

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

PRINTED: 03/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS AMENDED 03/07/12 An abbreviated survey was initiated on 02/16/12 and concluded on 02/22/12 investigating KY17866. The Division of Health Care substantiated the allegation. Immediate Jeopardy and Substandard Quality of Care was identified on 02/17/12 at 42 CFR 483.25 Quality of Care (F333 S/S "J"), and was determined to exist on 12/25/11 through 01/21/12. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 02/16/12, thus resulting in the determination of Past Jeopardy. The Immediate Jeopardy was determined to be removed on 01/22/12. Resident #1 had a physician's order dated 12/01/11 to flush a midline (intravenous catheter) with five (5) cc's (cubic centimeters) normal saline and three (3) cc's (cubic centimeters) Heparin (blood thinner) q (every) shift. Registered Nurse (RN) #1 flushed Resident #1's midline catheter with six (6) cc's of Novolin R (short-acting) Insulin (anti-diabetic drug) instead of Heparin. RN #1 immediately discovered the significant medication error and called Licensed Practical Nurse (LPN) #11 who notified the physician. Resident #1 was sent to the hospital by emergency medical services on 12/25/11, was treated in an intensive care unit, and returned to the facility on 12/27/11.	F 000			
F 333 SS-J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333			

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

Stace W. Daniel

TITLE

Administrator

(X6) DATE

3/8/12

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



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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41086	
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F 333	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, adverse drug report, and in-service records it was determined the facility failed to ensure one (1) of six (6) sampled residents, Resident #1, was free of a significant medication error. Resident #1 had a physician's order dated 12/01/11 to flush the midline (intravenous catheter) with five (5) cc's (cubic centimeters) normal saline and three (3) cc's (cubic centimeters) Heparin (blood thinner) q (every) shift. On 12/25/11 Registered Nurse (RN) #1 flushed Resident #1's midline catheter with six (6) cc's of Novolin R (short-acting) insulin (anti-diabetic drug) instead of Heparin. Resident #1 was sent to the hospital by emergency medical services on 12/25/11, was treated in an intensive care unit, and returned to the facility on 12/27/11. The facility's failure to ensure Resident #1 was free of a significant medication error resulted in a situation that was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 12/25/11 through 01/21/12. The facility implemented corrective action prior to the State Agency's investigation on 02/16/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 01/22/12. The findings include: Review of the facility's policy, Flushing Peripheral and Central Vascular Access Devices (dated 06/01/99), revealed all vascular access devices (intravenous catheters) used for intermittent	F 333	Past noncompliance: no plan of correction required.	



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F 333	<p>Continued From page 2</p> <p>Heparin) technique. Variations from recommended flushes were based on physician orders. The procedure was to obtain MD/NP order for appropriate flush solutions and refer to the Flush Chart. Review of the Flush Chart revealed all intravenous catheters were to be flushed with saline and Heparin when ordered by the physician or nurse practitioner.</p> <p>Review of the facility's policy Medication Administration - General Guidelines (undated) revealed administration: 2) Medications are administered in accordance with written orders of the attending physician.</p> <p>Review of a facility in-service document dated 09/27/11 revealed the nursing staff was reminded to check the medication/medication administration record (which contains the current physician orders) three (3) times prior to medication administration for each resident.</p> <p>Review of the Adverse Drug Report dated 12/25/11 revealed Resident #1 received 6 cc of Novolin R per Peripherally Inserted Central Catheter (PICC) line instead of Heparin. RN #1 returned to the cart approximately one minute later and found the Heparin vial sitting on the medication cart with the lid still on it. Thus she realized her error. The physician was notified on 12/25/11 at 2040 (8:40 PM) with orders to send the resident to the hospital for an evaluation.</p> <p>Record review for Resident #1 revealed the facility admitted the resident on 09/16/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Decubitus Ulcer, and a Urinary Tract Infection (UTI). The facility assessed</p>	F 333		
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F 333	<p>Continued From page 3</p> <p>Resident #1 with a moderate cognitive loss. Record review for Resident #1 indicated a 12/01/11 physician order for Ampicillin (antibiotic) intravenously for UTI with a flush per the S-A-S-H method (Saline, administer therapy, Saline then Heparin). Nursing notes dated 12/25/11 at 8:34 PM documented a significant medication error by RN #1. The nursing notes revealed Resident #1 was sent to the local hospital by the emergency medical services after the significant medication error and was then transferred to an intensive care unit at another hospital. Review of the discharge summary from the hospital revealed Resident #1 was admitted with hypoglycemia (low blood sugar), required monitoring in the intensive care unit, and required a dextrose (sugar) intravenous drip (to combat the effects of the insulin). The discharge summary revealed the resident was "a bit more awake" on 12/27/11 and was transferred back to the facility.</p> <p>Interview with RN #1, on 02/16/12 at 5:15 PM, revealed she did not follow nursing practice and the facility's policy on 12/25/11 when she administered Insulin instead of Heparin for the intravenous flush for Resident #1. She stated the Insulin and the Heparin were sitting on top of her medication cart and she picked up the wrong bottle of medication to prepare for the flush of Resident #1's intravenous catheter. RN #1 stated she recognized the significant medication error as soon as she returned to the medication cart and saw the bottles of Insulin and Heparin on the cart. RN #1 called for assistance from LPN #11 who notified the physician. She indicated she also failed to follow nursing practice and policy by leaving two (2) bottles of medication on the top of the medication cart. RN #1 stated she informed</p>	F 333			

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F 333	<p>Continued From page 4</p> <p>the Director of Nursing (DON) after the resident was stabilized and sent to the hospital for care. She indicated the DON instructed her not to pass any medications the rest of the shift that evening but to complete her nursing documentation. She also stated the DON wanted to meet with her on 12/26/11 for re-training and the DON told her she could work but not to pass medications until she had a medication pass observation with the DON.</p> <p>Interview with the facility's Pharmacist, on 02/17/12 at 10:30 AM, revealed he was informed of the significant medication error for Resident #1 on 12/26/11. He stated the medication error could have been fatal for Resident #1.</p> <p>Interview with the DON, on 02/16/12 at 2:30 PM, revealed she was aware the medication error for Resident #1 was a significant medication error and she created a Plan of Action to address the error. Interview with the facility Administrator, on 02/17/12 at 12:00 Noon, revealed the Risk Management (Quality Assurance) team held a meeting on 12/29/11 and discussed the significant medication error. She stated the team approved the DON's Plan of Action.</p> <p>An attempt to interview the Physician and the Medical Director was made on 02/17/12 at 1:00 PM; however, they were not available for interview.</p> <p>Review of the facility's roster matrix during the abbreviated survey revealed Resident #1 was out of the facility in an acute care hospital for an unrelated illness.</p> <p>The facility implemented the following actions to</p>	F 333		

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F 333	<p>Continued From page 5 correct the deficiency:</p> <ul style="list-style-type: none"> * Instruction to RN #1 not to pass any medications on the evening of 12/25/11 after the medication error. * A meeting was held on 12/26/11 with RN #1 to re-in-service her on the facility policy regarding medication administration and prevention of medication errors. * A joint decision between the DON and the facility's pharmacist was made on 12/26/11 to replace all multi-dose vials of Heparin with pre-filled Heparin syringes for flush in the facility to prevent a recurrence of this type of error. * A memorandum was posted to all nursing staff on 12/26/11 regarding the replacement of Heparin multi-dose vials for Heparin pre-filled syringes for flush. * The completion of a medication administration observation with RN #1 on 12/28/11 was found to be without error. * The Policy and Procedure for Medication Errors was revised on 12/29/11 to reflect the notification of the Director of Nurses and the Administrator must occur immediately. * On 12/30/11 multi-dose vials of Heparin were replaced with pre-filled Heparin syringes. * Audits were completed on all medication rooms and medication carts on 01/10/12 to ensure no multi-use vials of Heparin were available for use by nursing staff. 	F 333		

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F 333	<p>Continued From page 6</p> <ul style="list-style-type: none"> * Pharmacy completed med pass observations on 01/20/12. * A packet was given to all nursing staff from 01/10/12-01/21/12 which included written information regarding medication administration techniques and the medication error policy. All nurses were to complete that education assignment and sign they read and understood the medication administration policy of the facility. <p>These actions were validated as follows:</p> <ul style="list-style-type: none"> * Interview with RN #1, on 02/16/12 at 5:15 PM, revealed she was given an in-service related to prevention of medication errors, a review of the medication administration policy, and the medication pass observation with the DON on 12/28/11 with no errors. * Interview with the facility's Pharmacist, on 02/17/12 at 10:30 AM, revealed he met with the DON on 12/26/11 about the error and he ensured replacement of all multi-dose vials of Heparin in the facility by 12/30/11 with pre-filled Heparin syringes for flush. He also indicated the pharmacy conducted a medication pass observation on 01/20/12 and that observation revealed no medication errors. * Record review revealed medication pass observations by the Pharmacist were completed on 01/20/12 and 02/08/12. * Observation of a medication pass, on 02/16/12 at 3:50 PM and on 02/17/12 at 8:20 AM, revealed no medication errors. Observation of all facility 	F 333		

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F 333	<p>Continued From page 7</p> <p>medication rooms revealed no multi-dose bottles of Heparin but rather pre-filled Heparin syringes for flush.</p> <p>* Interview with the Quality Assurance Nurse, on 02/16/12 at 11:30 AM, revealed she completed an audit of all medication rooms and all medication carts on 01/10/12 to ensure Heparin flush was in pre-filled syringes and there were no multi-dose vials of Heparin available to the nursing staff.</p> <p>* Review of the medication room and medication cart audits on 02/16/12 validated completion on 01/10/12.</p> <p>* Review of the training records dated 01/12/12 through 01/20/12 validated forty (40) of forty (40) nurses had completed the training regarding addendum to the Medication Error Policy, Quality Assurance Review form, Eight Rights of Medication Administration, Flush Chart, Flushing Considerations and Techniques, Heparin Syringes, Nursing Memo dated 01/10/12 and Review of the Med Pass observation technique.</p> <p>* Interview with LPN #6, on 02/22/12 at 9:50 AM, revealed she was re-in-serviced on the facility medication administration policy sometime during the first two (2) weeks of January 2012 and she saw the memorandum from the DON regarding the Heparin pre-filled syringes.</p> <p>* Interview with LPN #4, on 02/22/12 at 10:00 AM, revealed she was given a packet of information by the DON in January 2012 regarding the facility medication administration policy and she stated she saw the memorandum regarding Heparin pre-filled syringes in December 2011.</p>	F 333			

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F 333	Continued From page 8 * Interview with LPN #7, on 02/22/12 at 10:20 AM, revealed she was given a packet of information by the DON in January 2012 regarding the facility medication administration policy as a re-in-service but she did not remember the exact date. * Interview with LPN #8, on 02/22/12 at 10:25 AM, revealed she was re-in-serviced on medication administration on 01/12/12 with a read/sign packet from the DON. * Interview with LPN #9, on 02/22/12 at 10:40 AM, revealed he had a read/sign packet of information from the DON in January 2012 regarding the facility policy on medication administration. * Review of the nursing department's read/sign documentation for medication administration on 02/22/12 at 11:00 AM revealed signed/dated documents for LPNs' #4, #6, #7, #8, and #9. * Interview with the Administrator, on 02/17/12 at 12 Noon, revealed pharmacy will complete additional in-services with nurses and conduct medication pass observations monthly. The QA Committee will track and trend medication errors and will follow up with the DON and Pharmacy regarding any issues identified to maintain compliance.	F 333			