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

PRINTED: 06/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185461		C 06/09/2011

NAME OF PROVIDER OR SUPPLIER: GLEN RIDGE HEALTH CAMPUS

STREET ADDRESS, CITY, STATE, ZIP CODE: 6415 CALM RIVER WAY, LOUISVILLE, KY 40299

(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	F 000		

An abbreviated survey to investigate KY00016431 was conducted from 05/17/11-05/20/11 and found KY00016431 substantiated with regulatory violations cited. The facility was notified of Immediate Jeopardy (IJ) on 05/19/11.

The facility failed to provide direct supervision to a Licensed Practical Nurse Applicant (LPNA) who was working independently on the resident's unit. The facility failed to ensure Resident #1 received Lovenox 40mg as ordered by the physician. On 05/10/11, LPNA transcribed admission orders without direct supervision, in doing so the LPNA failed to transcribe the physician ordered Lovenox 40mg (blood thinner) resulting in the resident not being administered the medication for two (2) days). On 05/12/11, Resident #1 was diagnosed with Deep Vein Thrombosis (DVT - clotting of blood in the vein), developed a blood clot in the left groin, and was hospitalized.

A partially extended survey was conducted on 05/20/11 and determined IJ existed from 05/10/11 in the areas of 42 CFR 483.20 Resident Assessment (F281) S/S: J, 42 CFR 483.25 Quality of Care (F309) S/S: J, and 42 CFR 483.75 Administration (F490) S/S: J. Substandard Quality of Care (SQC) was identified at F309 S/S: J.

After state agency review the investigation was reopened on 06/07-06/09/11. The facility provided a credible allegation of compliance (AOC) on 05/20/11. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42

June 30, 2011

Glen Ridge Health Campus
6415 Calm River Way
Louisville, Kentucky 40299

The submission of this Plan of Correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Glen Ridge. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).

To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] | TITLE: X Executive Director | (X6) DATE: X 6/30/11

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.

SM

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F 000	Continued From page 1 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Qualitiy Assurance monitors new admissions for medication errors.	F 000		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of Kentucky Administrative Regulation (KAR) 201 KAR 20:400 and the facility policy based on the Kentucky Board of Nursing Website, it was determined the facility failed to provide the necessary services that meet professional standards of quality for one (1) of nineteen (19) sampled residents (Resident #1). The facility failed to directly supervise a Licensed Practical Nurse Applicant (LPNA), an LPN graduate with no license; therefore, the facility failed to meet professional standards of practice. The facility failed to ensure the LPNA did not provide care independently to residents on the Health Care Wing and Transitional Care Unit of the facility. The LPNA failed to transcribe a Lovenox (blood-thinning agent) medication from the Discharge Medication Reconciliation form on to the admitting orders, thus Resident #1 did not receive multiple doses of the medication and developed Deep Vein Thrombosis (DVT - blood clotting to veins) a blood clot to the left groin. The facility failed to ensure a qualified nurse conducted or reviewed the task of transcribing medication orders.	F 281	7/8/11 F 281 Services that were provided by the facility were not according to acceptable standards of practice. 1. The Licensed Practical Nurse Applicant (LPNA) that transcribed the order incorrectly was terminated on May 16, 2011 related to Job Performance. There are no other Applicant Nurses employed by the facility. 2. All records that LPNA completed admissions on were audited and no other residents impacted. 3. Licensed staff were educated on 5/19, 5/20/11 and 7/6/11 related to Supervision of Nurse Applicants when working. Should unlicensed staff ever be employed, they will have Direct supervision by a Licensed Nurse as defined by 201 KAR 20:400, Section 4. . Supervision shall be determined by evaluation of resident acuity, competency of the delegatee, complexity of task and proximity of delegator to delegatee. 4. Ongoing compliance will be monitored by Director of Health Services/designee by review of daily schedule.	

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F 281	Continued From page 2 The facility's failure to ensure a qualified nurse or that LPNA received direct supervision as outlined by the Kentucky Board of Nursing while providing care to Resident #1, caused or was likely to cause Resident #1 and other residents with whom the LPNA worked serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist from 05/10/11 and is ongoing at F281 S/S: "J", F309 S/S: "J" and F490 S/S: "J". After state agency review the investigation was reopened on 06/07-06/09/11. The facility provided a credible allegation of compliance (AOC) on 05/20/11. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors new admissions for medication errors. The findings include: Review of 201 KAR 20:400 revealed Supervision means the provision of guidance by a qualified nurse for the accomplishment of a nursing task with periodic observation and evaluation of the performance of the task including validation that the nursing task had been performed according to established standards of Practice. The nurse shall provide supervision of a delegated nursing task. The degree of supervision required shall be determined by the delegator after an evaluation of appropriate factors involved including the following: The stability and acuity of the clients condition, the training and competency of the	F 281		

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F 281	Continued From page 3 delegatee, the complexity of the nursing task being delegated; and the proximity and availability of the delegator to the delegatee when the nursing task is performed." "Supervision" as defined in 201 KAR 20:400 Section 1 (9) means "the provision of guidance by a qualified nurse for the accomplishment of a nursing task with periodic observation and evaluation of the performance of the task including validation that the nursing task has been performed according to established standards of practice. The facility policy, which was obtained from the Kentucky Board of Nursing Website by the facility, revealed to qualify as "direct supervision", the nurse responsible for the applicant shall at all times be physically present in the facility and immediately available to the applicant while the applicant is engaged in the clinical internship. It is up to the facility conducting the internship to establish the schedule for the new graduate based on availability of resources. If more than one nurse will serve in this role, it is advised that the facility identify a nurse that will be responsible for verifying that the internship was completed. An LPNA shall only work under the direct supervision of a nurse and shall not engage in independent nursing practice.. Interview with a Kentucky Board of Nursing Representative, on 05/19/11 at 10:14am, revealed that often times long term care facilities try to give the LPNA and the other nurse their own work loads, and this is not defined as direct supervision. If the applicant needs someone immediately, a nurse should be there to assist immediately. The representative stated Direct Supervision is defined in 201 KAR 20:400 (as	F 281		

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F 281	Continued From page 4 noted above). Interview with the Director of Nursing (DON), on 05/19/11 at 11:00am, revealed after applying for a Provisional License, LPNA was hired on 10/28/10, in which she completed one hundred and twenty (120) hours of clinical work. Review of the Provisional License of the LPNA revealed an expiration date of May 31, 2011 and it stated this nurse must practice under the direct supervision of an Advanced Nurse Practitioner, a Registered Nurse, or a Licensed Practical Nurse. Interview with LPNA, on 05/20/11 at 1:35pm, revealed when her clinical hours were completed, the LPNA received two (2) days of orientation and then was directed to work the units by herself. Record review of the LPNA's personnel file that contained counseling records revealed the LPNA had received written counseling for missing four (4) skin assessments dated 03/07/11, 03/14/11, 03/17/11 and 03/21/11. In addition, it was noted on 03/16/11 that she did not complete the midnight census, did not change tubing and syringes for tube feeders, failed to give 6am medications, did not consistently get paperwork ready for discharge, and did not consistently complete lab requisitions. Review of the Daily Staffing Sheets revealed on 05/04/11 the LPNA worked part of a second shift and third shift on the 400 Hall Transitional Care Unit (TCU), on 05/06/11 part of a second shift, third, then again first shift on the 500 Hall Transitional Care Unit (TCU), independently with no direct supervision. On 05/09 and 05/10/11 the LPNA worked part of a second shift and all of third shift on the 500 Hall Transitional Care Unit	F 281		

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F 281	Continued From page 5 (TCU), independently with no direct supervision. Closed record review revealed on 05/10/11 Resident #1 was admitted to the 500 hall at 9:15pm. A review of the Discharge Medication Reconciliation Report form from the hospital revealed the physician ordered Resident #1's continuation of the following medications: Pyridoxine HCL 100 mg, Lasix 20 mg, Simvastatin 40 mg, Lisinopril 40 mg, Vitamin E 400 units, Amlodipine Besylate 5 mg, Ascorbic Acid 500 mg, Aspirin 81 mg, Lovenox 40 mg, Laxative of choice, Oxycodone-Acet 5/325 mg, Meclizine HCL 12.5 mg, Throat Lozenges, Metoprolol 25 mg, Ambien 5 mg, Tylenol 650 mg and Zofran 4 mg. Review of the MAR, transcribed by the LPNA, revealed no evidence that one medication, Lovenox 40 mg, had been transcribed to the MAR. The Lovenox 40 mg was not transcribed nor was there documented evidence that the facility had administered the medication to Resident #1 for two (2) days. Further review of the Resident Transfer Form revealed Resident #1 developed a blood clot to the left groin and was sent to the Hospital for treatment on 05/12/11. Interview with the admitting Physician at the hospital, Physician #1, on 05/18/11 at 9:36am, revealed if a resident did not receive Lovenox as ordered for two days, the resident could develop a blood clot. Interview with the Physician at the facility, Physician #2, on 05/18/11 at 2:33pm, revealed if the resident came in the facility with a blood clot and did not receive Lovenox as ordered, the blood clot could become worse. The Physician	F 281		

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F 281	Continued From page 6 additionally stated if a resident had no blood clot and did not receive Lovenox as ordered, a blood clot could develop. Interview with the LPNA, on 05/18/11 at 2:00pm, revealed that she was unaware that she had made a transcription error when it came to Resident #1's Lovenox order on 05/10/11 and there had been no one to supervise her to make sure all orders were taken off accurately for Resident #1. The facility left her alone on many occasions and never identified anyone on the schedule as her supervisor during the shift. The LPNA stated she had worked alone since December 2010, and was told after orientation she could be alone on the units. The LPNA stated she had her own work load and was not aware she was to be supervised. Sometimes, the LPNA stated, she would carry three (3) halls at a time with no supervision. The LPNA verbalized she did not learn how to do the paperwork part or administrative duties until after orientation was completed; and found out herself how to do them upon being assigned to the floor and working. Interview, on 05/20/11 at 1:35pm, with the LPNA verbalized she received verbal and written warnings because she was unable to carry the load of work and would sometimes miss skin assessments and administrative work. Further review of LPNA's personnel file revealed on 05/11/11 the employee was counseled for events that occurred on 05/10/11: employee did not talk appropriately to new resident/family, did not sign MAR or narcotic count, did not complete daily routine charting, and did not complete assessment or admitting note for a resident.	F 281		

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F 281	Continued From page 7 Interview with Registered Nurse (RN) #2, on 05/20/11 at 9:25am, revealed that out of all the halls, 500 hall (TCU) was a very difficult unit. RN #2 stated she defined direct supervision as someone who watched over you and helped you with hands on. RN #2 also defined immediately as right now. RN #2 remembered LPNA worked the 500 hall at times by herself and during orientation the LPNA never received training on how to do admissions. RN#2 stated that the KBN law stated an LPNA was to work under an RN or LPN and be directly supervised. RN #2 further stated if the LPNA was to call out for help on the Health Care Unit and she was on the TCU unit, she would not be able to hear the LPNA cry out for help. Interview with LPN #2, on 05/20/11 at 11:10am, revealed that direct supervision was defined as where I go he/she follows. LPN #2 defined immediately as right now. LPN #2 defined independent nursing practice as able to perform nursing duties such as medication pass, assessments, treatments and charting on your own. LPN #2 further stated she was not aware the LPNA could not engage in independent nursing practice without direct supervision. The LPN #2 stated if the LPNA was on the Health Care Unit, and she was on the Transitional Care Unit, she would not be able to hear the LPNA scream for help if she needed help. The LPNA would have to rely on the Certified Nursing Assistant (CNA) for help. LPN#2 further stated that she would not be able to be at the LPNA's side immediately but would come as quickly as she could. LPN#2 stated she was not told she would be the supervisor for the LPNA, but everyone knew she was a new LPNA.	F 281		

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F 281	Continued From page 8 Interview with the Director of Health Services (DHS), on 05/19/11 at 11:00am, revealed she was responsible for the Daily Staffing Sheet and no one was identified as the supervisor for the LPNA on the staffing sheet. Nurses were assigned their own work loads and it was not unusual to have one nurse on the 400 and 500 hall (TCU units) at night. The DHS stated that nurses were responsible for medication pass, charting, treatments, admissions and glucometer checks. The DHS verbalized there was no formal form used to evaluate the LPNA's tasks and that the supervisors did not check every single day or every single time to make sure tasks were completed thoroughly. The DHS defined supervision as another nurse in the building and it did not necessarily mean someone working the same floor or unit. The DHS further stated she knew the laws of the Kentucky Board of Nursing and that Direct Supervision meant having someone in close proximity to utilize. The DHS stated she was aware the LPNA was having a difficult time completing tasks, and that the LPNA was counseled on a few occasions. The DHS also stated on one occasion she had an employee help to assist the LPNA with her work and came to the conclusion that the LPNA was just "slow". Interview with the Administrator, on 05/19/11 at 3:10pm, revealed that LPNA's are supervised by the nurses on campus, but not supervised hand in hand. The Administrator defined direct supervision as having someone accessible for guidance and support and whether the LPNA used the direct supervision was up to his/her discretion. The Administrator further stated that	F 281		

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F 281	Continued From page 9 she was not aware of KBN's law that states LPNA's must work under direct supervision. Review of the allegation of compliance dated 05/20/11 and interview with the Interim Director of Health Services on 06/07/11 at 3:50pm and the Administrator on 06/09/11 at 2:05pm revealed the facility took the following immediate actions: 1. Resident #1 was discharged to the hospital on 05/12/11 for treatment. 2. Residents currently on Lovenox and other anticoagulants were reviewed to determine orders were transcribed accurately and medication was being administered as ordered by the Physician with no adverse effects. 3. Medical Records of residents admitted during the last thirty (30) days were reviewed to ensure orders were transcribed correctly from the hospital Discharge Summary and Medication Reconciliation Forms to their current admission orders. 4. Any transcription errors identified from the review of orders from the hospital were discussed with the attending physician and corrected. Additional measures taken were: 1. CQI meetings were conducted every morning to review the facility audit forms, resident reconciliation of medications were transcribed correctly, review of the twenty-four (24) hour nursing reports and the circumstance form which was used by the nursing staff when a medication error arise.	F 281		

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F 281	Continued From page 10	F 281		
	2. Education of all staff regarding the signs and symptoms of deep vein thrombosis, anticoagulation therapy, and following physician orders.			
	3. Education of the nursing staff regarding transcription of physician orders, admission process and physician notification.			
	4. Education of all licensed staff related to supervision of Nurse Applicants when working.			
	5. The Quality Assurance Process was reviewed with the Executive Director by the Home Office Support.			
	6. A Peer Review Process (a Quality Assurance Process that looks at trending for the last six months) was implemented and will occur every six months to ensure effective systems are in place.			
	Interview with Certified Nursing Assistant (CNA) #1, on 06/07/11 at 9:15am, revealed she received training on how to identify skin changes and to notify nursing when she noticed those skin issues.			
	Interview with Register Nurse (RN)#1, on 06/07/11 at 2:04pm, revealed she was taught to reconcile medications by comparing the Discharge Summary to the Medication Reconciliation form. Any discrepancies in the medications are to be called in to the Physician for clarification. RN #1 further stated when she transcribes medication on to the Physician Order Form there is a little space to the right of the			

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F 281	Continued From page 11 order in which she is to initial to verify the order was taken off successfully. Once the medications are reconciled she is to sign the bottom of the Physician Order form to show all the orders were taken off appropriately. Interview with RN #4, on 06/07/11 at 2:30pm, revealed all Licensed Practical Nursing Applicants and Registered Nurse Applicants are to be supervised. This includes watching Applicants when they are doing a nursing task and signing behind the Nurse Applicant to verify that the task was completed appropriately. Interview with Licensed Practical Nurse (LPN) #1, at 06/07/11 at 2:35pm, revealed all Nurse Applicants are to work one-on-one with the nurse they are assigned to. The nurse is to monitor the Nurse Applicant when they are completing tasks like taking off orders, doing treatments to residents or any task that a nurse would complete and sign off that the task was completed appropriately. Interview with the Administrator, on 06/09/11 at 2:05pm, revealed CQI meetings were held every morning to review audits, circumstance forms, and that orders were verified and no transcription errors occurred. Validation of staff training May 19 - 20, 2011 via sign-in rosters revealed all staff received training prior to being assigned to work with the residents. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42	F 281		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/09/2011
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	

(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 281	Continued From page 12 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors new admissions for medication errors.	F 281		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, provisional license review, review of the Kentucky Board of Nursing (KBN) law 201 KAR 20:400 and the KBN policy used by the facility, it was determined the facility failed to provide the necessary care and services to one (1) of nineteen (19) sampled residents (Resident #1). The facility failed to provide direct supervision to a Licensed Practical Nurse Applicant (LPNA) who was working independently on the resident's unit. The facility failed to ensure Resident #1 received Lovenox 40mg as ordered by the physician. On 05/10/11, LPNA transcribed admission orders without direct supervision, in doing so the LPNA failed to transcribe the physician ordered Lovenox 40mg (blood thinner) resulting in the resident not being administered the medication for two (2) days). On 05/12/11, Resident #1 was diagnosed with Deep Vein Thrombosis (DVT - clotting of blood in the vein), developed a blood clot in the	F 309	7/8/11 F309 Resident did not receive necessary care and services to maintain highest wellbeing. 1. Affected resident was discharged to hospital on 5/12/11. Resident was readmitted to facility on 5/19 11 until 6/4/11 when he was discharged to home. 2. Residents on Lovenox or other anticoagulants were reviewed to determine orders were transcribed accurately and medication is being administered per MD order and there have been no adverse effects. Medical Records of residents admitted during May 2011 were reviewed to ensure orders have been transcribed correctly from Hospital Discharge Summary and Medication Reconciliation Forms to their current admission orders. Any discrepancies noted were discussed with the attending physician and corrected. 3. All licensed staff was reeducated on 5/19, 5/20/11 and 7/6/11 by Assistant Director of Health Services (ADHS) and Dircetor of Helath Services related to Transcribing MD orders correctly with emphasis on New admissions using the Discharge Summary and Medication Reconciliation Form, admission process, physician notification, signs and symptoms of DVT, anticoagulation therapy and following physician orders. 4. Ongoing compliance will be maintained by New Admission orders being reviewed by Director of Health Services and /or Nurse Managers. Any discrepancies will be corrected in conjunction with the attending physician and with the individual nurse who will be counseled as necessary.	

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F 309	Continued From page 13 left groin, and was hospitalized. The facility's failure to ensure the LPNA recieved direct supervision as outlined by the Kentucky Board of Nursing while providing care to Resident #1 has caused or is likely to cause Resident #1 and other residents with whom the LPNA worked with serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist from 05/10/11 and is ongoing at F281 S/S: "J", F309 S/S: "J" and F490 S/S: "J". Substandard Quality of Care was identified at F309. After state agency review the investigation was reopened on 06/07-06/09/11. The facility provided a credible allegation of compliance (AOC) on 05/20/11. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Qualitiy Assurance monitors new admissions for medication errors. The findings included: The Kentucky Board of Nursing (KBN) policy used by the facility states to qualify as "direct supervision", the nurse responsible for the applicant shall at all times be physically present in the facility and immediately available to the applicant while the applicant is engaged in the clinical internship. Interview with Registered Nurse (RN) #2 revealed that immediately meant right now. An LPNA shall only work under the direct supervision of a nurse and shall not engage in independent nursing practice. Interview with	F 309	Results of audits will be reviewed and discussed during Monthly QA meetings with action plan continued or revised until substantial compliance is achieved. Monitoring will also occur as part of Peer Review Process every six months .	

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F 309	Continued From page 14 the Director of Health Services (DHS) on 05/20/11 on 5:30pm revealed that nursing practice means patient care, passing medications, Activities of Daily Living (ADL's), Treatments, writing physician orders and noting orders. 201 KAR 20:400 states Supervision means the provision of guidance by a qualified nurse for the accomplishment of a nursing task with periodic observation and evaluation of the performance of the task including validation that the nursing task had been performed according to established standards of Practice. The nurse shall provide supervision of a delegated nursing task. The degree of supervision required shall be determined by the delegator after an evaluation of appropriate factors involved including the following: The stability and acuity of the clients condition, The training and competency of the delegatee, the complexity of the nursing task being delegated; and the proximity and availability of the delegator to the delegatee when the nursing task is performed A review of the Provisional License issued on 11/30/10 revealed the LPNA received a provisional license which states "This individual must practice under the direct supervision of an Advanced Nurse Practitioner, a Registered Nurse, or a Licensed Practical Nurse". Through interviews with the LPNA, on 05/18/11 at 2:00pm and 05/20/11 at 1:35pm, it was revealed the LPNA worked on the Health Care Unit and Transitional Unit by him/her self without direct supervision. Interview with RN #1, on 05/20/11 at 10:45am, revealed direct supervision meant when a LPNA took off an order or did a treatment	F 309		

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F 309	Continued From page 15	F 309		

someone was there with them to help assist them. Interview with Licensed Practical Nurse (LPN) #1 revealed she was always taught that LPNA's or RNA's were to be supervised. LPN #1 stated she did not remember anyone supervising the LPNA and she actually gave her nursing report on a couple of occasions directly to the LPNA with no other nurse present.

Review of the Daily Staffing Sheets revealed on 05/04/11 the LPNA worked part of a second shift and third shift on the 400 Hall Transitional Care Unit (TCU), on 05/06/11 part of a second shift, third, then again first shift on the 500 Hall Transitional Care Unit (TCU), independently with no direct supervision. On 05/09 and 05/10/11 the LPNA worked part of a second shift and all of third shift on the 500 Hall Transitional Care Unit (TCU), independently with no direct supervision.

Interview with LPN #1, on 05/20/11 at 11:30am, revealed she remembered giving report to the LPNA on 05/10/11 and that two (2) admissions were scheduled to come in that night.

Closed record review revealed, on 05/10/11 at 9:15pm, the facility admitted Resident #1 with a history of falls, acute left hip fracture, hypertension, hyperlipidemia, chronic heart failure, mild delirium tremors and dizziness. Review of the Hospital Discharge Medication Reconciliation Report form dated 05/09/11 revealed the physician order for Resident #1 to continue these medication: Pyridoxine HCL 100mg, Lasix 20mg, Simvastatin 40mg, Lisinopril 40mg, Vitamin E 400 units, Amlodipine Besylate 5mg, Ascorbic Acid 500mg, Aspirin 81mg, Lovenox 40mg, Laxative of choice,

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F 309	Continued From page 16 Oxycodone-Acet 5/325mg, Meclizine HCL 12.5mg, Throat Lozenges, Metoprolol 25mg, Ambien 5mg, Tylenol 650mg and Zofran 4mg. Review of Resident #1's Medication Administration Record (MAR) revealed Lovenox 40mg had not been transcribed onto the MAR on 05/10/11. The MAR detailed LPNA had transcribed the admission orders. Further review revealed no documented evidence the facility administered the Lovenox on 05/11/11 or 05/12/11. Interview with Physical Therapy (PT), on 05/18/11 at 10:30am, revealed on 05/11/11 Resident #1 complained of hip pain and bruising to the posterior part of the leg, which made her concerned. The PT stated that she remembered talking to a nurse about her concerns and remembered having a discussion with the nurse about a doppler being ordered. Record review revealed on 05/11/11 an order for a Dopler was to be completed to the left leg. Interview with CNA #1, on 05/19/11 at 7:10am, revealed she remembered Resident #1 complained of his/her testicles being blue on 05/12/11 and within a half an hour Resident #1 was out the door to the Emergency room. Review of the Resident Transfer Form signed and dated 05/12/11 revealed a venous doppler study was positive for Deep Vein Thrombosis (DVT) of the lower left leg from the groin to the knee. The left lower leg had some discoloration from the scrotal area to the left hip incision with moderate drainage. The area was observed to be firm with edema to the ankle and foot. Further review of	F 309		

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F 309	Continued From page 17 the resident's record revealed Resident #1 developed a blood clot to the left groin and was transferred to the hospital for treatment on 05/12/11. Interview with Resident #1, on 05/18/11 at 9:15am, revealed he/she did not receive a Lovenox shot or any shots to his/her belly the whole time he/she was in the facility. Interview with the LPNA, who transcribed Resident #1's medications, on 05/18/11 at 2:00pm, revealed she was not aware the Lovenox was missing from Resident #1's admission orders. Interview with the admitting Physician at the hospital, Physician #1, on 05/18/11 at 9:36am, revealed if a resident did not receive Lovenox as ordered for two days, the resident could develop a blood clot. Interview with the Physician at the facility, Physician #2, on 05/18/11 at 2:33pm, revealed if the resident came in the facility with a blood clot and did not receive Lovenox as ordered, the blood clot could become worse. The Physician additionally stated if a resident had no blood clot and did not receive Lovenox as ordered, a blood clot could develop. Interview with the Associate Director of Nursing (ADON), on 05/18/11 at 3:15pm, revealed they audit some records daily and that was how they found, on 05/12/11, two days after the transcription error, that the LPNA did not complete items. Further record review of the Employee Counseling Record Form revealed on	F 309		

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F 309	Continued From page 18 05/12/11 it was discovered that the employee did not transcribe admission orders for Lovenox and therefore Resident #1 missed doses of the medication. Interview with the DHS, on 05/19/11 at 11:00am, revealed there was no specific auditing form completed daily to evaluate tasks of the LPNA; however, they checked her charting the next morning (05/11/11), and did not understand how they missed the Lovenox order. She further stated the supervisors did not audit every single day or every single time the LPNA conducted tasks, as they audited charts randomly, so they would not have audited every transcription or task completed. There was no evidence of documentation detailing the facility provided supervisor oversight related to the accuracy and the completion of tasks by the LPNA. Interview with the DHS, on 05/19/11 at 11:00am, revealed she did not identify a nurse on the daily staffing sheet as the supervisor for the LPNA, though every nurse was aware that they were to be the LPNA's supervisor when the LPNA worked. However, interview with Registered Nurse #1, on 05/20/11 at 10:45am, revealed she was not aware LPNA was an applicant. Furthermore, she was not aware they were to be the LPNA's supervisor when the LPNA worked on the unit or that any one was assigned to be the LPNA's supervisor. Interview with the Administrator, on 05/19/11 at 3:10pm, revealed that the LPNA was supervised by the nurses on campus, but not supervised hand in hand. The Administrator stated no nurse was over the LPNA's shoulder guiding the LPNA	F 309		

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F 309	Continued From page 19	F 309		

to tell the LPNA what to do. The Administrator further stated that direct supervision means having someone assessable for guidance and support. The Administrator stated the CNA could call the other unit or go over to the other unit to find a nurse if the LPNA screamed for help.

Review of the allegation of compliance dated 05/20/11 and interview with the Interim Director of Health Services on 06/07/11 at 3:50pm and the Administrator on 06/09/11 at 2:05pm revealed the facility took the following immediate actions:

1. Resident #1 was discharged to the hospital on 05/12/11 for treatment.

2. Residents currently on Lovenox and other anticoagulants were reviewed to determine orders were transcribed accurately and medication was being administered as ordered by the Physician with no adverse effects.

3. Medical Records of residents admitted during the last thirty (30) days were reviewed to ensure orders were transcribed correctly from the hospital Discharge Summary and Medication Reconciliation Forms to their current admission orders.

4. Any transcription errors identified from the review of orders from the hospital were discussed with the attending physician and corrected.

Additional measures taken were:

1. CQI meetings were conducted every morning to review the facility audit forms, resident

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

PRINTED: 06/23/2011
FORM APPROVED
OMB NO. 0938-0391

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F 309	Continued From page 20 reconciliation of medications were transcribed correctly, review of the twenty-four (24) hour nursing reports and the circumstance form which was used by the nursing staff when a medication error arrised. 2. Education of all staff regarding the signs and symptoms of deep vein thrombosis, anticoagulation therapy, and following physician orders. 3. Education of the nursing staff regarding transcription of physician orders, admission process and physician notification. 4. Education of all licensed staff related to supervision of Nurse Applicants when working. 5. The Quality Assurance Process was reviewed with the Executive Director by the Home Office Support. 6. A Peer Review Process (a Quality Assurance Process that looks at trending for the last six months) was implemented and will occur every six months to ensure effective systems are in place. Interview with Certified Nursing Assistant (CNA) #1, on 06/07/11 at 9:15am, revealed she received training on how to identify skin changes and to notify nursing when she noticed those skin issues. Interview with Register Nurse (RN)#1, on 06/07/11 at 2:04pm, revealed she was taught to reconcile medications by comparing the Discharge Summary to the Medication	F 309		

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F 309	Continued From page 21 Reconciliation form. Any discrepancies in the medications are to be called in to the Physician for clarification. RN #1 further stated when she transcribes medication on to the Physician Order Form there is a little space to the right of the order in which she is to initial to verify the order was taken off successfully. Once the medications are reconciled she is to sign the bottom of the Physician Order form to show all the orders were taken off appropriately. Interview with RN #4, on 06/07/11 at 2:30pm, revealed all Licensed Practical Nursing Applicants and Registered Nurse Applicants are to be supervised. This includes watching Applicants when they are doing a nursing task and signing behind the Nurse Applicant to verify that the task was completed appropriately. Interview with Licensed Practical Nurse (LPN) #1, at 06/07/11 at 2:35pm, revealed all Nurse Applicants are to work one-on-one with the nurse they are assigned to. The nurse is to monitor the Nurse Applicant when they are completing tasks like taking off orders, doing treatments to residents or any task that a nurse would complete and sign off that the task was completed appropriately. Interview with the Administrator on 06/09/11 at 2:05pm revealed CQI meetings were held every morning to review audits, circumstance forms, and that orders were verified and no transcription errors occurred. Validation of staff training May 19 - 20, 2011 via sign-in rosters revealed all staff received training prior to being assigned to work with the residents.	F 309		

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F 309	Continued From page 22	F 309		
	The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Qualitiy Assurance monitors new admissions for medication errors.			7/8/11
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490	F 490 Facility must be administered in a manner that enables it to use its resources effectively.	
	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.		1. Resident #1 was discharged to hospital on 5/12/11. Resident was readmitted to facility on 5/19/11 until 6/4/11 when resident discharged to home. 2. Residents on Lovenox or other anticoagulants were reviewed to determine orders were transcribed accurately and medication is being administered per MD order and there have been no adverse effects. Residents admitted during May, 2011 were reviewed to ensure orders have been transcribed correctly from Hospital Discharge Summary and Medication Reconciliation Forms to their current admission orders.. Any discrepancies noted were discussed with the attending physician and corrected. 3. Quality Assurance Program was reviewed with Executive Director by Home Office Support on 5/19 and 5/20/11. Quality Assurance Process was inserviced by the Executive Director. The QA process will monitor for compliance of system implementation, following guidelines and professional standards of practice. A Quality Assurance Meeting held on 7/1/11 to identify and discuss trends occuring in the facility with emphasis on Medication errors, admission orders. Licensed staff were reeducated by Interim Director of Health Services emphasizing identification, investigation and followup on Medication errors. All licensed staff was reeducated related to supervision of Nurse Applicants when working. Employees will have direct supervision by a licensed nurse as defined by 201 KAR 20: 400, Section 4. Supervision shall be determined by evaluation resident acuity, competency of the delegatee, complexity of task and proximity of delegator to delegatee.	
	This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of daily staffing sheets, and the Kentucky Board of Nursing Regulation 201 KAR 20:400 and section 1(9), it was determined that the facility's Administration failed to use its resources effectively and efficienctly to attain or maintain the highest practicable physical, mental psychosocial well-being for one (1) of nineteen (19) sampled residents (Resident #1). The facility administration failed to ensure policies and procedures were developed and implemented regarding the direct supervision of a LPNA by licensed nursing staff. The facility failed to follow the Kentucky Board of Nursing regulations as it pertained to direct supervisiondelegation of tasks for a LPNA. These failures prevented the facility from ensuring the LPNA performed tasks			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185461		C 06/09/2011

NAME OF PROVIDER OR SUPPLIER
GLEN RIDGE HEALTH CAMPUS

STREET ADDRESS, CITY, STATE, ZIP CODE
6415 CALM RIVER WAY
LOUISVILLE, KY 40299

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F 490	Continued From page 23 assisned appropriately and accurately. On 05/10/11, the LPNA failed to transcribe the physician ordered Lovenox (blood thinner) to the Medication Administration Record (MAR) which resulted in the facility not administering the medication for two (2) days. On 05/12/11, Resident #1 was diagnosed with Deep Vein Thrombosis (DVT - clotting of blood in the vein), developed a blood clot in the left groin, and was hospitalized. Interview with the admitting Physician at the hospital, Physician #1, on 05/18/11 at 9:36am, revealed if a resident did not receive Lovenox as ordered for two days, the resident could develop a blood clot. Interview with the Physician at the facility, Physician #2, on 05/18/11 at 2:33pm, revealed if the resident came in the facility with a blood clot and did not receive Lovenox as ordered, the blood clot could become worse. The Physician additionally stated if a resident had no blood clot and did not receive Lovenox as ordered, a blood clot could develop. The facility's failure to ensure the LPNA recieved direct supervision as outlined by the Kentucky Board of Nursing, while providing care to Resident #1 has caused or is likely to cause Resident #1 and other residents with whom the LPNA worked with serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist from 05/10/11 and is ongoing at F281 S/S: "J", F309 S/S: "J" and F490 S/S: "J". Refer to F281 and F309. Substandard Quality of Care was identified at F309.	F 490	4. Ongoing compliance will be monitored monthly during QA meetings. These meetings will provide a means whereby negative outcomes relative to resident care and safety can be identified and resolved through interdisciplinary approach to ensure effective systems are in place. Monitoring will also occur as part of Peer Review Process every six months.	

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F 490	Continued From page 24 After state agency review the investigation was reopened on 06/07-06/09/11. The facility provided a credible allegation of compliance (AOC) on 05/20/11. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Qualitiy Assurance monitors new admissions for medication errors. The findings include: Review of the 201 KAR 20:400 defined in detail the need for LPNA's to have supervision of delegated nursing tasks with periodic observation and evaluation of performance of the task and to validate the nursing task has been performed according to established standards of practice, although no evidence could be provided that the tasks were completed as required by standards of practice. Review of the Kentucky Board of Nursing (KBN) definition of supervised nursing practice revealed direct supervision means the nurse responsible for the applicant shall at all times be physically present in the facility and immediatelty available to the applicant while the applicant was engaged in the clinical internship. Review of the Daily Staffing Sheets revealed on 05/04/11 the LPNA worked part of a second shift and third shift on the 400 Hall Transitional Care Unit (TCU), on 05/06/11 part of a second shift, third, then again first shift on the 500 Hall Transitional Care Unit (TCU), independently with	F 490		

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F 490	Continued From page 25 no direct supervision. On 05/09 and 05/10/11 the LPNA worked part of a second shift and all of third shift on the 500 Hall Transitional Care Unit (TCU), independently with no direct supervision. Closed Record review revealed on 05/10/11, a LPNA admitted Resident #1 with a diagnosis of a fall and left hip fracture. The Discharge Medication Reconciliation form revealed multiple medications were continued for Resident #1 which included Lovenox 40mg, a blood thinner. Review of the MAR's revealed Lovenox had not been transcribed to the MAR on 05/10/11. There was no documented evidence the facility administered this medication to Resident #1 on 05/11/11 or 05/12/11. Interview with Resident #1, on 05/18/11 at 9:15am, revealed he/she did not receive a Lovenox shot or any shots to his/her belly the whole time he/she was in the facility. A doppler performed on 05/12/11 revealed that Resident #1 was positive for a Deep Vein Thrombosis (DVT) to the left groin. Interview on 05/19/11 at 7:10am with Certified Nursing Assistant (CNA) #1, revealed on 05/12/11 Resident #1 complained that his/her testicles were turning blue and within one and a half (1 1/2) hours, Resident #1 was sent to the Hospital, where he was diagnosed with a blood clot. Interview with the Administrator, on 05/19/11 at 3:10pm, revealed the facility utilized the Kentucky Board of Nursing Regulations as their policy and did not have a formal policy for how to supervise LPNA's. Interview with the Director of Health Services (DHS), on 05/19/11 at 11:00am, revealed while there was no written policy on the supervision of	F 490		

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F 490	Continued From page 26 Licensed Practical Nurse Applicants (LPNA), it was the Licensed staff knowledge that when the nurses worked on the units they were to supervise the LPNA, though these licensed nurses had their own work load. The DHS further stated the supervisors were not asked to complete audits or check behind the LPNA but to be support when the LPNA needed the support. Interview with the Administrator, on 05/19/11 at 3:10pm, revealed the LPNA was supervised by the nursing staff on campus, but not supervised hand in hand. The Administrator revealed that she was not aware that LPNA's were to be directly supervised while on the unit and the LPNA's direct supervision was the support of the campus. The Administrator further stated that whether the LPNA used the supervision was up to her discretion. Continued interview, on 05/20/11 at 5:30pm, revealed she identified, through a satisfaction survey with the staff, that the facility was utilizing alot of new nurses on the night shift. She did not believe the nurses knew to supervise the LPNA. The Administrator stated that harm could result to a resident as a result of a blood clot. Review of the allegation of compliance dated 05/20/11 and interview with the Interim Director of Health Services on 06/07/11 at 3:50pm and the Administrator on 06/09/11 at 2:05pm revealed the facility took the following immediate actions: 1. Resident #1 was discharged to the hospital on 05/12/11 for treatment. 2. Residents currently on Lovenox and other	F 490		

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F 490	Continued From page 27 anticoagulants were reviewed to determine orders were transcribed accurately and medication was being administered as ordered by the Physician with no adverse effects. 3. Medical Records of residents admitted during the last thirty (30) days were reviewed to ensure orders were transcribed correctly from the hospital Discharge Summary and Medication Reconciliation Forms to their current admission orders. 4. Any transcription errors identified from the review of orders from the hospital were discussed with the attending physician and corrected. Additional measures taken were: 1. CQI meetings were conducted every morning to review the facility audit forms, resident reconciliation of medications were transcribed correctly, review of the twenty-four (24) hour nursing reports and the circumstance form which was used by the nursing staff when a medication error arrised. 2. Education of all staff regarding the signs and symptoms of deep vein thrombosis, anticoagulation therapy, and following physician orders. 3. Education of the nursing staff regarding transcription of physician orders, admission process and physician notification. 4. Education of all licensed staff related to supervision of Nurse Applicants when working.	F 490		

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F 490	Continued From page 28 5. The Quality Assurance Process was reviewed with the Executive Director by the Home Office Support. 6. A Peer Review Process (a Quality Assurance Process that looks at trending for the last six months) was implemented and will occur every six months to ensure effective systems are in place. Interview with Certified Nursing Assistant (CNA) #1, on 06/07/11 at 9:15am, revealed she received training on how to identify skin changes and to notify nursing when she noticed those skin issues. Interview with Register Nurse (RN)#1, on 06/07/11 at 2:04pm, revealed she was taught to reconcile medications by comparing the Discharge Summary to the Medication Reconciliation form. Any discrepancies in the medications are to be called in to the Physician for clarification. RN #1 further stated when she transcribes medication on to the Physician Order Form there is a little space to the right of the order in which she is to initial to verify the order was taken off successfully. Once the medications are reconciled she is to sign the bottom of the Physician Order form to show all the orders were taken off appropriately. Interview with RN #4, on 06/07/11 at 2:30pm, revealed all Licensed Practical Nursing Applicants and Registered Nurse Applicants are to be supervised. This includes watching Applicants when they are doing a nursing task and signing behind the Nurse Applicant to verify that the task was completed appropriately.	F 490		

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F 490	Continued From page 29 Interview with Licensed Practical Nurse (LPN) #1, at 06/07/11 at 2:35pm, revealed all Nurse Applicants are to work one-on-one with the nurse they are assigned to. The nurse is to monitor the Nurse Applicant when they are completing tasks like taking off orders, doing treatments to residents or any task that a nurse would complete and sign off that the task was completed appropriately. Interview with the Administrator on 06/09/11 at 2:05pm revealed CQI meetings were held every morning to review audits, circumstance forms, and that orders were verified and no transcription errors occurred. Validation of staff training May 19 - 20, 2011 via sign-in rosters revealed all staff received training prior to being assigned to work with the residents. The state agency verified Immediate Jeopardy was removed 05/21/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F281, 42 CFR 483.25 Quality of Care, F309 and 42 CFR 483.75 Administration, F490, while the facility's Qualitiy Assurance monitors new admissions for medication errors.	F 490		

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