

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

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2011
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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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(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 An abbreviated survey (KY # 15897) was conducted on 02/02/11-02/04/11. Immediate Jeopardy was identified at 483.20 and 483.25 on 02/04/11. Substandard Quality of Care was identified at 483.25. An acceptable Allegation of Compliance (AoC) was received on 02/10/11. A partial extended survey and verification of the removal of the Immediate Jeopardy was conducted on 02/11/11. Immediate Jeopardy was verified removed on 02/05/11, as alleged in the AoC.	F 000	The submission of this plan of correction does not constitute an admission by the facility of the cited deficiencies or any violation of a regulation or standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any disputes about the accuracy of this information.	
F 281 SS=K	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality, related to medication administration, which affected three residents, (#1, #2 and #3) in the selected sample of three.</p> <p>During a medication pass, on 01/28/11, approximately 8:30 AM until 11:30 AM, three Certified Medication Technicians failed to follow acceptable Standard of Practice for medication administration (Five Rights), which resulted in the hospitalization of one resident (#1), due to adverse effects of the medication error. Resident #1's heart rate and blood pressure decreased to a dangerous level, requiring hospitalization.</p>	F 281	<p>F281-483.20(k)(3)(I)</p> <p>1. Employee reprimands were done 01-28-11. Immediate in-servicing on acceptable standards of practice for medication administration (Five Rights) performed by ADON and Administrator. Follow up in-servicing performed by staff development for cmts involved in errors on 02-01-11. Further in-servicing for licensed nursing staff and cmts by pharmacy on 02-04-11. Resident #1, cmt immediately reported incident to nurse who then reported to ADON and DON. Nurse immediately notified attending physician regarding incident. New orders received to monitor resident. Resident monitored for adverse signs or symptoms regarding medication error. Resident #1's heart rate and blood pressure decreased, requiring transfer to emergency room. A late entry notation was added to the resident's clinical record (nurse's notes) to identify the medication given in error. Resident #2, error reported</p>	03-08-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: NHA (X6) DATE: 4-6-11

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

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F 281	<p>Continued From page 1</p> <p>The facility failed to provide supervision to ensure medications were prepared and administered in accordance with acceptable standards of practice, resulting in additional medication errors for two residents (#2 and #3). Two CMT's prepared medication for the residents. One CMT prepared the medication and the second CMT administered the medication. Resident #2 received Resident #5's medication, to include cardiac and hypertensive medications, which presented a high risk for adverse effects for Resident #2.</p> <p>The facility failed to ensure that CMT #1 documented she had administered medication for Resident #3 timely. CMT #3 administered Resident #3's medication for the second time, resulting in the resident receiving twice as much of the medication as prescribed. Medications included a blood thinner and a drug to lower the blood sugar, which presented a high risk for adverse effect for Resident #3.</p> <p>The facility's failure to ensure medications were administered in accordance with acceptable professional standards of quality, resulted in multiple medication errors affecting Resident #1, #2 and #3 placing the residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified and the facility notified, on 02/04/11.</p> <p>Findings include:</p> <p>Review of the "Lippincott Nursing Drug Guide" revealed, "Ensuring that the drug being administered is the correct dose of the correct drug at the correct time, and is being given to the correct patient, by the correct route, is standard of</p>	F 281	<p>Immediately to nurse who notified administration and attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects to resident were noted. Resident #3, error reported immediately to the nurse who notified administration and attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects to resident were noted. Late entry notation was added to residents #1, #2 & #3 in clinical record (nurse's notes) to identify the medication given in error.</p> <p>2. On 01-28-11 ADON reviewed facility Medication Administration Policy & Procedure regarding medication administration. Administrator instructed ADON to complete review of pictures on MAR. Facility will perform daily, weekly and monthly audits to ensure that all residents will receive medications in accordance with standards of practice for medication administration (Five Rights). ADON, nurse and cmts reviewed all current residents who had the potential to be affected immediately following medication errors on 01-28-11. Facility did not find any problems regarding the medication pass to any other residents in the facility. Medical records / designee will audit resident identification (photograph) daily Monday through Friday. RN supervisor will audit on weekends.</p>	

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F 281	<p>Continued From page 2</p> <p>nursing practice". Additionally, the standard includes recording the delivery of the correct drug and dosage, correct route, correct time to the correct patient.</p> <p>A review of the facility's investigation, dated 01/31/11 revealed three medication errors were made during an 8:30 AM -9:30 AM medication pass, on 01/28/11.</p> <p>1. Resident #1 was admitted to the facility on 01/19/11, with diagnoses to include Organic Heart Disease and Chronic Kidney Disease. A review of clinical record to include the Medication Administration Record (MAR), dated January 2011 MAR, revealed Cardizem was listed as an allergy for the resident.</p> <p>An interview with Resident #1's family member, on 02/03/11 at 12:00 noon, revealed the resident had received Cardizem prior to admission to the facility and the drug caused the resident's heart rate to "bottom out".</p> <p>An interview with CMT #1, on 02/03/11 at 12:00 PM, revealed she administered medication, which included the drug Cardizem (lowers the blood pressure) 90 milligrams (mg) two tablets, which was prescribed for Resident #4, to Resident #1 on 01/28/11, during the 8:30 AM to 9:30 AM medication pass. CMT #1 stated she did not verify the resident's identity prior to the administration of the medication. The CMT stated she entered the resident's room and "assumed" Resident #4 was the resident lying on a bed. After she administered the medication, she realized she gave the medication to the wrong resident and reported the error to the nurse immediately.</p>	F 281	<p>Staff development / designee will audit weekly. DON to monitor daily and weekly audit forms. Administrator will review audits weekly and submit to QA committee monthly for review for 12 months.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #1 (who was affected by significant med error) on 01-28-11 immediately after med error was reported by cmt.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #2 (who was affected by significant med error) on 01-28-11 immediately after med error was reported by cmt.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #3 (who was affected by significant med error) on 01-28-11 immediately after med error was reported by cmt.</p> <p>3. Medication Administration Policy and Procedure (NP-00158) updated to reflect the following changes: resident identification through photograph, review of name plate on resident's door and by asking "What is your name?".</p> <p>A. Admitting nurse to obtain photograph and place on MAR on day of admission. Nurse / cmt will ensure identification prior to initiating a medication administration by reviewing name plate on resident's door, reviewing photograph, and by asking resident "What is your name?"</p> <p>B. Medical records / designee will audit resident identification</p>	
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F 281	<p>Continued From page 3</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/02/11 at 12:00 PM, revealed CMT #1 reported she had given Resident #4's 9:30 AM medications to Resident #1, at approximately 8:50 AM. She immediately assessed Resident #1 and reviewed Resident #1's allergies. Resident #1's chart and MAR indicated the resident was allergic to Cardizem. LPN #1 stated she called the physician and notified him of the medication error and resident's allergy to Cardizem. An order was received to monitor the resident's vital signs every 15 minutes. A review of the Resident #1's vital signs revealed the resident's blood pressure was 122/48 and heart rate was 88 at 8:50 AM. A review of the Nurse's Notes, dated 01/28/11 at 10:10 AM, revealed the resident's heart rate decreased to 68 (normal 84-74) and the resident's blood pressure decreased to 80/40 (normal 120's/80's). LPN#1 stated the physician was called and the resident was transferred to the hospital and was admitted.</p> <p>A review of the hospital records and interview with the Physician/Hospitalist (physician who cared for the resident while in the hospital), on 02/03/11 at 4:00 PM, revealed the resident's blood pressure medication was withheld and Resident #1 was placed in a monitor bed so his/her heart rate could be monitored closely. The physician stated there was a chance the resident's heart rate could have fallen enough to cause the resident to require resuscitation.</p> <p>2. Resident #2 was admitted to the facility on 08/20/10 with diagnoses to include Alzheimer Disease, Congestive Heart Failure and Hypertension.</p>	F 281	<p>(photograph) daily Monday through Friday. RN supervisor will audit on weekends. Staff development / designee will audit weekly. DON to monitor daily and weekly audit forms. Administrator will review audit forms weekly and submit to QA committee monthly for review for 12 months.</p> <p>C. Staff development / designee will audit med pass process weekly. Pharmacy will perform monthly medication pass audits. Weekly and monthly audits will be monitored by DON. Audits will be reviewed by QA committee monthly for 12 months.</p>	

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F 281	<p>Continued From page 4</p> <p>An interview with CMT #1, CMT #2 and CMT #3, on 02/02/11 at 12:25 PM and on 02/03/11 at 10:00 AM and at 12:00 noon, revealed the three CMT's worked together to complete the medication pass. CMT #1 prepared medications, which were administered to the residents by CMT #2 and CMT #3. At a point in the process, LPN #2 approached the CMT's, during the medication pass, and told CMT #1 to take a break, which left CMT #2 and CMT #3. At that time, CMT #2 "pulled up" the medication and CMT #3 administered the medication to the residents. During the process, CMT #2 handed CMT #3 a medicine cup containing medication with a blue paper, which indicated the medication belonged to Resident #5. However, CMT #3 stated she "thought" CMT #2 told her the medication was for Resident #2 and she administered the medication, belonging to Resident #5, to Resident #2. On return to the cart, CMT #2 gave her the next medicine cup and told her the medication was for Resident #2. The CMT's realized, at that time, a second error had occurred as they had administered Resident #5's medications to Resident #2.</p> <p>A review of Resident #5's MAR, dated January 2011, revealed the following medications Lanoxin (heart medication) 0.25 micrograms (mcg.), Monopril (lowers blood pressure) 20 mg, and Klor Kon (Potassium) 10 mill Equivalents (meq) were administered to Resident #2 in error. An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #2's physician was notified and orders were received to monitor the resident's vital signs.</p> <p>Interviews with CMT #2 and CMT #3 revealed they were aware the CMT who prepared the</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>medication should also administer the medication; however, they thought it would be faster if one of them prepared the medication and the other gave the medication.</p> <p>On 02/02/11 at 12:00 noon and at 1:00 PM, interviews with LPN #1 and LPN #2, who were responsible for the supervision of the CMT's, revealed they did not identify that the CMT's were not following acceptable standards of practice for medication administration.</p> <p>An interview with the Assistant Director of Nursing (DON) and LPN #2 on 02/02/11 at 11:05 AM and 1:00 PM, revealed CMT #2 and #3 immediately reported the medication error and how it happened; however, they did not identify the CMT's were not administering the medications in accordance with acceptable standards of practice.</p> <p>Further interview with CMT #2 and CMT #3, on 02/02/11 at 10:00 AM and at 12:25 PM, revealed after they reported the medication error to the DON and LPN #2, which affected Resident #2, they resumed the medication pass, utilizing the same techniques used which resulted in the medication error.</p> <p>3. Resident #3 was admitted to the facility on 07/09/10 with diagnoses to include Cerebral Vascular Disease and Diabetes Mellitis.</p> <p>Interviews with CMT #2 and CMT #3, on 02/02/11 at 02/02/11 at 2:25 PM and on 02/03/11 at 10:00 AM revealed after completing the medication pass, the CMT's reviewed the MARs and discovered a third medication error had occurred for Resident #3. On MAR review, they realized</p>	F 281			

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F 281	<p>Continued From page 6</p> <p>CMT #1 did not initial Resident 3's MAR to indicate the 9:30 AM medications had been given and as a result, CMT #2 and CMT #3 gave the resident the medication a second time. Further review of the MAR, revealed Resident #3 received Plavix (blood thinner) 75 mg., Aspirin 81 mg. (blood thinner) and Glyburide (lowers the blood sugar) 5 mg. twice.</p> <p>An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #3's physician was notified and orders were received to monitor the resident's vital signs and blood sugars every 15 minutes. A review of the vital sign and blood sugar flow sheet, dated 01/28/11, revealed Resident #2 had no adverse effects.</p> <p>An acceptable Allegation of Compliance was received on 02/10/11 and detailed as follows:</p> <p>On 01/28/11, CMT #1 immediately reported a medication error to LPN #1. LPN #1 immediately reported incident to DON and ADON. Facility began monitoring resident. LPN #1 immediately contacted attending physician office and spoke with ARNP. Facility received order to send to ER at hospital. ADON spoke with Administrator and ADON was asked to immediately relieve CMT #1 of her duties. Contacted OIG, DCBS, Medical Director, owner, and pharmacy on 01/28/11, regarding medication error.</p> <p>Employee reprimands were done on day of incident. Immediate in-servicing was initiated by ADON, followed up by Administrator on evening of 01/28/11. Administrator performed walking in-services throughout facility regarding events that occurred earlier in the day. Administrator discussed with employees on duty that a</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>medication error had occurred due to CMT's not following standards of practice during medication administration and by not following facility policy and procedure NP-00158. Discussed poor judgement used by CMT's when they deviated from standards of practice and by not following policy & procedure (NP-00158). Explained to staff what employees failed to do and then reviewed what they should have done according to standards of practice and facility policy (NP-00158). Administrator repeated walking in-service with staff on duty for 7-3 and 3-11 shifts on 01/29/11 (See attached exhibit A-1). Follow up In-servicing was performed by staff development for CMT's involved in errors on 02/01/11. Further in-servicing was completed with licensed nursing staff and CMT's from pharmacy on 02/04/11. Resident #1 did not receive any medication or treatment at the local hospital to counteract the medication he had received in error and had no adverse effect related to the medication error. He was placed in observation for bradycardia. He was admitted to hospital on 01/29/11 for diagnosis of pneumonia.</p> <p>4. (1) Date the IJ was removed? 02/05/11</p> <p>(2) A. What caused the IJ?</p> <p>CMT's made medication error despite repeated training on policy and procedure of facility regarding resident identification and standards of practice for medication delivery. CMT # 1 administered medications to the wrong resident when she failed to follow facility policy and procedure on identification of resident.</p> <p>CMT # 2 and CMT # 3 caused medication errors to occur when they did not follow facility policy &</p>	F 281		

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F 281	<p>Continued From page 8 procedure and current standards of practice.</p> <p>(2) B. What residents/patients are impacted by the IJ? Residents #1, #2 and #3. All residents have the potential to be impacted.</p> <p>(2) C. What staff is involved in IJ? CMT's #1, #2 and #3. All licensed nurses and CMT's have the potential to be impacted.</p> <p>(2) D. What area of the facility are impacted by the IJ? Entire facility has the potential to be impacted by the IJ.</p> <p>(3) Detail how the IJ will be prevented from recurring to this resident/patient, and to other residents/patients. This may include the following, but is not limited to: A. Investigation to determine the cause of the IJ 01/28/11 - Reviewed facility Medication Administration Policy and procedures regarding medication administration, policy number NP-00158. Review completed by ADON. Administrator Instructed ADON to complete review of pictures on MARS. 02/01/11 - Medication Administration Policy & Procedure (NP-00158) reviewed with addendum added for staff to ask resident "What is your name?" before administering medications. 02/04/11 - Camera in business office made</p>	F 281		

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F 281	<p>Continued From page 9 available to nursing staff at all times.</p> <p>B-1 In-service training; content, staff attending, implementation of 01/28/2011. Proper identification of resident prior to treatment or medication administration by ADON; Persons trained licensed nurses and CMT's.</p> <p>02/01/11 - 5 Rights of Medication Administration and general medication guidelines, conducted by Staff Development LPN to CMT's #2 and #3.</p> <p>02/04/11 - Medication Administration inservice completed by LPN Med Care Pharmacy Consultant. In-service included IJ deficiencies, correct policies and procedures identification process. Persons included licensed nurses and CMT's.</p> <p>02/04/11 - All staff in-serviced in person or via telephone before returning to work on IJ deficiencies.</p> <p>02/04/11 - Management Team in-serviced on audit process. Management team consists of: DON, ADON, Administrator, Admissions/Social Services, Activities, Staff Development/HR, MDS Coordinator, Dietary Manager, Environmental Director, Maintenance Director and Medical Records.</p> <p>B-2 - Disciplinary actions: LPN #1 on 01/28/11 CMT #1 on 01/28/11 with suspension CMT #2 on 01/28/11 CMT #3 on 01/28/11 LPN #3 on 02/04/11</p>	F 281	

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F 281	<p>Continued From page 10 C-2 - Monitoring/Tracking System:</p> <p>A. Resident Identification through Photograph, Policy and Procedure. Admitting nurse to obtain photograph and place on MAR on day of admission. Nurse or CMT will ensure identification prior to completing a medication administration by reviewing name plate on door, reviewing photograph and by asking resident "What is your name?"</p> <p>Medical Records or designee monitor resident identification (photograph) daily Monday thru Friday, RN supervisor to monitor on weekends. Staff development to monitor weekly, DON to audit daily and weekly audit form. CMT is supervised by licensed nurse. Licensed nurse is supervised by ADON and DON, DON is supervised by Administrator. Medical Records is supervised by DON. Staff Development is supervised by Administrator. CMT's supervised by licensed nurses performing daily shift rounds. Monitoring: Audit review by QA committee on a monthly basis for 12 months.</p> <p>B. Medication, Administration of: Oral administration, etc. policy and procedure.</p> <p>Staff development/designee audit med pass process weekly. Pharmacy performs monthly medication pass audit. Weekly and monthly audits monitored by DON. Audit reviewed by QA committee monthly for 12 months.</p> <p>C. Root Cause Analysis Policy and Procedure</p> <p>All departments submit as needed to administrator. Audit reviewed thru QA process monthly for 12 months.</p>	F 281		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 281	Continued From page 11 D. Development/Revision of Assessment Tools Root cause analysis report form. 01/28/11 - Resident identification and Med pass audit process was developed, concerning formal auditing of both processes. Root Cause Analysis performed to ensure compliance according to federal and state guidelines and policies and procedures of facility. Analysis to record problem and identify the cause of the problem. Lists actions taken to reduce risk of a future occurrence. Dept. managers will be initiating root cause analysis and Administrator will review and submit at monthly QA meeting. 01/31/11 - Formal auditing procedures initiated ensuring resident ID on MAR's and name plates on resident doors and med pass performed according to standards of practice and policies and procedures of facility. During the partial extended survey on 02/11/11, verification of the removal of Immediate Jeopardy was completed as follows: Interviews with RN #1, LPN #1, CMT #2 and CMT #4 on 02/11/11 at 1:30 PM, 3:30 PM, 4:50 PM and 5:05 PM revealed they were educated on the five rights and professional standards of practice of medication administration. A review of the February 2011 schedule revealed two staff was scheduled to administer medication (one on each hall). A review of the facility's policy and procedure for Medication Administration revealed an addendum was added for staff to ask the resident their name, prior to administering the	F 281			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 281	Continued From page 12 medication and the person who initiates the medication pass should complete the medication pass for that resident. Observation of a medication pass on 02/11/11 at 12:50 PM revealed one staff was administering the medication to include looking at the residents' pictures with the MARs, asking the resident their name and initialing the MAR, after the medication was administered. Interviews with RN #1, LPN #1 and LPN #2 on 02/11/11 at 12:50 PM, 4:50 PM and 5:05 PM revealed the admitting nurse was responsible for taking the resident's picture and ensuring the picture was placed with the resident's MAR. Observation of the business office on 02/11/11 at 3:55 PM revealed the camera was kept on a stand so staff would have access to it at all times. Observation of the MARs on 02/11/11 at 12:50 PM revealed pictures were with the MAR for each resident. Interview with the Housekeeping Supervisor on 02/11/11 at 3:30 PM revealed she was responsible for placing the resident's name on the doors for new admissions and when a resident was moved to another room. Observations revealed all residents' names were on their bedroom doors. Interviews Staff Development LPN, Medical Records, ADON and the DON on 02/11/11 at 4:05 PM, 4:08 PM, 4:10 PM and 4:15 PM revealed they were educated on the audit process put in place to ensure pictures of residents were with the Medication Administration Records (MAR), residents' names were on the doors and staff were administering medications according to professional standards of practice. A review of the daily and weekly audits revealed the audits were conducted to ensure the resident pictures were with the MAR, resident names were on the doors and staff was administering medications according to the five rights and professional standards of practice. A	F 281			

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 281	Continued From page 13 review of the Inservice training, dated 02/04/11 at 3:00 PM and 5:00 PM revealed the Pharmacy Nurse Consultant educated all licensed staff and Certified Nurse Technicians on medication administration to include the five rights (right resident, right medication, right time, right dose and right route) and documentation. A review of the Inservice training, dated 02/04/11 at 4:00 PM, revealed members of the Management Team were educated on the audit process and root cause analysis. Based on the above observations, interviews and review of records, it was determined the Immediate Jeopardy was removed, effective 02/05/11, as alleged in the AoC with the scope and severity lowered to a "E" based on the need for the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 281			
F 333 SS=K	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure three residents (#1, #2, & #3), in the selected sample of three, were free of any significant medication errors. The facility failed to ensure staff was following nursing standards of practice as it relates to medication administration. The facility failed to ensure resident identification systems were	F 333	F333-483.25(M)(2) 1. Employee reprimands were done on 01-28-11. Immediate inservicing on acceptable standards of practice for medication administration (Five Rights) performed by ADON and administrator. Follow up inservicing performed by staff development for cmts involved in med errors on 02-01-11. Further inservicing for licensed nursing staff and cmts by pharmacy on 02-04-11. Resident #1, CMT immediately reported incident to nurse who then reported to ADON and DON. Nurse immediately notified attending physician regarding incident. New	03-08-11	

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FORM APPROVED
OMB NO. 0938-0391

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

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F 333	<p>Continued From page 14</p> <p>Implemented and effective on 01/28/11. CMT #1 administered Resident #4's medications to Resident #1, which included Cardizem (calcium channel blocker), a medication for which Resident #1 had a known allergy. The resident's heart rate decreased to the low 30s (normal 64/74) for which the resident required hospitalization and cardiac monitoring.</p> <p>On 01/28/11, CMT #2 and CMT #3 failed to follow standards of practice related medication administration as they both participated in the administration of Resident #5's medication to the wrong resident (#2), which included cardiac medication, antihypertensives and a potassium supplement.</p> <p>Additionally, CMT #1 failed to document on the MAR timely after administration of medications. This failure resulted in another CMT administering a second dose to Resident #3, which included blood thinners and an antidiabetic medication.</p> <p>The facility's failure to ensure Resident #1 was not administered a contraindicated medication and failure to ensure repeated medication errors were not made without intervention placed Resident #1, #2 and #3 at risk for serious injury, harm, impairment or death. Immediate Jeopardy and substandard quality of care (SQC) was identified on 02/04/11.</p> <p>Findings include: Refer to F281</p> <p>Based on interviews and record reviews, it was determined the facility failed to ensure three Certified Medication Technicians (CMT)</p>	F 333	<p>orders received to monitor resident. Resident monitored for adverse signs or symptoms regarding medication error. Resident #1's heart rate and blood pressure decreased, requiring transfer to emergency room.</p> <p>A late entry notation was added to the resident's clinical record (nurse's notes) to identify the medication given in error.</p> <p>Resident #2, error reported immediately to the nurse who notified administration and attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects noted.</p> <p>Resident #3, medication error reported immediately to the nurse who notified administration and attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects to resident noted.</p> <p>Late entry notation was added to resident's #1, #2 & #3 clinical record (nurse's notes) to identify the medication given in error.</p> <p>2. On 01-28-11 ADON reviewed facility Medication Administration Policy and Procedure (NP-00158) regarding medication administration. Administrator instructed ADON to complete review of pictures on MAR. Facility will perform daily, weekly and monthly audits to ensure that all residents will receive medications in</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 333	<p>Continued From page 15</p> <p>administered medications to three resident (#1, #2 and #3) in accordance with professional standards of quality, during a medication pass, on 01/28/11. The facility failed to ensure staff administered medications in accordance with the "Five Rights" and the facility's established policy related to identification of the residents prior to administration of medications.</p> <p>A review of the policy and procedure entitled, "Medication Administration of: Oral Administration" (undated), revealed the person administering medication must check the drug label three times, during preparation of each medication. The identity of the resident must be validated prior to administering any drug, by checking the resident's ID picture and verifying the resident's name by calling the resident's name.</p> <p>Review of the "Lippincott Nursing Drug Guide" revealed, "Ensuring that the drug being administered is the correct dose of the correct drug at the correct time, and is being given to the correct patient, by the correct route, is standard of nursing practice". Additionally, the standard includes recording the delivery of the correct drug and dosage, correct route, correct time to the correct patient.</p> <p>1. Record review revealed Resident #1 was admitted to the facility on 01/19/11, with diagnoses to include Organic Heart Disease, Chronic Kidney Disease and Hypertension. A review of Resident #1's chart and January 2011 MAR, revealed Cardizem was listed as an allergy. An interview with Resident #1's family member, on 02/03/11 at 12:00 noon, revealed the resident had received Cardizem, prior to admission to the</p>	F 333	<p>In accordance with standards of practice for medication administration (Five Rights). ADON, LPN and cmts reviewed all current residents who had the potential to be affected immediately following medication errors on 01-28-11. Facility (ADON, 7am-7pm LPN and 6-2 cmts) did not find any other medication errors regarding the medication pass to any other residents in the facility on 01-28-11. Medical records / designee will audit identification (photograph) daily Monday through Friday. RN supervisor will audit on weekends. Staff development / designee will audit weekly. DON will monitor daily and weekly audits forms. Administrator will review audits weekly and submit to QA committee for review monthly for 12 months. LPN on 7am-7pm shift and ADON reviewed Resident #1 affected by the significant medication error on 01-28-11 immediately when reported by the cmt. LPN on 7am-7pm shift & ADON reviewed resident #2 affected by the significant medication error on 01-28-11 immediately when reported by the cmt. LPN on 7am-7pm shift & ADON reviewed resident #3 affected by significant medication error on 01-28-11 immediately when reported by cmt.</p> <p>3. Medication Administration Policy and Procedure (NP-00158) updated to reflect the following changes:</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 333	<p>Continued From page 16</p> <p>facility, and it had caused the resident's heart rate to "bottom out".</p> <p>An interview with the Administrator, on 02/03/11 at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed CMT #1 administered Resident #4's 9:30 AM medications to Resident #1 on 01/28/11. A review of the "Resident Abuse Investigation Report, dated 01/31/11, revealed the medication error was reported by CMT #1 on 01/28/11 at approximately 9:00 AM. The report indicated the resident experienced an adverse effect as a result of the error, which was documented as a decrease in blood pressure and pulse. The report revealed Resident #1 was allergic to the drug recieved (Cardizem) and was transferred to the hospital emergency room. The investigative report did not reveal the root cause of the error and/or any corrective actions taken by the facility to prevent a recurrence.</p> <p>Interview with CMT #1, on date 02/03/11 at 12:00 noon, revealed Resident #4 had been admitted during her days off and there were no identification pictures on the MAR for Resident #1 and Resident #4, at the time the medication error occurred. She stated she entered the resident's room and "assumed" the resident lying on a bed in the room was Resident #4. After she administered the medication, she observed a urinal hanging on the other resident's bed labeled with the name of Resident #4. At that time, she realized she had given Resident #1, medication prescribed for Resident #4. She reported the error to the nurse immediately.</p> <p>A review of Resident #4's January 2011 Medication Administration Record (MAR),</p>	F 333	<p>resident identification through photograph, review of name plate on resident's door and by asking "What is your name?".</p> <p>A. Admitting nurse to obtain photograph and place on MAR on day of admission. Nurse / cmt will ensure identification prior to initiating a medication administration by reviewing name plate on resident's door, reviewing photograph and by asking "What is your name?".</p> <p>B. Medical records / designee will audit resident identification (photograph) daily Monday through Friday. RN supervisor will audit on weekends. Staff development / designee will audit weekly. DON to monitor daily and weekly audit forms. Administrator will review audits weekly and submit to QA committee monthly for review for 12 months.</p> <p>C. Staff development / designee will audit med pass process weekly. Pharmacy will perform monthly med pass audit. Weekly and monthly audits will be monitored by DON. Audits will be reviewed by QA committee monthly for 12 months.</p>	

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

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

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F 333	<p>Continued From page 17</p> <p>revealed Resident #1 received Cardizem (antihypertensive) 90 milligrams (mg) two tablets.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/02/11 at 12:00 PM, revealed Resident #1's physician was made aware of the medication error and an order was received to monitor the resident's vital signs every 15 minutes. A review of the Nurse's Notes, dated 01/28/11 at 10:10 AM, revealed the resident's heart rate was 58 (normal 64-74) and the resident's blood pressure was 80/40 (normal 120's/80's). The physician was called and the facility transferred the resident to the hospital.</p> <p>A review of the hospital records and interview with the Hospitalist (physician who cared for the resident while in hospital), on 02/03/11 at 4:00 PM, revealed the resident's blood pressure medication was withheld and Resident #1 was placed in a monitor bed so his/her heart rate could be monitored closely. The Hospitalist stated there was a chance the resident's heart rate could have fallen enough to cause the resident to require resuscitation.</p> <p>Interviews with the Director of Nursing (DON) on 02/03/11 at 2:00 PM revealed the facility did not follow acceptable standards of practice for medication administration when the CMT did not validate the resident's identity prior to medication administration.</p> <p>2. A record review revealed Resident #3 was admitted to the facility with diagnoses to include Diabetes Mellitus, Type II and Cerebral Vascular Disease.</p> <p>An interview with the Administrator, on 02/03/11</p>	F 333		

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0301

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

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F 333	<p>Continued From page 18</p> <p>at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed Resident #3 received his/her 9:30 AM medications twice, on 01/28/11. A review of the "Resident Abuse Investigation Report, dated 01/31/11, revealed the medication error was reported by CMT #2 on 01/28/11 at approximately 12:00 noon. The report indicated the resident's physician was called with an order received to monitor the resident. The investigative report did not reveal the root cause of the error and/or any corrective actions taken by the facility to prevent a recurrence. Interviews with CMT #2 and CMT #3 on 02/02/11 at 12:25 PM and 02/03/11 at 10:00 AM revealed CMT #1 had failed to initial Resident #3's MAR to indicate the medicines had been given. They revealed when they opened the MAR and there were no initials in the boxes for 01/28/11, they pulled up the medicine and administered it.</p> <p>A review of the January 2011 MAR, revealed Resident #3 received Plavix (blood thinner) 75 mg. every day, Aspirin 81 mg. every day (blood thinner) and Glyburide (lowers the blood sugar) 5 mg. every morning.</p> <p>An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #3's physician was called with orders received to monitor the resident's blood sugars every 15 minutes to ensure the double dose of the antidiabetic did not cause the resident's blood sugar to drop too low. A review of the vital sign and blood sugar flow sheet, dated 01/28/11, revealed Resident #2 had no adverse effects.</p> <p>3. A record review revealed Resident #2 was admitted to the facility, on 08/20/10, with diagnoses to include Congestive Heart Failure</p>	F 333		

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

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

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F 333	<p>Continued From page 19 and Hypertension.</p> <p>An interview with the Administrator, on 02/03/11 at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed Resident #2 was given Resident #5's medications during the 9:30 AM medication pass on 01/28/11. A review of the "Resident Abuse Investigation Report, dated 01/31/11, revealed the medication error was reported by CMT #2 and CMT #3 01/26/11 at approximately 11:00 AM. The report indicated the resident's physician was called with an order received to monitor the resident. The investigative report did not reveal the root cause of the error and/or any corrective actions taken by the facility to prevent a recurrence.</p> <p>Interviews with CMT #2 and CMT #3, on 02/02/11 at 12:55 PM and 02/03/11 at 10:00 AM revealed during the administration pass CMT #2 "pulled up" the medication and CMT #3 administered the medication to the residents. During the process, CMT #2 handed CMT #3 a medicine cup containing medication with a blue paper, which indicated the medication belonged to Resident #5. However, CMT #3 stated she "thought" CMT #2 told her the medication was for Resident #2 and she administered the medication, belonging to Resident #5, to Resident #2. On return to the cart, CMT #2 gave her the next medicine cup and told her the medication was for Resident #2. The CMT's realized, at that time, a second error had occurred as they had administered Resident #5's medications to Resident #2.</p> <p>A review of Resident #5's January 2011 MAR, revealed Resident #2 received Lanoxin (cardiac medication) 0.25 micrograms (mcg.) every day. Monopril (lowers blood pressure) 20 mg. every</p>	F 333			

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

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 333	<p>Continued From page 20</p> <p>day and Klor Kon (Potassium)10 millIEquivalents (meq) every day.</p> <p>An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #2's physician was called with orders received to monitor the resident's vital signs every 15 minutes to ensure the resident's blood pressure and heart rate did not drop too low. A review of the vital sign flow sheet, dated 01/28/11, revealed the resident had no adverse effects.</p> <p>Interview with the Director of Nursing on 02/03/11 at 2:00 PM revealed the CMTs did not follow acceptable standards of practice regarding validation of the resident's identity and did not follow the established policy and procedure for medication administration in regard to providing a complete report prior to assuming responsibility for the medication pass and also in regard to the process of preparation and administration of medication by the same individual. Staff responsible for the supervision of the medication administration did not identify the CMTs failure to follow acceptable practices and did not intervene to correct the problem and prevent a recurrence.</p> <p>An acceptable Allegation of Compliance was received on 02/10/11 and detailed as follows:</p> <p>On 01/28/11, CMT #1 immediately reported medication error to LPN #1. LPN #1 immediately reported incident to DON and ADON. Facility began monitoring resident. LPN #1 immediately contacted attending physician office and spoke with ARNP. Facility received order to send to ER at hospital. ADON spoke with Administrator and ADON was asked to immediately relieve CMT #1 of her duties. Contacted OIG, DCBS, Medical</p>	F 333		

PRINTED: 02/25/2011
FORM APPROVED
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2011
NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141		
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F 333	<p>Continued From page 21</p> <p>Director, owner, and pharmacy on 01/28/11, regarding medication error.</p> <p>Employee reprimands were done on day of incident. Immediate in-servicing was initiated by ADON, followed up by Administrator on evening of 01/28/11. Administrator performed walking in-services throughout facility regarding events that occurred earlier in the day. Administrator discussed with employees on duty that a medication error had occurred due to CMT's not following standards of practice during medication administration and by not following facility policy and procedure NP-00158. Discussed poor judgement used by CMT's when they deviated from standards of practice and by not following policy & procedure (NP-00158). Explained to staff what employees failed to do and then reviewed what they should have done according to standards of practice and facility policy (NP-00158). Administrator repeated walking in-service with staff on duty for 7-3 and 3-11 shifts on 01/29/11 (See attached exhibit A-1). Follow up in-servicing was performed by staff development for CMT's involved in errors on 02/01/11. Further in-servicing was completed with licensed nursing staff and CMT's from pharmacy on 02/04/11. Resident #1 did not receive any medication or treatment at the local hospital to counteract the medication he had received in error and had no adverse effect related to the medication error. He was placed in observation for bradycardia. He was admitted to hospital on 01/29/11 for diagnosis of pneumonia.</p> <p>4. (1) Date the IJ was removed? 02/05/11</p> <p>(2) A. What caused the IJ?</p>	F 333			

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	<p>Continued From page 22</p> <p>CMT's made medication error despite repeated training on policy and procedure of facility regarding resident identification and standards of practice for medication delivery. CMT # 1 administered medications to the wrong resident when she failed to follow facility policy and procedure on identification of resident.</p> <p>CMT # 2 and CMT # 3 caused medication errors to occur when they did not follow facility policy & procedure and current standards of practice.</p> <p>(2) B. What residents/patients are impacted by the IJ?</p> <p>Residents #1, #2 and #3. All residents have the potential to be impacted.</p> <p>(2) C. What staff is involved in IJ?</p> <p>CMT's #1, #2 and #3. All licensed nurses and CMT's have the potential to be impacted.</p> <p>(2) D. What area of the facility are impacted by the IJ?</p> <p>Entire facility has the potential to be impacted by the IJ.</p> <p>(3) Detail how the IJ will be prevented from recurring to this resident/patient, and to other residents/patients. This may include the following, but is not limited to:</p> <p>A. Investigation to determine the cause of the IJ</p> <p>01/28/11 - Reviewed facility Medication Administration Policy and procedures regarding medication administration, policy number</p>	F 333			

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	<p>Continued From page 23</p> <p>NP-00158, Review completed by ADON. Administrator instructed ADON to complete review of pictures on MARS.</p> <p>02/01/11 - Medication Administration Policy & Procedure (NP-00158) reviewed with addendum added for staff to ask resident "What is your name?" before administering medications.</p> <p>02/04/11 - Camera in business office made available to nursing staff at all times.</p> <p>B-1 In-service training; content, staff attending, implementation of 01/29/2011. Proper identification of resident prior to treatment or medication administration by ADON; Persons trained licensed nurses and CMT's.</p> <p>02/01/11 - 5 Rights of Medication Administration and general medication guidelines, conducted by Staff Development LPN to CMT's #2 and #3.</p> <p>02/04/11 - Medication Administration inservice completed by LPN Med Care Pharmacy Consultant. In-service included IJ deficiencies, correct policies and procedures identification process. Persons included licensed nurses and CMT's.</p> <p>02/04/11 - All staff in-serviced in person or via telephone before returning to work on IJ deficiencies.</p> <p>02/04/11 - Management Team in-serviced on audit process. Management team consists of: DON, ADON, Administrator, Admissions/Social Services, Activities, Staff Development/HR, MDS Coordinator, Dietary Manager, Environmental</p>	F 333			

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OMB NO. 0838-0391

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F 333	<p>Continued From page 24</p> <p>Director, Maintenance Director and Medical Records.</p> <p>B-2 - Disciplinary actions: LPN #1 on 01/28/11 CMT #1 on 01/28/11 with suspension CMT #2 on 01/28/11 CMT #3 on 01/28/11 LPN #3 on 02/04/11</p> <p>C-2 - Monitoring/Tracking System:</p> <p>A. Resident Identification through Photograph, Policy and Procedure. Admitting nurse to obtain photograph and place on MAR on day of admission. Nurse or CMT will ensure identification prior to completing a medication administration by reviewing name plate on door, reviewing photograph and by asking resident "What is your name?"</p> <p>Medical Records or designee monitor resident identification (photograph) daily Monday thru Friday, RN supervisor to monitor on weekends. Staff development to monitor weekly, DON to audit daily and weekly audit form. CMT is supervised by licensed nurse. Licensed nurse is supervised by ADON and DON. DON is supervised by Administrator. Medical Records is supervised by DON. Staff Development is supervised by Administrator. CMT's supervised by licensed nurses performing daily shift rounds. Monitoring: Audit review by QA committee on a monthly basis for 12 months.</p> <p>B. Medication, Administration of: Oral administration, etc. policy and procedure.</p> <p>Staff development/designee audit med pass</p>	F 333			

PRINTED: 02/25/2011
FORM APPROVED
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F 333	<p>Continued From page 25</p> <p>process weekly. Pharmacy performs monthly medication pass audit. Weekly and monthly audits monitored by DON. Audit reviewed by QA committee monthly for 12 months.</p> <p>C. Root Cause Analysis Policy and Procedure</p> <p>All departments submit as needed to administrator. Audit reviewed thru QA process monthly for 12 months.</p> <p>D. Development/Revision of Assessment Tools</p> <p>Root cause analysis report form.</p> <p>01/28/11 - Resident Identification and Med pass audit process was developed, concerning formal auditing of both processes.</p> <p>Root Cause Analysis performed to ensure compliance according to federal and state guidelines and policies and procedures of facility. Analysis to record problem and identify the cause of the problem. Lists actions taken to reduce risk of a future occurrence. Dept. managers will be initiating root cause analysis and Administrator will review and submit at monthly QA meeting.</p> <p>01/31/11 - Formal auditing procedures initiated ensuring resident ID on MAR's and name plates on resident doors and med pass performed according to standards of practice and policies and procedures of facility.</p> <p>During the partial extended survey on 02/11/11, verification of the removal of Immediate Jeopardy was completed as follows:</p> <p>Interviews with RN #1, LPN #1 and CMT #2 on</p>	F 333			

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FORM APPROVED
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F 333	Continued From page 26 02/11/11 at 1:30 PM, 4:50 PM and 5:05 PM revealed they were educated on the five rights and professional standards of practice of medication administration. A review of the February 2011 schedule revealed two staff was scheduled to administer medication (one on each hall). A review of the facility's policy and procedure for Medication Administration revealed an addendum was added for staff to ask the resident their name, prior to administering the medication and the person who initiates the medication pass should complete the medication pass for that resident. Observation of a medication pass on 02/11/11 at 12:50 PM revealed one staff was administering the medication to include looking at the residents' pictures with the MARs, asking the resident their name and initialing the MAR, after the medication was administered. Interviews with RN #1, LPN #1 and LPN #2 on 02/11/11 at 12:50 PM, 4:50 PM and 5:05 PM revealed the admitting nurse was responsible for taking the resident's picture and ensuring the picture was placed with the resident's MAR. Observation of the business office on 02/11/11 at 3:55 PM revealed the camera was kept on a stand so staff would have access to it at all times. Observation of the MARs on 02/11/11 at 12:50 PM revealed pictures were with the MAR for each resident. Interview with the Housekeeping Supervisor on 02/11/11 at 3:30 PM revealed she was responsible for placing the resident's name on the doors for new admissions and when a resident was moved to another room. Observations revealed all residents' names were on their bedroom doors. Interviews Staff Development LPN, Medical Records, ADON and DON on 02/11/11 at 4:05 PM, 4:08 PM, 4:10 PM and 4:15 PM revealed they were educated on the audit process put in place to ensure pictures of	F 333		

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F 333	Continued From page 27 residents were with the Medication Administration Records (MAR), residents' names were on the doors and staff were administering medications according to professional standards of practice. A review of the daily and weekly audits revealed the audits were conducted to ensure the resident pictures were with the MAR, resident names were on the doors and staff was administering medications according to the five rights and professional standards of practice. A review of the inservice training, dated 02/04/11 at 3:00 PM and 5:00 PM revealed the Pharmacy Nurse Consultant educated all licensed staff and Certified Nurse Technicians on medication administration to include the five rights (right resident, right medication, right time, right dose and right route) and documentation. A review of the inservice training, dated 02/04/11 at 4:00 PM, revealed members of the Management Team were educated on the audit process and root cause analysis. Based on the above observations, interviews and review of records, it was determined the Immediate Jeopardy was removed, effective 02/05/11, as alleged in the AoC with the scope and severity lowered to a "E" based on the need for the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 333			
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	F490-483.75 1. Employee reprimands were done on 01-28-11. Immediate inservicing on acceptable standards of practice for medication administration (Five Rights) performed by ADON and administrator. Follow up inservicing performed by staff	03-08-11	

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F 490	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, related to provision of care in accordance with acceptable Standards of Quality, assurance of the freedom of significant medication errors and maintenance of the clinical records.</p> <p>Administration failed to ensure appropriate nursing supervision was provided to three CMTs (#1, #2 and #3) who failed to administer medication in accordance with acceptable nursing standards of practice. Additionally, the facility failed to ensure the resident identification systems were implemented and effective. Furthermore, the facility failed to identify through their investigation the root cause of the medication errors. These failures resulted in three residents having medication administration errors, one of which was significant, on 01/28/11.</p> <p>The facility's failure to ensure Resident #1 was not administered a contraindicated medication and failure to ensure repeated medication errors were not made without intervention placed Resident #1, #2 and #3 at risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified and the facility notified, on 02/04/11.</p> <p>Findings include: Reference to F281, F333 and F514.</p>	F 490	<p>development for crmts involved in errors on 02-01-11. Further in-servicing for licensed nursing staff and crmts by pharmacy on 02-04-11.</p> <p>Resident #1, CMT immediately reported incident to nurse who then reported to ADON and DON. Nurse immediately notified attending physician regarding incident. New orders received to monitor resident. Resident monitored for adverse signs or symptoms regarding medication error. Resident #1's heart rate and blood pressure decreased, requiring transfer to emergency room. A late entry notation was added to the resident's clinical record (nurse's notes) to identify the medication given in error.</p> <p>Resident #2, error reported immediately to the nurse who then notified administration and the attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects to resident noted.</p> <p>Resident #3, medication error reported immediately to the nurse who then notified administration and the attending physician. Orders received to monitor resident for any adverse effects due to medication error. No adverse effects to resident noted. Late entry notation was added to residents #1, #2 & #3 clinical record (nurse's notes) to identify the medication given in error.</p>		

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F 490	<p>Continued From page 29</p> <p>1. The facility failed to ensure services provided or arranged by the facility met professional standards of quality, related to medication administration, which affected three residents, (#1, #2 and #3) in the selected sample of three. During a medication pass, on 01/28/11, at approximately 8:30 AM until 11:30 AM, three Certified Medication Technicians failed to follow acceptable Standard of Practice for medication administration (Five Rights), which resulted in the hospitalization of one resident (#1), due to adverse effects of the medication error. Resident #1's heart rate and blood pressure decreased to a dangerous level, requiring hospitalization.</p> <p>The facility failed to provide supervision to ensure medications were prepared and administered in accordance with acceptable standards of practice, resulting in additional medication errors for two residents (#2 and #3). Two CMTs prepared medication for the residents. One CMT prepared the medication and the second CMT administered the medication. Resident #2 received Resident #5's medication, to include cardiac and hypertensive medications, which presented a high risk for adverse effects for Resident #2.</p> <p>The facility failed to ensure that CMT #1 documented she had administered medication for Resident #3 timely. CMT #3 administered Resident #3's medication for the second time, resulting in the resident receiving twice as much of the medication as prescribed. Medications included a blood thinner and a drug to lower the blood sugar, which presented a high risk for adverse effect for Resident #3.</p> <p>2. The facility failed to ensure three residents (#1,</p>	F 490	<p>2. On 01-28-11 ADON reviewed facility Medication Administration Policy and Procedure regarding medication administration. Administrator instructed ADON to complete review of pictures on MAR. Facility will perform daily, weekly and monthly audits to ensure that all residents will receive medications in accordance with acceptable standards of practice for medication.</p> <p>ADON, LPN and cmts reviewed all current residents who had the potential to be affected immediately following medication errors on 01-28-11. Facility (ADON, 7am-7pm LPN and 6-2 cmts) did not find any Other medication errors regarding the medication pass to any other residents in the facility on 01-28-11..</p> <p>Medical records / designee will audit resident identification (photographs) daily Monday through Friday. RN supervisor will audit on weekends. Staff development / designee will audit weekly. DON to monitor daily and weekly audit forms. Administrator will review and submit audit forms monthly to QA committee for review for 12 months.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #1, affected by the significant med error on 01-28-11 immediately when reported by cmt.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #2, affected by significant med error on 01-28-11</p>	

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F 490	<p>Continued From page 30</p> <p>#2, & #3), in the selected sample of three, were free of any significant medication errors. The facility failed to ensure staff was following nursing standards of practice as it relates to medication administration. The facility failed to ensure resident identification systems were implemented and effective on 01/28/11. CMT #1 administered Resident #4's medications to Resident #1, which included Cardizem (calcium channel blocker), a medication for which Resident #1 had a known allergy. The resident's heart rate decreased to the low 30s (normal 64/74) for which the resident required hospitalization and cardiac monitoring.</p> <p>On 01/28/11, CMT #2 and CMT #3 failed to follow standards of practice related medication administration as they both participated in the administration of Resident #5's medication to the wrong resident (#2), which included cardiac medication, antihypertensives and a potassium supplement.</p> <p>Additionally, CMT #1 failed to document on the MAR timely after administration of medications. This failure resulted in another CMT administering a second dose to Resident #3, which included blood thinners and an antidiabetic medication.</p> <p>3. The facility failed to ensure the clinical records for three residents (#1, #2 & #3), in the selected sample of three, were complete and accurate.</p> <p>An interview with the Administrator on 02/03/11 at 2:05 PM revealed she was not at the facility at the time the medication errors occurred. She stated the Licensed staff had called and made her aware of the errors. She sent CMT #1 home pending an investigation of the incident. She</p>	F 490	<p>Immediately when reported by the cmt.</p> <p>LPN on 7am-7pm shift & ADON reviewed resident #3, affected by significant med error, on 01-28-11 immediately when reported by cmt.</p> <p>3. Medication Administration Policy and Procedure (NP-00158) updated to reflect the following changes: Resident identification through photograph, review of name plate on resident's door and by asking "What is your name?". The administrator reviewed and updated the facility policy and procedures and ensured that disciplinary action and in-servicing performed to ensure medication administration system is performed according to standards of practice and facility policy and procedures. The administrator will be reviewing the daily, weekly and monthly audits to ensure that medications are given according to standards of practice of medication administration and according to the policy and procedures of the facility.</p> <p>A. Admitting nurse to obtain photograph and place on MAR on day of admission. Nurse / cmt will ensure identification prior to initiating a medication administration by reviewing name plate on door, reviewing photograph and by asking "What is your name?".</p> <p>B. Medical records / designee will audit resident identification (photograph) daily Monday through Friday. RN supervisor</p>	

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F 490	<p>Continued From page 31</p> <p>revealed during her investigation of the errors she had identified CMT #1 had not recognized Resident #1 and there were too many hands on the medication cart. She revealed she talked to the nurses on duty that night and on Saturday so she could make sure they knew what had happened. She stated it was her understanding after talking to the DON the photographs were with the MARs. She stated inservices were not completed with all licensed staff and CMTs because she looked at the errors as individuals making mistakes.</p> <p>An acceptable Allegation of Compliance was received on 02/10/11 and detailed as follows:</p> <p>On 01/28/11, CMT #1 immediately reported medication error to LPN #1. LPN #1 immediately reported incident to DON and ADON. Facility began monitoring resident. LPN #1 immediately contacted attending physician office and spoke with ARNP. Facility received order to send to ER at hospital. ADON spoke with Administrator and ADON was asked to immediately relieve CMT #1 of her duties. Contacted OIG, DCBS, Medical Director, owner, and pharmacy on 01/28/11, regarding medication error.</p> <p>Employee reprimands were done on day of incident. Immediate in-servicing was initiated by ADON, followed up by Administrator on evening of 01/28/11. Administrator performed walking in-services throughout facility regarding events that occurred earlier in the day. Administrator discussed with employees on duty that a medication error had occurred due to CMTs not following standards of practice during medication administration and by not following facility policy and procedure NP-00158. Discussed poor</p>	F 490	<p>To audit on weekends. Staff development will audit weekly. DON to monitor daily and weekly audits forms. Administrator will review audit forms weekly and submit to QA committee monthly for review for 12 months. Staff development / designee will audit med pass process weekly. Pharmacy will perform monthly medication pass audit. Weekly and monthly audits will be monitored by DON. Audits will be reviewed by QA committee monthly for 12 months.</p> <p>C. The in-service regarding Medication Administration Policy and Procedure (NP-00158) updates was given by Staff Development Coordinator on 02-04-11.</p> <p>4. Administrator will present findings from audits to the QA committee monthly for 12 months..</p>	

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

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F 490	<p>Continued From page 32</p> <p>judgement sued by CMT's when they deviated from standards of practice and by not following policy & procedure (NP-00158). Explained to staff what employees failed to do and then reviewed what they should have done according to standards of practice and facility policy (NP-00158). Administrator repeated walking in-service with staff on duty for 7-3 and 3-11 shifts on 01/29/11 (See attached exhibit A-1). Follow up in-servicing was performed by staff development for CMT's involved in errors on 02/01/11. Further in-servicing was completed with licensed nursing staff and CMT's from pharmacy on 02/04/11. Resident #1 did not receive any medication or treatment at the local hospital to counteract the medication he had received in error and had no adverse effect related to the medication error. He was placed in observation for bradycardia. He was admitted to hospital on 01/29/11 for diagnosis of pneumonia.</p> <p>4. (1) Date the IJ was removed? 02/05/11</p> <p>(2) A. What caused the IJ?</p> <p>CMT's made medication error despite repeated training on policy and procedure of facility regarding resident identification and standards of practice for medication delivery. CMT # 1 administered medications to the wrong resident when she failed to follow facility policy and procedure on identification of resident.</p> <p>CMT # 2 and CMT # 3 caused medication errors to occur when they did not follow facility policy & procedure and current standards of practice.</p> <p>(2) B. What residents/patients are impacted by the IJ?</p>	F 490		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 33</p> <p>Residents #1, #2 and #3. All residents have the potential to be impacted.</p> <p>(2) C. What staff is involved in IJ?</p> <p>CMT's #1, #2 and #3. All licensed nurses and CMT's have the potential to be impacted.</p> <p>(2) D. What area of the facility are impacted by the IJ?</p> <p>Entire facility has the potential to be impacted by the IJ.</p> <p>(3) Detail how the IJ will be prevented from recurring to this resident/patient, and to other residents/patients. This may include the following, but is not limited to:</p> <p>A. Investigation to determine the cause of the IJ</p> <p>01/28/11 - Reviewed facility Medication Administration Policy and procedures regarding medication administration, policy number NP-00158. Review completed by ADON. Administrator instructed ADON to complete review of pictures on MARS.</p> <p>02/01/11 - Medication Administration Policy & Procedure (NP-00158) reviewed with addendum added for staff to ask resident "What is your name?" before administering medications.</p> <p>02/04/11 - Camera in business office made available to nursing staff at all times.</p> <p>B-1 In-service training: content, staff attending,</p>	F 490		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2011
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F 490	<p>Continued From page 34</p> <p>Implementation of 01/28/2011. Proper identification of resident prior to treatment or medication administration by ADON; Persons trained licensed nurses and CMT's.</p> <p>02/01/11 - 5 Rights of Medication Administration and general medication guidelines, conducted by Staff Development LPN to CMT's #2 and #3.</p> <p>02/04/11 - Medication Administration Inservice completed by LPN Med Care Pharmacy Consultant. In-service included IJ deficiencies, correct policies and procedures identification process. Persons included licensed nurses and CMT's.</p> <p>02/04/11 - All staff In-serviced in person or via telephone before returning to work on IJ deficiencies.</p> <p>02/04/11 - Management Team in-serviced on audit process. Management team consists of: DON, ADON, Administrator, Admissions/Social Services, Activities, Staff Development/HR, MDS Coordinator, Dietary Manager, Environmental Director, Maintenance Director and Medical Records.</p> <p>B-2 - Disciplinary actions: LPN #1 on 01/28/11 CMT #1 on 01/28/11 with suspension CMT #2 on 01/28/11 CMT #3 on 01/28/11 LPN #3 on 02/04/11</p> <p>C-2 - Monitoring/Tracking System: A. Resident Identification through Photograph, Policy and Procedure. Admitting nurse to obtain</p>	F 490		

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

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F 490	<p>Continued From page 35</p> <p>photograph and place on MAR on day of admission. Nurse or CMT will ensure identification prior to completing a medication administration by reviewing name plate on door, reviewing photograph and by asking resident "What is your name?"</p> <p>Medical Records or designee monitor resident identification (photograph) daily Monday thru Friday, RN supervisor to monitor on weekends. Staff development to monitor weekly, DON to audit daily and weekly audit form. CMT is supervised by licensed nurse. Licensed nurse is supervised by ADON and DON, DON is supervised by Administrator. Medical Records is supervised by DON. Staff Development is supervised by Administrator. CMT's supervised by licensed nurses performing daily shift rounds. Monitoring: Audit review by QA committee on a monthly basis for 12 months.</p> <p>B. Medication, Administration of: Oral administration, etc. policy and procedure.</p> <p>Staff development/designee audit med pass process weekly. Pharmacy performs monthly medication pass audit. Weekly and monthly audits monitored by DON. Audit reviewed by QA committee monthly for 12 months.</p> <p>C. Root Cause Analysis Policy and Procedure</p> <p>All departments submit as needed to administrator. Audit reviewed thru QA process monthly for 12 months.</p> <p>D. Development/Revision of Assessment Tools</p> <p>Root cause analysis report form.</p>	F 490			

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

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F 490	<p>Continued From page 36</p> <p>01/28/11 - Resident Identification and Med pass audit process was developed, concerning formal auditing of both processes.</p> <p>Root Cause Analysis performed to ensure compliance according to federal and state guidelines and policies and procedures of facility. Analysis to record problem and identify the cause of the problem. Lists actions taken to reduce risk of a future occurrence. Dept. managers will be initiating root cause analysis and Administrator will review and submit at monthly QA meeting.</p> <p>01/31/11 - Formal auditing procedures initiated ensuring resident ID on MAR's and name plates on resident doors and med pass performed according to standards of practice and policies and procedures of facility.</p> <p>During the partial extended survey on 02/11/11, verification of the removal of Immediate Jeopardy was completed as follows:</p> <p>Interviews with RN #1, LPN #1 and CMT #2 on 02/11/11 at 1:30 PM, 4:50 PM and 5:05 PM revealed they were educated on the five rights and professional standards of practice of medication administration. A review of the February 2011 schedule revealed two staff was scheduled to administer medication (one on each hall). A review of the facility's policy and procedure for Medication Administration revealed an addendum was added for staff to ask the resident their name, prior to administering the medication and the person who initiates the medication pass should complete the medication pass for that resident. Observation of a medication pass on 02/11/11 at 12:50 PM</p>	F 490			

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

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F 490	Continued From page 37 revealed one staff was administering the medication to include looking at the residents' pictures with the MARs, asking the resident their name and initialing the MAR, after the medication was administered. Interviews with RN #1, LPN #1 and LPN #2 on 02/11/11 at 12:50 PM, 4:50 PM and 5:05 PM revealed the admitting nurse was responsible for taking the resident's picture and ensuring the picture was placed with the resident's MAR. Observation of the business office on 02/11/11 at 3:55 PM revealed the camera was kept on a stand so staff would have access to it at all times. Observation of the MARs on 02/11/11 at 12:50 PM revealed pictures were with the MAR for each resident. Interview with the Housekeeping Supervisor on 02/11/11 at 3:30 PM revealed she was responsible for placing the resident's name on the doors for new admissions and when a resident was moved to another room. Observations revealed all residents' names were on their bedroom doors. Interviews Staff Development LPN, Medical Records, ADON and DON on 02/11/11 at 4:05 PM, 4:08 PM, 4:10 PM and 4:15 PM revealed they were educated on the audit process put in place to ensure pictures of residents were with the Medication Administration Records (MAR), residents' names were on the doors and staff were administering medications according to professional standards of practice. A review of the daily and weekly audits revealed the audits were conducted to ensure the resident pictures were with the MAR, resident names were on the doors and staff was administering medications according to the five rights and professional standards of practice. A review of the inservice training, dated 02/04/11 at 3:00 PM and 5:00 PM revealed the Pharmacy Nurse Consultant educated all licensed staff and Certified Nurse Technicians on medication	F 490		

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

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F 490	Continued From page 38 administration to include the five rights (right resident, right medication, right time, right dose and right route) and documentation. A review of the inservice training, dated 02/04/11 at 4:00 PM, revealed members of the Management Team were educated on the audit process and root cause analysis. Based on the above observations, interviews and review of records, it was determined the Immediate Jeopardy was removed, effective 02/05/11, as alleged in the AoC with the scope and severity lowered to a "E" based on the need for the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 490			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure the clinical records for three residents (#1, #2 & #3), in the	F 514	F514 483.75(l)(1) It is the position of Glenview Health Care that on the day of the alleged deficient practice, current nursing policy (NP-00163) regarding Medication Error and Drug Reaction was followed and documentation in each resident's clinical record was sufficient. Based on nursing policy (NP-00163), procedure was followed at time of medication error to (1) report medication error to attending physician, (2) complete a Medication Error Report, describing error and action taken, (3) perform a nursing assessment and document in resident's clinical record, and (4) observe resident for drug reaction and notify physician of change in condition. Per nursing policy (NP-00163) physician was notified of error and Medication Error Report was completed on resident #1 on 01-28-11 at 8:15am. Nursing assessment was completed and documented in resident's clinical record	03-08-11	

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F 514	<p>Continued From page 39</p> <p>selected sample of three, were complete and accurate. Findings include: Reference F281</p> <p>A review of the facility's Charting and Documentation policy and procedure revealed all accidents and incidents should be documented in the nurses notes.</p> <p>1. An interview with the Administrator, on 02/03/11 at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed CMT #1 administered Resident #4's 9:30 AM medications to Resident #1 on 01/28/11.</p> <p>A review of Resident #4's January 2011 Medication Administration Record (MAR), revealed Resident #1 received Cardizem (calcium channel blocker) 90 milligrams (mg) two tablets.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/02/11 at 12:00 noon, revealed Resident #1's physician was made aware of the medication Resident #1 received and an order was received to monitor the resident's vital signs every 15 minutes.</p> <p>A review of Resident #1's clinical record revealed there was no documentation to indicate what medication the resident had received or the care provided for the resident.</p> <p>2. An interview with the Administrator, on 02/03/11 at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed Resident #3 received his/her 9:30 AM medications twice on 01/28/11.</p>	F 514	<p>(nurse's notes) on 01-28-11 by 9:15am. Resident's change in condition was documented in clinical record (nurse's notes) on 01-28-11 by 10:10am with physician order obtained to transfer to emergency room for evaluation. Per nursing policy (NP-00163) resident #2 physician was notified of error and Medication Error Report was completed on resident #2 on 01-28-11 by 12:00PM. Nursing assessment was completed and documented in clinical record (nurse's notes) by 12:15pm. Resident monitored for adverse reactions with none noted. Per nursing policy (NP-00163) physician Was notified of error and Medication Error Report was completed on resident #3 on 01-28-11 at 12:15pm. Nursing assessment was completed and documented in clinical record (nurse's notes) by 1:30pm. Resident monitored for adverse reactions with none noted. It is the position of Glenview Health Care That on the day of the alleged deficient practice, nursing policy (NP-00163) regarding Medication Error and Drug Reaction was followed to include performance of a nursing assessment which was documented in the residents' clinical record. On resident #1 entry was made in clinical record on 01-28-11 at 9:15am; on resident #2 entry was made in clinical record on 01-28-11 at 12:15pm; on resident #3 entry was made in clinical record on 01-28-11 at 1:30pm. However, pursuant to citation of N353 Current nursing policy (NP-00163) regarding Medication Error and Drug Reaction procedure for documentation of nursing assessment in clinical record is deficient, the following will occur:</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/25/2011
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F 514	<p>Continued From page 40</p> <p>A review of the January 2011 MAR, revealed Resident #3 received Plavix 75 mg. every day, Aspirin 81 mg. every day (blood thinners) and Glyburide (antidiabetic) 5 mg. every morning.</p> <p>An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #3's physician was called with orders received to monitor the resident's vital signs and blood sugars every 15 minutes.</p> <p>A review of the clinical record revealed there was no documentation to indicate what medication the resident received or the care that was provided for the resident.</p> <p>3. An interview with the Administrator, on 02/03/11 at 11:05 AM, and review of the facility's investigation, dated 01/31/11, revealed Resident #2 was given Resident #5's medications during the 9:30 AM medication pass on 01/28/11.</p> <p>A review of Resident #5's January 2011 MAR, revealed Resident #2 received Lanoxin 0.25 micrograms (mcg.) every day, Monopril 20 mg. every day and Klor Kon 10 milliequivalents (meq) every day.</p> <p>An interview with LPN #2, on 02/02/11 at 1:00 PM, revealed Resident #2's physician was called with orders received to monitor the resident's vital signs every 15 minutes.</p> <p>A review of the clinical record revealed there was no documentation to indicate what medication the resident received or the care that was provided to the resident.</p>	F 514	<ol style="list-style-type: none"> 1. A late entry notation will be added to resident's clinical record (nurse's notes) to identify the medication given in error for each resident affected by the cited deficient practice. Resident #1 entry added on 03-04-11; resident #2 entry added on 03-04-11; resident #3 entry added on 03-04-11. 2. Nursing policy (NP-00163) revised to include documentation to identify medication received in resident's clinical record effective 03-07-11. All residents in the facility who have medication errors that occur will be reported to the attending physician and a nursing assessment completed and documented in the clinical record (nurse's notes). 3. Education of licensed nursing staff by DON on revision of nursing policy (NP-00163) to include documentation to identify medication received in the resident's clinical record in-service on 03-07-11. 4. DON / ADON will review Medication Error Report and corresponding documentation in resident's clinical record as errors occur. 5. QA committee will review finding by DON / ADON regarding review of Medication Error Report and corresponding documentation in resident's clinical record on a monthly basis for 12 months. 		