DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				PRINTED:7/30/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TON	(X3) DATE SURVEY COMPLETED 03/08/2014
NAME OF PROVIDER OF SUR GOLDEN LIVINGCENTER -	185095 PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
JOEDEN EIVINGCENTER -	INELECKEEK		LOUISVILLE, KY 40220	
	home's plan to correct this deficient	J-1 C	, , ,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	MATION)		Y FULL REGULATORY
F 0281	 description 	l by the nursing facility meet pro	ofessional standards of	
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET Based on interview, record review the Licensed Practical Nursing Sc	v, and review of the facility's Inve	stigation Report, Medication Adm	ninistration Policy and
Residents Affected - Few	system to ensure medications wer residents (Resident #1). On 02/19 orientation with LPN #3, adminisresident and without LPN #3 bein were not prescribed for him/her were not prescribed for him were not prescribed for him were not prescribed for him her were not	/14 at approximately 8.45 AM to tered Resident #2's medication to go present to supervise the task. Resident included an antihypertensive mpare the resident to the resident? I experienced increased shortness Registered Nurse Practitioner (AR nd the ARNP ordered the resident emergency room physician and a MEDICAL CONDITION] and [Mixiew and review of the facility's N to been validated per the facility's sing standards of practice has cau. Immediate Jeopardy was identifunediate Jeopardy was identifunediate Jeopardy was identifunediate Jeopardy on 02/28/14, A of the Immediate Jeopardy on 03/05/14, levelops and implements the Plan of the systemic changes. The finditucky, dated July 2013, revealed tact may be within the scope, if the facility's Nursing Competency Coleted during the orientation period so fhire. Validation for clinical cov of the facility's Medication Adm prior to administration of medica ministration. Room numbers should following procedures: check the ord; and/or verify the resident #3 indicant #2 to Resident #1. Further the properties of the prop	9:00 AM, Licensed Practical Nurs Resident #1 without ensuring he/seident #1 without ensuring the profession of air between 8:00 AM and 9:00 ANP) was notified, on 02/19/14 at the sent to the hospital for a medidimitted with the clinical impression of the profession of the	se (LPN) #1, who was in she was the right 5) medications that 61, and an opioid pain rt and oriented 6 AM, of the medication cal evaluation. 60 AM prior to the 69:04 AM, of the medication cal evaluation. 60 on of Dyspnea, Accidental the first was hospitalized for 6 In the first was hospitalized for 6 In the first was first w
	Licensed Practical Nursing Scope of Nursing was not followed by the her nursing boards and was an LP	ne nurse administering the medica	tion to the wrong resident. She sta	ated LPN #1 had passed

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

TITLE

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

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

nad been in piace, 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

(X6) DATE

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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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/30/2014 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 03/08/2014
CORRECTION	NUMBER			03/00/2014
NAME OF PROVIDER OF SU	185095 PPI IER	KTR	EET ADDRESS, CITY, ST.	ATE 7IP
GOLDEN LIVINGCENTER		3116	BRECKINRIDGE LANE	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or	the state survey agency.	
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY	/ MUST BE PRECEDED B	Y FULL REGULATORY
F 0281	OR LSC IDENTIFYING INFORM (continued from page 1)	WATION)		
Level of harm - Immediate jeopardy	administration, Medication Error Nursing Care Center Pharmacy P	Practical Nurses received education o and Adverse Drug Reaction Reporting olicy & Procedure Manual - 2007 Phar	Policy 6.2, and Medication rMerica Corp. 3. On 02/19/1-	Administration Policy 7.1, 4, the Director of Clinical
	Nursing Care Center Pharmacy P Education immediately began education immediately began education and Adverse Drug Reaction Adverse Drug Reporting and 7.1 Manual - 2007 PharMerica Corp. shift on 02/23/14 by the RN Nurs be allowed to work after 02/24/14 medication administration, Medicand have medication pass observation competer nursing staff. 4. On 02/19/14 at a audit to ensure each resident had photograph. The Admission Coop photo taken and uploaded into the House Supervisors, and Unit Marattended Quality Assurance Perfic condition. The Medical Director the licensed practical nurse who a licensed practical nurse and a sec Rights of medication administration of the IJs., is of medication administration Pharmacist was During his visit, the pharmacist aconducting a 3-way audit of physpass observations, in-service edutracked and trended with follow-time. 7. Medication errors for the Clinical Director on 02/26/14 wit conducted an audit of all doors to name. It was replaced immediate resident room doors are accurate, audit of all residents for arm band bands in place. The facility decid facility's policy. The Admission (has a new arm band placed on the becomes soiled or illegible. Educ the DNS on 02/27/14. 10. On 02/Coordinator as another form of ider for correct names; revising the or assigned to the floor; notifying the and audits; reviewing the previou weekly. The Executive Director, Services, Transitional Care Nurse The meeting minutes were review with all licensed nurses on Care I the resident, how to utilize the nu updated, care plan criteria, and coare plans in the Point Click Care for each resid of care to provide care every shift the dashboard; medical diagnosis have H&Ps and physician progre and, performed return demonstra medication pass observation		comeria Corp. 3. On 02/19/1. Re rights of medication admin ministration Policy 7.1. Polic he Nursing Care Center Pharm competencies for all licensed ad both trainings completed idication administration using ng Policy 6.2 and Medication N, prior to passing any medication error is identified, and Xursing Services (DNS) con MAR/eTAR. All residents in agers are responsible to ensign and the ensure resident shave at the properties of admission. Education for 1/14. 5. On 02/20/14 at 11:00 as the medication errors, which inclusive the medication errors, which inclusive the properties of Medication or 1/14. 5. On 02/20/14 at 11:00 as the medication errors, which inclusive the medication errors, which inclusive the properties of Medication Administration Policy 7.1; and auditin macist regarding the medicate at DNS spoke with the consultable of Medication Administration Policy 7.1; and auditin macist regarding the medicate at DNS spoke with the consultable of Medication cart reviewed the QAPI meeting, 03/04/14 additional Pharmacy reviewed the QAPI meeting, 03/04/14 additional Pharmacy reviewed the QAPI meeting, 03/04/14 additional Pharmacy reviewed the QAPI meeting, 03/04/19 and medication cart residents of the properties of the care plan, at one care properties of the care plan, at one care properties of the pro	4, the Director of Clinical histration; Medication cy 6.2 Medication Error and macy Policy & Procedure I nurses was started first by 02/24/14. No nurse would g the 8 rights of n Administration policy 7.1, cations. Education included an order for [REDACTED]. Innually for all licensed mpleted an electronic n house on 02/19/14 had a sure a new resident has a r Admission Coordinator, AM, the Medical Director Resident #1's current uded: immediately removing on cart; education for 14 on using the 8 Medication Administration tration, Medication ng resident photographs in ion error and requested the litant pharmacist and olan for the coming and AOC/plan from 03/04/14. cy consultants began is, along with medication of of audits would be be re identified at this and Field Services 1 the Staffing Coordinator hall had a missing lible to ensure the names on redinator conducted an only two (2) had arm ation per the oensure a new resident mband is missing, Managers was provided by oordinator and Staffing eld to discuss the oval of the licensed and on the licensed and on the licensed and the Resident of the licensed and the staffing eld to discuss the oval of the licensed and the Records Clerk were present. It Coordinators began education and the to the care of dian is developed and coessing and reviewing and progress note, all tions included how to orming I ne resident's charts; verbalized understanding; 4 will include and sassigned to the floor s to conduct on the increased and sassigned to the floor s to conduct on the increased and sassigned to the floor s to conduct on the increased and sassigned to the floor s to conduct on the increased and coessing and reviewing and progress note, all tions included how to orming I ne resident's charts; verbalized understanding; 4 will include and sassigned to the floor s to conduct on the increased and coessing and reviewing ind progress note, all tions i
	role as a preceptor/mentor. Until on the floor orientation with all n times per week to ensure all resid immediately have an arm band pl	ntee/Director of Clinical Education; an additional training can be initiated, the ew licensed nurses. 14. The Unit Mana ents have an arm band in place. Any re aced and the reason the arm band was	Director of Clinical Educatingers began audits on 02/28/ esident who does not have are not in place would be invest	ion, will complete 14 of all residents 5 1 arm band in place will 1 igated, by the Unit Manager
	conducting the audit. The results results would be discussed weekl times per week to ensure all resid photo in place will immediately linvestigated, by the Unit Manage by the Unit Managers. The result began conducting a medication preduce errors. Results would be a	of the audits would be analyzed and trey in the QAPI meeting. 15. The Unit Ments have a photo loaded into Point Cliave a photo taken and loaded into PCC or conducting the audit. The results of the swould be discussed weekly in the QA ass audit on 03/01/14, 5 times per weeknalyzed and trends noted weekly by the	ends noted weekly by the Un 4 anagers began audits on 02. ick Care (PCC). Any residen C and the reason the photo w the audits would be analyzed API meeting. 16. The DNS, A k, to ensure continued effecti e DNS. The results would be	nit Manager and DNS. The 228/14 of all residents 5 at who does not have a as not in place would be and trends noted weekly ADNS, DCE, & RN Supervisors iveness of the plan to e reviewed and discussed
		03/03/14, an Ad Hoc QAPI was held to		

DEFICIENCIES AND PLAN OF IDEI CORRECTION NUM	NNTIFICATION MBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	195		03/08/2014
1850			
NAME OF PROVIDER OF SUPPLIE			ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - HILL	CREEK		CKINRIDGE LANE LLE, KY 40220
For information on the nursing home's	plan to correct this deficien	y, please contact the nursing home or the sta	ite survey agency.
	MARY STATEMENT OF D SC IDENTIFYING INFORM		ST BE PRECEDED BY FULL REGULATORY
	nued from page 2)		
Level of harm - Immediate nurse jeopardy revie	es on Care Plans and how the wing care plans in PCC. The		
Residents Affected - Few update medined medined by pinter she with Regis mess mess send #1's v DNS with medined Reviet their in-se woull Interneme become occur orien adversion of the Reviet complicent for the Reviet complicent for the Reviet complicent for the Reviet for the	intee will review effectiven, ite, and develop action plans, cation pass audits. Audits wied by the QAPI Committee. Ione with Executive Directoriew and record review. I. Ir vas notified of the medication civer and 1904 AM, provided the age, identified with the ARN Resident #1 to the hospital fixed it also good an ewly licensed, Licensed I cation cart and medication pass and record review, on 03/08 a newly licensed, Licensed I cation cart and medication pass of the education attendana attendance. Interview with rivice was provided by herseld be provided during the moview with LPN #1, on 02/26 wed from the medication carme more aquatinted with the rence, on 02/19/14, complet tation. She completed an incise drug reaction reporting. To 18/14, for E-Kit use and reord olled medications. She was sew of the rights of medication deled and incised on 02/19/14, 02/21/14, ed nurses on the 8 rights of land Medication Administratinistration are from the Nusry Nurse Managers. All nurs 02/24/14 unless training was cation Error and Adverse Drivation competencies complete medications or no crushaf and the provided and the control of absence and had not competencies complete medications or no 02/21/14 at 7:25 cation administration. Intervior absence and had not competencies complete medications or no crushaf and the provided and the provided and the control of the provided and the control of the provided the medications or no 02/24/14 unless training was cation Error and Adverse Drivation competencies complete medications or no 02/25/14 at 1:45 PM, revealed she pictures. Review of the audit core each resident had a curren PM. Review of the audit core each resident had a curren per ph. The Admission Coordinator, revealed the picture of the provided the medicatication pass observations revealed the did the did the did the consus and included the midication pass observations revealed the did the consus and included the midication pass observations revealed the did on 02/23/14, indinght census and included the midication pass observa	ss and compliance with the plan to decrease based on any issues identified in review of at all be tracked and trended with follow-up actic f the Medical Director is unavailable in person and/or DNS. The State Survey Agency valid terview with the Director of Nursing Service a error shortly after the error occurred. She stat NP) via text message per LPN/Unit Manage en emedications involved and the oxygen (O2) P's name, date and time, revealed the ARNP or a medical evaluation. Review of the emerg d: however, he/she did have a significantly a (14 at 10:45 AM, revealed the initial investig ractical Nurse (LPN). The nurse was identifies so orientation. She was provided education of the protector of Resident Assessment Coordina (5, no 03/04/14, to the staff that was in orientation of the control of the staff that was in orientation. Greview of the staff attendar 14 at 1:15 PM, revealed once the medication as he statement stated, LPN #2 completed the nring, oral medications, eye medications, ented diministered two (2) test for competency verification administration education, evidenced by the O2/22/14 and Dictation and the statement stated, LPN #2 completed the nring, oral medications, eye medications, ented diministered two (2) test for competency verification administration, Medication Error on Policy 7.1. Policy 6.2 Medication Error on Policy 7.1. Policy 6.2 Medication Error on Policy 7.1. Policy 6.2 and Medication Error on Policy 7.1. Policy 6.2 and Medication accompetency has swho worked had both trainings crompleted completed on medication administration using Reporting Policy 6.2 and Medication Andrews when the NS, on 03/08/14 at 1:30 PM, accurate photograph in the eMAR/eTAR. A diluted the training by the Director of Clinical allowed to work. There were three (3) on meause Supervisor had a packet of education matication and the control of the protector of Nursing, accurate photograph in the eMAR/eTAR. A diluted on 02/19/14, which was identified a regular schecic control of the protector of the protector of the p	medication errors, and will review, revise, udits including arm bands, photos, and ons or education for staff completed as on on a weekly basis, he will review progress lated the AOC on 03/08/14 through observation, as (DNS), on 03/08/14 at 10:45 AM, revealed ated, the staff notified the Advanced refrom 100 Unit, on 02/19/14 at 9:04 AM. The text levels at 82%. Review of the copied text returned orders at 9:05 AM via text message to gency department records revealed Resident abnormal chest x-ray. 2. Interview with the gation identified the medication error occurred end as LPN #1. She was removed from the on the 8 rights of medication administration. at LPN #1 and #2 signed the sheet indicating ation, on 03/08/14 at 4:45 PM revealed an ation on 02/19/14. She stated, training nee form validated inservice attendance. 1 error was identified and reported, she was inicial Education and Restorative Nursing to xtended. Review of the statement of N #2 was in her fifth (5th) and last day of diministration and medication error, and needication administration competency, on errals, injections and the disposition of fification. She passed both examinations. 3. attendance roster revealed education with all and Adverse Drug Reaction Reporting Policy and Adverse Drug Reaction Reporting Policy and Adverse Drug Reaction Reporting Policy and Adverse Drug Reaction administration, ministration policy 7.1, and had medication pass ms. Education included not crushing extended order for [REDACTED]. Interview with RN #1 yad received in-servicing on the 8 rights of the 520 PM, revealed any staff identified as on 1 Education would receive the education upon dical leave and four (4) as needed staff who terials for each person when any of these revealed and the first shift on 02/23/14 by 14 ph proposed to the review of the 1-pad with the DNS, on an insiston. Review of the 1-pad with the DNS, on 1 picture. She stated she did update two (2) evealed education for Admission Coordinator, roordication and proposed proposed proposed proposed propo

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/30/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUC A. BUILDING	TION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		03/08/2014
NAME OF PROVIDER OF SU	185095 PPLJER		STREET ADDRESS, CITY, ST	ATE ZIP
GOLDEN LIVINGCENTER			3116 BRECKINRIDGE LANG LOUISVILLE, KY 40220	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing ho		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0281	(continued from page 3)	WITHOUT)		
Level of harm - Immediate jeopardy	accessing and reviewing care plan Click Care, and explaining the plan	ns in Point Click Care. Demonstr an of care was an integral part in	of a nursing progress note. It also ations included: how to access the performing individualized care for	e plan of care in Point or each resident. The
Residents Affected - Few	locate plan of care documentation the MAR. In addition the education All training was performed in sm verbalized understanding and per Coordination, on 03/08/14 at 4:45 orientation on 02/19/14. She state	n under the dashboard; medical d on covered the residents' charts c all groups or 1:1 by the RN Asse formed return demonstration. Int 5 PM, revealed an in-service was 4d, training would be provide during training with staffing related	to provide care every shift. Educiagnosis; orders; care plan tabs in containing H&Ps and physician pressment Coordinators. Participants erview with the Director of Resid provided by herself, on 03/04/14, ing the monthly orientation relate to the use of the care plans, how	the PCC; and also on ogress notes [REDACTED]. asked questions; ent Assessment to the staff that was in d to the care plans.
F 0282	Provide care by qualified pe **NOTE- TERMS IN BRACKET			*
Level of harm - Immediate jeopardy Residents Affected - Few	Based on observation, interview, the facility's Resident Care Plan p ordered per the care plan for one	record review, review of the faci policy and procedure, it was deter (1) of ten (10) sampled residents	ility's Investigation, Hospital Histormined the facility failed to admin (Resident #1). On 02/19/14 at app	ory and Physical and ister medications as proximately 8:45 AM to
Residents Affected - Few	9:00 AM, Licensed Practical Nur Resident #1 without ensuring he/ #1 was administered five (5) med antidepressant, an antiplatelet, an picture, and failed to ask the alert between 8:00 AM and 9:00 AM p on 02/19/14 at 9:04 AM, of the m the hospital for a medical evaluat	se (LPN) #1, who was in oriental she was the right resident and wi ications that were not prescribed d an opioid pain medication. The and oriented resident his/her nar prior to the medication error. The tedication error and shortness of ion. Resident #1 was evaluated b	tion with LPN #3, administered R thout LPN #3 being present to sup for him/her which included an an LPN failed to compare the reside me. Resident #1 experienced increased Advanced Registered Nurse Pracair status, and the ARNP ordered by the emergency room physician icidental). [MEDICAL CONDITIC	esident #2's medication to bervise the task. Resident tithypertensive, an ent to the resident's eased shortness of air titioner (ARNP) was notified, the resident be sent to and admitted with the
	CONDITION]. Resident #1 was hospitalized for the administration of medications impairment, or death to a resident The facility was notified of the In on 03/07/14 alleging the removal 03/08/14, the Immediate Jeopard lowered to a D while the facility of (QA) monitors the effectiveness of Services (DNS) on 02/27/14 reve Assessment Instrument (RAI) as Resident Assessment Instrument (RAI) as Resident Assessment Instrument Chapter 4, page 12, revealed appristaff. Precise and concise instruct should be oriented towards apply investigation, undated, revealed froom and called Resident #1 by F. Resident #2's medications to Resiwrong medication. Once the Nursadmitted with [MEDICAL CONI resident, on 07/02/12, and readmitted with [MEDICAL CONI resident, on 07/02/14, the medica were coded on the MAR indicate his/her ordered medications relate scheduled to receive, on 02/19/14 AM: [MEDICATION NAME] 5 millig Constipation; [MEDICATION NAME] 20 mg for Diuretic-Esset [MEDICATION NAME] 20 grams (GM)/30 millil Resident #2's, February 2014 phy	[REDACTED]. (Refer to F333) as ordered by the physician has a Immediate Jeopardy on 02/28/14 of the Immediate Jeopardy on 02/28/14 of the Immediate Jeopardy on 03/05/14. develops and implements the Pla of the systemic changes. The find aled the facility referred to the Fetheir guidance on care planning. (RAI) 3.0 Manual, Chapter 1, pa oaches serve as instructions for 1 ions help staff understand and in ing current standards of practice tesident #2's name and Resident dent #1. The resident had a change Practitioner was made aware so DITION]. Review of the clinical tted., on 01/03/14, with [DIAGN aled the facility assessed Reside 15) of fifteen (15). Review of Reside medications as ordered by the tions ordered by the physician was the second of the transfer out to the hospitate so the second of the	The facility's failure to implement caused or is likely to cause seriou field on 02/28/14, and was determ An acceptable Allegation of Comy 3/05/14. The State Survey Agency, as alleged, prior to exit. The scop of Correction (POC) and the facilities include: Per interview with tederal Regulatory Requirements a Review of the Centers for Medicage 10, revealed residents respond resident care and provide for control applement interventions consistent in the care planning process. Revit medication on 02/19/14. LPN #1 #1 answered and sat up in the bed ge of condition within the hour price he sent the resident to the hospital record for Resident #1 revealed the JOSES REDACTED]. Review of mt #1 as cognitively intact with a I ident #1's, Comprehensive Care P physician. Review of Resident #1 revealed the scheduled for administration, a nurses notes dated 02/19/14 indicated for an evaluation. The medicat ON NAME] 800 milligram (mg) I DITION]; [MEDICATION NAME] M20 a Potassium Sumedication NAME] M2.5 mg:	the care plan related to s injury, harm, ined to exist on 02/19/14. plinate (AOC) was received (SSA) validated, on one and severity was ility's Quality Assurance he Director of Nursing and the Resident re and Medicaid (CMS) to individualized care. muity of care by all y. Overall care plans ew of the facility's entered the resident's . LPN #1 administered ior to receiving the lwhere he/she was he facility admitted the the Quarterly Minimum Data Set Brief Interview Mental lan revised on 02/27/13, 's, February 2014 MAR, at 8:00 AM and 9:00 AM, cated Resident #1 did not receive ions Resident #1 did not receive ions Resident #1 did not receive ions Resident #1 was for Muscle Spasm; and at 9:00 E] Sodium 200 mg for pplement-Hypertension; an Antihypertensive. Review of ME] 25-200 mg an Antiplatelet,
	Antidepressant, [MEDICATION Blocker/Heart. Interview with LPN #3, on 02/25, when the incident occurred. She swith LPN #1, on 02/26/14 at 1:15 Resident #2 and Resident #1 ansv 02/10/14 and was still in orientati 11:45 AM, revealed she did not rewith LPN #3 and that was not parwas not familiar with any of the revealed the purpose of the care pto receive the care that was care pto receive the care that was care pshift. She stated each resident had plan for each resident would ensu Manager, on 03/08/14 at 6:00 PM staff should be reviewing the care ensure the residents received the planning was not part of the new Coordinators developed the care the care plans for resident specifion documentation than the care p 2/19/2014 at approximately 9:00 nursing staff. The ARNP on call Resident #1 was transported by E in stable condition. 2. All residen safety of all residents. Licensed P	/13 at 11:35 AM and on 02/26/14 stated she did not review the care PM, revealed she entered Resid vered. She administered the medion and not familiar with the resieview the care plan prior to passit of the morning process before sesidents' care plans. Interview we blan was to ensure proper care we be also and estigated individually reach resident received the care, I revealed she received training to plan and following the care plan care to meet their needs. Intervie employee orientation and the face plans and new orders and change or care. There had been a short distant. The facility implemented the AM, Resident #1 received five news a notified and an order was recomergency Medical Services (EM ts had the potential to be affected ractical Nurse #1, who gave Res	4 at 3:22 PM, revealed she was trate plans with LPN #1 prior to medicent #1's room and called the residications she had prepared. She stadents. Further interview with LPN ing medications on 02/19/14. She starting the morning medication pith the 200 Unit Manager, on 03/03 as provided to the correct resident re plan should be reviewed for net ly for that resident. Per interview, e designed for that resident. Intervon the care plans when she was hin. She stated being familiar with the with the DNS, on 02/28/14 at 5 cility did not have a policy on cares were added to the care plans os excussion about care plans; however the control of the care plans of the care plans. The care plans of the care plans of the care plans of the plans of t	ining LPN #1, on 02/19/14 cation pass. Interview ent by the name of ted she started to work on #1, on 03/08/14 at stated she was assigned ass. LPN #1 revealed she 88/14 at 5:45 PM, and for each resident w and/or changes each following the care riew with the 100 Unit red at the facility. The ne care plans would coo PM, revealed care plans. The MDS taff should be looking at rr, the focus was more Immediate Jeopardy: 1. On simmediate Jeopardy: 1. On simmediately identified by som (ER) at 9:04 AM. the hospital, he/she was on to ensure the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

Facility ID: 185095

If continuation sheet Page 4 of 10

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/30/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED 03/08/2014
CORRECTION	NUMBER 185095			
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, ZIP
GOLDEN LIVINGCENTER	- HILLCREEK		3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	:
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0282	(continued from page 4)	WITHOUT)		
Level of harm - Immediate jeopardy	medication administration, Medicand have medication pass observa	ation Error and Adverse Drug Reation competencies completed by	on medication administration using eporting Policy 6.2 and Medication an RN, prior to passing any medications and to ensure residents have	n Administration policy 7.1, cations. Education included
Residents Affected - Few	4. On 02/19/14 at approximately each resident had a current, accur Admission Coordinator, House S	7:00 PM, the Director of Nursing ate photograph in the eMAR/eTA upervisor or Unit Managers are re	Services (DNS) completed an ele AR. All residents in house on 02/19 esponsible to ensure a new residen	ectronic audit to ensure 9/14 had a photograph. The at has a photo taken and
	Supervisors, and Unit Managers and Quality Assurance Performance I Medical Director agreed with the practical nurse who administered practical nurse and a second licen medication administration; Medicin-service education for all licens Adverse Drug Reporting Policy 6 eMARs/eTARs. 6. On 02/22/14 the pharmacy's assistance in medicatid discussed notification of the IJs, i week. Consultant Pharmacist was During his visit, the pharmacist a conducting a 3-way audit of physpass observations, in-service eductracked and trended with followtime. 7. Medication errors for the Clinical Director on 02/26/14 wit conducted an audit of all doors to name. It was replaced immediatel resident room doors are accurate, audit of all residents for arm band bands in place. The facility decid facility's policy. The Admission (has a new arm band placed on the becomes soiled or illegible. Educthe DNS on 02/27/14. 10. On 02/	was provided by DNS on 02/27/1- mprovement (QAPI) to discuss the plan/AOC to address medication medications in error to Resident sed practical nurse who also was action Error and Adverse Drug Re ed nurses on using the 8 Rights of .2 and Medication Administration to DNS contacted the consultant on pass observations. On 03/02/1 nitial AOC Plan, QAPI to be held at the facility on 03/04/14. The I tso conducted medication reviews ician orders/medication administration, and medication room audi up actions or education for staff co previous 6 month period were re no trends noted. 8. On 02/23/14 ensure the correct resident name y. The Admissions Coordinator c 9. On 02/23/14, the Admissions 0 s. There were one-hundred thirty ed all residents would wear arm b Coordinator, House Supervisor, or resident at the time of admission ation for the Admission Coordina 24/14, arm bands were placed on	on. Education for Admission Coon 4. 5. On 02/20/14 at 11:00 AM, the medication error and Resident # errors, which included: immediat #1 from the medication cart; educin orientation on 02/19/14 on usir eporting Policy 6.2 and Medication f Medication Administration, Medication Administration, Medication Administration, Medication Folicy 7.1; and auditing resident pharmacist regarding the medication to the DNS spoke with the consult on 02/24/14, and the pharmacy pDNS reviewed the QAPI meeting, so On 03/04/14 additional Pharmaciation records and medication cart ts. Any issues identified in review ompleted as needed. No issues we viewed and analyzed by the DNS 4, the Admissions Coordinator and was listed. One door on the 300 hor Staffing Coordinator is responsionands as another form of identificar Unit Managers are responsible to and to replace armbands if the artor, House Supervisors, and Unit all residents by the Admission Co	le Medical Director attended the late of the licensed attended to the licensed to the
	Coordinator as another form of id facility's implementation of their practical nurse who administered practical nurse who administered practical nurse and a second licen medication administration, Medic completing medication observatic armbands as another form of iden for correct names; revising the or assigned to the floor; notifying the and audits; reviewing the previou weekly. The Executive Director, Services, Transitional Care Nurse The meeting minutes were review with all licensed nurses on Care I the resident, how to utilize the nu updated, care plan criteria, and co care plans in the Point Click Care staff members should be able to pracess the plan of care in Point C individualized care for each resid of care to provide care every shift the dashboard; medical diagnosis have H&Ps and physician progres and, performed return demonstrat medication pass observation com for orientation with another licen:	entification. 11. On 02/24/14 at 8 plan to decrease medication error medications in error to Resident sed practical nurse who also was ation Error and Adverse Drug Re on pass competencies with an RN tification; immediately auditing a tentation process to include medice pharmacist of the error and request of months of medication errors to Director of Nursing Services, 2-U, a Business Office Manager, Hum red with the Medical Director. 12 Plans which included: initiating the rising process in the development of a nursing progress r. By understanding the componer rovide proper and individualized lick Care, and explaining the planent. It was also explained the nurs. In additional education was process notes [REDACTED]. Participa ion. 13. Orientation for all new lipetencies by the Director of Clinised nurse. Licensed nurses selected	8:00 AM, an Ad Hoc QAPI was he so which included; immediate reme #1 from the medication cart, educin orientation on 02/19/14 on using porting Policy 6.2 and Medication; auditing all records for photogra all residents for armbands; auditing cation administration competencie uesting assistance with medication oidentify trends; and conducting. Juit Managers, Director of Clinica and Resources Personnel, Medical. On 03/04/14 the RN Assessment ecare plan, how the care plan relation to the plan of care, when a care poote. The training also included aches and purpose of the care plan, a care to each resident. Demonstrat of care is an integral part in perfeses must utilize information found vided on how to locate plan of care. And also on the MAR. In additionts were allowed to ask questions iccased nurses hired after 02/24/12 ical Education (DCE) prior to being be proposed to the process of the prior to being the properties of the process of the prior to being the process of the process of the prior to being the prior to prior to prior to prior to the process of the prior to prior t	eld to discuss the oval of the licensed ation for the licensed ation for the licensed at license at lic
	prior to orientating any additional explaining the role of preceptor a of being a preceptor; goals of the diversity; safe and ethical practic preceptor progress; skills objectiv preceptor/orientee, preceptor/orientee, preceptor/orientee, preceptor/orientee, preceptor/orientee, preceptor/orientee, preceptor/orientee, preceptor/orientee, orientation with all not times per week to ensure all resid immediately have an arm band pleonducting the audit. The results results would be discussed weekl times per week to ensure all resid photo in place will immediately hinvestigated, by the Unit Manage by the Unit Manages. The results began conducting a medication preduce errors. Results would be a weekly in QAPI meeting. 17. On decrease medication errors. Also, administration records and medic observations. Training was also be conducted of the medication roon nurses on Care Plans and how the reviewing care plans in PCC. The 18. A QAPI Committee meeting committee will review effectivem update, and develop action plans,	licensed nursing staff. This train do orientee; adult learning princip program; working with staff at die; communication; critical thinkine; knowledge objective; affective intee/Director of Clinical Education and training can be initiated additional training can be initiated and the reason the arm band of the audits would be analyzed a y in the QAPI meeting. 15. The Uents have a photo loaded into Poi ave a photo taken and loaded into Poi ave a photo taken and loaded into a conducting the audit. The results would be discussed weekly in the assaudit on 03/01/14, 5 times per nalyzed and trends noted weekly 03/03/14, an Ad Hoc QAPI was 1 the Pharmacy consultants plan for ation carts was discussed. Pharmacing conducted on narcotic recon as and carts. In addition, discussive are plan related to the care of the meeting minutes were reviewed will be held weekly for 4 weeks, tess and compliance with the plan based on any issues identified in	raining provided by Director of Cling will include: defining precepted ples; strategies for effective preceptiferent stages of clinical competering; nursing process to problem solo objective; continuous interaction on; and progress, conflict, and trard, the Director of Clinical Education, and progress, conflict, and trard, the Director of Clinical Education on; and progress, conflict, and trard, the Director of Clinical Education on; and progress, conflict, and trard, the Director of Clinical Education of the Conflict of Conflic	or/mentor; pting; challenges nce; working with ve; assessing and feedback on sistion, for their on, will complete 14 of all residents 5 1 arm band in place will igated, by the Unit Manager it Manager and DNS. The 28/14 of all residents 5 t who does not have a as not in place would be and trends noted weekly ADNS, DCE, & RN Supervisors iveness of the plan to e reviewed and discussed oring of the plan to oysician orders/medication etting medication etting medication pass its would also be with all licensed accessing and S via telephone on 03/04/14. monthly thereafter. The d will review, revise, unds, photos, and

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:7/30/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 03/08/2014
CORRECTION	NUMBER 185095			03/00/2014
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, ST	ATE, ZIP
GOLDEN LIVINGCENTER	- HILLCREEK		3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing ho		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICI MATION)	ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0282	(continued from page 5)	nterview with the Director of Nur	rsing Services (DNS), on 03/08/14	at 10:45 AM revealed
Level of harm - Immediate jeopardy	she was notified of the medicatio Registered Nurse Practitioner (Al message, at 9:04 AM, provided the	n error shortly after the error occ RNP) via text message per LPN/Une medications involved and the	urred. She stated, the staff notified Unit Manager from 100 Unit, on 0 oxygen (O2) levels at 82%. Review	I the Advanced 2/19/14 at 9:04 AM. The text w of the copied text
Residents Affected - Few	message, at 9:04 AM, provided the message, identified with the ARN send Resident #1 to the hospital fall's vital signs were not suppress DNS and record review, on 03/08 with a newly licensed, Licensed I medication cart and medication p Review of the education attendantheir attendance. Interview with tin-service was provided by hersel would be provided during the mo Interview with LPN #1, on 02/26 removed from the medication car become more aquatinted with the occurrence, on 02/19/14, complet orientation. She completed an inadverse drug reaction reporting. 702/23/14, for E-Kit use and reord controlled medications. She was Review of the rights of medicatic completed on 02/19/14, 02/21/14 licensed nurses on the 8 rights of 6.2, and Medication Administration administration administration administration competencies completed on 02/19/14, 02/21/14 licensed nurses on the 8 rights of 6.2, and Medication Administration observation competencies completed and LPN #4, on 02/27/14 at 7:25 medication administration. Interview of absence and had not contheir return before they would be rarely worked a schedule. The Hc individuals worked again. 4. Interensure each resident had a curren 7:00 PM. Review of the audit cornesure each resident had a curren photograph. The Admission Coophoto taken and uploaded into the 03/08/14 at 1:45 PM, revealed sh of the pictures. Review of the ins House Supervisors, and Unit Mar responsible to ensure a new residadmission. Telephone interview verspectively, revealed they had be S. Review of the QAPI attendad with the Director of Nursing Servisions, included the medication pass observations revobservations revobservations. The pharmacy cons and medication carts, along with had been identified with the cominterview with the DNS and Field previous six (6) month period we of twenty-five (25) rooms on the the outside of the door in the hall Staffing Coordinator, revealed the Midnight census and included the Coordinator's written statements, Interview with the Admission Co 02/22/14 midnight census to	ne medications involved and the ether where the medications involved and the the Practical Nurse (LPN). The nurse associated Nurse (LPN) and the Nurse (LPN) and the Nurse (LPN) and the Nurse (LPN). The Nurse (LPN) and the Nurse (LPN) and (LPN) associated Nurse (LPN) and (LPN). The Nurse (LPN) and (LPN). The Nurse (LPN) and (LP	oxygen (O2) levels at 82%. Review of the ARNP returned orders at 9:0 of the emergency department recognificantly abnormal chest x-ray, itital investigation identified the means are to a substantial investigation identified the means of 14, revealed LPN #1 and #2 sign ent Coordination, on 03/08/14 at 42 as in orientation on 02/19/14. She staff attendance form validated in emedication error was identified a irector of Clinical Education and Intation was extended. Review of the revealed LPN #2 was in her fifth (medication administration and mentications, enterals, injections and the petency verification. She passed because by the attendance roster revector of Clinical Education beganication. Error and Adverse Drug Reptotion Error and Erro	w of the copied text by 5AM via text message to ords revealed Resident 2. Interview with the edication error occurred as removed from the ication administration, ed the sheet indicating i:45 PM revealed an estated, training service attendance. Indicating estated, training service attendance. Indicating estated, training service attendance. Indication error, and it is the statement of 5th) and last day of dication error, and it is competency, on the disposition of sooth examinations. 3. ealed education was education with all eaction Reporting Policy orting and 7.1 Medication referred and indication error, and it is search as a seal of the state of the search of the s
	bands were audited on 02/23/14, the midnight census and included Staffing Coordinator's written sta residents. Interview with the Adn	and placed on the residents as and the run date, of 02/22/14 at 11:5 tements, dated 02/26/14, revealed hission Coordinator and the Staff	other form of identification. The a 19 PM. Review of the Admission C d an audit of resident armbands w ing Coordinator, on 02/27/14 at 8: n armband. There was a total of or	udit form used was from Coordinator and the as completed for of all 25 AM, revealed they
	(139) residents on the census. The armband. Review of the inservice the Admission Coordinator, Staff residents on 02/26/14 revealed th	ey found two residents who alrea e staff attendance record revealed ing Coordinator, House Supervis e residents had arm bands in plac	dy had an armband on and the rest an inservice on arm bands was cosors and the Unit Managers. 10. Older. 11. Review of the QAPI attendations.	t were provided a new onducted on 02/27/14, with observations of fifteen (15) ance record, on 03/08/14,
	Director and three (3) plus Direct to decrease medication errors. Ar dated 02/19/14, for ongoing audit 03/08/14 at 2:00 PM, revealed the findings of the auditing and on ta	ors in attendance and was a routi Ad Hoc QAPI meeting was held ting, monitoring and re-evaluation e QAPI meetings are ongoing we rget. 12. Review of the education	14, with the Director of Nursing S ine monthly meeting. The topic of id, on 02/24/14, related to the medin. Interview with the Executive Direkly, with the auditing, reviewing a content regarding care plans, com it included: initiating the care pla	discussion was the plan cation error occurrence, irrector and The DNS, on and re-evaluation of the pleted on 03/04/14, by
	related to the care of the resident; plan is developed and updated; ca accessing and reviewing care plan Click Care, and explaining the pl nurses must utilize information fol locate plan of care documentation	how to utilize the nursing procesure plan criteria; and components ns in Point Click Care. Demonstr an of care was an integral part in pund in the resident's plan of care n under the dashboard; medical displants of the dashboard; medical displant	is included: initiating the care pia so f a nursing progress note. It also ations included: how to access the performing individualized care fo to provide care every shift. Educa iagnosis; orders; care plan tabs in containing H&Ps and physician pro-	of care; when a care included training on plan of care in Point reach resident. The atton included how to the PCC; and also on

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	185095		
NAME OF PROVIDER OF SUI	PPLIER	STREET ADDRESS, CITY, STA	ATE, ZIP
GOLDEN LIVINGCENTER - HILLCREEK 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220			
For information on the nursing	home's plan to correct this deficience	cy, 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)		Y FULL REGULATORY	
F 0282 (continued from page 6)			
Level of harm - Immediate jeopardy			

Residents Affected - Few

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure that residents are safe from serious medication errors.

*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 while the facility's even years and implements the rain of Contection (rew of the facility's Quanty Assurance (QA) monitors 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 #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 expected the Nurse Practitioner can the resident to the beginning them to the project of 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 as cognitively mack with a Brief Interview Mental Status (BIMS) score of Intern (13). 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 Resident #2 insher inductations. LPIN #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 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 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

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(X4) ID PREFIX TAG	· ·	DEFICIENCIES (EACH DEFICIENCE)		Y FULL REGULATORY
	OR LSC IDENTIFYING INFOR	MATION)		
F 0333	(continued from page 7) cart. Licensed Practical Nurse #2.	who had previously worked at the fa	acility for several years, was a	so in orientation.
Level of harm - Immediate jeopardy	Both Licensed Practical Nurses re Error and Adverse Drug Reaction Pharmacy Policy & Procedure Ma	eceived education on 02/19/14 on the Reporting Policy 6.2, and Medication anual - 2007 PharMerica Corp. 3. On	e 8 rights of medication admini on Administration Policy 7.1, N n 02/19/14, the Director of Clin	stration, Medication Nursing Care Center nical Education immediately
Residents Affected - Few	Pharmacy Policy & Procedure M began education with all licensed Reaction Reporting Policy 6.2; M and 7.1 Medication Administratic Corp. Initiation of medication observations of medication of RN Nurse Managers. All nurses v 02/24/14 unless training was com Medication Error and Adverse Droservation competencies comple release medications or no crushat observation competencies will be staff. 4. On 02/19/14 at approximensure each resident had a curren photograph. The Admission Coop photo taken and uploaded into the House Supervisors, and Unit Marattended Quality Assurance Perfocondition. The Medical Director the licensed practical nurse and a sec Rights of medication administrati Policy 7.1; in-service education ferror and Adverse Drug Reportin eMARs/eTARs. 6. On 02/22/14 t pharmacy's assistance in medicati discussed notification of the IJs, it week. Consultant Pharmacist was During his visit, the pharmacist a conducting a 3-way audit of physpass observations, in-service edutracked and trended with follow-time. 7. Medication errors for the Clinical Director on 02/26/14 wit conducted an audit of all doors to name. It was replaced immediatel resident room doors are accurate, audit of all residents for arm banc bands in place. The facility decidifacility's policy. The Admission Chas a new arm band placed on the becomes soiled or illegible. Educ the DNS on 02/27/14. 10. On 02/Coordinator as another form of idacility's implementation of their practical nurse and a second licen medication administration, Medic completing medication observatia armbands as another form of iden for correct names; revising the previou weekly. The Executive Director, Services, Transitional Care Nurse The meeting minutes were review with all licensed nurses on Care Fithe resident, how to utilize the nu updated, care plan criteria, and care plans in the Point Click Care from the control of the point Clindividualized care for each resid of care to provide care every shift the dashboard; medical diagnosis have H&Ps and physician progreand, perfor		administration; Medication Error a Pharmacy Policy & Procedure Sed nurses was started first shif leted by 02/24/14. No nurse wu using the 8 rights of medication it on Administration policy 7.1, aedications. Education includes the have an order for [REDACT is identified, and annually for an g-Services (DNS) completed at TAR. All residents in house of langers are responsible to ensure of the most of the control of the contro	nical Education immediately rror and Adverse Drug and Adverse Drug and Adverse Drug Reporting Manual - 2007 PharMerica ft on 02/23/14 by the ould be allowed to work after on administration, and have medication pass d not crushing extended fED]. Medication all licensed nursing an electronic audit to on 02/19/14 had a ure a new resident has a Admission Coordinator, AM, the Medical Director Resident #1's current deed: immediately removing on cart; education for 4 on using the 8 Medication Administration tration, Medication gresident photographs in ion error and requested the tant pharmacist and lan for the coming and AOC/plan from 03/04/14. Exy consultants began so allow the state of a diagraphs with the staffing Coordinator and Held Services the Staffing Coordinator and staffing ble to ensure the names on dinator conducted an only two (2) had arm tion per the poensure a new resident mband is missing, Managers was provided by oordinator and Staffing eld to discuss the oval of the licensed and of the licensed and the Resident of t
	times per week to ensure all resid photo in place will immediately h investigated, by the Unit Manage by the Unit Managers. The results	y in the QAPI meeting. 15. The Unit ents have a photo loaded into Point C ave a photo taken and loaded into PC c conducting the audit. The results of s would be discussed weekly in the Q	Click Care (PCC). Any resident CC and the reason the photo was the audits would be analyzed a API meeting. 16. The DNS, A	t who does not have a as not in place would be and trends noted weekly ADNS, DCE, & RN Supervisors
	began conducting a medication pareduce errors. Results would be a	ass audit on 03/01/14, 5 times per we nalyzed and trends noted weekly by	eek, to ensure continued effecti the DNS. The results would be	veness of the plan to reviewed and discussed

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE (PRINTED:7/30/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
DEFICIENCIES	/ CLIA	À. BUILDING		COMPLETED
AND PLAN OF	IDENNTIFICATION	B. WING		03/08/2014
CORRECTION	NUMBER			
LAME OF PROMINER OF GU	185095	kan	PET ADDRESS CITY OF	ATE TIP
NAME OF PROVIDER OF SU			REET ADDRESS, CITY, STA	· · ·
GOLDEN LIVINGCENTER -	· HILLCREEK		6 BRECKINRIDGE LANE UISVILLE, KY 40220	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or	•	
	· ·			VEHI DECHI ATODV
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	EFICIENCIES (EACH DEFICIENCY MATION)	I MUSI DE PRECEDED D	I FULL REGULATOR I
F 0333	(continued from page 8)	,		
	observations. Training was also b	eing conducted on narcotic reconciliat		
Level of harm - Immediate		as and carts. In addition, discussion of		
jeopardy		care plan related to the care of the res meeting minutes were reviewed with		
Residents Affected - Few	18. A QAPI Committee meeting	will be held weekly for 4 weeks, then b	bi-weekly for 4 weeks, then n	nonthly thereafter. The
		ess and compliance with the plan to de based on any issues identified in revie		
		ll be tracked and trended with follow-		
	needed by the QAPI Committee.	If the Medical Director is unavailable i	in person on a weekly basis,	he will review progress
		and/or DNS. The State Survey Agenc terview with the Director of Nursing S		
		error shortly after the error occurred.		
	Registered Nurse Practitioner (Al	RNP) via text message per LPN/Unit M	Manager from 100 Unit, on 02	2/19/14 at 9:04 AM. The text
		e medications involved and the oxyge P's name, date and time, revealed the		
		or a medical evaluation. Review of the		
	#1's vital signs were not suppress	ed; however, he/she did have a signific	cantly abnormal chest x-ray.	2. Interview with the
		/14 at 10:45 AM, revealed the initial in ractical Nurse (LPN). The nurse was i		
		ass orientation. She was provided educ		
	Review of the education attendan	ce roster recorded dated of 02/19/14, re	evealed LPN #1 and #2 signer	ed the sheet indicating
		ne Director of Resident Assessment Co f, on 03/04/14, to the staff that was in		
		nthly orientation. Review of the staff a		
		14 at 1:15 PM, revealed once the med		
		She was reassigned with the Director residents. She reported her orientation		
	occurrence, on 02/19/14, complet	ed by the DNS, dated 02/27/14, reveal	led LPN #2 was in her fifth (5	5th) and last day of
		service related to the 8 rights of medical		
		The statement stated, LPN #2 complete ering, oral medications, eye medication		
	controlled medications. She was	dministered two (2) test for competen-	cy verification. She passed b	oth examinations. 3.
	Review of the rights of medication	n administration education, evidenced	by the attendance roster reve	ealed education was
		02/22/14 and 02/24/14. The Director medication administration, Medication		
	6.2, and Medication Administrati	on Policy 7.1. Policy 6.2 Medication E	Error and Adverse Drug Repo	rting and 7.1 Medication
		ing Care Center Pharmacy Policy & Pr		
		ation competencies for all licensed nur es who worked had both trainings com		
	after 02/24/14 unless training was	completed on medication administrati	ion using the 8 rights of med	ication administration,
		ug Reporting Policy 6.2 and Medication		
		ted by an RN, prior to passing any me le medications and to ensure resident l		
	and LPN #4, on 02/27/14 at 7:25	AM and 7:40 AM, respectively, reveal	led they had received in-serv	icing on the 8 rights of
		iew with House Supervisor #2, on 03/0	ar 1 m 1	
		pleted the training by the Director of Callowed to work. There were three (3)		
	rarely worked a schedule. The Ho	use Supervisor had a packet of educati	ion materials for each person	when any of these
		view with the DNS, on 03/08/14 at 1:3 , accurate photograph in the eMAR/eT		
	7:00 PM. Review of the audit cor	pleted on 02/19/14, by the Director of	f Nursing Services, revealed	it was completed to
		, accurate photograph in the eMAR/eT		
		dinator, House Supervisor or Unit Man electronic charting system at the time		
	03/08/14 at 1:45 PM, revealed sh	checked to ensure each resident had a	a current picture. She stated s	she did update two (2)
		ervice on electronic photos, dated 02/2		
		agers was provided by DNS. The Adn ent has a photo taken and uploaded into		
	admission. Telephone interview v	vith the 200 Unit Manager and 100 Un	it Manager, on 03/08/14 at 5	:41 PM and 6:00 PM,
		en trained and directed to ensure each e record, on 03/08/14, verified a regula		
	with the Director of Nursing Serv	ices, the Medical Director and three (3	3) plus Directors in attendance	e. Topics of
	discussion, included the medicati	on error of 02/19/14, which was identify	fied as a routine monthly me	eting. 6. Review of the
		ealed the consultant pharmacist was on ultant began conducting a 3-way audit		
		nedication pass observations, in-service		
		eleted med pass observation; however,		
		Services Clinical Director on 03/07/1- re reviewed and analyzed on 02/26/14		
		300 Hall, on 03/08/14 at 5:15 PM, reve		
		Review of written statements, dated 0		
		doors (resident rooms) were audited or run date, of 02/22/14 at 11:59 PM. Re		
		dated 02/26/14, revealed an audit of re		
		ordinator and the Staffing Coordinator		
		k each door for a resident name. There ed 02/26/14, from the Admission Coor		
	bands were audited on 02/23/14,	and placed on the residents as another	form of identification. The au	udit form used was from
		the run date, of 02/22/14 at 11:59 PM		
		tements, dated 02/26/14, revealed an autission Coordinator and the Staffing Co		
	utilized the 02/22/14 midnight ce			,
F 0356	 b>Post nurse staffing informat			
		·	N 0. 00 0	
Level of harm - Minimal harm or potential for actual		record review and review of the Daily ffing data at the beginning of each shif		
harm		ve (12) of twelve (12) days. In addition		
	included staff in orientation as pa	rt of the staffing level. The findings in	clude: The facility did not ha	ve a policy
Residents Affected - Some		sing staff. Interview with the Director for the posting of the nurse staffing ho		

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE (PRINTED:7/30/2014 FORM APPROVED
TATEMENT OF EFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
ND PLAN OF DRRECTION	IDENNTIFICATION NUMBER	B. WING	03/08/2014
ME OF PROVIDER OF SU	185095 PPLIER	STREET	ADDRESS, CITY, STATE, ZIP
LDEN LIVINGCENTER -	- HILLCREEK		CCKINRIDGE LANE ILLE, KY 40220
information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the s	
(4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM		ST BE PRECEDED BY FULL REGULATORY
F 0356	(continued from page 9)	had there (2) DNs yourse the form (4) DNs a	osted. The Licensed Practical Nurses (LPN) on
narm or potential for actual	the assignment sheet was five (5) day of the medication error) and t	LPN verses the six (6) posted. Review of the Daily Assignment Sheet revealed the nig	e Daily Staffing Form, dated 02/19/14, (the ht shift had four (4) LPNs working verses the
Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	day of the medication error) and posted five (5). There were a tota in orientation. Observation, on 02 Nurse Staffing Form was comple dated 03/02/14, and the Daily Austowork was three (3) verses the fposted. Review of the Daily Nurs to work was three (3) verses the fposted. There was one (1) CNA is 03/05/14 at 5:15 PM, of the Daily for all three shifts. Review of the verses the seven (7) posted. Furth posting. Interview with the Staffinstaff scheduling and to schedule the residents. She stated every me Form, and made sure it was poste wall outside of the door to her off and Sunday and placed them in the updated the forms other than hers stated she just filed the ones from staff in orientation (RN/LPN/CN. Supervisor #1, on 03/06/14 at 5:0 the Daily Nurse Staffing Form the verified her staff from that particulations of the staff are the staff and the staff are the staff and 03/07/14 at 3:15 PM, revealed the	the Daily Assignment Sheet revealed the nig 1 (276/14 at 10:00 AM, of the Daily Nurse Stated for all three shifts versus the day shift or signment Sheet revealed the LPNs on day she Staffing Form, dated 03/03/14, and the Daily Nurse Stated for all three shifts versus the day shift or signment Sheet revealed the LPNs on day she (5) posted. The CNAs scheduled for the norientation which was included in the Daily Nurse Staffing Form, dated 03/05/14, reve. Daily Assignment Sheet revealed the CNAs ter review revealed two (2) staff had called in gCoordinator, on 03/06/14 at 4:25 PM, revelhe staff was on duty. She was responsible to ming she calculated the Daily Assignment ds. She stated she had this form completed bice. She stated on Friday mornings, she con the posting sleeve on the bulletin board for the left. The forms were completed in the morning the day before without updating each form. A) and the count included the Unit Manager is PM, revealed there were two forms. One was twas to be posted with the staffing level. Stalar form. She documented on the Daily Assed she did not do anything to the daily staffialable for the next shift. Continued interview	ht shift had four (4) LPNs working verses the owever, that included the four (4) nurses 'fing Form, dated 02/26/14, revealed the Daily ly. Review of the Daily Nurse Staffing Form, ift totaled seven (7) verses the eight (8) illy Assignment Sheet revealed the LPNs scheduled night shift was eight (8) verses the nine (9) y Nurse Staffing data posted. Observation, on led the Daily Nurse Staffing Form was completed scheduled for the night shift was six (6) in however, this was not reflected on the ealed one of her responsibilities was for ensure sufficient staff to meet the needs of Sheets, calculated the Daily Nurse Staffing etween 7:00 AM - 9:00 AM and posted it on the pleted the weekend forms for Friday, Saturday e whole weekend. She revealed no one really gand never changed through out the day. She She stated the staffing numbers included the that worked the desk. Interview with House was a Daily Assignment Sheet and the other was ne reviewed the Daily Assignment Sheets and ignment Sheet when there was a call in or if ng sheets before the next shift to show w with the Director of Nursing Services, on in the early morning by the Staffing Coordinator