

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

PRINTED: 08/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195398	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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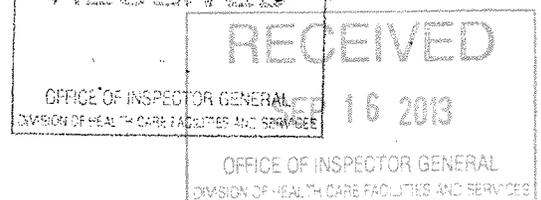
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey to investigate KY 20387 was initiated on 07/01/13 and concluded on 07/05/13. KY20387 was re-opened on 07/22/13 for further investigation in conjunction with the standard recertification survey. The standard/abbreviated/extended survey was conducted 07/22/13 through 08/02/13. The Division of Health Care substantiated the allegation with deficiencies cited at the highest scope and severity of a "K".</p> <p>The Division of Health Care identified immediate jeopardy on 07/24/13 and was determined to exist on 03/22/13 at 42 CFR 483.20 Resident Assessment (F281) at a scope and severity "K", 42 CFR 483.25 Quality of Care (F333) at a scope and severity "J" and 42 CFR 483.75 Administration (F490, F514, and F520) at a scope and severity of a "K" with Substandard Quality of Care at 42 CFR 483.25 Quality of Care.</p> <p>On 03/22/13 the facility admitted Resident #1 with an order for Cefazolin (an antibiotic) two (2) grams to be administered daily intravenously (IV) for twenty-eight (28) days for a hip and elbow infection. However, the facility staff failed to transcribe the order to the Medication Administration Record to ensure medication administration occurred. In addition, the admitting Licensed Practical Nurse (LPN) #3 altered the physician's order by adding to the directions to administer the antibiotic "after HD on HD", (after hemodialysis on hemodialysis days). This order was never verified with the resident's physician and the dialysis center was not aware of the antibiotic therapy. Record review revealed no documented evidence Resident #1 received the</p>	F 000	<p>DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES WITH AND DISPUTES THE DEFICIENCIES STATED IN THE 2567 AND THE SCOPE AND SEVERITY AT WHICH THEY ARE CITED. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE ALLEGED DEFICIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF INTERVIEWS, THE CHRONOLOGICAL/TIMING SEQUENCE OF EVENTS AND CONTACT WITH HEALTH CARE PROFESSIONALS, THE DESCRIPTION OF THE CARE AND SUPERVISION PROVIDED TO THE RESIDENTS AND ANY CONCLUSIONS, CHARACTERIZATIONS, OPINIONS OR SUGGESTION AS TO THE CAUSE OR EFFECT OF ANY ACTION OR INACTION. THE FACILITY RESERVES ITS RIGHT TO CONTINUE DISPUTING, APPEALING AND CONTESTING THESE DEFICIENCIES AND ANY ACTION RELATED TO OR ARISING THEREFROM IN ANY OTHER FORUM AS IT DEEMS APPROPRIATE.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Suzanne Davis* TITLE *Executive Director/Administrator* (X6) DATE *8/29/13*

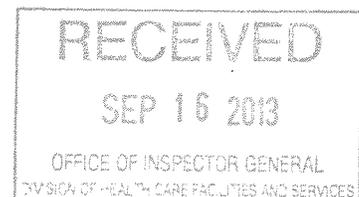
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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 000	Continued From page 1 antibiotic on 03/22/13 through 04/14/13 twenty-four (24) of the twenty-eight (28) days as ordered by the physician. On 04/15/13, the resident developed a mental status change and was transferred to the hospital and admitted with an impression of Toxic Metabolic Encephalopathy secondary to gram-positive cocci Septicemia with Bacteremia, likely a recurrence of underlying MSSA Sepsis. The resident did not return to the facility, but was transferred to another local Long Term Care facility and expired on 05/02/13. Additional deficiencies were cited as a result of the standard survey at F323, F428, and F431 at a scope and severity of an "E". The Life Safety Code survey was conducted on 07/23/13 with the highest scope and severity of an "E". The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit on 08/02/13. 42 CFR 483.20 Resident Assessment (F281), and 42 CFR 483.75 Administration (F490, F514, and F520) scope and severity was lowered to a "E" and 42 CFR 483.25 Quality of Care (F333) scope and severity was lowered to a "D" while the facility continues to implement and monitor quality assurance measures.	F 000			
F 281 SS=K	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	1. Resident #1, #3, # 16, # 29 # 31, # 35, and H were identified as being affected by the identified issue: The residents were addressed as follows: • Resident #1 was discharged from the facility to the hospital on 4-15-13 and did not return. • Resident #3 - a clarification order was obtained from the attending physician signed on 7-24-2013. Resident #3 had received the Lovenox per the physician order as indicated on the medication administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Physician's Order was signed on 8/5/2013.</i>		



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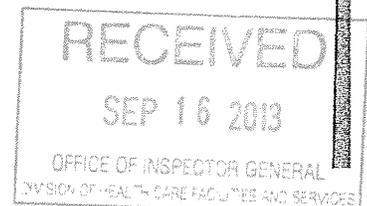
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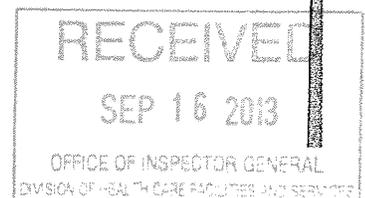
F 281	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and review of nursing standards of practice and the facility's policy, it was determined the facility failed to have an effective system to ensure services provided met professional standards of quality related to physician orders. Interview and record review revealed licensed staff were not ensuring physician orders were reviewed and validated for accuracy for six (6) of thirty-eight (38) sampled residents. (Resident #1, #3, #16, #29, #31 and #35) and one (1) of the eight (8) unsampled residents (Unsampled Resident H).</p> <p>On 03/22/13 the facility admitted Resident #1 with an order for Cefazolin (an antibiotic) two (2) grams to be administered daily intravenously (IV) for twenty-eight (28) days for a hip and elbow infection. The admitting Licensed Practical Nurse (LPN) #3 altered the physician's order by adding to the directions to administer the antibiotic "after HD on HD", (after hemodialysis on hemodialysis days). This order was never verified with the resident's physician; the dialysis center was not aware of the antibiotic therapy; and, the facility staff failed to transcribe the order to the Medication Administration Record to ensure medication administration occurred. Record review revealed no documented evidence Resident #1 received the antibiotic on 03/22/13 through 04/14/13, twenty-four (24) of the twenty-eight (28) days as ordered by the physician. On 04/15/13, the resident developed a mental status change and was transferred to the hospital and admitted with an impression of Toxic Metabolic Encephalopathy secondary to gram-positive cocci Septicemia with Bacteremia, likely a recurrence of underlying MSSA Sepsis.</p>	F 281	<ul style="list-style-type: none"> • Resident #16 - attending physician signed the order for Levaquin on 7-9-2013. Resident #16 did receive the medication under physician order after hospital discharge. The facility disagrees that this is breach of professional standard by the nurse involved. • Resident #29 - an order for Lasix 20mg was obtained from the nurse practitioner on 7-15-2013. The facility disagrees that this is a breach of professional standard by the nurse involved. • Resident #31 - 40 mg Lasix order reviewed by physician on 7/26/2013. <i>EMAR corrected on 7/16/2013</i> • Resident #35 - a clarification order was obtained on 7-29-2013 to correct the administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. • Resident #H was addressed on 4-22-13 by floor RN that completed the transcription of the order for Melatonin. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Incident report made on 4-22-2013 and Physician notified on 4/22/2013</i> <p>2. To identify other residents that might be affected the Quality Assurance Consultants, under recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC), completed a chart review, between 7/1/2013 and 7/31/2013, that included review of current residents' physician orders and medication administration records. For 100% of residents, Nursing Reviews also included a review of current residents' physician orders and medication administration records as documented from the original physician order source were completed 7/1/2013 through 7/25/2013. These were completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrative Nurse Consultant (ANC), and Nursing Consultants on all existing residents' orders, new orders, and new admissions' orders. All transcription orders were reviewed by DON, ADON, and ANC on 7/25/2013.</p>	
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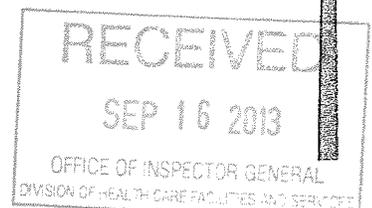
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F 281	<p>Continued From page 3</p> <p>The resident did not return to the facility, but was transferred to another local Long Term Care facility and expired on 05/02/13.</p> <p>In addition, the Assistant Director of Nursing (ADON), wrote an order for Resident #3 on the physician order sheet to receive Lovenox daily without direction from the attending physician for the frequency of the Lovenox.</p> <p>LPN #8 transcribed an order, for Levaquin 500 milligrams (mg) every day for ten (10) days from the emergency room information for Resident #16, without verifying the order with the resident's physician.</p> <p>The ADON wrote a physician's order on the physician order sheet for Lasix 20 mg for Resident #29 without an order from the physician and did not have the physician sign the order.</p> <p>LPN #2 transcribed a duplicated medication order for Lasix 40 mg that caused a double dose of the medication to be given three times to Resident #31 before it was identified and there was no evidence the physician had been notified of the duplicated error.</p> <p>LPN #14 failed to accurately transcribe a physician's order for Resident #35 onto the EMAR for Vitamin B-12. The physician's order should have read Vitamin B-12 1000 microgram (mcg) orally to be given every day. However, it was written as Vitamin B-12 250 mcg orally every day. A clarification order was not obtained until 07/29/13, thirty-four (34) days after the medication was entered incorrectly into the EMAR computer system.</p>	F 281	<p>3. In-services conducted at the facility:</p> <p>a. In-services were conducted from 7/2/13 through 7/25/13. The in-services were conducted by the ADON, the Quality Consultants, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses and included emphasis on verification of orders with the attending physician transcribed accurately per the original order source and the entering of orders into the facility EMAR system correctly, and that the pharmacy notification protocol be followed. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.</p> <p>b. Consulting pharmacy conducted in-services for all Licensed Practical Nurses, Registered Nurses, and Agency Nurses beginning on 7/26/13 through 8/1/13. These in-services included instruction on professional standards of practice related to transcription of physician orders, physician order transcription process, communication to pharmacy, medication error process, and re-verification of orders into the EMAR system and medication administration records. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.</p> <p>c. The orientation process and checklist for newly hired licensed nurses was revised by the Director of Nursing, the Assistant Director of Nursing, and the Administrative Nursing Consultant on 7/12/2013. The orientation process and checklist was reviewed and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/12/13. The Assistant Director of Nursing conducts the new hire orientation for licensed nurses. The Assistant Director of Nursing was trained on the orientation process and checklist by the Administrative Nursing Consultants on 7/12/2013. Agency Nurse orientation process was developed by the DON, ADON, ANC, and nursing Consultant on 7/1/2013 and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/1/2013. The orientation process was conducted by the ADON to new agency nurses on 7/1/2013 and 7/2/2013, prior to nurses beginning work assignments.</p>		



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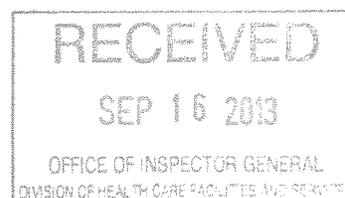
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F 281	<p>Continued From page 4</p> <p>Unsampled Resident H had an order for Melatonin which was not transcribed on the resident's Medication Administration Record (MAR) and Resident H did not receive the medication for four (4) days.</p> <p>The facility's failure to have an effective system in place to ensure services provided met professional standards of practice has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/24/13 and determined to exist on 03/22/13.</p> <p>The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit. The scope and severity was lowered to a "E" while the facility continues to implement and monitor quality assurance measures.</p> <p>The findings include:</p> <p>A review of the Kentucky Board of Nursing, Advisory Opinion Statement, (AOS) #14 Patient Care Orders, revised 02/2005, #5 revealed a nurse was obligated to not change an order of a physician/provider without the physician/provider's order to do so. Review of the Scope of Practice Determination Guidelines, revised 04/2005 revealed Licensed Practical Nurses would practice the administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with standards of</p>	F 281	<p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <p>Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new hires on 7/22/2013 and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance.</p> <p>Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new agency hires on 7/1/2013 and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance.</p> <p>The Director of Nursing, Assistant Director of Nursing, Administrative Nurse Consultants, and other professional Consultants will conduct daily reviews of new admissions and daily orders to monitor that the transcription process is performed accurately. This Quality Assurance process was revised on 7/1/2013 per recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC). DON is submitting all reviews to the Quality Assurance Committee (DON, ADON, Administrator, ANC) weekly for review to ensure effectiveness of the allegation of compliance.</p> <p>Also the Quality Assurance Committee (included Medical Director, DON, ADON, Administrator, ANC) met on the following dates: 7/1, 7/2, 7/3, 7/4, 7/5, 7/8, 7/9, 7/11, 7/12, 7/15, 7/18, 7/22, 7/24, 7/25, and 7/29 to assess reviews and make recommendations. These reviews were assessed by the Quality Assurance Committee (DON, ADON, Administrator, ANC) and will continue to be monitored to ensure effectiveness of the allegation of compliance.</p> <p>The Director of Nursing will make a monthly report of the audits to the full Quality Assurance Committee for assessment and recommendation. The audit schedule will be continued until revised by the Quality Assurance Committee.</p> <p>The Administrator will be responsible to assure that the compliance plan is monitored by the Quality Assurance Committee. Administrator will be responsible for monitoring to ensure</p>		



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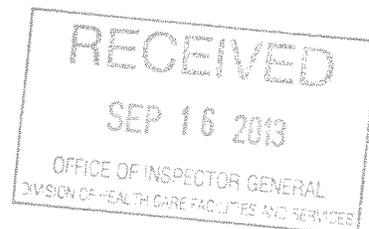
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F 281	<p>Continued From page 5 practice established by nationally accepted organizations of licensed practical nurses.</p> <p>Review of the facility's policy regarding Medication Orders, not dated, revealed medications are administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. Elements of the medication order include the name of the medication, strength of the medication, time or frequency of administration, route of administration, quantity or duration of therapy and diagnosis or indication for use.</p> <p>1. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 03/22/13 with diagnoses of Sepsis (Methicillin Sensitive Staphylococcus Aureus MSSA), Bilateral Infected Hip Prosthesis, Hypertension, Coronary Artery Disease, Spinal Stenosis, Low Back Pain, Urinary Incontinence, Left Hip Pain, Status Post Left Hip Replacement, Infection of Olecranon Bursa (back of the elbow) and Acute Kidney Injury. Review of the Discharge Summary, dated 03/22/13, revealed Resident #1 was to receive Cefazolin two (2) grams intravenously (IV) for twenty-eight (28) days.</p> <p>Further review of the Physician Orders, dated 03/22/13, revealed Licensed Practical Nurse (LPN) #3 documented Resident #1 was to receive Cefazolin two (2) grams intravenously daily after hemodialysis (HD) on HD days. LPN #3 then signed on the reviewed line that she had called the Physician to verify the orders.</p> <p>Interview with LPN #3, on 07/02/13 at 3:56 PM, revealed she transcribed the orders from the discharge summary onto the physician's order</p>	F 281	<p>ensure effectiveness of the compliance plan.</p> <p>The Quality Assurance Committee will review required audits and supportive documentation to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis</p> <p>5. Completed by:</p>	8-28-2013



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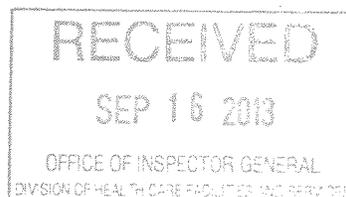
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F 281	<p>Continued From page 6 sheet. She stated she changed the order to read after dialysis on dialysis days as this was the usual routine so the antibiotic did not get flushed from the system. LPN #3 further stated she did not verify the order because she did not want to call the physician at 2:00 AM. She further stated she did not transcribe the order onto the Medication Administration Record (MAR). Further interview with LPN #3 revealed she did sign the order to indicate it was verified with the physician even though she did not call the physician to receive verification of the orders she wrote. LPN #3 stated she should not have changed the order without a physician's order to do so.</p> <p>Interview with LPN #1, on 07/01/13 at 1:13 PM, revealed she could not remember working on Resident #1's admission. LPN #1 did not remember putting the orders into the computer and further did not remember working on the unit.</p> <p>Interview with LPN #4, on 07/05/13 at 11:50 AM, revealed she would not add to an order on the Physician Order Sheet, unless directed by a physician. LPN #4 stated it was not her scope of practice to add to the order that a physician had given her. She stated she would call and verify the order with the doctor and sign the physician's order statement (POS) indicating that the order had been verified.</p> <p>Interview with the House Leader LPN #2, on 07/05/13 at 12:19 PM, revealed she was not teaching the nursing staff to add (on HD after HD) to the orders. The House Leader stated it was above the nurses scope of practice to add to an order that the doctor did not give her.</p>	F 281		



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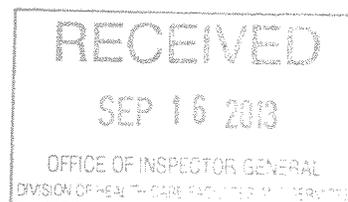
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F 281	<p>Continued From page 7</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/05/13 at 1:10 PM, revealed the orders were not accurate since the order had been changed without physician clarification.</p> <p>Interview with the Director of Nursing (DON), on 07/02/13 at 4:50 PM, revealed the facility had identified transcription of medications as a concern when the medication error was discovered for Resident #1 and was it was being investigated. She stated the nurses had to ensure the orders validated what was in the computer.</p> <p>Interview with Physician #1, on 07/05/13 at 1:35 PM, revealed he did not remember instructing the nurse to give Resident #1's antibiotic on hemodialysis days after the hemodialysis treatment. He further stated nurses should not add to the orders.</p> <p>2. Review of the clinical record for Resident #31 revealed the resident was readmitted to the facility on 07/02/13 with diagnoses of End Stage Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF).</p> <p>Review of the readmission physician order sheet (POS), dated 07/02/13, revealed Resident #31 had an order for Lasix (a drug used to remove extra fluid), 40 milligrams by mouth daily. Further review of Resident #31's physician orders revealed a telephone order, dated 07/12/13, to increase Lasix to 40 milligrams daily and to add Lasix 20 milligrams by mouth daily for three (3) days.</p> <p>Review of the Electronic Medication Administration Record (EMAR) revealed the Lasix 40 milligram order was on the EMAR twice (a</p>	F 281		



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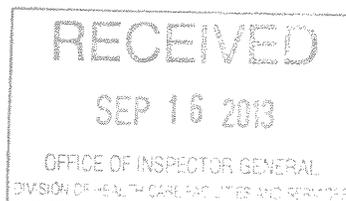
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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F 281	<p>Continued From page 8</p> <p>duplicated order) and the duplicated Lasix 40 milligrams was documented as having been given twice on 07/13/13, 07/14/13, once on 07/15/13 and then twice on 07/16/13 for a total of 80 mg each day.</p> <p>Review of the notes attached to the EMAR revealed the Certified Medication Technician (CMT) administered the routine 40 mg dose of Lasix and held the duplicated dose on 07/15/13 as the CMT assigned to administer those medications had recognized the duplicated order. However, continued review of the EMAR revealed the resident received another 80 mg dose on 07/16/13, even though the CMT had noted it was a duplicate order.</p> <p>Attempt to interview Resident #31's physician, on 08/01/13 at 10:50 AM, revealed she was on vacation and unavailable.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 08/01/13 at 11:00 AM, revealed she could not locate a medication error incident report for the three (3) doses of 80 mg of Lasix Resident #31 received in the computerized nurses notes and she did not find any evidence the resident's physician was informed.</p> <p>Interview with CMT #15, on 08/01/13 at 11:30 AM, revealed she did recognize the duplicate order of Lasix for Resident #31, but as a CMT, she was not authorized to correct the order in the EMAR or to complete a medication error incident report. She stated she did tell the nurse on duty on 07/15/13 when she recognized the error but she did not remember who the nurse was and she did not document what she did.</p>	F 281		



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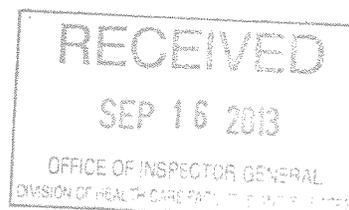
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F 281	<p>Continued From page 9</p> <p>Interview with LPN #2, on 08/01/13 at 3:40 PM, revealed she was the nurse who transcribed the duplicate order of Lasix onto Resident #31's EMAR, but she did not realize it was a duplicate order at that time. She stated she should have discontinued the 07/02/13 order for Lasix 40 milligrams when she entered the 07/12/13 order for Lasix 40 milligrams.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 08/01/13 at 1:45 PM, revealed she recognized the duplicate order for Lasix 40 milligrams for Resident #31 on 07/15/13 after the duplicate dose had been given and she completed a medication error report. She presented the report with no indication the physician was informed and no date of completion. She indicated she did not follow-up with the CMT or nurses involved, but passed that responsibility on to the nurse House Leader who no longer worked at the facility.</p> <p>3. Record review revealed the facility admitted Resident #35, on 06/24/13 with the diagnoses of Dementia with Behavior, Osteoarthritis, Anxiety, Gastric Reflux, Vitamin B-12 Deficiency, and Coronary Heart Disease. Review of the admission orders revealed the physician ordered Vitamin B-12 1000 microgram (mcg) orally to be given every day. However, review of the EMAR revealed the order was entered, on 06/25/13, by the facility as Vitamin B-12 250 mcg orally every day. The resident received the 250 mcg every day. A clarification order was not obtained until 07/29/13, thirty-four (34) days after the medication was entered incorrectly into the EMAR computer system.</p> <p>Interview with Licensed Practical Nurse (LPN)</p>	F 281		



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F 281	<p>Continued From page 10</p> <p>#14, on 08/01/13 at 3:40 PM, revealed she did remember completing the admission for Resident #35, but did not remember the resident's ordered Vitamin B-12 dosage. The LPN revealed no one had told her of an order entry error, or questioned the admission orders.</p> <p>Interview with Physician #2, on 08/01/13 at 3:16 PM, revealed the facility entering the wrong dosage was not a significant error that would have hurt the resident, but was definitely wrong and a transcription error. The physician revealed he was not notified by the facility of the error.</p> <p>Interview with ADON, on 08/01/13 at 3:05 PM, revealed Resident #35's medication error was discovered with the audits that were taking place in the building on 07/01/13 to 07/05/13. The ADON revealed she did complete the clarification order. However, the ADON revealed she did not complete an incident report or complete an investigation as to why the error occurred.</p> <p>4. Review of the clinical record for Resident #29 revealed the facility admitted the resident on 06/28/13 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (HTN). On admission the resident had a physician order for Lasix 20 mg every morning. On 07/14/13 the physician ordered to increase Lasix to 40 mg daily for five (5) days for edema. On 07/15/13 the ADON clarified the order. The order was not signed by the physician from 07/15/13 to 08/02/13 (21 days).</p> <p>Interview with the ADON, on 07/25/13 at 2:20 PM, revealed she had written the order to be signed on the physician's next visit. Although the EMAR was correct and the resident received the</p>	F 281			



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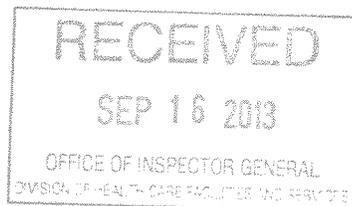
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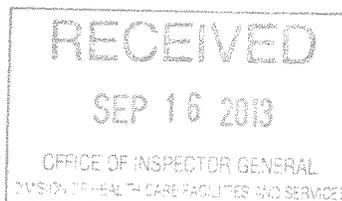
F 281	<p>Continued From page 11 appropriate amount of Lasix, there was no order signed by the physician.</p> <p>Interview with the DON, on 07/25/13 at 2:40 PM, revealed she did not know the ADON was writing orders without legal authorization to do so. She further revealed she was not aware the resident received additional Lasix without a signed physician's order.</p> <p>5. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 06/27/13 with the diagnosis of Septicemia related to his/her dialysis catheter, End Stage Renal Disease resulting in hemodialysis, Peripheral Vascular Disease, Thrombocytopenia, Diabetes, Atrial Fibrillation, Hepatitis C, Hypertension, Degenerative Disc Disease, and Anemia.</p> <p>Review of the Admission orders, dated 06/27/13, revealed an order for Lovenox 30 mg subcutaneously for Deep Vein Thrombosis (DVT) prophylaxis. There was no frequency (how often the drug should be given) included in the admission order. Review of the Electronic Medication Administration Record (EMAR) revealed on 07/24/13 the order was placed in the electronic system to be given daily despite no physician's orders or an order clarifying the medication. Further review of the resident's medical record revealed an order clarification for Lovenox 30 mg subcutaneously daily was written on 07/24/13 at 9:00 PM. The clarification order did not indicate which physician gave the order, or how the order was obtained. The order sheet was marked as being faxed to pharmacy.</p> <p>Telephone interview with Physician #5, on 07/25/13 at 10:10 AM, revealed he did not receive</p>	F 281		
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F 281	<p>Continued From page 12</p> <p>a phone call from the facility to verify the resident's order for Lovenox, or any other order.</p> <p>Interview with the Advanced Practice Registered Nurse (APRN), on 07/25/13 at 10:39 AM, revealed she was not asked by any member of the facility staff to clarify any orders for the resident and did not write any orders for the resident the evening of 07/24/13.</p> <p>Interview with the ADON, on 07/25/13 at 2:20 PM, revealed the clarification order was written by her. The ADON confirmed she did write the order without obtaining a physician's order, or from anyone legally authorized to do so. The ADON revealed she knew writing the order was outside her scope of practice, but wanted to ensure clarification was done. The ADON revealed she thought she could just get the doctor to sign the order for her when he came in the next day.</p> <p>6. Record review for Resident #16, on 07/25/13, revealed there was an order for Levaquin 500 mg daily for ten (10) days written by a local hospital's Emergency Room physician on 07/06/13. Review of Resident #16's Electronic Medication Administration Record (EMAR) revealed the order was transcribed onto the resident's EMAR and faxed to the pharmacy on 07/07/13. Further review of Resident #16's EMAR revealed the medication was administered to the resident for two (2) days on 07/07/13 and 07/08/13, before the attending physician was notified and the order verified.</p> <p>Interview with LPN #8, on 07/25/13 at 12:02 PM, revealed she received Resident #16 (a current resident) from an Emergency Room (ER) visit at a local hospital on 07/06/13. The ER physician</p>	F 281		



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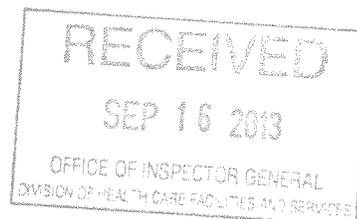
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F 281	<p>Continued From page 13</p> <p>(no name) wrote an order for Levaquin 500 mg daily for ten (10) days for a diagnosis of Pneumonia. She sent the order to the pharmacy and added the medication to the resident's EMAR; however, she did not validate the order with the resident's attending physician. LPN #8 stated, she always writes the orders from the ER per the ER physician and she does not verify the order with the attending physician. However, review of the facility's policy revealed the nurse who received the order was to verify the order with the current attending physician before medications were administered.</p> <p>Interview with LPN #9, on 07/25/13 at 11:40 AM, revealed if she had received an order from a local hospital she would call the attending physician for approval of the orders.</p> <p>Interview with the Director of Nursing (DON), on 07/25/13 at 11:15 AM, revealed the nurse receiving the order from a local hospital should call the primary care physician to obtain approval for the medication ordered. There should have been a clarification order from the primary care physician for Resident #16.</p> <p>7. Review of the closed record for Unsampled Resident H revealed the resident was ordered to receive Melatonin 3 milligrams (mg) at night (HS) on 04/18/13. The Melatonin order was not placed onto the Medication Administration Record (MAR) until 04/22/13. Therefore, Resident H did not receive his/her medication until four (4) days later.</p> <p>Review of the Medication Error Report revealed the error was discovered through a chart audit completed on 07/01/13 to 07/05/13; however, an investigation was not completed as to what the</p>	F 281		
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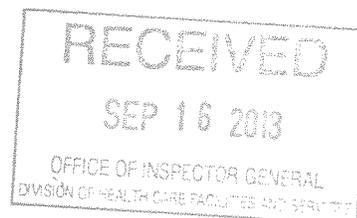
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F 281	Continued From page 14 root cause was for the medication not being transcribed onto the MAR. Interview with the Assistant Director of Nursing (ADON), on 07/23/13 at 10:40 AM, revealed there was no documented investigation report for the medication error. The investigation report would document who reported the incident, whom was involved, notifications to the House Leader, ADON, Director of Nursing (DON) with date and time. In addition there was no follow-up provided with the medication error. Interview with the DON, on 07/23/13 at 10:01 AM, revealed she did not complete an investigation into Resident H's medication error. She stated she thought the House Leader would of completed one. The DON stated she did print out incident reports, but did not have one for Resident H. Review of the Acceptable Allegation of Compliance (AOC) on 08/02/13, revealed the facility took the following immediate actions: 1. Resident #1 was discharged to the hospital on 04/15/13 and did not return. 2. For the facility to identify other residents that might be affected, the quality assurance consultants, under recommendation of the Quality Assurance Committee, completed a chart review that verified care plan were updated, beginning 07/01/13 through 07/31/13. 3. In-services were conducted from 07/02/13 through 07/25/13. The in-services included topics of updating the care plan related to medication orders were conducted by the ADON, the Quality	F 281		
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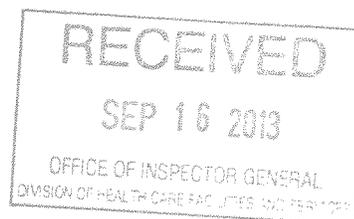
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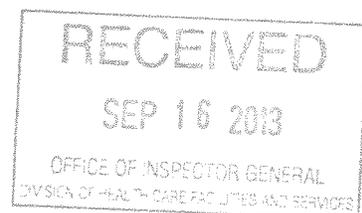
F 281	<p>Continued From page 15</p> <p>Consultant, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses.</p> <p>4. The DON, ADON, Administrative Nurse Consultant and other professional consultants were conducting daily reviews of new admissions and daily orders to monitor for accurate processing of new orders and that care plans were updated accordingly.</p> <p>5. The DON was responsible for assuring the daily review process of physician orders and care plan updates as discussed were audited and reported for weekly review by the Quality Assurance Committee.</p> <p>The State Survey Agency validated the AOC on 08/02/13 prior to exit as follows:</p> <p>1. Record review revealed Resident #1 had been discharged on 04/15/13 and not scheduled to return.</p> <p>2. Record review revealed chart audits were completed on 07/01/13 through 07/31/13 to ensure nursing care plans for residents were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily to include physician orders and medication administration records. Interview with the interim DON (Consultant), on 07/26/13 at 12:30 PM, revealed she had completed all chart audits from 07/01/13 to 07/31/13 by looking at physician orders and medication administration records.</p> <p>3. Record review revealed an in-service was</p>	F 281		
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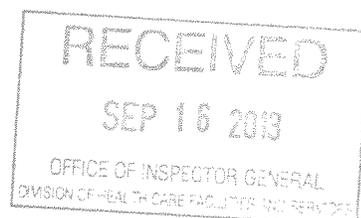
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F 281	Continued From page 16 provided by ADON and Quality Consultant on 07/02/13 through 07/25/13, by review of the content of the in-service and review of the attendance logs for the in-service revealed all nursing staff attended the inservice. Interviews conducted on 08/02/13 with five (5) Licensed Practical Nurses: LPN #4 at 4:55 PM, LPN #2 at 6:05 PM, LPN #13 at 5:45 PM, LPN #14 at 6:33 PM, LPN #15 at 6:33 PM, two (2) Registered Nurses: RN #5 at 4:50 PM, and RN #4 at 5:57 PM, and three (3) Certified Medication Technicians (CMT)'s; CMT #1 at 11:22 AM, CMT #20 at 5:55 PM, and CMT #21 at 5:50 PM revealed they were educated on standards of practice, transcription process, communication to pharmacy, medication error process, and re-verification of orders in the EMAR system. Interview with LPN #3 at 08/01/13 at 1:37 PM, revealed she was educated on the transcription process, standards of practice, communication and ensuring re-verification of orders in the EMAR system. Interview with LPN #16 on 08/02/13 at 6:33 PM, revealed she was also educated on checking for accuracy and making sure not to interpret the orders, but to write the orders exactly as the physician wrote them. 4. Record review revealed the Administrative staff conducted dally reviews of new admission and daily orders to monitor to ensure records were accurate. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily. Interview with the ADON, on 07/24/13 at 10:35 AM, revealed she made copies of discharge summaries, written admission physician order sheet and then compared these documents to the computer to ensure items were correct and matched. Record review revealed the DON submitted all reviews to	F 281		



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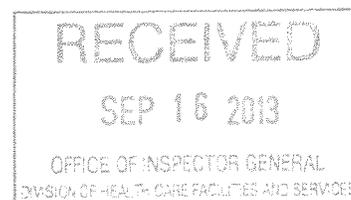
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F 281	Continued From page 17 the Quality Assurance Committee.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to maintain an environment free from accidents and hazards evidenced by water temperatures that exceeded 110 degrees Fahrenheit (F) in nine (9) resident bathrooms, affecting three (3) sampled (Residents #8, #18 and #19) and seven (7) unsampled residents, (Residents A, B, C, D, E, F, and G), in the Walters and Chandler households of the facility.	F 323	1. Residents #8, #18, #19, #A, #B, #C, #D, #E, #F, and #G were identified as affected by the identified issue. The facility addressed the residents as follows: • Skin assessments were conducted on resident #8 and #A due to being non-interviewable on 7/24/2013. No residents were determined to be affected by the issue identified. • Skin assessments were conducted on resident #E, #F, and #G due to no BIM score on 7/24/2013. No residents were determined to be affected by the issue identified. • Resident Interviews were conducted on 7/24/2013 with residents #18, #19, #B, #C, and #D by Administrator and Social Services Director. No residents were determined to be affected by the issue identified. • Written notification was posted in all rooms in the area identified that the household spa would be utilized in lieu of private bathroom until replacement of boiler in identified areas. 2. To identify other residents potentially affected by the identified issue, the facility initiated the following corrective actions: • Skin assessments were conducted on all non-interviewable residents in the area identified on 7/24/2013. No residents were determined to be affected by the issue identified.	



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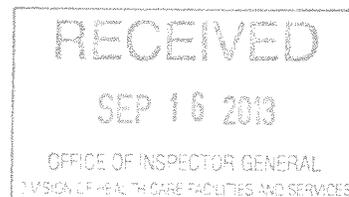
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F 323	Continued From page 18 The findings include: Review of the Water Temperature Protocol (Undated), revealed water heaters that serviced the residents' bathrooms, common areas, and tub/shower areas were checked routinely for proper temperatures. The maintenance department was responsible for monitoring and recording water temperatures. Maintenance staff performed water temperature audits weekly. If water temperatures exceeded the 110 degree (F) limit, the Administrator, the Director of Nursing, and Nursing Supervisor of the House would be notified. All staff should report water temperatures that felt excessive to touch to their immediate supervisors. Water temperature audits were reported to the Quality Assurance Committee routinely. Observation, on 07/23/13 at 11:00-11:20 AM, in the Walters and Chandler Households revealed water temperatures (using the State Surveyor's thermometer, calibrated to 32.0 degrees) at the hand sinks in the following residents' rooms: Resident #8 at 116 degrees (F); Resident #18 at 118 degrees (F); Resident #19 at 122 degrees (F); and Unsampled Resident A at 114 degrees (F); Unsampled Resident B at 118 degrees (F); Unsampled Resident C at 122 degrees (F); Unsampled Resident D at 118 degrees (F); Unsampled Resident E at 120 degrees (F); Unsampled Resident F at 120 degrees (F); Unsampled Resident G at 118 degrees (F). Interview, on 07/23/13 at 11:55 AM, with the facility's Administrator revealed she was not aware of elevated water temperatures until notified by the survey team. Upon becoming	F 323	<ul style="list-style-type: none"> Resident Interviews and Notifications were conducted on 7/24/2013 with all interviewable residents in the area identified by Administrator and Social Services Director. No residents were determined to be affected by the issue identified. Written notification was posted in all rooms in the area identified that the household spa would be utilized in lieu of private bathroom until replacement of boiler in identified areas. <p>3. The facility initiated the following corrective actions to assure that the identified issue does not reoccur as follows:</p> <ul style="list-style-type: none"> Administrator met with Director of Maintenance, Assistant Maintenance Director and to re-educate them and the administrative assistant on the need to notify the Administrator and DON of any temperatures that are out of the acceptable range. Policy was reviewed and discussed with both individuals on 7/24/13. Administrator re-educated the entire maintenance team on the Water Temperature Protocol on 8/13/13. Administrator held an in-service with all staff on 8/14/13 to re-educate staff about the Water Temperature Protocol and the importance of maintaining a safe environment. Facility had Plumbing contractor install a new water heater to service the kitchens on both identified households on 7-25-2013. This correction allowed the facility to control water temperatures to resident bathrooms and spas on a separate water heater. <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure the performance is sustained as follows:</p> <ul style="list-style-type: none"> Maintenance staff will perform a weekly audit of water temperatures on all households in resident bathrooms and spa baths to monitor proper temperatures for resident safety as per the Water Temperature Protocol and will submit to Quality Assurance committee for monthly review. 	



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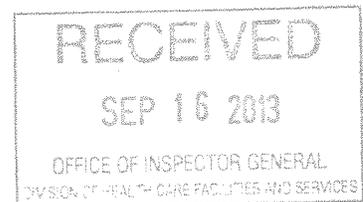
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F 323	<p>Continued From page 19</p> <p>aware of the hot water temperatures, the nursing staff in the Chandler and Walters Households were notified to suspend all bathing and hot water usage in the affected wings until further notice. In addition, interviewable residents were informed of the hot water concerns and advised not to use the hot water in their restrooms.</p> <p>Observation, on 07/23/13 at 12:50 PM, in the Walters Household revealed the Maintenance Director obtained water temperatures at the hand sinks, using the facility's thermometer, calibrated to 33.4 degrees (F) in the following resident rooms: Resident #19 at 131.2 degrees (F) and Unsampled Resident B at 131.3 degrees (F).</p> <p>Observation, on 07/23/13 at 12:55 PM, in the Chandler Household revealed the Maintenance Director obtained a water temperature at the hand sink, using the facility's thermometer, calibrated to 33.4 degrees (F) in Unsampled Resident C's room to be 138.0 degrees (F).</p> <p>Interview, on 07/23/13 at 1:10 PM, with the Maintenance Director revealed the water temperatures exceeded the acceptable range of 110.0 degrees (F) and stated he would adjust the temperature. He stated the problem with high water temps was the potential for residents to be burned.</p> <p>Observation, on 07/23/13 at 3:10 PM, revealed the following water temperatures at the hand sinks, measured by the Maintenance Director for Resident #19 at 111.0 degrees (F) and Unsampled Resident B at 111.4 degrees (F).</p> <p>Observation, on 07/23/13 at 3:15 PM, revealed the following water temperatures at the hand</p>	F 323	<ul style="list-style-type: none"> Weekly water temperature audit will be submitted to the Administrator weekly for review. These will be submitted to the QA committee monthly. Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan and reporting to QA Committee monthly. QA Committee reviewed water temperature protocol and Plan of Correction on 8/12/2013. <p>The Quality Assurance Committee will review required audits and supportive documentation to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis</p> <p>5. Completed by:</p>	8-28-2013	



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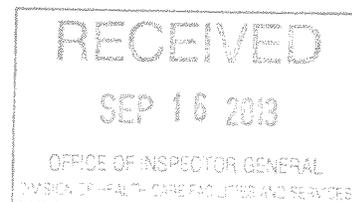
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F 323	<p>Continued From page 20</p> <p>sinks, measured by the Maintenance Director for Unsampled Resident F at 111.4 degrees (F); and Unsampled Resident C at 107.4 degrees (F).</p> <p>Interview, on 07/23/13 at 3:17 PM, with the Maintenance Director revealed some of the water temperatures were still above the acceptable range and he was going to make an additional adjustment at the mixing valve to bring the water temperatures below 110 degrees (F).</p> <p>Observation, on 07/23/13 at 4:16 PM, revealed the following water temperatures at the hand sinks, measured by the Maintenance Director for Resident #19's room at 109.8 (F); and Unsampled Resident B's room at 110.3 (F).</p> <p>Interview, on 07/23/13 at 5:00 PM, with the facility's Administrator revealed a 100% audit of water temperatures in the Walters and Chandler Households had been completed by the maintenance staff on 07/23/13, and the highest water temperature was 110.4 degrees (F). To ensure continued safety of the residents, the Administrator stated all necessary bathing of residents would occur in the spa rooms on the unaffected wings of the Walters and Chandler Households. Water temperatures would be checked hourly for two additional times on the evening shift. There would be no hot water usage on the affected wings of Chandler and Walters during the evening shifts of 07/23/13 and the night shift of 07/24/13. Water temperature monitoring would resume at 8:00 AM on 07/24/13. Signs would be posted in each residents' room on the affected wings, advising residents not to use the hot water in the restrooms until further notice.</p>	F 323			



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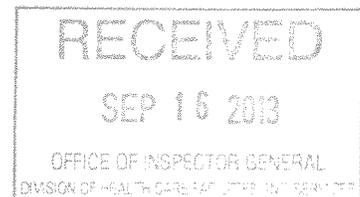
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F 323	<p>Continued From page 21</p> <p>Interview, on 07/24/13 at 11:12 AM, with CNA #1 revealed that upon reporting to work at Chandler Household on the morning of 07/24/13, the Director of Nursing (DON) informed her of the hot water issues and she was instructed to shower residents in the spa room on the unaffected wings. Further, she was instructed to first turn on the cold water spigot in a resident's room and slowly mix with warm water to assure a comfortable temperature was achieved before use by the residents.</p> <p>Review of water temperatures taken by the facility staff on 07/25/13, revealed the water temperature was in acceptable range in all resident restrooms and spa rooms at the Chandler and Walters Households.</p> <p>Review of the facility's documented water temperatures from 02/04/13-07/25/13, did not reveal any water temperatures that exceeded 110.0 degrees (F) in the residents' rooms.</p> <p>Interview, on 07/24/13 at 9:37 AM, with Unsampled Resident D revealed he/she used the hand sink in his/her restroom and had noticed the water was a little too hot to touch while rinsing out some clothing. However, he/she did not report this to the staff, and had not received an injury from contact with the water.</p> <p>Interview, on 07/24/13 at 9:45 AM, with Unsampled Resident G revealed he/she had lived in the room since 07/19/13 and used the sink and shower in his/her restroom, and stated it had been too warm, but did not report it to the staff. The resident had not been injured and had not noticed any discoloration of his/her skin.</p>	F 323		



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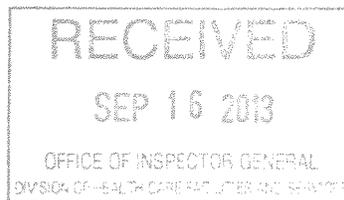
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F 323	<p>Continued From page 22</p> <p>Interview, on 07/24/13 at 10:15 AM, with Unsampled Resident C revealed he/she typically took showers in his/her bathroom, but the water temperature had not been uncomfortable.</p> <p>Interview, on 07/24/13 at 11:05 AM, with Unsampled Resident F revealed he/she used water from the sink and shower in his/her bathroom, and stated he/she had no problems with the temperature. He/she had not noticed skin discomfort/nor injury.</p> <p>interview, on 07/24/13 at 11:10 AM, with Resident #18 revealed he/she had not experienced any problems with the water temperature in his/her bathroom sink or shower.</p> <p>Review of skin assessments of non-interviewable residents on the affected hallways, did not reveal that any of them had experienced burns, or pink/red discoloration to their skin.</p> <p>Interview, on 07/23/13 at 12:30 PM, with the facility's Maintenance Director revealed his Administrative Assistant took water temperatures in the spa rooms and in designated resident restrooms in each household three times a week, and recorded the results. The Maintenance Director said if his Assistant found water temperatures that were out of the acceptable range, she notified him immediately. The Maintenance Director stated he did not notify the Administrator every time an out of range temperature was reported, but he went immediately to investigate and fix the problem.</p> <p>Interview, on 07/23/13 at 2:45 PM, with the Maintenance Director's Administrative Assistant revealed she was responsible for taking the water</p>	F 323			



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F 323	Continued From page 23 temperatures in each household on Mondays, Wednesdays and Fridays, and she recorded the results. She was instructed by the Maintenance Director to measure the water temperatures at the hand sinks of the first and last rooms in each household, and the spa rooms. The Administrative Assistant stated the normal range for water temperatures was 100-110 degrees (F) and she reported temperatures that exceeded 110 degrees (F) to the Maintenance Director. Review of the water temperatures obtained on 07/23/13 revealed no elevated temperatures were obtained. Further interview with the Administrator, on 07/26/13 at 4:40 PM, revealed she was not aware of any high water temperatures in the facility in the short time she had been at the facility (35 days).	F 323	
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system to ensure residents were free from significant medication errors for two (2) of thirty-eight (38) sampled residents (Residents #1 and #2). On 03/22/13 the facility admitted Resident #1 with an order for Cefazolin (an antibiotic) two (2) grams to be administered daily intravenously (IV)	F 333	1. Resident #1 and #5 were identified as being affected by the identified issue: The residents were addressed as follows: • Resident #1 was discharged from the facility to the hospital on 4-15-13 and did not return. • Resident #5 - on 6-11-13 the nurse practitioner ordered Allopurinol in response to a pharmacy recommendation. The order was discontinued on 7-9-13 by the nurse practitioner due to resident refusal of medication. 2. To identify other residents that might be affected, the Quality Assurance Consultants, under recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC), completed a chart review that included review of current residents' physician orders and medication administration records.



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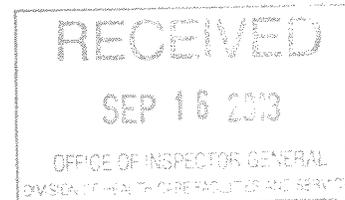
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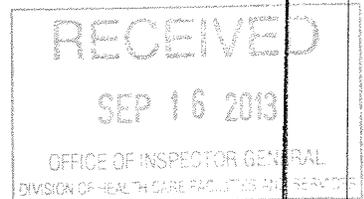
F 333	<p>Continued From page 24</p> <p>for twenty-eight (28) days for a hip and elbow infection. The admitting Licensed Practical Nurse (LPN) #3 altered the physician's order by adding to the directions to administer the antibiotic "after HD on HD", (after hemodialysis on hemodialysis days). This order was never verified with the resident's physician; the dialysis center was not aware of the antibiotic therapy; and, staff failed to transcribe the order to the Medication Administration Record to ensure medication administration occurred. Record review revealed no documented evidence Resident #1 received the antibiotic from 03/22/13 to 04/14/13, twenty-four (24) of the twenty-eight (28) days, as ordered by the physician. On 04/15/13, the resident developed a mental status change and was transferred to the hospital and admitted with an impression of Toxic Metabolic Encephalopathy secondary to gram-positive cocci Septicemia with Bacteremia, likely a recurrence of underlying MSSA Sepsis. The resident did not return to the facility, but was transferred to another local Long Term Care facility and expired on 05/02/13.</p> <p>In addition, the facility re-admitted Resident #5 with a diagnosis of Gout and to receive Allopurinol 200 mg every bedtime for Gout. The facility staff discontinued the Allopurinol from the EMAR and it was not administered from January through May 2013. The physician orders revealed there was no discontinue (D/C) order for the Allopurinol for Resident #5.</p> <p>The facility's failure to have an effective system in place to ensure the residents were free of significant medication errors has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/24/13 and determined to exist on</p>	F 333	<ul style="list-style-type: none"> • For 100% resident review, Nursing Reviews, completed between 7/1/2013 and 7/25/2013 included review of current residents' physician orders and medication administration records as documented from the original physician order source by Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrative Nurse Consultants (ANC), and Nursing Consultants on all existing residents' orders, new orders, and new admissions' orders. • All transcription orders were reviewed by DON, ADON, and ANC on 7/25/2013 upon the recommendations of the Pharmacy medication regimen order review completed on 7/25/2013. <p>3. In-services conducted at the facility from 7/2/13 through 8/1/13.</p> <ul style="list-style-type: none"> • In-services were conducted from 7/2/13 through 7/25/13. The in-services were conducted by the ADON, the Quality Consultants, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses and included emphasis on verification of orders with the attending physician, transcribed accurately per the original order source and the entering of orders into the facility EMAR system correctly, and that the pharmacy notification protocol be followed. A question and answer period was incorporated in each in-service session to assure comprehension of education presented. • Consulting pharmacy conducted in-services for all Licensed Practical Nurses, Registered Nurses, and Agency Nurses beginning on 7/26/13 through 8/1/13. These in-services included instruction on professional standards of practice related to transcription of physician orders, physician order transcription process, communication to pharmacy, medication error process, and re-verification of orders into the EMAR system and medication administration records. A question and answer period was incorporated in each in-service session to assure comprehension of education presented. • The orientation process and checklist for newly hired licensed nurses was revised by the Director of Nursing, the Assistant Director of Nursing, and the Administrative Nursing Consultants on 7/12/2013. The orientation process and checklist 	
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F 333	Continued From page 25 03/22/13. The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit. The scope and severity was lowered to a "D" while the facility continues to implement and monitor quality assurance measures. The findings include: Review of the facility's Medication Error Policy and Procedure, revised 10/03/07, revealed if an error occurred with any frequency, there was reason to classify the error as significant. Therefore if a resident's drug was omitted several times, the error would be classified as significant. The policy also revealed the facility would report immediately, significant and non-significant medication errors to the attending physician, responsible party and immediate supervisor. The facility would also develop and maintain processes for defining, identifying and reviewing these significant medication errors collaboratively with nursing, pharmacy and other appropriate staff. 1. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 03/22/13 with diagnoses of Sepsis (Methicillin Sensitive Staphylococcus Aureus MSSA), Bilateral Infected Hip Prosthesis, Hypertension, Coronary Artery Disease, Spinal Stenosis, Low Back Pain, Urinary Incontinence, Left Hip Pain, Status Post Left Hip Replacement, Infection of Olecranon Bursa (back of the elbow) and Acute Kidney Injury. Review of the Minimum Data Set (MDS), dated 03/29/13, revealed the facility	F 333	was reviewed and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/12/13. The Assistant Director of Nursing conducts the new hire orientation for licensed nurses. • The Assistant Director of Nursing was trained on the orientation process and checklist by the Administrative Nursing Consultants on 7/12/2013. Agency Nurse orientation process was developed by the DON, ADON, ANC, and nursing Consultants on 7/1/2013 and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/1/2013. The orientation process was conducted by the ADON to new agency nurses on 7/1/2013 and 7/2/2013, prior to nurses beginning work assignments. 4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows: • The Director of Nursing, Assistant Director of Nursing, Administrative Nurse Consultants, and other professional Consultants are conducting daily reviews of new admissions and daily orders to monitor that the transcription process is performed accurately. This Quality Assurance process was revised on 7/1/2013 per recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC). DON is submitting all reviews to the Quality Assurance Committee (DON, ADON, Administrator, ANC) weekly for review to ensure effectiveness of the allegation of compliance. • The Director of Nursing will make a monthly report of the audits to the full Quality Assurance Committee for assessment and recommendation. The audit schedule will be continued until revised by the Quality Assurance Committee. The Administrator will be responsible to assure that the compliance plan is monitored by the Quality Assurance Committee. Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan. • Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new agency hires on 7/1/2013 and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance.		



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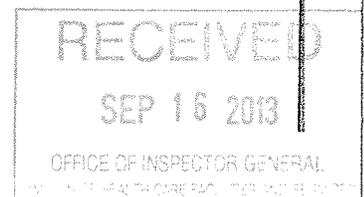
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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041
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F 333	<p>Continued From page 26</p> <p>assessed Resident #1's BIMs score at a twelve (12) which revealed Resident #1 was interviewable.</p> <p>Review of the Discharge Summary, dated 03/22/13, revealed Resident #1 was to start Cefazolin two (2) grams intravenously (IV) daily for twenty-eight (28) days. Review of Physician Orders, dated 03/22/13, revealed Licensed Practical Nurse (LPN) #3 documented Resident #1 was to receive Cefazolin 2 grams intravenous daily after hemodialysis on hemodialysis days. However, the resident received dialysis three times a week and not daily. Further review revealed there was no signature to show who read and verified the order or who faxed the order to pharmacy. Review of the March 2013 and April 2013 Medication Administration Record revealed the Cefazolin two (2) grams was not transcribed to be administered.</p> <p>Interview with LPN #3, on 07/02/13 at 3:56 PM, revealed she had seven (7) admissions that night and Resident #1 was her last admission of the night. She stated she did transcribe the orders from the discharge summary onto the physician order sheet and did not want to call the physician at 2:00 AM, but decided to report to LPN #1 that the orders needed to be called to the physician, and transferred into the computer. LPN #3 stated she wrote the hemodialysis on hemodialysis days in parenthesis and that no doctor gave her the order to do so. LPN #3 stated she wrote the order herself, so the oncoming nurse would know how to enter it in the computer. LPN #3 stated she probably should not have added to the order from the discharge summary, but typically a lot of the dialysis patients received their antibiotics in dialysis and wanted to make sure it was clarified</p>	F 333	<ul style="list-style-type: none"> Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new hires on 7/22/2013 and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance. Also the Quality Assurance Committee (included Medical Director, DON, ADON, Administrator, ANC) met on the following dates: 7/1, 7/2, 7/3, 7/4, 7/5, 7/8, 7/9, 7/11, 7/12, 7/15, 7/18, 7/22, 7/24, 7/25, and 7/29 to assess reviews and make recommendations. These reviews were assessed by the Quality Assurance Committee (DON, ADON, Administrator, ANC) and will continue to be monitored to ensure effectiveness of the allegation of compliance. <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by:</p>	8-28-2013
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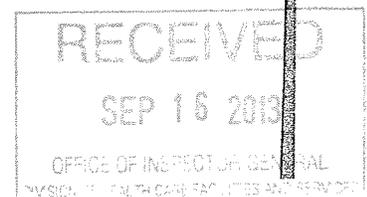
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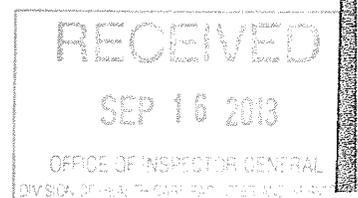
F 333	<p>Continued From page 27</p> <p>in the computer. LPN #3 stated she did not normally document that the order was read and verified to the doctor. LPN #3 stated that the pharmacy normally received a copy of the discharge summary and the Physician Order sheet.</p> <p>Interview with LPN #1, on 07/01/13 at 1:13 PM, revealed she could not remember working on Resident #1's admission. LPN #1 did not remember putting the orders into the computer and further did not remember working on the unit.</p> <p>However, interview with the Assistant Director of Nursing (ADON), on 07/02/13 at 12:45 PM, revealed the ADON called their Computer Department and was informed LPN #1 was the nurse who placed the order in the system and who would have called the physician for verification of the orders.</p> <p>Further review of the Dialysis orders, dated 03/22/13, revealed no antibiotics were ordered for Resident #1. Review of the Nephrologist's orders, dated 03/22/13, revealed the antibiotic section stated "N/A". Review of the Physician Orders Sheet, dated 03/22/13 revealed there was no signature to show who read and verified the order or who would have faxed the order to pharmacy and/or the Dialysis Center.</p> <p>Review of an e-mail sent by the Pharmacy Staff to the ADON, on 04/16/13 at 4:47 PM, revealed the pharmacy only sent one (1) dose on 03/22/13 from the discharge summary. The admission orders said it was to be given after hemodialysis on hemodialysis days, and this indicated to the pharmacy that it was to be given at dialysis. Therefore, pharmacy never sent any further</p>	F 333		
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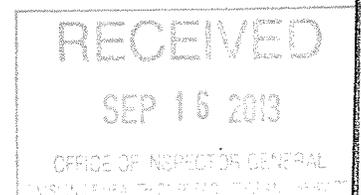
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F 333	<p>Continued From page 28</p> <p>doses. However review of the residents MAR revealed no evidence the resident received the dose issued to the facility on 03/22/13. Review of the Medication Regimen Review, revealed a pharmacy review was completed on 04/01/13 by the Pharmacy Consultant; however, it did not identify the resident was currently on an antibiotic.</p> <p>Interview with the Pharmacy Consultant, on 07/05/13 at 11:34 AM, revealed when she completed a pharmacy review she looked for drug interactions, gradual dose reductions, labs and what was necessary for the patient. The Pharmacy Consultant stated when she received a new patient she did not generally look at the discharge orders, because the Doctor may change the orders. The Pharmacy Consultant stated she looked at the new orders and the verified orders because a lot of medications may change. However, did not see the order for the antibiotic at dialysis.</p> <p>Interview with Resident #1's Physician, on 07/03/13 at 12:53 PM, revealed he was aware Resident #1 was to receive an antibiotic daily. He stated the facility did not formally notify him of the medication error per facility policy or call for the Quality Assurance team to meet to talk about the medication error. Per interview and record review, Resident #1 did not have any signs of fever, head pain or chills, which all were signs of Sepsis, and his/her white cell count was within normal range, so the Physician thought the resident was still receiving the antibiotic. Continued interview with Resident #1's Physician, on 07/05/13 at 1:35 PM, revealed he did not remember instructing the nurse to write the order to say after hemodialysis on hemodialysis days.</p>	F 333			



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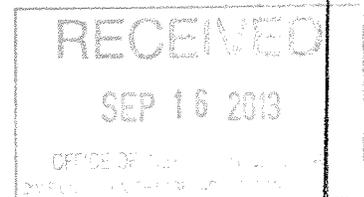
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F 333	<p>Continued From page 29</p> <p>Interview with the Advanced Practice Registered Nurse (APRN), on 07/02/13 at 2:00 PM, and review of the APRN's progress note dated 04/15/13, revealed she assessed Resident #1, on 04/15/13. Resident #1 had complained of nausea and vomiting. Therapy had reported the resident was now a maximum assist and prior to this, Resident #1 was a minimal assist. The APRN stated Resident #1 was slow to respond, and she decided to send Resident #1 to the Emergency Room for evaluations and treatment of the mental status changes. It was on 04/15/13 while reviewing the resident's chart, when it was discovered the resident had not been receiving the antibiotic therapy.</p> <p>Interview with the Administrator (new to the facility for one month), on 07/03/13 at 10:41 AM, revealed she was not aware of the medication error for Resident #1. The Administrator stated she did see a write-up dated 06/05/13 regarding LPN #3 related to a physician's order written without a physician's direction and thought she needed to follow up. The Administrator stated she became aware of the concern when the State Survey Agency came into the building, and did not have any more investigative information to provide regarding the medication error.</p> <p>2. Review of the clinical record for Resident #5 revealed the facility re-admitted the resident on 12/13/12 with diagnoses of Dementia and Gout. The facility assessed the resident on 11/19/12 as cognitively impaired with a Brief Interview Mental Status (BIMS) of four (4). The physician order sheet (POS), upon readmission 12/13/12, revealed the resident was to receive Allopurinol 200 mg every bedtime for Gout. Additionally, the</p>	F 333		



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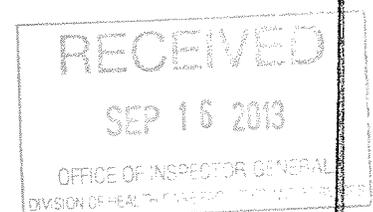
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F 333	<p>Continued From page 30</p> <p>POS for January 2013 through May 2013 revealed the Allopurinol was not listed to be administered. Review of the physician orders revealed there was no discontinue (D/C) order for the Allopurinol for Resident #5.</p> <p>Review of Resident #5's electronic record revealed a facility staff member entered Allopurinol 200 mg to be given every bedtime into the electronic record to start the medication on 12/13/12 at 10:03 PM and stop the medication on 12/14/12 at 8:00 PM. The EMAR, beginning 12/13/12 and ending 06/10/13, revealed the resident did not receive the Allopurinol medication until 06/11/13 when the medication was placed on the POS and EMAR. The EMARs for January 2013 through May 2013 did not have the Allopurinol listed to be administered to the resident.</p> <p>On 07/25/13 at 1:18 PM, interview with Licensed Practical Nurse (LPN) #6 revealed the POS came from the EMAR. The LPN stated if a medication was not in the EMAR, then it also would not be on the POS. She stated Resident #5's Allopurinol was not on the POS for several months. The LPN stated the resident's Allopurinol was started 12/13/12 in the EMAR, upon readmission to the facility, and stopped 12/14/13. She stated if the medication was not listed on the EMAR then the medicine would not be administered to the resident. The LPN stated the nurse receiving the physician order was responsible to enter the orders into the EMAR. She stated the Nurse Leader on the unit was responsible to verify the orders entered into the EMAR were correct; however, the unit was without a Nurse Leader. The LPN stated without a Nurse Leader the nurse on the next shift should check the information.</p>	F 333			



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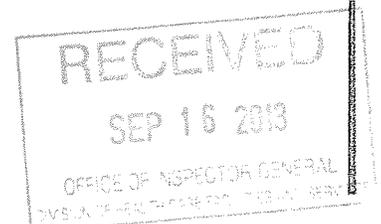
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F 333	Continued From page 31 Interview, on 07/25/13 at 1:55 PM and 2:40 PM, and on 07/26/13 at 9:48 AM, 12:20 PM, and 2:52 PM, with the Director of Nursing (DON) revealed Resident #5's Allopurinol had not been D/C'd by the physician after the resident's readmission to the facility 12/13/12 and when it was stopped in the EMAR on 12/14/12. She stated if the medication was not on the EMAR then it would not be administered to the resident and the medication would not be listed on the POS. The DON stated Resident #5 should have received the medication from the time the facility readmitted the resident 12/13/12 to 06/11/13 when the facility began to administer the medication. She stated the House Leader was responsible to audit resident charts; however, the unit was without a House Leader since 06/24/13. She stated the responsibility would fall on herself or the Assistant Director of Nursing (ADON). The DON stated Resident #5 was on a long term care unit which was audited the previous evening; however, she could not recall if anyone audited the resident's chart. The DON stated if the resident did not receive the Allopurinol for six (6) months the resident could have had a flare up of the disease which could cause the resident pain. Interview with Resident #5's physician (MD), on 07/25/13 at 3:11 PM, revealed the resident should have been receiving the Allopurinol unless there was a written order to D/C the medication. He stated without a D/C order by him, the medication should have been given and should not have been stopped. The MD stated it was a medication error if the medicine was not administered. He stated without the medication, the resident's Gout could flare up resulting in swollen joints and kidney stones.	F 333			



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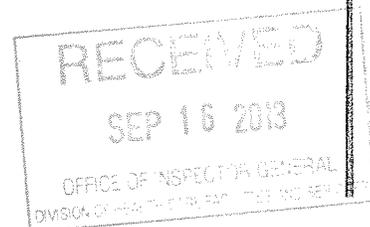
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F 333	Continued From page 32 Review of the Acceptable Allegation of Compliance (AOC) on 08/02/13, revealed the facility took the following immediate actions: 1. Resident #1 was discharged to the hospital on 04/15/13 and did not return. 2. For the facility to identify other residents that might be affected, the quality assurance consultants, under recommendation of the Quality Assurance Committee, completed a chart review that verified care plan were updated, beginning 07/01/13 through 07/31/13. 3. In-services were conducted from 07/02/13 through 07/25/13. The in-services included topics of updating the care plan related to medication orders were conducted by the ADON, the Quality Consultant, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses. 4. The DON, ADON, Administrative Nurse Consultant and other professional consultants were conducting daily reviews of new admissions and daily orders to monitor for accurate processing of new orders and that care plans were updated accordingly. 5. The DON was responsible for assuring the daily review process of physician orders and care plan updates as discussed were audited and reported for weekly review by the Quality Assurance Committee. The State Survey Agency validated the AOC on 08/02/13 prior to exit as follows:	F 333			



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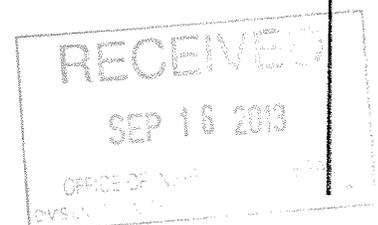
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F 333	<p>Continued From page 33</p> <p>1. Record review revealed Resident #1 had been discharged on 04/15/13 and not scheduled to return.</p> <p>2. Record review revealed chart audits were completed on 07/01/13 through 07/31/13 to ensure nursing care plans for residents were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily to include physician orders and medication administration records. Interview with the interim DON (Consultant), on 07/26/13 at 12:30 PM, revealed she had completed all chart audits from 07/01/13 to 07/31/13 by looking at physician orders and medication administration records.</p> <p>3. Record review revealed an in-service was provided by ADON and Quality Consultant on 07/02/13 through 07/25/13, by review of the content of the in-service and review of the attendance logs for the In-service revealed all nursing staff attended the inservice. Interviews conducted on 08/02/13 with five (5) Licensed Practical Nurses: LPN #4 at 4:55 PM, LPN #2 at 6:05 PM, LPN #13 at 5:45 PM, LPN #14 at 6:33 PM, LPN #15 at 6:33 PM, two (2) Registered Nurses: RN #5 at 4:50 PM, and RN #4 at 5:57 PM, and three (3) Certified Medication Technicians (CMT)'s; CMT #1 at 11:22 AM, CMT #20 at 5:55 PM, and CMT #21 at 5:50 PM revealed they were educated on standards of practice, transcription process, communication to pharmacy, medication error process, and re-verification of orders in the EMAR system. Interview with LPN #3 at 08/01/13 at 1:37 PM, revealed she was educated on the transcription process, standards of practice, communication</p>	F 333		



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F 333	Continued From page 34 and ensuring re-verification of orders in the EMAR system. Interview with LPN #16 on 08/02/13 at 6:33 PM, revealed she was also educated on checking for accuracy and making sure not to interpret the orders, but to write the orders exactly as the physician wrote them. 4. Record review revealed the Administrative staff conducted daily reviews of new admission and daily orders to monitor to ensure records were accurate. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily. Interview with the ADON, on 07/24/13 at 10:35 AM, revealed she made copies of discharge summaries, written admission physician order sheet and then compared these documents to the computer to ensure items were correct and matched. Record review revealed the DON submitted all reviews to the Quality Assurance Committee. 5. Review of the care plan audit updates and weekly review information given to the QA committee revealed the documents were completed and reviewed by the Committee. Interview with the Interdisciplinary Team (IDT), (Nursing, Activities, Social Services and Dietary), on 08/02/13 at 2:03 PM, revealed the interdisciplinary team met daily to review audits for updates and weekly review of all information obtained through out the week.	F 333			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	1. Resident #5, # 31, and #35 were identified as being affected by the identified issue. The residents were addressed as follows: Resident #5 – on 6-11-2013 the nurse practitioner ordered Allpurinol in response to a pharmacy recommendation. The order was discontinued on 7-9-13 by the nurse practitioner due to resident refusal of medication.		



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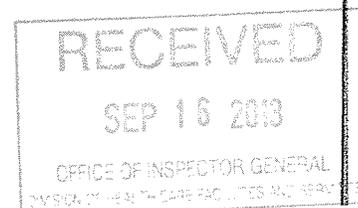
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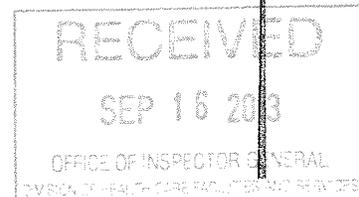
F 428	Continued From page 35 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to act on pharmacy recommendations for one (1) of thirty-eight (38) sampled residents (Resident #5) and the Consultant Pharmacist failed to identify medication transcription errors through the medication regimen review for two (2) of thirty-eight (38) sampled residents (Resident #31 and #35). The findings include: Review of the facility policy Consultant Pharmacist Services Provider Requirements, not dated, revealed the Consultant Pharmacist (CP) would evaluate the process of reconciling and administering all medications. The CP would also assist to identify and evaluate medication related issues, including the prevention and reporting of medication errors. Additionally, the CP would review the Medication Administration Record (MAR) monthly to ensure proper documentation of medication orders and administration of medications to residents. Review of the facility policy Medication Regimen Review, not dated, revealed the facility would	F 428	Resident #31 – resident #31 40 mg Lasix order reviewed by physician on 7/26/2013. <i>EMAR corrected on 7/16/2013</i> Resident #35 - a clarification order was obtained to correct the administration record on 7-29-2013. 2. To identify other residents potentially affected by the identified issue, the facility initiated the following corrective actions: • All transcription orders were reviewed on 7/25/2013 upon the recommendations of the Pharmacy medication regimen order review. • Consultants Pharmacy (CP) conducted re-education for all Licensed Practical Nurses, Registered Nurses, and Agency Nurses. These in-services included instruction on transcription of physician orders, physician order transcription process, communication to pharmacy, medication error process, and re-verification of orders into the EMAR system and medication administration records. A question and answer period was incorporated in each in-service session to assure comprehension of education presented. • The orientation process and checklist for newly hired licensed nurses was revised by DON, ADON, and ANC on 7/12/2013 to include the transcription of physician orders, physician order transcription process, communication to pharmacy, and medication error process 3. The facility has initiated the following corrective actions to assure that identified issue does not reoccur as follows: • The Director of Nursing conducted an in-service with the nursing house leaders on 7/31/2013 to review their responsibilities to include monitoring professional standards of practice in transcription of physician orders, verification of orders, medication error reporting. • The Director of Nursing conducted in-service with all licensed nursing staff on 8/13/2013 through 8/19/2013 to include practicing within professional standards in the transcription of physician orders, verification of orders, medication error reporting. • CP conducted review of applicable internal medication storage policies to verify current application to facility operations on 8/12/2013.	
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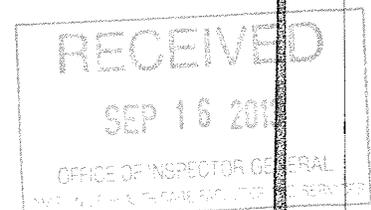
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2013
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
(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 428	<p>Continued From page 36</p> <p>assure the CP had access to resident medical records. The medication regimen review (MRR) would be conducted at least monthly by the CP. The CP would use a variety of sources to conduct the MMR including the resident's Medication Administration Record (MAR). Additionally, the CP's evaluation included review of medication errors.</p> <p>Review of the facility policy Documentation and Communication of Consultant Pharmacist Recommendations, not dated, revealed the CP would document potential or actual medication related problems and other MRR findings appropriate for nursing review. Recommendations should be responded to prior to the next MRR. Additionally, recommendations would be acted upon and documented by facility staff.</p> <p>Review of the CP Agreement, dated 07/18/09, revealed the pharmacy would provide the facility with a medication administration system and software interface with EMAR system when acquired by the facility. Additionally, the facility would provide the pharmacy access to all resident records necessary for the performance of the pharmacy's duties.</p> <p>1. Review of the clinical record for Resident #5 revealed the facility re-admitted the resident on 12/13/12 with diagnoses of Dementia and Gout. The facility assessed the resident on 11/19/12 as cognitively impaired with a Brief Interview Mental Status (BIMS) of four (4). The physician order sheet (POS), upon readmission 12/13/12, revealed the resident was to receive Allopurinol 200 mg every bedtime for Gout. Additionally, the POS for January 2013 through May 2013</p>	F 428	<p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> • The Director of Nursing will direct a daily audit of new orders and admission orders to monitor that the professional standards of practice are followed during transcription of physician orders. The completed audits are maintained on file and are reported to the Quality Assurance Committee (QA) weekly for review and recommendation. This audit process will be continued weekly until revised by the QA. The Administrator is responsible for monitoring that the audit process is maintained. • The Director of Nursing will make a monthly trending report of the audits to the full Quality Assurance Committee for assessment and recommendation. The audit schedule will be continued until revised by the Quality Assurance Committee. The Administrator will be responsible to assure that the compliance plan is monitored by the Quality Assurance Committee. • CP will perform weekly audits to verify the accuracy of all medication orders prior to the order being finalized in the CP medication record system and make audit report to QA weekly. • Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan. • The Quality Assurance Committee will review required audits and supportive documentation monthly to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis. <p>5. Completed by:</p>	8-28-2013	



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F 428	<p>Continued From page 37</p> <p>revealed the Allopurinol was not listed to be administered. Review of the physician orders revealed there was no discontinue (D/C) order for the Allopurinol for Resident #5.</p> <p>Review of the Consultant Pharmacist Communication to Nursing, dated 02/15/13, 03/06/13, and 05/31/13, revealed Resident #5 was readmitted on 12/13/12 with Allopurinol 200 mg every bedtime, and this was being filled by the pharmacy per the physician order. Additionally, the Allopurinol was not found on the POS and the facility was requested to ensure the medication was on the POS and the MAR.</p> <p>Review of Resident #5's electronic record revealed a facility nurse entered Allopurinol 200 mg to be given every bedtime into the electronic record to begin the medication on 12/13/12 at 10:03 PM and stop the medication on 12/14/12 at 8:00 PM. The EMAR, beginning 12/13/12 and ending 06/10/13, revealed the resident did not receive the Allopurinol medication until 06/11/13 when the medication was placed on the POS and EMAR. The EMARs for January 2013 through May 2013 did not have the Allopurinol listed to be administered to the resident.</p> <p>However, review of the pharmacy Fill History, from 12/14/12 through 06/20/13, revealed four hundred forty-six (446) doses of Allopurinol were dispensed to the facility for Resident #5. One hundred forty-six (146) doses were returned to the pharmacy by the facility, leaving three hundred (300) doses of Allopurinol in the facility to be administered to Resident #5.</p> <p>Interview with CP #2, on 07/26/13 at 10:43 AM, revealed the CP used their own computer system</p>	F 428			



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F 428	<p>Continued From page 38</p> <p>when conducting monthly reviews, which was different from the facility's electronic charting system. He stated the POS was included in the monthly review; however, the CP did not review the resident EMARs. The CP stated Consultant Pharmacists did not review the electronic record or EMARs. He stated the CP and the pharmacy had no way to know if a medication had been administered. Additionally, if a medication was not listed on the POS, then it would not be on the EMAR, as the nurses generate the POS from the EMAR.</p> <p>Interview, on 07/26/13 at 1:50 PM, interview with CP #1 revealed the original recommendation for Resident #5's Allopurinol was made in February 2013. On 03/06/13 the recommendation was still pending facility follow-up. She stated in April 2013 the Allopurinol was not identified again as at times the pharmacy recommendation could still be pending. The CP stated in May 2013 the pharmacy did not address with the facility that Resident #5's Allopurinol was still not listed on the POS or EMAR. The CP stated she did not have access to the facility EMAR and she worked in another room from the facility computer. She stated she did not get into the electronic chart when at the facility. She stated nursing entering physician orders into the electronic chart was problematic as pharmacy would not have pharmaceutical oversight. The CP stated no one at the facility had informed her of a computer problem with the electronic chart or EMAR.</p> <p>2. Review of the clinical record for Resident #31 revealed the resident was readmitted to the facility on 07/02/13 with diagnoses of End Stage Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of</p>	F 428		
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