical competency of nursing personnel would be completed during the orientation period. The competency checklist was an on going tool, to be completed within ninety (90) days of hire. Validation for clinical competency would be completed during orientation with the various assigned staff. Review of the facility's Medication Administration, General Guidelines, dated October 2007, revealed residents were identified prior to administration of medications. Residents should be identified using three (3) identifiers prior to medication administration. Room numbers should not be used as one (1) of two (2) identifiers. The procedure was to use one (1) of the following procedures: check the identification band; check the photograph attached to the medication administration record; and/or verify the resident's identification with other nursing care center personnel.<br>Review of the facility's investigation, undated, revealed Resident #1 received the incorrect medication on 02/19/14. LPN #1 entered the resident's room and called Resident #1 by Resident #2's name and Resident #1 answered and sat up in the bed. LPN #1 administered Resident #2's medications to Resident #1. Further review revealed there was no evidence LPN #1 compared the pictures of Resident #1 or Resident #2 to Resident #1 or asked Resident #1 his/her name. Review of Resident #1's Medication Administration Record (MAR), dated February 2014, revealed on 02/19/14 the medications scheduled for 8:00 AM and 9:00 AM, were coded on the MAR as not administered indicating the documentation would be located in the nurses notes as to why the medications were not administered. Corresponding nurses notes indicated Resident #1 did not receive his/her ordered medications related to the transfer out to the hospital for an evaluation. Interview with LPN #3, on 02/25/14 at 11:35 AM and on 02/26/14 at 3:22 PM, revealed LPN #1 was assigned to her for the day shift, on 02/19/14, when the medication error occurred. She stated she had observed LPN #1 preparing and administering medications for another resident just prior to the incident. She had no concerns with LPN #1's ability to perform the task at that time; however, LPN #3 stated she was not familiar with where LPN #1 was in her orientation. LPN #3 revealed the rights of medication administration should be observed; however, LPN #1 did not do this and administered the medications to the wrong resident. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed she was hired on 02/10/14 and had been on the unit providing direct resident care for three shifts. She stated, prior to coming to work at this facility, she had worked in a physician's office since October 2013.<br>She revealed she entered Resident #1's room and called the resident by the name of Resident #2. Resident #1 answered and she proceeded to administer the medications to Resident #1 which had been prepared for Resident #2. She stated she had several interruptions during the medication pass. LPN #1 stated she should have gone back and checked the photo in the MAR and had someone else to go with her to identify the resident. She stated she was still in orientation and was not familiar with the residents. LPN #1 revealed she did not follow the nurse practice by not making sure the right resident was administered the right medications. She stated her medication competency was not completed prior to the medication pass on the morning of 02/19/14. Interview with the Director of Nursing Services (DNS), on 02/26/14 at 5:31 PM, revealed the Licensed Practical Nursing Scope of Practice in Kentucky was the standards of practice used in this facility. The LPN Scope of Nursing was not followed by the nurse administering the medication to the wrong resident. She stated LPN #1 had passed her nursing boards and was an LPN; therefore, she felt that qualified LPN #1 to pass medications. LPN #1 was assigned to a seasoned nurse on the unit during orientation and remained assigned to this nurse. She stated the staff in orientation had ninety (90) days to complete their competency check off list and the medication competency was included in the competency check list to be completed within the ninety (90) days. She revealed the medication error should not have occurred. She further stated the prior nursing administration had stopped using the arm band as a form of identification; however, it remained as an option in the facility's policy and procedure for resident identification. If the identification bracelet had been in place, that would have been an additional layer for identifying the residents and possibly prevented the occurrence of the medication error. The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 2/19/2014 at approximately 9:00 AM, Resident #1 received five medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the emergency room (ER) at 9:04 AM. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital. Upon arrival at the hospital, he/she was in stable condition. 2. All residents had the potential to be affected. The facility took immediate action to ensure the safety of all residents. Licensed Practical Nurse #1, who gave Resident #1 the medications in error, was removed immediately from the cart. Licensed Practical Nurse #2, who had previously worked at the facility for several years, was |

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

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| F 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>also in orientation. Both Licensed Practical Nurses received education on 02/19/14 on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1, Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. 3. On 02/19/14, the Director of Clinical Education immediately began education with all licensed nurses on the 8 rights of medication administration; Medication Error and Adverse Drug Reaction Reporting Policy 6.2; Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. Initiation of medication observations competencies for all licensed nurses was started first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and have medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure residents have an order for [REDACTED]. Medication observation competencies will be completed when a medication error is identified, and annually for all licensed nursing staff. 4. On 02/19/14 at approximately 7:00 PM, the Director of Nursing Services (DNS) completed an electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 02/27/14. 5. On 02/20/14 at 11:00 AM, the Medical Director attended Quality Assurance Performance Improvement (QAPI) to discuss the medication error and Resident #1's current condition. The Medical Director agreed with the plan/AOC to address medication errors, which included: immediately removing the licensed practical nurse who administered medications in error to Resident #1 from the medication cart; education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration; Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; in-service education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; and auditing resident photographs in eMARs/eTARs. 6. On 02/22/14 the DNS contacted the consultant pharmacist regarding the medication error and requested the pharmacy's assistance in medication pass observations. On 03/02/14, the DNS spoke with the consultant pharmacist and discussed notification of the IJs, initial AOC Plan, QAPI to be held on 02/24/14, and the pharmacy plan for the coming week. Consultant Pharmacist was at the facility on 03/04/14. The DNS reviewed the QAPI meeting, and AOC/plan from 03/04/14. During his visit, the pharmacist also conducted medication reviews. On 03/04/14 additional Pharmacy consultants began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. Any issues identified in review of audits would be tracked and trended with follow-up actions or education for staff completed as needed. No issues were identified at this time. 7. Medication errors for the previous 6 month period were reviewed and analyzed by the DNS and Field Services Clinical Director on 02/26/14 with no trends noted. 8. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate. 9. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents for arm bands. There were one-hundred thirty-nine (139) residents audited and only two (2) had arm bands in place. The facility decided all residents would wear arm bands as another form of identification per the facility's policy. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for the Admission Coordinator, House Supervisors, and Unit Managers was provided by the DNS on 02/27/14. 10. On 02/24/14, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of identification. 11. On 02/24/14 at 8:00 AM, an Ad Hoc QAPI was held to discuss the facility's implementation of their plan to decrease medication errors which included; immediate removal of the licensed practical nurse who administered medications in error to Resident #1 from the medication cart, education for the licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; completing medication observation pass competencies with an RN; auditing all records for photographs; implementing use of armbands as another form of identification; immediately auditing all residents for armbands; auditing resident room doors for correct names; revising the orientation process to include medication administration competencies prior to being assigned to the floor; notifying the pharmacist of the error and requesting assistance with medication pass observations and audits; reviewing the previous 6 months of medication errors to identify trends; and conducting medication pass audits weekly. The Executive Director, Director of Nursing Services, 2-Unit Managers, Director of Clinical Education, 2-Social Services, Transitional Care Nurse, Business Office Manager, Human Resources Personnel, Medical Records Clerk were present. The meeting minutes were reviewed with the Medical Director. 12. On 03/04/14 the RN Assessment Coordinators began education with all licensed nurses on Care Plans which included: initiating the care plan, how the care plan related to the care of the resident, how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated, care plan criteria, and components of a nursing progress note. The training also included accessing and reviewing care plans in the Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstrations included how to access the plan of care in Point Click Care, and explaining the plan of care is an integral part in performing individualized care for each resident. It was also explained the nurses must utilize information found in resident's plan of care to provide care every shift. In additional education was provided on how to locate plan of care documentation under the dashboard; medical diagnosis; orders, care plan tabs in the PCC, and also on the MAR. In addition resident's charts have H&Ps and physician progress notes [REDACTED]. Participants were allowed to ask questions; verbalized understanding; and, performed return demonstration. 13. Orientation for all new licensed nurses hired after 02/24/14 will include medication pass observation competencies by the Director of Clinical Education (DCE) prior to being assigned to the floor for orientation with another licensed nurse. Licensed nurses selected by Director of Nursing Services to conduct on the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, prior to orientating any additional licensed nursing staff. This training will include: defining preceptor/mentor; explaining the role of preceptor and orientee; adult learning principles; strategies for effective precepting; challenges of being a preceptor; goals of the program; working with staff at different stages of clinical competence; working with diversity; safe and ethical practice; communication; critical thinking; nursing process to problem solve; assessing preceptor progress; skills objective; knowledge objective; affective objective; continuous interaction and feedback on preceptor/orientee, preceptor/orientee/Director of Clinical Education; and progress, conflict, and transition, for their role as a preceptor/mentor. Until additional training can be initiated, the Director of Clinical Education, will complete on the floor orientation with all new licensed nurses. 14. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in place will immediately have an arm band placed and the reason the arm band was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Manager and DNS. The results would be discussed weekly in the QAPI meeting. 15. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into Point Click Care (PCC). Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Managers. The results would be discussed weekly in the QAPI meeting. 16. The DNS, ADNS, DCE, & RN Supervisors began conducting a medication pass audit on 03/01/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Results would be analyzed and trends noted weekly by the DNS. The results would be reviewed and discussed weekly in QAPI meeting. 17. On 03/03/14, an Ad Hoc QAPI was held to discuss the facility's monitoring of the plan to decrease medication errors. Also, the Pharmacy consultants plan for conducting a 3-way audit of physician orders/medication |

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| F 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>conducted of the medication rooms and carts. In addition, discussion of the need to begin education with all licensed nurses on Care Plans and how the care plan related to the care of the resident, including training on accessing and reviewing care plans in PCC. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 03/04/14. 18. A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits. Audits will be tracked and trended with follow-up actions or education for staff completed as needed by the QAPI Committee. If the Medical Director is unavailable in person on a weekly basis, he will review progress by phone with Executive Director and/or DNS. The State Survey Agency validated the AOC on 03/08/14 through observation, interview and record review. 1. Interview with the Director of Nursing Services (DNS), on 03/08/14 at 10:45 AM, revealed she was notified of the medication error shortly after the error occurred. She stated, the staff notified the Advanced Registered Nurse Practitioner (ARNP) via text message per LPN/Unit Manager from 100 Unit, on 02/19/14 at 9:04 AM. The text message, at 9:04 AM, provided the medications involved and the oxygen (O2) levels at 82%. Review of the copied text message, identified with the ARNP's name, date and time, revealed the ARNP returned orders at 9:05 AM via text message to send Resident #1 to the hospital for a medical evaluation. Review of the emergency department records revealed Resident #1's vital signs were not suppressed; however, he/she did have a significantly abnormal chest x-ray. 2. Interview with the DNS and record review, on 03/08/14 at 10:45 AM, revealed the initial investigation identified the medication error occurred with a newly licensed, Licensed Practical Nurse (LPN). The nurse was identified as LPN #1. She was removed from the medication cart and medication pass orientation. She was provided education on the 8 rights of medication administration. Review of the education attendance roster recorded dated of 02/19/14, revealed LPN #1 and #2 signed the sheet indicating their attendance. Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provided during the monthly orientation. Review of the staff attendance form validated inservice attendance. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed once the medication error was identified and reported, she was removed from the medication cart. She was reassigned with the Director of Clinical Education and Restorative Nursing to become more aquatinted with the residents. She reported her orientation was extended. Review of the statement of occurrence, on 02/19/14, completed by the DNS, dated 02/27/14, revealed LPN #2 was in her fifth (5th) and last day of orientation. She completed an in-service related to the 8 rights of medication administration and medication error, and adverse drug reaction reporting. The statement stated, LPN #2 completed the medication administration competency, on 02/23/14, for E-Kit use and reordering, oral medications, eye medications, enterals, injections and the disposition of controlled medications. She was administered two (2) test for competency verification. She passed both examinations. 3. Review of the rights of medication administration education, evidenced by the attendance roster revealed education was completed on 02/19/14, 02/21/14, 02/22/14 and 02/24/14. The Director of Clinical Education began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. Initiation of medication administration observation competencies for all licensed nurses was started on the first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and had medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure resident has an order for [REDACTED]. Interview with RN #1 and LPN #4, on 02/27/14 at 7:25 AM and 7:40 AM, respectively, revealed they had received in-servicing on the 8 rights of medication administration. Interview with House Supervisor #2, on 03/08/14 at 5:20 PM, revealed any staff identified as on leave of absence and had not completed the training by the Director of Clinical Education would receive the education upon their return before they would be allowed to work. There were three (3) on medical leave and four (4) as needed staff who rarely worked a schedule. The House Supervisor had a packet of education materials for each person when any of these individuals worked again. 4. Interview with the DNS, on 03/08/14 at 1:30 PM, revealed she completed the electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR on 02/19/14, prior to her leaving the facility at 7:00 PM. Review of the audit completed on 02/19/14, by the Director of Nursing Services, revealed it was completed to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Review of the I-pad with the DNS, on 03/08/14 at 1:45 PM, revealed she checked to ensure each resident had a current picture. She stated she did update two (2) of the pictures. Review of the inservice on electronic photos, dated 02/27/14 revealed education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Telephone interview with the 200 Unit Manager and 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed they had been trained and directed to ensure each resident had a picture on their electronic record. 5. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance. Topics of discussion, included the medication error of 02/19/14, which was identified as a routine monthly meeting. 6. Review of the medication pass observations revealed the consultant pharmacist was on location on 03/04/14 and initiated medication pass observations. The pharmacy consultant began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. No issues had been identified with the completed med pass observation; however, this was ongoing and pending review. 7. Review and interview with the DNS and Field Services Clinical Director on 03/07/14 at 5:15 PM, revealed medication errors for the previous six (6) month period were reviewed and analyzed on 02/26/14 with no trends identified. 8. Observation during tour of twenty-five (25) rooms on the 300 Hall, on 03/08/14 at 5:15 PM, revealed each resident room had a name identification on the outside of the door in the hall. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the doors (resident rooms) were audited on 02/23/14. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident photos were completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each door for a resident name. There were no doors found without appropriate names. 9. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the arm bands were audited on 02/23/14, and placed on the residents as another form of identification. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident armbands was completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each resident for an armband. There was a total of one-hundred thirty-nine (139) residents on the census. They found two residents who already had an armband on and the rest were provided a new armband. Review of the inservice staff attendance record revealed an inservice on arm bands was conducted on 02/27/14, with the Admission Coordinator, Staffing Coordinator, House Supervisors and the Unit Managers. 10. Observations of fifteen (15) residents on 02/26/14 revealed the residents had arm bands in place. 11. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance and was a routine monthly meeting. The topic of discussion was the plan to decrease medication errors. An Ad Hoc QAPI meeting was held, on 02/24/14, related to the medication error occurrence, dated 02/19/14, for ongoing auditing, monitoring and re-evaluation. Interview with the Executive Director and The DNS, on 03/08/14 at 2:00 PM, revealed the QAPI meetings are ongoing weekly, with the auditing, reviewing and re-evaluation of the findings of the auditing and on target. 12. Review of the education content regardng care plans, completed on 03/04/14, by |

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

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| F 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 3)<br>plan is developed and updated; care plan criteria; and components of a nursing progress note. It also included training on accessing and reviewing care plans in Point Click Care. Demonstrations included: how to access the plan of care in Point Click Care, and explaining the plan of care was an integral part in performing individualized care for each resident. The nurses must utilize information found in the resident's plan of care to provide care every shift. Education included how to locate plan of care documentation under the dashboard; medical diagnosis; orders; care plan tabs in the PCC; and also on the MAR. In addition the education covered the residents' charts containing H&Ps and physician progress notes [REDACTED]. All training was performed in small groups or 1:1 by the RN Assessment Coordinators. Participants asked questions; verbalized understanding and performed return demonstration. Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM, revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provide during the monthly orientation related to the care plans. She reported she would be providing training with staffing related to the use of the care plans, how to access and update, when needed. Telephone intervie |
| F 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **<b>Provide care by qualified persons according to each resident's written plan of care.</b>**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, review of the facility's Investigation, Hospital History and Physical and the facility's Resident Care Plan policy and procedure, it was determined the facility failed to administer medications as ordered per the care plan for one (1) of ten (10) sampled residents (Resident #1). On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name. Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation. Resident #1 was evaluated by the emergency room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), [MEDICAL CONDITION] and [MEDICAL CONDITION].<br>Resident #1 was hospitalized for [REDACTED]. (Refer to F333) The facility's failure to implement the care plan related to the administration of medications as ordered by the physician has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/14, and was determined to exist on 02/19/14. The facility was notified of the Immediate Jeopardy on 02/28/14. An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a D while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Per interview with the Director of Nursing Services (DNS) on 02/27/14 revealed the facility referred to the Federal Regulatory Requirements and the Resident Assessment Instrument (RAI) as their guidance on care planning. Review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) 3.0 Manual, Chapter 1, page 10, revealed residents respond to individualized care. Chapter 4, page 12, revealed approaches serve as instructions for resident care and provide for continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions consistently. Overall care plans should be oriented towards applying current standards of practice in the care planning process. Review of the facility's investigation, undated, revealed Resident #1 received the incorrect medication on 02/19/14. LPN #1 entered the resident's room and called Resident #1 by Resident #2's name and Resident #1 answered and sat up in the bed. LPN #1 administered Resident #2's medications to Resident #1. The resident had a change of condition within the hour prior to receiving the wrong medication. Once the Nurse Practitioner was made aware she sent the resident to the hospital where he/she was admitted with [MEDICAL CONDITION]. Review of the clinical record for Resident #1 revealed the facility admitted the resident, on 07/02/12, and readmitted , on 01/03/14, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set Assessment, dated 02/03/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15) of fifteen (15). Review of Resident #1's, Comprehensive Care Plan revised on 02/27/13, revealed an intervention to provide medications as ordered by the physician. Review of Resident #1's, February 2014 MAR, revealed on 02/19/14, the medications ordered by the physician were scheduled for administration, at 8:00 AM and 9:00 AM, were coded on the MAR indicated [REDACTED]. Corresponding nurses notes dated 02/19/14 indicated Resident #1 did not receive his/her ordered medications related to the transfer out to the hospital for an evaluation. The medications Resident #1 was scheduled to receive, on 02/19/14 at 8:00 AM: were [MEDICATION NAME] 800 milligram (mg) for Muscle Spasm; and at 9:00 AM:<br>[MEDICATION NAME] 5 milligram (mg) for [MEDICAL CONDITION]; [MEDICATION NAME] Sodium 200 mg for Constipation; [MEDICATION<br>NAME] 20 mg for Diuretic-Essential Hypertension; [MEDICATION NAME] M20 a Potassium Supplement-Hypertension; [MEDICATION<br>NAME] 20 grams (GM)/30 milliliter (ml) for Constipation; and [MEDICATION NAME] 12.5 mg an Antihypertensive. Review of Resident #2's, February 2014 physician orders [REDACTED].#1 in error were [MEDICATION NAME] 25-200 mg an Antiplatelet, [MEDICATION NAME] ([MEDICATION NAME] HCL-Opiate for Pain) 160 mg extended release, [MEDICATION NAME] HCL 20 mg an<br>Antidepressant, [MEDICATION NAME] HCL 10 mg an Antihypertensive and [MEDICATION NAME] 12.5 mg a Beta Blocker/Heart.<br>Interview with LPN #3, on 02/25/13 at 11:35 AM and on 02/26/14 at 3:22 PM, revealed she was training LPN #1, on 02/19/14 when the incident occurred. She stated she did not review the care plans with LPN #1 prior to medication pass. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed she entered Resident #1's room and called the resident by the name of Resident #2 and Resident #1 answered. She administered the medications she had prepared. She stated she started to work on 02/10/14 and was still in orientation and not familiar with the residents. Further interview with LPN #1, on 03/08/14 at 11:45 AM, revealed she did not review the care plan prior to passing medications on 02/19/14. She stated she was assigned with LPN #3 and that was not part of the morning process before starting the morning medication pass. LPN #1 revealed she was not familiar with any of the residents' care plans. Interview with the 200 Unit Manager, on 03/08/14 at 5:45 PM, revealed the purpose of the care plan was to ensure proper care was provided to the correct resident and for each resident to receive the care that was care planned for each resident. The care plan should be reviewed for new and/or changes each shift. She stated each resident had a care plan designed individually for that resident. Per interview, following the care plan for each resident would ensure each resident received the care designed for that resident. Interview with the 100 Unit Manager, on 03/08/14 at 6:00 PM, revealed she received training on the care plans when she was hired at the facility. The staff should be reviewing the care plan and following the care plan. She stated being familiar with the care plans would ensure the residents received the care to meet their needs. Interview with the DNS, on 02/28/14 at 5:00 PM, revealed care planning was not part of the new employee orientation and the facility did not have a policy on care plans. The MDS Coordinators developed the care plans and new orders and changes were added to the care plan so staff should be looking at the care plans for resident specific care. There had been a short discussion about care plans; however, the focus was more on documentation than the care plan. The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 2/19/2014 at approximately 9:00 AM, Resident #1 received five medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the emergency room (ER) at 9:04 AM. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital. Upon arrival at the hospital, he/she was in stable condition. 2. All residents had the potential to be affected. The facility took immediate action to ensure the safety of all residents. Licensed Practical Nurse #1, who gave Resident #1 the medications in error, was removed immediately from the cart. Licensed Practical Nurse #2, who had previously worked at the facility for several years, was |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**185095** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**03/08/2014** |
|---|---|---|---|
| NAME OF PROVIDER OF SUPPLIER<br>**GOLDEN LIVINGCENTER - HILLCREEK** | | STREET ADDRESS, CITY, STATE, ZIP<br>**3116 BRECKINRIDGE LANE<br>LOUISVILLE, KY 40220** | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 4)<br>be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and have medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure residents have an order for [REDACTED]. 4. On 02/19/14 at approximately 7:00 PM, the Director of Nursing Services (DNS) completed an electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 02/27/14. 5. On 02/20/14 at 11:00 AM, the Medical Director attended Quality Assurance Performance Improvement (QAPI) to discuss the medication error and Resident #1's current condition. The Medical Director agreed with the plan/AOC to address medication errors, which included: immediately removing the licensed practical nurse who administered medications in error to Resident #1 from the medication cart; education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration; Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; in-service education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; and auditing resident photographs in eMARs/eTARs. 6. On 02/22/14 the DNS contacted the consultant pharmacist regarding the medication error and requested the pharmacy's assistance in medication pass observations. On 03/02/14, the DNS spoke with the consultant pharmacist and discussed notification of the IJs, initial AOC Plan, QAPI to be held on 02/24/14, and the pharmacy plan for the coming week. Consultant Pharmacist was at the facility on 03/04/14. The DNS reviewed the QAPI meeting, and AOC/plan from 03/04/14. During his visit, the pharmacist also conducted medication reviews. On 03/04/14 additional Pharmacy consultants began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. Any issues identified in review of audits would be tracked and trended with follow-up actions or education for staff completed as needed. No issues were identified at this time. 7. Medication errors for the previous 6 month period were reviewed and analyzed by the DNS and Field Services Clinical Director on 02/26/14 with no trends noted. 8. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate. 9. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents for arm bands. There were one-hundred thirty-nine (139) residents audited and only two (2) had arm bands in place. The facility decided all residents would wear arm bands as another form of identification per the facility's policy. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for the Admission Coordinator, House Supervisors, and Unit Managers was provided by the DNS on 02/27/14. 10. On 02/24/14, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of identification. 11. On 02/24/14 at 8:00 AM, an Ad Hoc QAPI was held to discuss the facility's implementation of their plan to decrease medication errors which included; immediate removal of the licensed practical nurse who administered medications in error to Resident #1 from the medication cart, education for the licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; completing medication observation pass competencies with an RN; auditing all records for photographs; implementing use of armbands as another form of identification; immediately auditing all residents for armbands; auditing resident room doors for correct names; revising the orientation process to include medication administration competencies prior to being assigned to the floor; notifying the pharmacist of the error and requesting assistance with medication pass observations and audits; reviewing the previous 6 months of medication errors to identify trends; and conducting medication pass audits weekly. The Executive Director, Director of Nursing Services, 2-Unit Managers, Director of Clinical Education, 2-Social Services, Transitional Care Nurse, Business Office Manager, Human Resources Personnel, Medical Records Clerk were present. The meeting minutes were reviewed with the Medical Director. 12. On 03/04/14 the RN Assessment Coordinators began education with all licensed nurses on Care Plans which included: initiating the care plan, how the care plan related to the care of the resident, how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated, care plan criteria, and components of a nursing progress note. The training also included accessing and reviewing care plans in the Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstrations included how to access the plan of care in Point Click Care, and explaining the plan of care is an integral part in performing individualized care for each resident. It was also explained the nurses must utilize information found in resident's plan of care to provide care every shift. In additional education was provided on how to locate plan of care documentation under the dashboard; medical diagnosis; orders, care plan tabs in the PCC, and also on the MAR. In addition resident's charts have H&Ps and physician progress notes [REDACTED]. Participants were allowed to ask questions; verbalized understanding; and, performed return demonstration. 13. Orientation for all new licensed nurses hired after 02/24/14 will include medication pass observation competencies by the Director of Clinical Education (DCE) prior to being assigned to the floor for orientation with another licensed nurse. Licensed nurses selected by Director of Nursing Services to conduct on the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, prior to orientating any additional licensed nursing staff. This training will include: defining preceptor/mentor; explaining the role of preceptor and orientee; adult learning principles; strategies for effective precepting; challenges of being a preceptor; goals of the program; working with staff at different stages of clinical competence; working with diversity; safe and ethical practice; communication; critical thinking; nursing process to problem solve; assessing preceptor progress; skills objective; knowledge objective; affective objective; continuous interaction and feedback on preceptor/orientee, preceptor/orientee/Director of Clinical Education; and progress, conflict, and transition, for their role as a preceptor/mentor. Until additional training can be initiated, the Director of Clinical Education, will complete on the floor orientation with all new licensed nurses. 14. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in place will immediately have an arm band placed and the reason the arm band was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Manager and DNS. The results would be discussed weekly in the QAPI meeting. 15. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into Point Click Care (PCC). Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Managers. The results would be discussed weekly in the QAPI meeting. 16. The DNS, ADNS, DCE, & RN Supervisors began conducting a medication pass audit on 03/01/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Results would be analyzed and trends noted weekly by the DNS. The results would be reviewed and discussed weekly in QAPI meeting. 17. On 03/03/14, an Ad Hoc QAPI was held to discuss the facility's monitoring of the plan to decrease medication errors. Also, the Pharmacy consultants plan for conducting a 3-way audit of physician orders/medication administration records and medication carts was discussed. Pharmacy consultants also began conducting medication pass observations. Training was also being conducted on narcotic reconciliation and documentation. Audits would also be conducted of the medication rooms and carts. In addition, discussion of the need to begin education with all licensed nurses on Care Plans and how the care plan related to the care of the resident, including training on accessing and reviewing care plans in PCC. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 03/04/14. 18. A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits. Audits will be tracked and trended with follow-up actions or education for staff completed as |

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

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FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**185095** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**03/08/2014** |
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| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **GOLDEN LIVINGCENTER - HILLCREEK** | **3116 BRECKINRIDGE LANE<br>LOUISVILLE, KY 40220** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 5)<br>interview and record review. 1. Interview with the Director of Nursing Services (DNS), on 03/08/14 at 10:45 AM, revealed she was notified of the medication error shortly after the error occurred. She stated, the staff notified the Advanced Registered Nurse Practitioner (ARNP) via text message per LPN/Unit Manager from 100 Unit, on 02/19/14 at 9:04 AM. The text message, at 9:04 AM, provided the medications involved and the oxygen (O2) levels at 82%. Review of the copied text message, identified with the ARNP's name, date and time, revealed the ARNP returned orders at 9:05 AM via text message to send Resident #1 to the hospital for a medical evaluation. Review of the emergency department records revealed Resident #1's vital signs were not suppressed; however, he/she did have a significantly abnormal chest x-ray. 2. Interview with the DNS and record review, on 03/08/14 at 10:45 AM, revealed the initial investigation identified the medication error occurred with a newly licensed, Licensed Practical Nurse (LPN). The nurse was identified as LPN #1. She was removed from the medication cart and medication pass orientation. She was provided education on the 8 rights of medication administration. Review of the education attendance roster recorded dated of 02/19/14, revealed LPN #1 and #2 signed the sheet indicating their attendance. Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provided during the monthly orientation. Review of the staff attendance form validated inservice attendance. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed once the medication error was identified and reported, she was removed from the medication cart. She was reassigned with the Director of Clinical Education and Restorative Nursing to become more aquatinted with the residents. She reported her orientation was extended. Review of the statement of occurrence, on 02/19/14, completed by the DNS, dated 02/27/14, revealed LPN #2 was in her fifth (5th) and last day of orientation. She completed an in-service related to the 8 rights of medication administration and medication error, and adverse drug reaction reporting. The statement stated, LPN #2 completed the medication administration competency, on 02/23/14, for E-Kit use and reordering, oral medications, eye medications, enterals, injections and the disposition of controlled medications. She was administered two (2) test for competency verification. She passed both examinations. 3. Review of the rights of medication administration education, evidenced by the attendance roster revealed education was completed on 02/19/14, 02/21/14, 02/22/14 and 02/24/14. The Director of Clinical Education began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. Initiation of medication administration observation competencies for all licensed nurses was started on the first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and had medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure resident has an order for [REDACTED]. Interview with RN #1 and LPN #4, on 02/27/14 at 7:25 AM and 7:40 AM, respectively, revealed they had received in-servicing on the 8 rights of medication administration. Interview with House Supervisor #2, on 03/08/14 at 5:20 PM, revealed any staff identified as on leave of absence and had not completed the training by the Director of Clinical Education would receive the education upon their return before they would be allowed to work. There were three (3) on medical leave and four (4) as needed staff who rarely worked a schedule. The House Supervisor had a packet of education materials for each person when any of these individuals worked again. 4. Interview with the DNS, on 03/08/14 at 1:30 PM, revealed she completed the electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR on 02/19/14, prior to her leaving the facility at 7:00 PM. Review of the audit completed on 02/19/14, by the Director of Nursing Services, revealed it was completed to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Review of the I-pad with the DNS, on 03/08/14 at 1:45 PM, revealed she checked to ensure each resident had a current picture. She stated she did update two (2) of the pictures. Review of the inservice on electronic photos, dated 02/27/14 revealed education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Telephone interview with the 200 Unit Manager and 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed they had been trained and directed to ensure each resident had a picture on their electronic record. 5. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance. Topics of discussion, included the medication error of 02/19/14, which was identified as a routine monthly meeting. 6. Review of the medication pass observations revealed the consultant pharmacist was on location on 03/04/14 and initiated medication pass observations. The pharmacy consultant began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. No issues had been identified with the completed med pass observation; however, this was ongoing and pending review. 7. Review and interview with the DNS and Field Services Clinical Director on 03/07/14 at 5:15 PM, revealed medication errors for the previous six (6) month period were reviewed and analyzed on 02/26/14 with no trends identified. 8. Observation during tour of twenty-five (25) rooms on the 300 Hall, on 03/08/14 at 5:15 PM, revealed each resident room had a name identification on the outside of the door in the hall. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the doors (resident rooms) were audited on 02/23/14. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident photos were completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each door for a resident name. There were no doors found without appropriate names. 9. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the arm bands were audited on 02/23/14, and placed on the residents as another form of identification. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident armbands was completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each resident for an armband. There was a total of one-hundred thirty-nine (139) residents on the census. They found two residents who already had an armband on and the rest were provided a new armband. Review of the inservice staff attendance record revealed an inservice on arm bands was conducted on 02/27/14, with the Admission Coordinator, Staffing Coordinator, House Supervisors and the Unit Managers. 10. Observations of fifteen (15) residents on 02/26/14 revealed the residents had arm bands in place. 11. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance and was a routine monthly meeting. The topic of discussion was the plan to decrease medication errors. An Ad Hoc QAPI meeting was held, on 02/24/14, related to the medication error occurrence, dated 02/19/14, for ongoing auditing, monitoring and re-evaluation. Interview with the Executive Director and The DNS, on 03/08/14 at 2:00 PM, revealed the QAPI meetings are ongoing weekly, with the auditing, reviewing and re-evaluation of the findings of the auditing and on target. 12. Review of the education content regardng care plans, completed on 03/04/14, by the RN Assessment Coordinators with all licensed nurses revealed it included: initiating the care plan; how the care plan related to the care of the resident; how to utilize the nursing process in the development of the plan of care; when a care plan is developed and updated; care plan criteria; and components of a nursing progress note. It also included training on accessing and reviewing care plans in Point Click Care. Demonstrations included: how to access the plan of care in Point Click Care, and explaining the plan of care was an integral part in performing individualized care for each resident. The nurses must utilize information found in the resident's plan of care to provide care every shift. Education included how to locate plan of care documentation under the dashboard; medical diagnosis; orders; care plan tabs in the PCC; and also on the MAR. In addition the education covered the residents' charts containing H&Ps and physician progress notes [REDACTED]. All training was performed in small groups or 1:1 by the RN Assessment Coordinators. Participants asked questions; |

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|---|---|---|---|
| | **185095** | A. BUILDING ______<br>B. WING _____ | **03/08/2014** |

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| F 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 6) |

F 0333

**Level of harm -** Immediate jeopardy

**Residents Affected -** Few

**<b>Make sure that residents are safe from serious medication errors.</b>**
**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**
Based on observation, interview, record review and review of the Hospital Emergency Department Report, the facility's Investigation Report, and the facility's Administration of Medication Policy, it was determined the facility failed to ensure one (1) of ten (10) sampled residents (Resident #1) was free of any significant medication errors. The facility failed to ensure staff followed the facility's policy and procedure related to ensuring medication was administered to the right resident. Resident #1 received another resident's medication which resulted in a significant medication error. On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name. Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation. Resident #1 was evaluated by the emergency room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), [MEDICAL CONDITION] and [MEDICAL CONDITION]. Resident #1 was hospitalized for [REDACTED]. The facility's failure to ensure that residents were free from significant medication errors has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/14, and was determined to exist on 02/19/14. The facility was notified of the Immediate Jeopardy on 02/28/14. An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a D while the facility develops and implements the Plan of Correction (POC) and facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy and procedure titled, Medication Administration, General Guidelines, Section 7.1, identification of residents before medication administration, dated October 2007, revealed medications would be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Residents would be identified prior to administration of medications. Residents would be identified using at least two (2) of the resident identifiers. The staff was to check the identification band as an option for resident identification. The procedure included comparing the name with the name on the Medication Administration Record (MAR) and compare the photo of the resident to the resident. If there was no photo, and the resident was unable to tell his/her full name, then the nurse was to validate the resident's identity with a second associate who was familiar with the resident and compare the name to the MAR. Room numbers or physical location were not used as an identifier. In addition, medications supplied for one (1) resident were never to be administered to another resident. Review of the facility's investigation, dated 02/19/14, revealed Resident #1 received incorrect medications. LPN #1 entered the resident's room and called Resident #1 by Resident #2's name and Resident #1 answered. Resident #1 received the medications prepared for Resident #2. Resident #1's vital signs were documented in the Situation Background Assessment Recommendation (SBAR) with a change of condition for a blood pressure of 169/80, heart rate 100 beats/minute, respirations 20-24 breaths/minute (shallow), a temperature of 98.8 degree Fahrenheit and an oxygen (O2) saturation of 90% with O2 set at 2 liters per minute (l/m), slight rales (abnormal breath sounds heard with a stethoscope) in the left lobe (left lung field). The oxygen saturation dropped to 82-86% while the Oxygen was increased to 4 l/m via a nasal cannula. The staff notified the Nurse Practitioner of the resident's change in status. Resident #1's oxygen (O2) saturation was 82%. The resident had a change of condition within the hour prior to receiving the medication error. After the medication error occurred the Nurse Practitioner sent the resident to the hospital where he/she was admitted for an evaluation. Review of the SBAR in the Nurse's Notes, dated 02/19/14 at 7:30 AM, revealed a change in Resident #1's condition. The SBAR documented the resident experienced trouble breathing within the hour before the medication error. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/02/12, and readmitted , on 01/03/14, with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set Assessment, dated 02/03/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15) of fifteen (15). Review of Resident #1's, Comprehensive Care Plan revised on 02/27/13, revealed an intervention to provide medications as ordered by the physician. Review of Resident #1's, February 2014, MAR revealed, on 02/19/14, the medications ordered by the physician to be administered at 8:00 AM and 9:00 AM were coded on the MAR as not administered indicating the documentation would be located in the nurses notes as to why the medications were not administered. Corresponding nurses notes, dated 02/19/14, indicated Resident #1 did not receive his/her ordered medications related to the transfer out to the hospital for an evaluation. The medications Resident #1 was scheduled to receive, on 02/19/14 at 8:00 AM was [MEDICATION NAME] 800 milligram (mg) for Muscle Spasm and at 9:00 AM: [MEDICATION NAME] 5 milligram (mg) for [MEDICAL CONDITION]; [MEDICATION
NAME] Sodium 200 mg for Constipation; [MEDICATION NAME] 20 mg for Diuretic-Essential Hypertension; [MEDICATION NAME] M20 a
Potassium Supplement-Hypertension; [MEDICATION NAME] 20 grams (GM)/30 milliliter (ml) for Constipation; and [MEDICATION
NAME] 12.5 mg an Antihypertensive. Review of Resident #2's, February 2014 physician orders [REDACTED].#1 in error were [MEDICATION NAME] 25-200 mg an Antiplatelet, [MEDICATION NAME] 160 mg extended release [MEDICATION NAME] HCL-Opiate for
Pain, [MEDICATION NAME] HCL 20 mg an Antidepressant, [MEDICATION NAME] HCL 10 mg an Antihypertensive and [MEDICATION NAME]
12.5 mg a Beta Blocker/Heart. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed she entered Resident #1's room and called Resident #2's name. Resident #1 answered and she administered the medications she had prepared for Resident #2 to Resident #1. She reported she had several interruptions during the medication pass which were distracting at the time. LPN #1 stated she should have gone back and checked the photo in the MAR and had someone else to go with her to identify the resident. Interview with LPN #3, on 02/25/13 at 11:35 AM and on 02/26/14 at 3:22 PM, revealed she was training LPN #1 on 02/19/14 when the incident occurred. LPN #3 stated she was with LPN #1 during the first medication pass and had been called to Resident #1's room on three (3) separate occasions. She reported, she had administered a nebulizer treatment for [REDACTED].#1 to notify the Unit Manager about the concerns with the resident's status and request an evaluation from the Nurse Practitioner. Upon return to Resident #1's room, LPN #1 was at the bedside of Resident #1 and stated she was giving Resident #2 his/her medications. LPN #3 stated, that was not Resident #2, that was Resident #1. Immediately upon identification of the medication error, LPN #3 notified the Unit Manager and she was advised by the Unit Manager to obtain a set of vital signs. The 100 Hall Unit Manager notified the Nurse Practitioner. Once the Nurse Practitioner provided the order to transfer the resident to the hospital, Emergency Medical Services (EMS) was requested for a transfer. Resident #1 received the medications between 8:45 AM and 9:00 AM and was transferred to the hospital at 9:35 AM. Interview with LPN #4, on 02/27/14 at 7:15 AM, RN #1 at 7:15 AM, LPN #8 at 10:40 AM, LPN/House Supervisor #2 at 5:20 PM, and 200 Hall Unit Manager
(UM) on 03/08/14 at 5:40 PM, revealed they were all trained to identify a resident by asking the resident his or her full name and by looking at the photo in the MAR. They stated the identifiers on the doors were not used as the residents get moved at times. RN #1 stated the staff was trained to ask another associate if in doubt of a resident's ability to provide accurate identification. Interview with the Director of Nursing Services, on 02/26/14 at 5:31 PM, revealed LPN #1 was pulled from the task of medication administration on 02/19/14 upon identification of the medication error. She was placed with restorative nursing so she could learn the residents and be more familiar with each resident. She had continued to work since the incident on 02/19/14, but had not passed medications again. She revealed the medication error should not have occurred. She stated the prior nursing administration had taken the arm band identification from the option of resident identification. The prior DNS requested staff to use the photo identification as the primary source of identification or have another staff to identify the resident. However, the policy was never changed to reflect the identification bracelet being removed from the options of identifications. If the identification bracelet had been in place, that would have been an additional layer for identifying the residents and may have prevented the occurrence of the medication error. The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 2/19/2014 at approximately 9:00 AM, Resident #1 received five medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the emergency room (ER) at 9:04 AM. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital. Upon arrival at the hospital, he/she was in stable condition. 2. All residents had the potential to be affected. The facility took immediate action to ensure the safety of all residents. Licensed Practical Nurse #1, who gave Resident #1 the medications in error, was removed immediately from the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**185095** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**03/08/2014** |
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| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0333

**Level of harm -** Immediate jeopardy

**Residents Affected -** Few

(continued... from page 7)
cart. Licensed Practical Nurse #2, who had previously worked at the facility for several years, was also in orientation. Both Licensed Practical Nurses received education on 02/19/14 on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1, Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. 3. On 02/19/14, the Director of Clinical Education immediately began education with all licensed nurses on the 8 rights of medication administration; Medication Error and Adverse Drug Reaction Reporting Policy 6.2; Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. Initiation of medication observations competencies for all licensed nurses was started first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and have medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure residents have an order for [REDACTED]. Medication observation competencies will be completed when a medication error is identified, and annually for all licensed nursing staff. 4. On 02/19/14 at approximately 7:00 PM, the Director of Nursing Services (DNS) completed an electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 02/27/14. 5. On 02/20/14 at 11:00 AM, the Medical Director attended Quality Assurance Performance Improvement (QAPI) to discuss the medication error and Resident #1's current condition. The Medical Director agreed with the plan/AOC to address medication errors, which included: immediately removing the licensed practical nurse who administered medications in error to Resident #1 from the medication cart; education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration; Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; in-service education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; and auditing resident photographs in eMARs/eTARs. 6. On 02/22/14 the DNS contacted the consultant pharmacist regarding the medication error and requested the pharmacy's assistance in medication pass observations. On 03/02/14, the DNS spoke with the consultant pharmacist and discussed notification of the IJs, initial AOC Plan, QAPI to be held on 02/24/14, and the pharmacy plan for the coming week. Consultant Pharmacist was at the facility on 03/04/14. The DNS reviewed the QAPI meeting, and AOC/plan from 03/04/14. During his visit, the pharmacist also conducted medication reviews. On 03/04/14 additional Pharmacy consultants began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. Any issues identified in review of audits would be tracked and trended with follow-up actions or education for staff completed as needed. No issues were identified at this time. 7. Medication errors for the previous 6 month period were reviewed and analyzed by the DNS and Field Services Clinical Director on 02/26/14 with no trends noted. 8. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate. 9. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents for arm bands. There were one-hundred thirty-nine (139) residents audited and only two (2) had arm bands in place. The facility decided all residents would wear arm bands as another form of identification per the facility's policy. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for the Admission Coordinator, House Supervisors, and Unit Managers was provided by the DNS on 02/27/14. 10. On 02/24/14, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of identification. 11. On 02/24/14 at 8:00 AM, an Ad Hoc QAPI was held to discuss the facility's implementation of their plan to decrease medication errors which included; immediate removal of the licensed practical nurse who administered medications in error to Resident #1 from the medication cart, education for the licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; completing medication observation pass competencies with an RN; auditing all records for photographs; implementing use of armbands as another form of identification; immediately auditing all residents for armbands; auditing resident room doors for correct names; revising the orientation process to include medication administration competencies prior to being assigned to the floor; notifying the pharmacist of the error and requesting assistance with medication pass observations and audits; reviewing the previous 6 months of medication errors to identify trends; and conducting medication pass audits weekly. The Executive Director, Director of Nursing Services, 2-Unit Managers, Director of Clinical Education, 2-Social Services, Transitional Care Nurse, Business Office Manager, Human Resources Personnel, Medical Records Clerk were present. The meeting minutes were reviewed with the Medical Director. 12. On 03/04/14 the RN Assessment Coordinators began education with all licensed nurses on Care Plans which included: initiating the care plan, how the care plan related to the care of the resident, how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated, care plan criteria, and components of a nursing progress note. The training also included accessing and reviewing care plans in the Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstrations included how to access the plan of care in Point Click Care, and explaining the plan of care is an integral part in performing individualized care for each resident. It was also explained the nurses must utilize information found in resident's plan of care to provide care every shift. In additional education was provided on how to locate plan of care documentation under the dashboard; medical diagnosis; orders, care plan tabs in the PCC, and also on the MAR. In addition resident's charts have H&Ps and physician progress notes [REDACTED]. Participants were allowed to ask questions; verbalized understanding; and, performed return demonstration. 13. Orientation for all new licensed nurses hired after 02/24/14 will include medication pass observation competencies by the Director of Clinical Education (DCE) prior to being assigned to the floor for orientation with another licensed nurse. Licensed nurses selected by Director of Nursing Services to conduct on the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, prior to orientating any additional licensed nursing staff. This training will include: defining preceptor/mentor; explaining the role of preceptor and orientee; adult learning principles; strategies for effective precepting; challenges of being a preceptor; goals of the program; working with staff at different stages of clinical competence; working with diversity; safe and ethical practice; communication; critical thinking; nursing process to problem solve; assessing preceptor progress; skills objective; knowledge objective; affective objective; continuous interaction and feedback on preceptor/orientee, preceptor/orientee/Director of Clinical Education; and progress, conflict, and transition, for their role as a preceptor/mentor. Until additional training can be initiated, the Director of Clinical Education, will complete on the floor orientation with all new licensed nurses. 14. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in place will immediately have an arm band placed and the reason the arm band was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Manager and DNS. The results would be discussed weekly in the QAPI meeting. 15. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into Point Click Care (PCC). Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Managers. The results would be discussed weekly in the QAPI meeting. 16. The DNS, ADNS, DCE, & RN Supervisors began conducting a medication pass audit on 03/01/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Results would be analyzed and trends noted weekly by the DNS. The results would be reviewed and discussed weekly in QAPI meeting. 17. On 03/03/14, an Ad Hoc QAPI was held to discuss the facility's monitoring of the plan to

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| F 0333<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 8)<br>observations. Training was also being conducted on narcotic reconciliation and documentation. Audits would also be conducted of the medication rooms and carts. In addition, discussion of the need to begin education with all licensed nurses on Care Plans and how the care plan related to the care of the resident, including training on accessing and reviewing care plans in PCC. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 03/04/14. 18. A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits. Audits will be tracked and trended with follow-up actions or education for staff completed as needed by the QAPI Committee. If the Medical Director is unavailable in person on a weekly basis, he will review progress by phone with Executive Director and/or DNS. The State Survey Agency validated the AOC on 03/08/14 through observation, interview and record review. 1. Interview with the Director of Nursing Services (DNS), on 03/08/14 at 10:45 AM, revealed she was notified of the medication error shortly after the error occurred. She stated, the staff notified the Advanced Registered Nurse Practitioner (ARNP) via text message per LPN/Unit Manager from 100 Unit, on 02/19/14 at 9:04 AM. The text message, at 9:04 AM, provided the medications involved and the oxygen (O2) levels at 82%. Review of the copied text message, identified with the ARNP's name, date and time, revealed the ARNP returned orders at 9:05 AM via text message to send Resident #1 to the hospital for a medical evaluation. Review of the emergency department records revealed Resident #1's vital signs were not suppressed; however, he/she did have a significantly abnormal chest x-ray. 2. Interview with the DNS and record review, on 03/08/14 at 10:45 AM, revealed the initial investigation identified the medication error occurred with a newly licensed, Licensed Practical Nurse (LPN). The nurse was identified as LPN #1. She was removed from the medication cart and medication pass orientation. She was provided education on the 8 rights of medication administration. Review of the education attendance roster recorded dated of 02/19/14, revealed LPN #1 and #2 signed the sheet indicating their attendance. Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provided during the monthly orientation. Review of the staff attendance form validated inservice attendance. Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed once the medication error was identified and reported, she was removed from the medication cart. She was reassigned with the Director of Clinical Education and Restorative Nursing to become more aquatinted with the residents. She reported her orientation was extended. Review of the statement of occurrence, on 02/19/14, completed by the DNS, dated 02/27/14, revealed LPN #2 was in her fifth (5th) and last day of orientation. She completed an in-service related to the 8 rights of medication administration and medication error, and adverse drug reaction reporting. The statement stated, LPN #2 completed the medication administration competency, on 02/23/14, for E-Kit use and reordering, oral medications, eye medications, enterals, injections and the disposition of controlled medications. She was administered two (2) test for competency verification. She passed both examinations. 3. Review of the rights of medication administration education, evidenced by the attendance roster revealed education was completed on 02/19/14, 02/21/14, 02/22/14 and 02/24/14. The Director of Clinical Education began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp. Initiation of medication administration observation competencies for all licensed nurses was started on the first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and had medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure resident has an order for [REDACTED]. Interview with RN #1 and LPN #4, on 02/27/14 at 7:25 AM and 7:40 AM, respectively, revealed they had received in-servicing on the 8 rights of medication administration. Interview with House Supervisor #2, on 03/08/14 at 5:20 PM, revealed any staff identified as on leave of absence and had not completed the training by the Director of Clinical Education would receive the education upon their return before they would be allowed to work. There were three (3) on medical leave and four (4) as needed staff who rarely worked a schedule. The House Supervisor had a packet of education materials for each person when any of these individuals worked again. 4. Interview with the DNS, on 03/08/14 at 1:30 PM, revealed she completed the electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR on 02/19/14, prior to her leaving the facility at 7:00 PM. Review of the audit completed on 02/19/14, by the Director of Nursing Services, revealed it was completed to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Review of the I-pad with the DNS, on 03/08/14 at 1:45 PM, revealed she checked to ensure each resident had a current picture. She stated she did update two (2) of the pictures. Review of the inservice on electronic photos, dated 02/27/14 revealed education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Telephone interview with the 200 Unit Manager and 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed they had been trained and directed to ensure each resident had a picture on their electronic record. 5. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance. Topics of discussion, included the medication error of 02/19/14, which was identified as a routine monthly meeting. 6. Review of the medication pass observations revealed the consultant pharmacist was on location on 03/04/14 and initiated medication pass observations. The pharmacy consultant began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. No issues had been identified with the completed med pass observation; however, this was ongoing and pending review. 7. Review and interview with the DNS and Field Services Clinical Director on 03/07/14 at 5:15 PM, revealed medication errors for the previous six (6) month period were reviewed and analyzed on 02/26/14 with no trends identified. 8. Observation during tour of twenty-five (25) rooms on the 300 Hall, on 03/08/14 at 5:15 PM, revealed each resident room had a name identification on the outside of the door in the hall. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the doors (resident rooms) were audited on 02/23/14. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident photos were completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each door for a resident name. There were no doors found without appropriate names. 9. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the arm bands were audited on 02/23/14, and placed on the residents as another form of identification. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM. Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident armbands was completed for of all residents. Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to |
| F 0356<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **<b>Post nurse staffing information/data on a daily basis.</b>**<br><br>Based on observation, interview, record review and review of the Daily Nurse Staffing form, it was determined the facility failed to post the Daily Nurse Staffing data at the beginning of each shift and the information posted did not match the Daily Assignment Sheets for twelve (12) of twelve (12) days. In addition, two (2) Daily Nurse Staffing Forms posted included staff in orientation as part of the staffing level. The findings include: The facility did not have a policy regarding the posting of daily nursing staff. Interview with the Director of Nursing Services (DNS), on 03/07/14 at 3:15 PM, revealed there was no policy for the posting of the nurse staffing hours. She reported the facility followed the |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0356<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 9)<br>Sheet. The night shift assignment had three (3) RNs verses the four (4) RNs posted. The Licensed Practical Nurses (LPN) on the assignment sheet was five (5) LPN verses the six (6) posted. Review of the Daily Staffing Form, dated 02/19/14, (the day of the medication error) and the Daily Assignment Sheet revealed the night shift had four (4) LPNs working verses the posted five (5). There were a total of ten (10) LPNs posted for the day shift; however, that included the four (4) nurses in orientation. Observation, on 02/26/14 at 10:00 AM, of the Daily Nurse Staffing Form, dated 02/26/14, revealed the Daily Nurse Staffing Form was completed for all three shifts versus the day shift only. Review of the Daily Nurse Staffing Form, dated 03/02/14, and the Daily Assignment Sheet revealed the LPNs on day shift totaled seven (7) verses the eight (8) posted. Review of the Daily Nurse Staffing Form, dated 03/03/14, and the Daily Assignment Sheet revealed the LPNs scheduled to work was three (3) verses the five (5) posted. The CNAs scheduled for the night shift was eight (8) verses the nine (9) posted. There was one (1) CNA in orientation which was included in the Daily Nurse Staffing data posted. Observation, on 03/05/14 at 5:15 PM, of the Daily Nurse Staffing Form, dated 03/05/14, revealed the Daily Nurse Staffing Form was completed for all three shifts. Review of the Daily Assignment Sheet revealed the CNAs scheduled for the night shift was six (6) verses the seven (7) posted. Further review revealed two (2) staff had called in; however, this was not reflected on the posting. Interview with the Staffing Coordinator, on 03/06/14 at 4:25 PM, revealed one of her responsibilities was for staff scheduling and to schedule the staff was on duty. She was responsible to ensure sufficient staff to meet the needs of the residents. She stated every morning she calculated the Daily Assignment Sheets, calculated the Daily Nurse Staffing Form, and made sure it was posted. She stated she had this form completed between 7:00 AM - 9:00 AM and posted it on the wall outside of the door to her office. She stated on Friday mornings, she completed the weekend forms for Friday, Saturday and Sunday and placed them in the posting sleeve on the bulletin board for the whole weekend. She revealed no one really updated the forms other than herself. The forms were completed in the morning and never changed through out the day. She stated she just filed the ones from the day before without updating each form. She stated the staffing numbers included the staff in orientation (RN/LPN/CNA) and the count included the Unit Manager, that worked the desk. Interview with House Supervisor #1, on 03/06/14 at 5:05 PM, revealed there were two forms. One was a Daily Assignment Sheet and the other was the Daily Nurse Staffing Form that was to be posted with the staffing level. She reviewed the Daily Assignment Sheets and verified her staff from that particular form. She documented on the Daily Assignment Sheet when there was a call in or if someone didn't show up. She stated she did not do anything to the daily staffing sheets before the next shift to show changes in the number of staff available for the next shift. Continued interview with the Director of Nursing Services, on 03/07/14 at 3:15 PM, revealed the Daily Nurse Staffing Form was completed in the early morning by the Staffing Coordinator and posted at that time. The Staffing Coordinator was not trained to the requirements of the regulation only that it was to be posted in the morning. |