STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115560	A. BUILDING _____ B. WING _____	01/17/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY HEALTH AND REHAB	3201 WESTMORELAND ROAD CLEVELAND, GA 30528

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)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, hospital History and Physical Report review, hospital Drug Quick Screen review, hospital Discharge Summary review, Lexi-Comp Geriatric Dosage Handbook, 12th Edition review, and Facility Investigative report review, the facility failed to ensure the provision of care in a manner that prevented the neglect of one (1) resident (#1), who received the narcotic [MEDICATION NAME] in the absence of a physician's orders [REDACTED]. Resident #1 received [MEDICATION NAME] in error, with no order to receive the drug, and was then observed by staff to be unresponsive. Resident #1 was transported to the hospital where a toxicology screen revealed a toxic [MEDICATION NAME] level. Resident #1 was then admitted to the Intensive Care Unit and was administered a [MEDICATION NAME] drip as a narcotic overdose antidote, and also intravenous fluids. The facility's neglect of Resident #1, involving the administration of [MEDICATION NAME] to the resident in the absence of a physician's orders [REDACTED]. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on January 15, 2014 at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 25, 2013 (the date the facility concluded that Resident #1 received [MEDICATION NAME] in error), continued through January 16, 2014, and was removed on January 17, 2014. During the January 15, 2014, 2:55 p.m. interview referenced above, the Administrator acknowledged the medication error involving Resident #1 receiving [MEDICATION NAME] without a physician's orders [REDACTED]. The Administrator stated that as a result of the August 2013 standard survey medication error citation, periodic medication pass observations had been conducted by supervisory staff, but also acknowledged the need for more supervision and more frequent observations of medication administration by facility nursing staff. An allegation of jeopardy removal was received on January 16, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on January 17, 2014, and the facility remained out of compliance at a lower scope and severity level of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: Record review for Resident #1 revealed a Minimum Data Set assessment of 11/08/2013 which documented in Section I-Active [DIAGNOSES REDACTED]. A Nurse's Notes (NN) entry of 12/26/2013 at 11:30 a.m. for Resident #1 documented that the resident would not respond or open his/her eyes and that, when contacted, the physician had ordered to send the resident to the hospital for evaluation. A 12/26/2013, 12:05 p.m. NN entry then documented Resident #1's transport to the hospital per this physician's orders [REDACTED]. The hospital History and Physical (H&P) referencing Resident #1's 12/26/2013 hospital admission documented a change in the resident's mental status, and documented that upon hospital arrival, the resident was somnolent and was noted to have pinpoint pupils. A dose of the narcotic antidote [MEDICATION NAME] was administered to Resident #1, and a toxicology screen completed in the emergency room revealed findings which included a large amount of [MEDICATION NAME] in the resident's system. This 12/26/2013 toxicology report, the emergency room Drug Quick Screen, for Resident #1 documented a toxic [MEDICATION NAME] level of 2023 nanograms/milliliter (ng/mL). (The Lexi-Comp Geriatric Dosage Handbook, 12th Edition, lists a [MEDICATION NAME] level greater than 2000 ng/mL as toxic.) Resident #1's hospital H&P referenced above, in addition to referencing the toxicology screen which had revealed a toxic [MEDICATION NAME] level of 2023 ng/mL, also documented in the Assessment Section that Resident #1 had overdosed on [MEDICATION NAME], and further documented Resident #1's admission to the Intensive Care Unit for the administration of a [MEDICATION NAME] drip and intravenous fluids. Resident #1's hospital Discharge Summary documented, in the Discharge [DIAGNOSES REDACTED]. Further review of Resident #1's clinical record revealed that, despite Resident #1 having been diagnosed at the hospital as having experienced a [MEDICATION NAME] overdose as indicated in the hospital H&P referenced above, there was no evidence to indicate that Resident #1 had a physician's orders [REDACTED]. In an Investigation Report (IR) completed by the facility as a result of an investigation into Resident #1's [MEDICATION NAME] overdose, the facility documented that a toxicologist, upon consultation, had stated that Resident #1's elevated [MEDICATION NAME] level was likely a peak level, occurring six to twelve hours after ingestion of the drug. This IR documented that based on the toxicologist's statement and on Resident #1's alertness until around 7:00 p.m. on 12/25/2013, the facility concluded that Resident #1's [MEDICATION NAME] medication error had occurred during the 12/25/2013, 8:00 p.m. to 9:00 p.m. medication pass. This IR further documented that the facility had found, via this investigation, that Resident #1 had received the 12/25/2013 bedtime medication which was ordered for, and intended for administration to, Resident #2. During an interview with the DON conducted on 01/14/2014 at 11:00 a.m. in reference to the incident involving Resident #1's [MEDICATION NAME] overdose, the DON acknowledged that Resident #1 did not have an order to receive [MEDICATION NAME], but stated that Resident #2, who resided on the same hall, did have an order for [REDACTED]. administered medications. Based on the above, the facility failed to provide care in a manner which prevented the neglect of Resident #1 by failing to ensure that the resident received only those medications ordered by the physician. Rather, Resident #1 received the narcotic [MEDICATION NAME] in the absence of a physician's orders [REDACTED]. Resident #1 was later found to be unresponsive and required hospital transfer and admission. A hospital toxicology screen revealed that Resident #1 had a toxic [MEDICATION NAME] level of 2023 ng/mL, requiring admission to the Intensive Care Unit and administration of a [MEDICATION NAME] drip and intravenous fluids for [DIAGNOSES REDACTED]. Cross refer to F333 for more information regarding Resident #1. The immediate jeopardy was determined to have been removed on 01/17/2014, at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On December 30, 2013, upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On December 30, 2013, the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On December 30, 2013, the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and the facility's plan to correct and monitor the problem regarding medication administration. As of 01/16/2014 (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining nurses, who had been unavailable for training due to being on leave or due to their part-time work status, will receive this in-service training on the date of their return to work. This procedure also specifies that all newly-hired nursing staff will receive training on the facility's medication

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) administration policies and procedures upon hire. 4. On December 30, 2013, the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of 01/16/2014, seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On December 31, 2013, the Assistant Director of Nursing (ADON) and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On December 31, 2013, the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of 12/26/2013, a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who had been on duty from 7:00 a.m. on 12/25/2013 through 7:00 a.m. on 12/26/2013. 7. On January 12, 2014, all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On January 16, 2014, the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct a medication cart audit utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of the medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On January 16, 2014, the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On January 16, 2014, the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form, would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on January 17, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. The facility had begun the process, initiated on 12/30/2013, of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of 01/16/2014 (the day prior to the 01/17/2014 exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on 12/30/2013, by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. As of 01/16/2014, (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the 01/17/2014 exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the severity is reduced to the D level.
F 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, hospital History and Physical Report review, hospital Discharge Summary review, Facility Investigative report review, and review of the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules, the facility failed to ensure that services were provided in accordance with professional standards of quality, regarding medication administration, for one (1) resident (#1) on the total survey sample of fifteen (15) residents. Resident #1 received the narcotic [MEDICATION NAME] without a physician's orders [REDACTED]. Resident #1 was determined, via a hospital laboratory test, to have a toxic [MEDICATION NAME] level, and was admitted to the Intensive Care Unit for receipt of a [MEDICATION NAME] drip for opioid overdose and intravenous fluids. This resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the immediate jeopardy on January 15, 2014 at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 25, 2013 (the date the facility concluded that Resident #1 received [MEDICATION NAME]), continued through January 16, 2014, and was removed on January 17, 2014. During an interview conducted on January 16, 2014 at 12:30 p.m., the Administrator acknowledged the significant medication error during which Resident #1 received [MEDICATION NAME]. The Administrator further stated that this medication error involving Resident #1 had required the facility to conduct thorough one-on-one training with nursing staff regarding the facility's medication administration policies and procedures. The Administrator also stated that the medication error had prompted the facility to initiate more frequent supervisory staff observations of nursing staff during the provision of resident medications to audit nursing staffs' accuracy during medication passes. An allegation of jeopardy removal was received on January 16, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on January 17, 2014, and the facility remained out of compliance at a lower scope and severity of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: Review of the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules revealed that Chapter 2 - Standards of Nursing Practice, Section 2.2.2, Standards Related to Registered Nurse (RN) Responsibility for Nursing Practice Implementation, requires in Section 2.2.2(g) that the nurse implements treatment, including medication administration. Additionally, Section 2.3.2, Standards Related to Licensed Practical Nurse (LPN/VN) Responsibilities for Nursing Practice Implementation, requires in Section 2.3.2(i)(3) that the nurse administers medications accurately. Resident #1's Minimum Data Set of 11/08/2013 documented, in Section I-Active Diagnoses, that the resident had [DIAGNOSES REDACTED]. Further record review for Resident #1, to include review of the December 2013 Physicians' Orders, revealed no evidence to indicate that Resident #1 had a physician's orders [REDACTED]. A 12/26/2013, 11:30 a.m. Nurse's Notes (NN) entry documented Resident #1 to be unresponsive, with a physician's orders [REDACTED]. A 12/26/2013, 12:05 p.m. NN entry then documented Resident #1's hospital transfer. The hospital History and Physical (H&P) documented that, upon hospital arrival, Resident #1 was somnolent and had pinpoint pupils, for which [MEDICATION NAME] was administered. A toxicology screen revealed Resident #1 to have a large amount of [MEDICATION NAME] (2023 nanograms/milliliter) in his/her system. However, as referenced above, Resident #1's facility clinical record revealed no evidence of a physician's orders [REDACTED]. Despite that fact, the hospital H&P documented that Resident #1 had overdosed on [MEDICATION NAME] and was admitted to the Intensive Care Unit. The subsequent hospital Discharge Summary for Resident #1 documented [DIAGNOSES REDACTED]. In an Investigation Report (IR) referencing Resident #1's [MEDICATION NAME] overdose, the facility acknowledged a conclusion that on 12/25/2013, Resident #1 had received the medication of another resident (Resident #2) in error. This IR documented that, based on consultation with a toxicologist and a review of

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) the emergence of Resident #1's altered level of consciousness on 12/26/2013, the facility concluded that the medication error involving [MEDICATION NAME] occurred during the 8:00 p.m. to 9:00 p.m. medication pass on 12/25/2013. The IR further documented that Nurse CC, who was the Charge Nurse for the evening shift of 12/25/2013, was most likely the one who made the medication error. During an interview conducted on 01/14/2014 at 11:00 a.m., the DON acknowledged that Resident #1 had been determined to be positive for [MEDICATION NAME] when transferred to the hospital on [DATE], and also acknowledged that Resident #1 did not have a facility physician's orders [REDACTED].#1's onset of symptoms on 12/26/2013 and had concluded that on the evening of 12/25/2013, Resident #1 could have been given, in error, the [MEDICATION NAME] which was actually prescribed for Resident #2, who resided on the same hall as Resident #1. The DON stated that all facility nurses, including Nurse CC, had been interviewed and none recalled making the medication error. However, the DON stated that based on the timeline involving the presentation of Resident #1's symptoms, disciplinary action had been taken against Nurse CC, who was the Charge Nurse for the 3:00 p.m. - 11:00 p.m. shift of 12/25/2013, due to the conclusion that the medication error could have occurred on that date during that shift while Nurse CC administered medications. The DON also stated that the facility had not been able to determine if Nurse CC actually made the medication error, but acknowledged the occurrence of the medication error involving the mistaken administration of [MEDICATION NAME] to Resident #1 without a physician's orders [REDACTED]. Based on the above, the facility failed to ensure that Resident #1 received care in conformance with professional standards of quality, related to medication administration in accordance with physician's orders [REDACTED].#1 did not have a physician's orders [REDACTED].#1 was administered [MEDICATION NAME] in error. Resident #1 was then found unresponsive, was transported to the hospital, and was determined, via a toxicology screen, to have a toxic [MEDICATION NAME] level of 2023 nanograms/milliliter. Resident #1 was admitted to the Intensive Care Unit and received a [MEDICATION NAME] drip and intravenous fluids. Cross refer to F333 for more information regarding Resident #1. The immediate jeopardy was determined to have been removed on 01/17/2014, at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On December 30, 2013, upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On December 30, 2013, the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On December 30, 2013, the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and the facility's plan to correct and monitor the problem regarding medication administration. As of 01/16/2014 (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining nurses, who had been unavailable for training due to being on leave or due to their part-time work status, were to receive this in-service training on the date of their return to work. This procedure also specified that all newly-hired nursing staff would receive training on the facility's medication administration policies and procedures upon hire. 4. On December 30, 2013, the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of 01/16/2014, seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On December 31, 2013, the Assistant Director of Nursing (ADON) and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On December 31, 2013, the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of 12/26/2013, a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who had been on duty from 7:00 a.m. on 12/25/2013 through 7:00 a.m. on 12/26/2013. 7. On January 12, 2014, all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On January 16, 2014, the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct a weekly medication cart audit utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of the medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On January 16, 2014, the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On January 16, 2014, the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form, would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on January 17, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. The facility had begun the process, initiated on 12/30/2013, of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of 01/16/2014 (the day prior to the 01/17/2014 exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on 12/30/2013, by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. As of 01/16/2014, (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the 01/17/2014 exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, hospital History and Physical Report review, hospital Drug Quick Screen review, hospital Discharge Summary review, Lexi-Comp Geriatric Dosage Handbook, 12th Edition review, and Facility Investigative report review, the facility failed to provide care, related to medication administration as per physician's orders [REDACTED].#1) on the total survey sample of fifteen (15) residents. For Resident #1, whose Care Plan noted the use of multiple medications including [MEDICATION NAME] ER, [MEDICATION NAME] XL, [MEDICATION NAME], and Tylenol per physician's orders [REDACTED]. An emergency room toxicology screen revealed a toxic level of [MEDICATION NAME] in Resident #1's system, even though the resident did not have a physician's orders [REDACTED].#1 was later admitted to the Intensive Care Unit and received a [MEDICATION NAME] drip as a opioid overdose antidote, and also received intravenous fluids, for [DIAGNOSES REDACTED]. This failure of the facility to administer to Resident #1 only those medications which were ordered, to avoid adverse effects from medications as specified by the Care Plan, resulted in a situation in which the facility's

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the immediate jeopardy on January 15, 2014 at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 25, 2013 (the date the facility concluded that Resident #1 received [MEDICATION NAME] in error), continued through January 16, 2014, and was removed on January 17, 2014. During an interview with the DON which had been conducted on January 14, 2014 at 11:00 a.m., the DON acknowledged the medication error in which Resident #1 received [MEDICATION NAME] in the absence of a physician's orders [REDACTED]. medications during medication passes. An allegation of jeopardy removal was received on January 16, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on January 17, 2014, and the facility remained out of compliance at a lower scope and severity of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: Record review for Resident #1 revealed a Minimum Data Set assessment of 11/08/2013 which documented, in Section I-Active Diagnoses, that the resident had [DIAGNOSES REDACTED]. Further review of Resident #1's clinical record revealed that the current Physician order [REDACTED].) at bedtime for Generalized Pain. Additional record review for Resident #1, to include review of this current Physician order [REDACTED]. Review of Resident #1's Care Plan revealed multiple identified Problems involving the administration of drug therapy, and specifying as Current Approaches that drug therapy be administered in accordance with physician's orders [REDACTED].#1 had a [DIAGNOSES REDACTED].#1's receipt of antipsychotic medications, also indicated as a Goal that Resident #1 would have no adverse effects from medication. Resident #1's Care Plan also identified, as another Problem, that Resident #1 was being treated for [REDACTED].#1's Care Plan further noted, as an additional Problem, that the resident exhibited signs/symptoms of discomfort/pain at times related to causes which included Peripheral [MEDICAL CONDITION] and Arthritis, and specified as a Current Approach to administer medication, including [MEDICATION NAME] and Tylenol, as per physician's orders [REDACTED].#1 made no reference to the administration of [MEDICATION NAME] to the resident. A 12/26/2013, 11:30 a.m. Nurse's Notes (NN) entry for Resident #1 documented that the resident would not respond or open the eyes, and documented that an order was received to send the resident to the hospital. The hospital History and Physical (H&P) report documented that, upon arrival at the hospital, Resident #1 was somnolent and had pinpoint pupils. A Drug Quick Screen for Resident #1 then revealed a toxic level of 2023 nanograms/milliliters (ng/mL) of [MEDICATION NAME] in the resident's system. (A [MEDICATION NAME] level greater than 2000 ng/mL was toxic, per the Lexi-Comp Geriatric Dosage Handbook, 12th Edition). This was despite the fact that, as referenced above, there was no nursing facility physician's orders [REDACTED]. Resident #1's hospital H&P referenced above documented that multiple doses of the opiate overdose antidote [MEDICATION NAME] were administered for the toxic level of [MEDICATION NAME] related to a [MEDICATION NAME] overdose, and documented that Resident #1 would be admitted to the Intensive Care Unit for administration of a [MEDICATION NAME] drip and intravenous fluids. The hospital Discharge Summary for Resident #1 documented [DIAGNOSES REDACTED]. A facility Investigation Report (IR) for Resident #1 referenced the [MEDICATION NAME] overdose, as indicated by the hospital drug screen revealing a toxic level of [MEDICATION NAME]. The IR documented that the facility's investigation found that on 12/25/2013, Resident #1 received another resident's medication. This IR documented that during the facility's investigation, which included consultation with a laboratory toxicologist, the facility concluded that the medication error involving Resident #1 receiving [MEDICATION NAME] had occurred during the 8:00 p.m. to 9:00 p.m. medication pass of 12/25/2013. During a 01/14/2014, 11:00 a.m. interview, the DON acknowledged that Resident #1's hospital drug screen had revealed a positive [MEDICATION NAME] result, but further acknowledged that Resident #1 did not have an order to receive [MEDICATION NAME]. The DON also acknowledged the facility's conclusion, as referenced in the IR above, that Resident #1 could have received [MEDICATION NAME] that was prescribed for Resident #2 on 12/25/2013. Based on the above, even though the Care Plan of Resident #1 specified that the resident would receive medications as per physician's orders [REDACTED].#1 did not have a physician's orders [REDACTED]. Resident #1 was then noted to be unresponsive and was transported to the hospital where he/she was observed to be somnolent with pinpoint pupils. A toxicology screen revealed a toxic [MEDICATION NAME] level of 2023 ng/mL, and Resident #1 was admitted to the Intensive Care Unit and received a [MEDICATION NAME] drip and intravenous fluids for [DIAGNOSES REDACTED]. The facility thus failed to ensure the administration of medications per physician's orders [REDACTED].#1, also as specified by the Care Plan. Cross refer to F333 for more information regarding Resident #1. The immediate jeopardy was determined to have been removed on 01/17/2014, at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On December 30, 2013, upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On December 30, 2013, the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On December 30, 2013, the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and facility's plan to correct and monitor the problem regarding medication administration. As of 01/16/2014 (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining charge nurses, who had been unavailable for training due to being on leave or due to their part-time work status, will receive this in-service training on the date of their return to work. This procedure also specified that all newly-hired nursing staff will receive training on the facility's medication administration policies and procedures upon hire. 4. On December 30, 2013, the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of 01/16/2014, seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On December 31, 2013, the ADON and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On December 31, 2013, the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of 12/26/2013, a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who had been on duty from 7:00 a.m. on 12/25/2013 through 7:00 a.m. on 12/26/2013. 7. On January 12, 2014, all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On January 16, 2014, the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct weekly medication cart audits utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On January 16, 2014, the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On January 16, 2014, the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on January 17, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115560	A. BUILDING _____ B. WING _____	01/17/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY HEALTH AND REHAB	3201 WESTMORELAND ROAD CLEVELAND, GA 30528

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)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) completion. The facility had begun the process, initiated on 12/30/2013, of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of 01/16/2014 (the day prior to the 01/17/2014 exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on 12/30/2013, by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. As of 01/16/2014, (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the 01/17/2014 exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.
F 0333 **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 clinical record review, staff interview, Poison Control Center pharmacist interview, SBAR Communication Form/Progress Note review, hospital History and Physical Report review, hospital Drug Quick Screen review, hospital Discharge Summary review, Lexi-Comp Geriatric Dosage Handbook, 12th Edition review, and Facility Investigative report review, the facility failed to ensure that one (1) resident (#1) was free of a significant medication error, regarding the administration of the narcotic [MEDICATION NAME], on the total survey sample of fifteen (15) residents. Resident #1, who did not have a physician's order for the administration of [MEDICATION NAME], received [MEDICATION NAME] in error. Subsequently, Resident #1 was observed by facility staff to be unresponsive to verbal or painful stimuli, and was transported via Emergency Medical Service to the hospital where he/she was noted with somnolence and to have pinpoint pupils. An emergency room toxicology screen for Resident #1 revealed a toxic [MEDICATION NAME] level, and thus the resident was admitted to the Intensive Care Unit and received a [MEDICATION NAME] drip, as an opioid overdose antidote, and also intravenous fluids for a [DIAGNOSES REDACTED]. This significant medication error involving the administration of [MEDICATION NAME] to Resident #1, with no physician's order for administration, resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the immediate jeopardy on [DATE] at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on [DATE] (the date the facility concluded that Resident #1 received [MEDICATION NAME] in error), continued through [DATE], and was removed on [DATE]. During the [DATE], 2:55 p.m. interview referenced above, the Administrator acknowledged the medication error involving Resident #1 having received [MEDICATION NAME]. During a later interview conducted on [DATE] at 12:30 p.m., the Administrator also acknowledged awareness of the facility being cited for having a medication error rate which exceeded five (5) percent during the standard survey of [DATE]. The Administrator stated that as a result of the [DATE] standard survey citation involving medication errors, periodic medication pass observations had been conducted by supervisory staff to audit medication administration, but further acknowledged the need for more supervision and frequent supervisory observations related to medication administration to facility residents. An allegation of jeopardy removal was received on [DATE]. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on [DATE], and the facility remained out of compliance at a lower scope and severity of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: Record review for Resident #1 revealed a Quarterly Minimum Data Set (MDS) assessment having an Assessment Reference Date of [DATE] which documented that the resident's year of birth was 1927, thus indicating the resident was [AGE] years of age. Section I-Active [DIAGNOSES REDACTED].#1 had [DIAGNOSES REDACTED]. Section G - Functional Status documented that Resident #1 was totally dependent on staff for transfer and for ambulation/locomotion. A Nurse's Notes (NN) entry of [DATE] at 10:00 a.m. for Resident #1 documented that the resident was lethargic, but that he/she would open his/her eyes. This NN documented that the physician was notified. A NN entry of [DATE] at 11:30 a.m. documented that by that time, staff was unable to get Resident #1 to respond at all, and that the resident would not open his/her eyes at that point. This NN documented that a physician's order was received to send Resident #1 to the hospital emergency room (ER) for evaluation and treatment. A facility SBAR Communication Form and Progress Note which referenced Resident #1 also documented the [DATE] physician notification and order for hospital transfer, and documented that the resident was not responding to either verbal or painful stimuli and would not open his/her eyes. A NN entry of [DATE] at 12:05 p.m. for Resident #1 documented that the resident had been transported to the hospital via Emergency Medical Service, per the physician's order referenced above. A hospital History and Physical (H&P) report for Resident #1 documented the resident's [DATE] admission to the hospital. This H&P documented, in the Chief Complaint section, that the resident had experienced a change in mental status. The History of Present Illness section of the H&P documented that upon arrival at the hospital, the resident was somnolent and was noted to have pinpoint pupils, for which a 0.4 milligram (mg) dose of [MEDICATION NAME] was administered. This section of the H&P documented that the resident's response to the dose of [MEDICATION NAME] prompted a toxicology screen, which revealed findings including a large amount of [MEDICATION NAME] following repeated dilution. Review of the toxicology screen, the hospital Drug Quick Screen, referenced above for Resident #1, dated and timed as having been collected on [DATE] at 12:57 p.m., documented that the [MEDICATION NAME] screen for the resident had revealed a result of 2023 nanograms/milliliter (ng/mL). The Lexi-Comp Geriatric Dosage Handbook, 12th Edition, indicated that a [MEDICATION NAME] level of greater than 2000 ng/mL was toxic. The hospital H&P referenced above for Resident #1 documented that the resident again became somnolent in the ER after the initial dose of [MEDICATION NAME], requiring the administration of another dose of [MEDICATION NAME], and thus Resident #1 was admitted to the hospital. The Labs section of this H&P referenced the toxicology screen of Resident #1 revealing an elevated [MEDICATION NAME] level of 2023 ug/mL, with the Assessment section of the H&P documenting that the resident had definitely overdosed on [MEDICATION NAME]. The Plan section of the H&P indicated that Resident #1 would be admitted to the hospital Intensive Care Unit, where he/she would receive a [MEDICATION NAME] drip and intravenous fluids. The hospital Discharge Summary for Resident #1 documented a hospital discharge date of [DATE]. The Hospital Course section of this Discharge Summary documented that while in the hospital, Resident #1 had begun to return to his/her baseline in terms of mentation, and that he/she was awake and interacting appropriately. The Discharge [DIAGNOSES REDACTED]. Review of Resident #1's nursing facility clinical record revealed an Entry MDS of [DATE] which documented that the resident had been readmitted to the nursing facility from the hospital. However, further record review for Resident #1, to include review of the resident's monthly [DATE] Physicians' Orders form which had been effect prior to the resident's [DATE] hospital transfer, revealed no evidence to indicate that Resident #1 had a physician's order to receive [MEDICATION NAME]. Additional record review, to include review of Resident #1's Medication Administration Record [REDACTED]. This was despite the fact that, as indicated in the hospital H&P and Discharge Summary referenced above, Resident #1 had been transferred from the nursing facility to the hospital on [DATE] after a significant change in mental status and had been determined to have an overdose of [MEDICATION NAME], with a toxic [MEDICATION NAME] level of 2023 ug/mL. During an interview with the DON conducted on [DATE] at 11:00 a.m., the DON was asked about Resident #1's hospital transfer and [MEDICATION NAME] overdose. The DON acknowledged that Resident #1 had been transferred to the hospital on [DATE] after a nurse had noted the resident to have a decreased level of consciousness. The DON further acknowledged that the drug screen performed at the hospital had revealed Resident #1 to be positive for [MEDICATION NAME]. The DON also stated that, although Resident #1 did not have an order to receive [MEDICATION NAME], another facility resident (Resident #2) who resided on the same hall as Resident #1 did receive [MEDICATION NAME] per a physician's order. Record review for Resident #2 revealed that this resident did reside on the same unit and hall as Resident #1. Further record review revealed that Resident #2 had a current physician's order,

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY HEALTH AND REHAB	3201 WESTMORELAND ROAD CLEVELAND, GA 30528

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)
F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) originally dating from [DATE], specifying that the resident receive a dose of four (4) 10 mg. [MEDICATION NAME] tablets, yielding a forty (40) mg. dose, by mouth three times daily, at 9:00 a.m., 2:00 p.m. and 9:00 p.m. The facility presented an Investigation Report (IR) related to the facility's investigation into Resident #1's significant medication error involving [MEDICATION NAME] and resulting in the [MEDICATION NAME] overdose. In this IR, the facility documented that, based on its investigation, it was found that on [DATE], Resident #1 had received the bedtime medication of another resident (Resident #2) who resided on the same hall as Resident #1, and two (2) doors down from Resident #1. The IR documented that this finding was based on information received from consultation with a laboratory toxicologist. The IR documented the toxicologist had stated that due to [MEDICATION NAME]'s specific and synthetic nature, Resident #1's hospital Drug Quick Screen laboratory test which revealed an elevated level of [MEDICATION NAME] would have been accurate for the presence of [MEDICATION NAME]. The toxicologist stated that the significantly high [MEDICATION NAME] level likely indicated that this was a peak level of the drug which would have occurred six (6) to twelve (12) hours after ingestion, and that [MEDICATION NAME] would not have shown in Resident #1's drug screen 72 hours after ingestion. This IR documented that, based on the toxicologist's statement regarding the peak [MEDICATION NAME] level indicated by the drug screen, and based on Resident #1's unaltered level of consciousness up until approximately 7:00 p.m. on [DATE] (the evening before Resident #1's subsequent [DATE] hospital transfer related to an altered level of consciousness) as reflected by the resident's meal intake, reports from staff, and family observations, the facility concluded that the medication error involving Resident #1 receiving [MEDICATION NAME] occurred during the 8:00 p.m. to 9:00 p.m. medication pass on [DATE]. During the [DATE], 11:00 a.m. DON interview referenced above, the DON acknowledged that, as the facility evaluated the onset of Resident #1's symptoms on [DATE], the facility had concluded after investigation that Resident #1 could have been given the [MEDICATION NAME] (actually prescribed for Resident #2) in error the prior evening of [DATE]. The DON further stated that in evaluating the timeline of Resident #1's development of symptoms, the facility had concluded that the medication error could have occurred on the 3:00 p.m.-11:00 p.m. shift of [DATE]. On [DATE] at 4:30 p.m., a telephone interview was conducted with a pharmacist from the Poison Control Center. During this interview, this pharmacist was questioned regarding [MEDICATION NAME] dosing and the toxicity level of the drug. She stated that if a person who was not accustomed to receiving [MEDICATION NAME] were to receive a single 40 mg dose of the drug, the person would at the very least become significantly sedated. She stated that a drug screen revealing a [MEDICATION NAME] level of 2023 ng/mL, as reflected on Resident #1's Drug Quick Screen, would indicate that the person received at least 40 mgs of [MEDICATION NAME], and potentially more, and further stated that the person could have possibly died with a toxic [MEDICATION NAME] level of 2023 ng/mL in his/her system. Based on the above, despite the absence of a physician's order for the administration of [MEDICATION NAME] to Resident #1, Resident #1 experienced a significant medication error by receiving [MEDICATION NAME] in error. Resident #1 was later noted by staff to be unresponsive and was transported to the hospital ER. In the ER, Resident #1 was noted to be somnolent and to have pinpoint pupils, resulting in the administration of [MEDICATION NAME]. An ER toxicology screen then revealed a toxic [MEDICATION NAME] level of 2023 ng/mL, requiring the administration additional [MEDICATION NAME], admission to the hospital Intensive Care Unit, and the administration of a [MEDICATION NAME] drip and intravenous fluids for a [DIAGNOSES REDACTED]. The immediate jeopardy was determined to have been removed on [DATE], at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On [DATE], upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On [DATE], the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On [DATE], the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and the facility's plan to correct and monitor the problem regarding medication administration. As of [DATE] (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining nurses, who had been unavailable for training due to being on leave or due to their part-time work status, were to receive this in-service training on the date of their return to work. This procedure also specified that all newly-hired nursing staff would receive training on the facility's medication administration policies and procedures upon hire. 4. On [DATE], the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of [DATE], seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On [DATE], the Assistant Director of Nursing (ADON) and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On [DATE], the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of [DATE], a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who had been on duty from 7:00 a.m. on [DATE] through 7:00 a.m. on [DATE]. 7. On [DATE], all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On [DATE], the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct a weekly medication cart audit utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of the medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On [DATE], the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On [DATE], the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form, would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on [DATE]. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. The facility had begun the process, initiated on [DATE], of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of [DATE] (the day prior to the [DATE] exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on [DATE], by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. As of [DATE], (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the [DATE] exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.

F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .**

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and hospital document review, the facility administration failed to ensure that resident drug therapy was provided in accordance with physician's orders [REDACTED].#1), who was administration the narcotic [MEDICATION NAME] in the absence of a physician's orders [REDACTED]. Resident #1, who did not have a physician's orders [REDACTED]. Resident #1 was later observed to be unresponsive to verbal or painful stimuli, was transported to the hospital and was noted to be somnolent and to have pinpoint pupils. An emergency room toxicology screen revealed a toxic [MEDICATION NAME] level. Resident #1 was then admitted to the Intensive Care Unit and received a [MEDICATION NAME] drip and intravenous fluids for [DIAGNOSES REDACTED]. The failure of the facility's administration to ensure the accurate administration of medication to Resident #1 resulted in a situation in which the facility's noncompliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on January 15, 2014 at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 25, 2013 (the date the facility concluded that Resident #1 received [MEDICATION NAME] in error), continued through January 16, 2014, and was removed on January 17, 2014. During the January 15, 2014, 2:55 p.m. interview referenced above, the Administrator acknowledged the medication error involving Resident #1 having received [MEDICATION NAME]. During a January 16, 2014, 12:30 p.m. interview, the Administrator also acknowledged being aware of the facility having been cited for a medication error rate in excess of five (5) percent during the standard survey of August 16, 2013. An allegation of jeopardy removal was received on January 16, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on January 17, 2014, and the facility remained out of compliance at a lower scope and severity of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: Cross refer to F333. Based on clinical record review, hospital record review, and staff interview, the facility failed to ensure that Resident #1 was free of a significant medication error involving the narcotic [MEDICATION NAME]. Resident #1, who had [DIAGNOSES REDACTED].#1 was later unresponsive and was transferred to the hospital, where he/she was found to have a toxic level of [MEDICATION NAME], registering at 2023 ng/mL. During an interview with the Administrator conducted on 01/16/2014 at 12:30 p.m., the Administrator was questioned regarding the facility's medication administration process, and also about the incident involving the significant medication error during which Resident #1 received [MEDICATION NAME] without a physician's orders [REDACTED].#1 becoming toxic with [MEDICATION NAME]. The Administrator stated that when the facility became aware of the medication error involving Resident #1, interventions had been developed to address the error, including immediate staff in-service training on the facility's medication administration policies and procedures, a complete chart audit for all residents, and a medication cart audit to ensure such things as correct medication labeling and accurate instructions for medication administration. During a 01/20/2014, 10:53 a.m. post-survey Quality Assurance telephone interview with the facility's Administrator, in reference to the facility's process of conducting drug cart audits, the Administrator stated that the process of weekly drug cart audits by the Patient Care Coordinator being utilized as part of the corrective plan to address the medication error involving Resident #1 had been in place for quite some time, even prior to the medication incident involving Resident #1. This weekly drug cart audit had continued by the Patient Care Coordinator after Resident #1's medication error as well. The Administrator acknowledged that it was only on 01/16/2014 (approximately three (3) weeks after the significant medication error involving Resident #1) that the facility had made the decision to include a second supervisory staff, that person being the ADON, in the weekly drug cart audits to ensure an accurate audit. In addition, the Administrator also acknowledged that the tool (the Med Care Audit Form) to be utilized to conduct and document this drug cart audit, and to allow for the ongoing analysis of the drug cart audit process by facility supervisory staff and the QA Committee, had not been developed and implemented until 01/16/104. Additionally, during the 01/16/2014, 12:30 p.m. interview referenced above, the Administrator acknowledged being aware of the facility having been cited for a medication error rate in excess of five (5) percent during the standard survey of August 16, 2013, approximately four months prior to the medication error involving [MEDICATION NAME] administration to Resident #1. The Administrator stated that as a result of the August 2013 standard survey citation involving medication errors, periodic medication pass observations had been conducted by supervisory staff to audit medication administration. During this interview, the Administrator acknowledged the need for more supervision and frequent supervisory observations of nursing staffs' administration of medications to facility residents, as a result of medication error involving Resident #1. Based on the above, the facility's administration failed to maintain a system that ensured the accurate administration of resident medication, in accordance with physician's orders [REDACTED].#1 when the resident received the narcotic [MEDICATION NAME] in the absence of a physician's orders [REDACTED]. The immediate jeopardy was determined to have been removed on 01/17/2014, at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On December 30, 2013, upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On December 30, 2013, the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On December 30, 2013, the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and the facility's plan to correct and monitor the problem regarding medication administration. As of 01/16/2014 (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining charge nurses, who had been unavailable for training due to being on leave or due to their part-time work status, will receive this in-service training on the date of their return to work. This procedure also specified that all newly-hired nursing staff would receive training on the facility's medication administration policies and procedures upon hire. 4. On December 30, 2013, the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of 01/16/2014, seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On December 31, 2013, the Assistant Director of Nursing (ADON) and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On December 31, 2013, the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of 12/26/2013, a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who had been on duty from 7:00 a.m. on 12/25/2013 through 7:00 a.m. on 12/26/2013. 7. On January 12, 2014, all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On January 16, 2014, the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct a weekly medication cart audit utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of the medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On January 16, 2014, the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On January 16, 2014, the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115560	A. BUILDING _____ B. WING _____	01/17/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY HEALTH AND REHAB	3201 WESTMORELAND ROAD CLEVELAND, GA 30528

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)
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) and Daily [MEDICATION NAME] Compliance Form would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on January 17, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. The facility had begun the process, initiated on 12/30/2013, of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of 01/16/2014 (the day prior to the 01/17/2014 exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on 12/30/2013, by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. As of 01/16/2014, (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the 01/17/2014 exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and hospital document review, the facility failed to have an effective Quality Assessment and Assurance Committee that developed and implemented a plan of action, and developed methods of monitoring the effect of implemented changes, in response to a significant medication error involving the administration of the narcotic [MEDICATION NAME] in the absence of a physician's orders [REDACTED].#1) on the total survey sample of fifteen (15) residents. Resident #1, who did not have a physician's orders [REDACTED]. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on January 15, 2014 at 2:55 p.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 25, 2013 (the date the facility concluded that Resident #1 received [MEDICATION NAME] in error), continued through January 16, 2014, and was removed on January 17, 2014. During an interview with the Administrator and DON conducted on January 16, 2014 at 12:30 p.m., the Administrator stated that after the incident involving Resident #1 receiving [MEDICATION NAME] in error, all members of the Quality Assurance (QA) Committee had been informed of the incident, but presented no evidence of the QA Committee's involvement in the formulation of, or involvement in, the corrective plan which was developed by the facility after this incident An allegation of jeopardy removal was received on January 16, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on January 17, 2014, and the facility remained out of compliance at a lower scope and severity of D while the process of evaluating nursing staffs' compliance with physicians' orders during medication administration, to ensure accurate medication administration, continued. In-service materials and records were reviewed. Interviews were conducted with nursing staff to ensure they were knowledgeable about the administration of resident medication. Observations were made of medication administration to residents to assess staffs' conformance with physicians' medication orders. Findings include: An interview was conducted with the Administrator on 01/16/2014 at 12:30 p.m. related to the facility's QA Committee and the Committee's oversight of resident medication administration. During this interview, the Administrator was questioned regarding the QA Committee's review of the medication error involving Resident #1 receiving [MEDICATION NAME] without having a physician's orders [REDACTED].#1, including actions initiated to allow nursing supervisory staff to monitor the effectiveness of the implemented corrective actions and procedural changes. The Administrator stated that all members of the QA Committee had been individually made aware of the medication error involving Resident #1, and had been informed of the corrective plan put into place by the facility in response to the incident. However, the Administrator further stated that the corrective plan which had been developed after Resident #1's [MEDICATION NAME] overdose had actually been formulated by herself, the DON, the ADON and the Pharmacy Consultant, and that there had been no meeting of the QA Committee since the 12/25/2013 incident to review the corrective plan. No evidence was presented to indicate that the QA Committee had conducted a review of the medication incident involving Resident #1 in an effort to evaluate the causal factor(s) of the incident. No evidence was presented to indicate that the QA Committee had reviewed, evaluated, or approved the corrective plan, which including procedural changes and which had been developed and implemented by facility administrative staff, to evaluate the effectiveness of the corrective actions in providing for consistent nursing staff compliance with the facility's medication administration policies and procedures. Additionally, no evidence was presented to show analysis by the QA Committee of the monitoring tools, such as the Med Cart Audit Form and the Daily [MEDICATION NAME] Compliance Form, developed as part of the corrective actions to ensure their effectiveness in monitoring ongoing compliance with medication administration in accordance with physicians' orders. The Administrator stated that next meeting of the QA Committee was scheduled to occur on January 29, 2014, and that this would be the first meeting of the QA Committee since the medication incident resulting in Resident #1 sustaining a [MEDICATION NAME] overdose. Cross refer to F333. The facility failed to provide medication administration in a manner to ensure that Resident #1 was free of a significant medication. Rather, Resident #1 received the narcotic [MEDICATION NAME] without having a physician's orders [REDACTED].#1 became unresponsive, was transferred to the hospital, and was diagnosed with [REDACTED]. The immediate jeopardy was determined to have been removed on 01/17/2014, at which time the facility had presented and implemented an allegation of jeopardy removal with the following interventions: 1. On December 30, 2013, upon learning of the medication error involving Resident #1 from the resident's family, the DON immediately checked Resident #1's medications to ensure all medications were correctly labeled and packaged. Additionally, the charts and narcotic sign-out sheets of the two residents in the facility who received [MEDICATION NAME] per physicians' orders were reviewed. This audit revealed no discrepancies. 2. On December 30, 2013, the incident involving the [MEDICATION NAME] medication error was initially submitted to the members of the Quality Assurance (QA) Committee to make them aware. 3. On December 30, 2013, the facility initiated one-on-one inservice training with all nursing staff, conducted by the DON, related to the medication error involving Resident #1 and facility's plan to correct and monitor the problem regarding medication administration. As of 01/16/2014 (the date of submission by the facility of the credible allegation of jeopardy removal), ten (10) nurses had received this in-service training. The five (5) remaining charge nurses, who had been unavailable for training due to being on leave or due to their part-time work status, will receive this in-service training on the date of their return to work. This procedure also specifies that all newly-hired nursing staff will receive training on the facility's medication administration policies and procedures upon hire. 4. On December 30, 2013, the facility initiated a procedure by which the DON, ADON, Clinical Case Manager, and/or Pharmacy Consultant were to conduct medication pass audits with all nursing staff on a weekly basis utilizing the Medication Pass Observation Report form. These medication pass audits were to involve observation of each nurse on duty on a weekly basis, and were to continue for a minimum of six (6) months. As of 01/16/2014, seven (7) charge nurses had been observed, with the remaining eight (8) nursing staff, who had thus far been unavailable, to be observed on the date of their return to work. 5. On December 31, 2013, the Assistant Director of Nursing (ADON) and Patient Care Coordinator conducted a complete resident chart audit and medication cart audit. During this audit, no discrepancies were noted. 6. On December 31, 2013, the DON conducted an investigation into the medication error involving the administration of [MEDICATION NAME] to Resident #1. This investigation included a review of Resident #1's status during the period of time leading up to the hospital transfer of 12/26/2013, a consultation with a toxicologist regarding Resident #1's drug screen results related to the resident's significantly high [MEDICATION NAME] level, and a discussion of the medication error with the nursing staff who

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	115560	A. BUILDING _____ B. WING _____	**01/17/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY HEALTH AND REHAB	**3201 WESTMORELAND ROAD CLEVELAND, GA 30528**

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)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) had been on duty from 7:00 a.m. on 12/25/2013 through 7:00 a.m. on 12/26/2013. 7. On January 12, 2014, all fifteen (15) facility nurses had watched the video series Passing Medications.ASP's Medication Administration Part 1, and all had passed the post-test. 8. On January 16, 2014, the facility initiated a procedure by which both the DON and Patient Care Coordinator were to conduct a weekly medication cart audit utilizing the Medication Cart Audit Form. This medication cart audit assesses multiple criteria, including the accuracy of medication labels, the accuracy of resident Medication Administration Records, and the accuracy of the medication cart content related to resident medication. These weekly cart audits will occur on an ongoing basis. 9. On January 16, 2014, the facility initiated a procedure by which two (2) nurses would be required to sign-out [MEDICATION NAME] and observe administration of the medication. This procedure would be monitored by the DON or ADON Monday through Friday, and by the Registered Nurse supervisor on Saturday and Sunday. The supervisory staff monitoring would be documented utilizing the Daily [MEDICATION NAME] Compliance Form. The results of this monitoring, via this Form, will be reported by the DON to the QA Committee. 10. On January 16, 2014, the facility initiated a procedure by which the results of supervisory staffs' audits and monitoring of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form, would be submitted by the DON to the QA Committee on a quarterly basis, for evaluation and tracking by the QA Committee. The QA Committee will, based on the submitted data, evaluate the need for additional staff training and policy review. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice, related to the significant medication error involving [MEDICATION NAME] administration, was removed on January 17, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. The facility had begun the process, initiated on 12/30/2013, of one-on-one nursing staff training regarding the facility's plan to address the significant medication error involving [MEDICATION NAME] administration. However, as of 01/16/2014 (the day prior to the 01/17/2014 exit date of this complaint survey), only ten (10) of the facility's fifteen (15) nurses had received this training, with the remaining nurses to receive training upon their return to work. Additionally, the facility had initiated a procedure, originally started on 12/30/2013, by which the facility administrative staff and/or the Pharmacy Consultant would conduct weekly medication pass audits involving the observation of each nurse to ensure accurate medication administration. However, as of 01/16/2014, (7) nurses had been observed, but eight (8) nursing staff would be unavailable for observation until they returned to work. Also, as part of the corrective plan, the facility initiated a procedure by which the results of supervisory staffs' audits of staff conformance with the facility's medication administration policies and procedures, via the Medication Pass Observation Report form, Medication Cart Audit Form, and Daily [MEDICATION NAME] Compliance Form would be submitted to the QA Committee on a quarterly basis for their review and evaluation. However, as of the 01/17/2014 exit date of this complaint survey, the QA Committee had not yet met to begin the process of evaluating facility nursing staffs' conformance with the facility's medication administration policies and procedures to ensure the accurate administration of resident medication. Thus, the QA Committee's ongoing process of procedural oversight, regarding accurate medication administration, could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.