

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

PRINTED: 03/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 03/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRING VIEW HEALTH &amp; REHAB CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>718 GOODWIN LANE LEITCHFIELD, KY 42754</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<b>INITIAL COMMENTS</b>  An Onsite Revisit Survey to the 12/23/15 Abbreviated Survey was conducted on 03/11/15-03/13/15 and determined the deficiencies were corrected on 02/05/15, as alleged in the acceptable PoC and the facility was in compliance on 02/28/15.	{F 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated/Partial Extended Survey investigating complaints #KY22519 and #KY22595 was conducted on 12/08/14 through 12/23/14 to determine the facility's compliance with Federal requirements. Complaint #KY22519 was initiated on 12/08/14 and #KY22595 was received during the survey and was initiated on 12/22/14. Complaint KY22595 was unsubstantiated with no deficiencies and #KY22519 was substantiated with deficiencies cited at the highest Scope and Severity of a "J".</p> <p>On 10/28/14, Registered Nurse (RN) #1 prepared several insulin doses in advance. RN #1 entered Resident #2's room with Resident #2 and Resident #3's insulin in her hand. RN #1 administered Resident #3's insulin (Lantus 30 units) to Resident #2 instead of the ten (10) units of Levemir that the resident's physician had ordered.</p> <p>On 11/17/14, RN #1 entered the dining room with a syringe of insulin and approached Resident #1 (who does not receive insulin) to administer the insulin; however, the nurse was stopped by the resident's family member who informed RN #1 that the resident did not take insulin.</p> <p>Immediate Jeopardy was identified at 42 CFR 483.20 Resident Assessment at F-281 and 42 CFR 483.25 Quality of Care at F-333 at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. Immediate Jeopardy was identified on 12/10/14 and determined to exist on 10/28/14. The facility was notified of the Immediate Jeopardy on 12/10/14. An acceptable Allegation</p>	F 000	<p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p><b>F 281 483.20 (k)(3)(i) Services Provided Meet Professional Standards.</b></p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency:</u>          [1] The error was immediately reported to resident #2's primary care physician on October 28, 2014 by the licensed nurse.          [2] Resident #2's blood sugar was checked every hour for that night by the licensed nurse. A snack with protein was given to the resident by the licensed nurse. Resident #2 was monitored by the licensed nurse per MD orders with no issues noted.          [3] RN #1 was re-educated to prepare medications for only one resident at a time and to never pre-fill insulin syringes for multiple residents by a Regional Resource</p>	2/5/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE MHA	(X6) DATE 3/11/15
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F 000	Continued From page 1 of Compliance (AoC) was received on 12/22/14 alleging the Immediate Jeopardy was removed on 12/17/14. The State Survey Agency validated the Immediate Jeopardy was removed on 12/17/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance Committee monitors the effectiveness of the system changes.	F 000	Nurse on 12/10/2014. [4] RN #1 was re-educated on following the "Six Rights of Medication Administration" by a Regional Resource Nurse on 12/10/2014. [5] RN #1 was re-educated by Regional Resource Nurse on 12/10/2014 to review the pictures of residents in the Licensed Nurses Administration Record prior to giving the medications. [6] RN #1 was observed during administration of insulin to verify competency in that task on 12/10/2014 by a Regional Resource Nurse. [7] Upon return from leave on 12/16/2014 a medication administration observation was conducted with RN #1. Although all ordered routes of administration were observed, residents requiring insulin were included in the sample. Additional observations were conducted each week for 3 weeks by the Director of Nursing and Regional Resource Nurse then will be monthly x 6 months in accordance with monitoring for all nurses.		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to have an effective system to ensure medication was administered according to the professional standards addressing the five (5) rights of medication administration for two (2) of four (4) sampled residents (Resident #1 and Resident #2).  On 10/28/14, Registered Nurse (RN) #1 prepared several insulin doses in advance. RN #1 entered Resident #2's room with Resident #2 and Resident #3's insulin in her hand. RN #1 administered Resident #3's insulin (Lantus 30 units) to Resident #2 instead of the 10 units of the	F 281	[8] Resident #1 identified did not have insulin ordered, therefore insulin was not administered. [9] Resident #3 received his insulin as ordered on 10/28/2014 <u>How Other Resident's Who May Be Affected By This Practice Were Identified</u> [11] Residents clinical records were reviewed by the Nursing Administrative Team on 12/10/14 to ensure to ensure there is a current and accurate photograph on the Medication Administration Record to assist with resident identification.	2/5/15	

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F 281	<p>Continued From page 2 physician ordered Levemir. (Refer to F333)</p> <p>On 11/17/14, RN #1 entered the dining room with a syringe of insulin and approached Resident #1 (who does not receive insulin) to administer the insulin. Resident #1's family member stopped RN #1 and informed her that the resident did not take insulin.</p> <p>The facility's failure to ensure medication was administered according to the nursing standards of practice has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/10/14 and was determined to exist on 10/28/14. The facility was notified of the Immediate Jeopardy on 12/10/14.</p> <p>The findings include:</p> <p>Review of the Nursing 2007 Drug Handbook, (2007) Lippincott Williams &amp; Wilkins: Philadelphia, Pennsylvania revealed the overwhelming talk of ensuring medication safety can be managed by consistency using the five (5) rights of drug administration: The right drug, right route, right dose, right time and right patient. Further review revealed the right patient should be confirmed by checking the patient's identification, and asking the resident's their name.</p> <p>Review of the facility's policy and procedure titled, "General Dose Preparation and Medication Administration", last revised 01/01/13 revealed facility staff should only prepare medications for one resident at a time. Further review revealed facility staff should verify each time a medication is administered that it is the correct medication, at</p>	F 281	<p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>[1] The Director of Nurses and Unit Managers were trained by a Regional Resource Nurse on the preparation for only one resident at a time on 12/10/2014 and 12/11/2014.</p> <p>[2] On December 10, 11, and 12, 2014, the Regional Resource Nurse provided education to all licensed nurses and Certified Medication Aides on the "Six Rights of Medication Administration " and the "Preparation of Medication for Only One Resident at a Time.</p> <p>[3] The Director of Nurses was educated by the Administrator and Regional Resource Nurse on 12/11/2014 regarding the need to thoroughly investigate medication errors and to identify the Root/Cause/Analysis of the error. The Director of Nurses was instructed to base the corrective action, education and or discipline on identified root cause. In all cases the error would be reviewed by the Director of Nurses and the Administrator and the potential significance of the error considered in the implementation of performance correction.</p> <p>[4] The current Director of Nursing was educated on Root/Cause/Analysis by the Regional Resource Nurse on 2/3/2015 during orientation process.</p> <p>[5] In the event a medication error occurs, the Director of Nurses will be notified and will assist in the identification of the root/cause. The error will be brought by the Director of Nurses to the Abbreviated Quality Assurance meeting [consisting of</p>	2/5/15

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F 281	<p>Continued From page 3</p> <p>the correct dose, at the correct route, at the correct rate, at the correct time and for the correct resident.</p> <p>Review of the facility's policy and procedure titled, "Resident Identification", dated 01/01/07, revealed its policy was to maintain a resident identification system to assure prescribed treatments were administered to the correct resident. Further review revealed the facility had adopted two (2) resident identification systems which were to be implemented upon admission to assist in assuring that drugs, medications, and treatments prescribed for one resident were not administered to another. The resident identification systems included the resident's photograph and/or wristband identification. The policy stated if pictures were utilized, the location of the resident's photograph would be on the Medication Administration Record (MAR).</p> <p>1. Record review revealed the facility admitted Resident #2 on 07/10/14 with diagnoses which included Alzheimer's disease and Diabetes Mellitus. Review of Physician's Orders, October 2014, for Levemir (Insulin); inject 10 units subcutaneous daily at bedtime.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment, dated 08/04/14, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of 99, which indicated the resident was not interviewable.</p> <p>Review of the facility's Medication Error Log, dated 10/28/14, revealed Resident #2 had received the wrong insulin.</p>	F 281	<p>Administrator, Director of Nursing, Dietary Manager, Social Services Director, Activity Director, MDS Coordinator, Business Office Manager, Plant Services Director, Unit Managers, Staff Development Coordinator and Admissions Director] daily Monday-Friday for review by the Interdisciplinary Team of the root/cause/analysis in order to determine proper corrective measures. On weekends the Director of Nurses or the on call nurse will analyze for root cause and review with the Interdisciplinary in the next Abbreviated Quality Assurance meeting. Based on the root/cause/analysis and Interdisciplinary review, the Director of Nurses in conjunction with the Administrator and Human Resources Director will determine the appropriate performance correction action based on the investigation, circumstances and prior performance correction within the progressive discipline process.</p> <p>[6] The process for responding and recording medication errors has been modified. Actions and corrective measures which are based on the root/cause/analysis findings, will be recorded and follow-up/monitoring scheduled by the Director of Nurses. A record will be maintained by the Director of Nursing, Assistant Director of Nursing and/or the Human Resources Director of education and/or performance corrective actions conducted with the employee involved. The employee will also be subject to progressive discipline by the Director of Nursing or the Assistant Director of Nursing.</p>	2/5/15	

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F 281	<p>Continued From page 4</p> <p>Interview with RN #1, on 12/09/14 at 3:40 PM, revealed she had prepared several insulin doses in syringes in advance on 10/28/14. RN #1 stated she entered Resident #2's room with Resident #2's and another resident's insulin in her hand. She stated she mistakenly picked up the other resident's insulin syringe and administered the insulin, Lantus 30 units, to Resident #2 instead of his/her 10 units of the physician ordered Levemir. RN #2 stated she immediately realized she had administered the wrong medication to Resident #2 and notified the Director of Nursing (DON) and the resident's physician. RN #1 stated Resident #2 was monitored throughout the night, as ordered by the physician, and no known adverse outcome was noted. Furthermore, RN #1 stated she had pre-filled the insulin syringes for residents frequently and did not realize it was an unsafe practice.</p> <p>2. Record review revealed the facility admitted Resident #1 on 04/30/11 with diagnoses which included Alzheimer's Disease, Hypertension and Depressive Disorder. Further review of the clinical record revealed the resident did not have a Physician's Order for insulin.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/30/14, revealed the facility had assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was not interviewable.</p> <p>Review of the facility's Medication Error Logs for 11/2014, revealed no documented evidence of a medication error for Resident #1.</p> <p>Interview with RN #1, on 12/09/14 at 3:40 PM,</p>	F 281	<p>[7] Medication Observations will be conducted monthly by the Director of Nurses, Assistant Director of Nursing and/or Unit Managers for next 12 months for all licensed nurses and Certified Medication Technicians. Any variances to the Standards of Practice will be addressed and corrected with the nurse/Certified Medication Technicians immediately at the time of the medication pass by the Director of Nurses, Assistant Director of Nurses, or the Unit Manager.</p> <p>[8] Monthly post testing on [a] "The 6 Rights of Medication Administration" and [b] "Medication Preparation For Only One Resident At A Time" will be completed monthly for 12 months by the Director of Nursing, Assistant Director of Nursing and/or the , Unit Managers for the licensed nurses and Certified Medication Technicians to ensure the Standards of Practice are followed.</p> <p>[9] A log was developed and implemented effective 12/15/2014 to assist in monitoring, implementation of corrective measures and to assist in trending error identified. This log is utilized at the time the medication error is identified. It will be reviewed as part of the Abbreviated Quality Assurance meeting led by the Administrator.</p> <p><u>Monitoring Measures To Maintain On-Going Compliance:</u></p> <p>[1] The Director of Nurses, Assistant Director of Nurses, Unit Managers, or the Regional Resource Nurse is responsible for the monitoring of the Medication</p>	2/5/15	

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F 281	<p>Continued From page 5</p> <p>revealed she had prepared several doses of insulin in advance on 10/28/14. RN #1 stated she had Resident #2 and Resident #3's insulin in her hand when she entered Resident #2's room. She stated she mistakenly picked up Resident #3's insulin (Lantus 30 units) and administered it to Resident #2 instead of the Levemir 10 units as ordered by the physician. She stated she immediately realized she had administered the wrong medication to Resident #2 and notified the Director of Nursing (DON) and the resident's physician. RN #1 stated she had pre-filled insulin syringes for residents frequently in the past and did not realize it was an unsafe practice. Further interview with RN #1 revealed she also had an incident with Resident #1 on 11/17/14. She stated she entered the dining room to administer the insulin and was told by the resident's family member that the resident did not take insulin. She stated she should have looked in the Medication Administration Record to identify the resident by his/her picture.</p> <p>Interview with the Director of Nursing (DON), on 12/09/14 at 9:43 AM and 12/10/14 at 5:43 PM, revealed she had talked with RN #1 after the medication error with Resident #2 and instructed her in the future to prepare the residents' insulin per policy and procedure, one resident at a time. The DON stated the facility did not have any documented evidence an investigation was conducted related to the incident with Resident #1 to determine the root cause, as she did not consider this to be a medication error because the medication was not administered to the resident. The DON stated that no action had been taken to prevent the incident from happening again. In addition, the DON stated the facility did not provide any re-education to the</p>	F 281	Administration Observations. Director of Nurses will bring the results of the observations to the monthly Quality Assurance Committee consisting of the Administrator, Director of Nurse, Dietary Manager, Social Services Director, Activity Director, MDSC, Business Office Manager, Plant Services Director, Medical Records, Unit Managers, Staff Development Coordinator and Admissions for review and development of action plan to ensure services meet professional standards of quality.	2/5/15	

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F 281	<p>Continued From page 6</p> <p>icensed nurses and had not developed an action plan or conducted any monitoring.</p> <p>Interview with the Administrator on 12/10/14 at 6:00 PM, revealed it was her expectation for staff to follow the facility's policy and procedures.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <ol style="list-style-type: none"> <li>1. On 12/10/14, RN #1 was re-educated to prepare medication for one resident at a time and was instructed never to pre-fill insulin syringes for multiple residents. In addition, RN #1 was re-educated on following the "Six Rights of Medication Administration" and to review the resident's photo in the MAR prior to administering medications. RN #1 was observed by the Regional Resource Nurse during administration of insulin to verify competency. Additionally, RN #1 was suspended without pay for three (3) days.</li> <li>2. The DON and the Unit Managers (UM) were trained by the Regional Recourse Nurse on preparation of medication for only one resident at a time on 12/10/14, and on 12/11/14.</li> <li>3. The facility provided education to all licensed nurses and Certified Medication Technicians (CMTs) on the "Six Rights of Medication Administration" and re-educated on the preparation of medication for only one resident at a time. This was done by the DON, UMs, and Regional Resource Nurse on 12/10/14, 12/11/14 and 12/12/14. In addition, the training has been incorporated into the orientation of all licensed nurse hires and CMT hires.</li> <li>4. The DON was educated regarding the need to</li> </ol>	F 281		2/5/15	

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F 281	<p>Continued From page 7</p> <p>thoroughly investigate medication errors and to identify the root cause of the error. This education was conducted on 12/11/14 by the Administrator and the Regional Recourse Nurse.</p> <p>5. The facility developed a process to ensure staff members were provided education/counseling to address the root cause of the error to prevent re-occurrence. The facility's Department Leaders consisting of the DON, Unit Managers, Dietary Supervisor, Activity Director, Social Service Director, Human Resource Director, and the Minimum Data Set (MDS) Coordinators were educated on the process on 12/11/14 and 12/12/14 by the Administrator.</p> <p>6. Medication Administration observations for all nurses and CMTs were completed by the Regional Resource Nurse, DON and Unit Managers on 12/10/14 through 12/13/14.</p> <p>7. Medication errors previously identified for 2014 were audited to verify that appropriate actions had been taken. The audit was completed on 12/12/14 by the Administrator, Regional Director of Operations and the Human Recourse Director.</p> <p>8. On 12/11/14, the Regional Resource Nurse conducted training for the Quality Assurance (QA) Team Members which included the Administrator, Director of Nursing, Unit Managers, MDS Coordinators, Social Service Director, Activity Director, Maintenance Director, Human Resources Director and the Medical Records Director regarding Root Cause Analysis.</p> <p>9. The QA committee, which includes the Administrator, Director of Nursing, Unit Managers, MDS Coordinators, Social Service</p>	F 281		2/5/15	

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F 281	<p>Continued From page 8</p> <p>Director, Activity Director, Maintenance Director, Human Resources Director and the Medical Records Director will track medication pass observation findings for six (6) months to verify that proper administration technique is being followed. The QA Committee will also confirm that measurable goals are presented on all medication error counseling to create follow up monitoring to evaluate the ongoing compliance with policies. Trends will also be reviewed in the monthly QA meeting in conjunction with the Medical Director.</p> <p>10. The facility modified the process for responding and recording Medication Errors to include implementation of corrective measures based on the root cause analysis findings. The facility will maintain a record of education and performance correction actions conducted with employees involved with medication errors. Employees involved in medication errors will be subject to progressive disciplinary actions.</p> <p>11. The facility modified the new employee orientation education to include the proper way to prepare and administer medication and the six (6) rights of medication administration. In addition, all new medication errors are now brought to the daily QA meetings Monday-Friday to discuss the root cause analysis and ensure employee follow up. The Administrator and DON or, the On Call Administrative Nurse will be notified when a medication error occurs. Additionally, on 12/12/14, a checklist was implemented to guide the staff through the appropriate steps following a medication error.</p> <p>12. The facility developed and implemented a log on 12/15/14 to assist in monitoring the</p>	F 281		2/5/15	

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F 281	<p>Continued From page 9</p> <p>implementation of corrective actions and to assist in trending errors identified which will be reviewed as part of the Abbreviated Quality Assurance Meeting.</p> <p>13. The QA Committee will review medication errors/performance correction to identify trends conduct root cause analysis and ensure appropriate interventions added to prevent re-occurrence.</p> <p>14. The DON, Unit Managers, and the Resource Nurses will conduct medication pass observations on all nurses and CMTs each month for six (6) months and then quarterly. Results of the observations will be reviewed at the monthly QA Committee meeting.</p> <p>15. Monthly post testing on the six (6) rights of medication administration, preparation of medication for one resident at a time, and resident identification will be completed for six (6) months and then reduced to quarterly.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <p>1. Interview with RN #1 on 12/23/14 at 10:55 AM, revealed she was re-educated to prepare medication for one resident at a time and was instructed never to pre-fill insulin syringes for multiple residents. In addition, RN #1 stated she was re-educated on following the "Six Rights of Medication Administration" and to review the resident's photo in the MAR prior to administering medications. RN #1 stated she was observed by the Regional Resource Nurse during administration of insulin to verify competency and was suspended for three (3) days. Review of a</p>	F 281		2/5/15

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F 281	<p>Continued From page 10</p> <p>"Staff Development Attendance Record" dated 12/10/14 validated RN #1 received the education.</p> <p>2. Interview with the DON on 12/23/14 at 11:05 AM, revealed she was trained by the Regional Recourse Nurse on preparation of medication for only one resident at a time.</p> <p>Interviews on 12/23/14 with Unit Manager, LPN #3 at 9:35 AM and Unit Manager, LPN #4 at 10:09 AM, revealed they were trained by the Regional Recourse Nurse on preparation of medication for only one resident at a time on 12/10/14 and on 12/11/14.</p> <p>Review of the facility's attendance records dated 12/10/14 and 12/11/14 verified training was conducted.</p> <p>3. Interview on 12/23/14 with LPN #2 at 10:00 AM, LPN #5 at 7:39 AM, LPN #6 at 7:29 AM, LPN #7 at 11:02 AM, and LPN #8 at 10:55 AM revealed they had been re-educated on the "Six Rights of Medication Administration" and preparation of medication for only one resident at a time.</p> <p>Interviews on 12/23/14 with CMT #2 at 9:18 AM and CMT #3 at 10:35 AM, revealed they had been re-educated on the "Six Rights of Medication Administration" and preparation of medication for only one resident at a time.</p> <p>4. Interview with the DON, on 12/23/14 at 11:05 AM, revealed she was educated by the Regional Resource Nurse regarding the need to thoroughly investigate medication errors and to identify the root cause of the error.</p>	F 281		2/5/15	

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F 281	<p>Continued From page 11</p> <p>5. Interview on 12/23/14, with the Dietary Manager at 8:55 AM, the Activity Director at 9:30 AM, and the Social Service Director at 9:12 AM, revealed they had received education on the facility's new process to address the root cause of medication errors to prevent re-occurrence. The facility's Department Leaders were educated on the process on 12/11/14 and 12/12/14 by the Administrator.</p> <p>6. Interviews on 12/23/14, with LPN #2 at 10:00 AM, LPN #5 at 7:39 AM, LPN #6 at 7:29 AM, LPN #7 at 11:02 AM, and LPN #8 at 10:55, revealed they had been observed during medication administration and received a check off for competency.</p> <p>7. Interview with the Administrator on 12/23/14 at 9:40 AM, revealed the facility reviewed all medication errors previously identified for 2014 and performed an audit to verify appropriate actions were taken.</p> <p>8. Interview on 12/23/14, with the Dietary Manager at 8:55 AM, the Activity Director at 9:30 AM, and the Social Service Director at 9:12 AM, revealed they received training conducted by the Regional Resource regarding Root Cause Analysis.</p> <p>9. Interview with the DON on 12/23/14 at 11:05 AM revealed the facility was performing audits and competency testing to confirm that proper medication administration techniques were followed. She stated that competencies audits were done randomly and included all nursing staff.</p> <p>Interview with the Administrator on 12/23/14 at</p>	F 281		2/5/15	

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F 281	<p>Continued From page 12</p> <p>9:40 AM, revealed the QA committee continues to meet monthly and the facility was evaluating for potential trends.</p> <p>Interview with the Medical Director on 12/23/14 at 12:00 PM revealed medication errors were a big concern for him. He stated the facility had implemented new processes to better determine the root cause of all medication errors and the QA committee will continue to evaluate for any potential trends.</p> <p>10. Interview with the Administrator on 12/23/14 at 9:40 AM, revealed the facility modified the process for responding and recording Medication Errors to include implementation of corrective measures based on the root cause analysis findings.</p> <p>11. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed education regarding the proper way to prepare and administer medication and the six (6) rights of medication administration was now included in the New Employee Orientation. Further interview revealed the facility had a daily Abbreviated Quality Assurance meeting Monday-Friday to determine the root cause for all medication errors. The DON stated that both she and the Administrator were notified immediately when a medication error occurred.</p> <p>12. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they each keep a log to monitor medication errors and ensure implementation of appropriate corrective actions.</p> <p>13. Interview on 12/23/14, with the Dietary</p>	F 281		2/5/15	

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F 281	Continued From page 13 Manager at 6:55 AM; the Activity Director at 9:30 AM; and, the Social Service Director at 9:12 AM, revealed as part of the QA Committee they now review medication errors/performance corrections each month during the QA meetings to identify trends, conduct root cause analysis, and ensure appropriate interventions were added to prevent further errors.  14. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they will continue to conduct Medication Pass Observations on all nurses and CMTs each month for six (6) months and then quarterly.  15. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they will continue to conduct monthly post testing on the six (6) rights of medication administration, preparation of medication for one resident at a time, and resident identification for all nurses and CMTs for six (6) months and then reduce to quarterly.	F 281			
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 review of the facility's policy and procedures it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #2)	F 333	F 333 483.25(m)(2) Residents Free of Significant Med Errors  <u>Corrective Measures For Resident[s] Identified In the Deficiency:</u> [1] The error was immediately reported to resident #2's primary care physician on October 28, 2014 by licensed nurse. [2] Resident #2's blood sugar was checked every hour by the licensed nurse for that night, a snack with protein was given to the resident and staff were instructed to monitor for signs/symptoms of hypoglycemia. Resident # 2 was monitored per the MD order by licensed nurse with no issues noted. [3] RN #1 was re-educated by the Director of Nurses 12/10/2014 on administration	2/5/15	

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F 333	<p>Continued From page 14</p> <p>was free of any significant medication errors. The facility failed to ensure licensed staff followed the facility's policy and procedure related to ensuring medication was administered to the right resident.</p> <p>Registered Nurse (RN) #1 prepared several Insulin doses, for different residents on 10/28/14, before it was time for the medication to be administered. RN #1 entered Resident #2's room with Resident #2 and Resident #3's Insulin in her hand. The RN administered Resident #3's Insulin (Lantus 30 units) to Resident #2 instead of giving the resident the 10 units of physician ordered Levemir.</p> <p>The facility's failure to ensure residents remained free of any significant medication errors has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 12/10/14 and was determined to exist on 10/28/14. The facility was notified of the Immediate Jeopardy on 12/10/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "General Dose Preparation and Medication Administration", revised 01/01/13 revealed facility staff should only prepare medications for one resident at a time. Further review revealed facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident.</p> <p>Review of the facility's policy and procedure titled, "Resident Identification", dated 01/01/07, revealed its policy was to maintain a resident</p>	F 333	<p>protocol for insulin, re-educated on following the "Six Rights of Medication Administration" for all medications, to include checking the MAR to the medication and was re-educated to review the pictures in the Licensed Nurse's Administration Record prior to giving the medication. RN#1 was re-educated, to prepare medications for only one resident at a time and to never pre-fill insulin syringes for multiple residents. Training for RN#1 was completed by Regional Resource Nurse on 12/10/2014.</p> <p>[4] Resident #1 identified does not have insulin ordered, therefore, insulin was not administered.</p> <p>[5] Resident #3 received his insulin as ordered 10/28/2014 by the licensed nurse.</p> <p><u>How Other Resident's Who May Have Been Affected by This Practice Were Identified:</u></p> <p>[1] Residents clinical records were reviewed by the Administrative Nursing Team to validate there is a current and accurate photograph of the resident on the resident's Medication Administration Record to assist with resident identification.</p> <p><u>Measures Implemented Or systems Altered To Prevent Re-Occurrence:</u></p> <p>[1] The Director of Nurses and Unit Managers were trained by a Regional Resource Nurse on the preparation for only one resident at a time on 12/10/2014 and on 12/11/2014.</p>	2/5/15	

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F 333	<p>Continued From page 15</p> <p>Identification system to assure prescribed treatments were administered to the correct resident. Further review revealed the facility had adopted two (2) resident identification systems which were to be implemented upon admission to assist in assuring that drugs, medications, and treatments prescribed for one resident were not administered to another. Additionally, the resident identification systems included Resident's photograph and/or wristband identification. The policy stated if pictures were utilized the location of the resident's photograph would be on the Medication Administration Record (MAR).</p> <p>Record review revealed the facility admitted Resident #2 to the facility on 07/10/14 with diagnoses which included Alzheimer's Disease and Diabetes Mellitus. Further review revealed Physician's Orders, dated October 2011, for Levemir (Insulin); inject 10 units subcutaneous daily at bedtime.</p> <p>Review of the facility's Medication Error Log, dated 10/28/14, revealed Resident #2 had received the wrong insulin.</p> <p>Interview with RN #1 on 12/09/14 at 3:40 PM, revealed she had prepared several insulin doses in syringes in advance on 10/28/14. RN #1 stated she had Resident #2's and another resident's insulin in her hand when she entered Resident #2's room. She stated she mistakenly picked up the other resident's insulin syringe and administered the insulin, Lantus 30 units, to Resident #2 instead of his/her 10 units of the physician ordered Levemir. She further stated she immediately realized she had administered the wrong medication to Resident #2 and notified</p>	F 333	<p>[2] On December 10,11,and 12, 2014 the Director of Nurses, Unit Managers and a Regional Resource Nurse provided education to all licensed nurses and Certified Medication Technicians on the "Six Rights of Medication Administration" and on "the Preparation of Medication for Only One Resident at a Time".</p> <p>[3] It is now the practice of Spring View to include in orientation [a] the procedure to prepare and administer medication including insulin,[b] the reiteration of the 6 Rights of Medication Administration and [c] Only Prepare One Resident's Medication At a Time. Med pass observations will be conducted with licensed nurses and Certified Medication Technicians during their orientation by the Staff Development Coordinator to validate competency regarding medication preparation and administration.</p> <p>[4] The Director of Nursing was educated by the Administrator and Regional Resource Nurse on 12/11/2014 regarding the need to thoroughly investigate medication errors and to identify the Root/Cause/Analysis of the error. She was instructed to base the corrective action,education and or discipline on identified root cause. An error that is the result of a failure to follow established practice standards or administration techniques would initially result in re-education of the individual with advancement through the progressive discipline process. In all cases the error would be reviewed and the potential significance of the error considered in the</p>	2/5/15	

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F 333	<p>Continued From page 16</p> <p>the Director of Nursing (DON) and the resident's physician. RN #1 stated Resident #2 was monitored throughout the night, as ordered by the physician, and no known adverse outcome was noted. Furthermore, RN #1 stated she had pre-filled the insulin syringes for residents frequently and did not realize it was an unsafe practice. However, the facility's policy entitled "General Dose Preparation and Medication Administration", revised 01/01/13 revealed facility staff should only prepare medications for one resident at a time.</p> <p>Interview with the DON, on 12/09/14 at 9:43 AM and 12/10/14 at 5:43 PM, revealed she had talked with RN #1 after the medication error and instructed her in the future to prepare the residents' insulin per policy and procedure, one resident at a time. Additionally, the DON stated the facility did not have any documented evidence that an investigation had been conducted to determine the root cause. There was also no documented evidence that any action(s) had been taken to prevent the incident from happening again. Furthermore, she stated the facility did not consider the medication error significant because Resident #2 did not experience an adverse outcome. Thus, the facility did not provide any re-education to the licensed nurses and had not developed an action plan. The DON stated she was made aware of a second incident involving medication administration with RN #1 by an upset family member. The DON stated but no action had been taken because a medication error had not occurred.</p> <p>Interview with the Administrator on 12/10/14 at 6:00 PM, revealed it was her expectation for staff</p>	F 333	<p>implementation of performance correction.</p> <p>[5] The Current Director of Nursing was educated on Root/Cause/Analysis by the Regional Resource Nurse on 2/3/2015 during her orientation.</p> <p>[6] In the event a medication error occurs, the Director of Nursing will be notified and will assist in the identification of the root/cause. The error will be brought by the Director of Nursing to the Abbreviated Quality Assurance meeting[consisting of Administrator, Director of Nursing, Dietary Manager, Social Services Director, Activity Director, MDS Coordinator, Unit Managers, Staff Development Coordinator, and Admissions Director] daily Monday-Friday for review by the Interdisciplinary Team of the root/cause/analysis in order to determine proper corrective measures. On weekends, the Director of Nurses or the on-call nurse will analyze for root cause and review with the Interdisciplinary team in the next AQA meeting. Based on root/cause/analysis and Interdisciplinary team reviews, the Director of Nurses in conjunction with the Administrator and Human Resources Director will determine the appropriate performance correction action based on the investigation, circumstances and prior performance correction within the progressive discipline process.</p> <p>[7] Medication Administration Observations for all licensed nurses and Certified Medication Aides will be conducted monthly by the Director of</p>	2/5/15	

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F 333	<p>Continued From page 17 to follow the policy and procedures.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>On 12/10/14, RN #1 was re-educated to prepare medication for one resident at a time and was instructed never to pre-fill insulin syringes for multiple residents. In addition, RN #1 was re-educated on following the "Six Rights of Medication Administration" and to review the resident's photo in the MAR prior to administering medications. RN #1 was observed by the Regional Resource Nurse during administration of insulin to verify competency. Additionally, RN #1 was suspended without pay for three (3) days.</li> <li>The DON and the Unit Managers (UM) were trained by the Regional Resource Nurse on preparation of medication for only one resident at a time on 12/10/14, and on 12/11/14.</li> <li>The facility provided education to all licensed nurses and Certified Medication Technicians (CMTs) on the "Six Rights of Medication Administration" and re-educated on the preparation of medication for only one resident at a time. This was done by the DON, UMs, and Regional Resource Nurse on 12/10/14, 12/11/14 and 12/12/14. In addition, the training has been incorporated into the orientation of all licensed nurse hires and CMT hires.</li> <li>The DON was educated regarding the need to thoroughly investigate medication errors and to identify the root cause of the error. This education was conducted on 12/11/14 by the Administrator and the Regional Resource Nurse.</li> </ol>	F 333	<p>Nurses, Assistant Director of Nurses, and/or the Unit Managers for the next 12 months</p> <p>[8] The process for responding and recording medication errors has been modified. Actions and corrective corrective measures which are based on the root/cause/analysis findings, will be recorded and follow-up monitoring scheduled on the Medication Error Log by the Director of Nurses. A record will be maintained of education and/or performance corrective actions conducted with the employee involved by the Director of Nurses, Assistant Director of Nurses and/or the Human Resources Director. The employee will also be subject to progressive discipline by the Director of Nurses or the Assistant Director of Nurses.</p> <p>[9] Monthly post testing on the Six Rights of Medication Administration, medication preparation for only one resident at a time and resident identification will be completed for 12 months by the Director of Nurses, Assistant Director of Nurses and the Unit Managers.</p> <p>[10] A log was developed and implemented effective 12/15/14 to assist in monitoring, implementation of corrective measures and to assist in trending errors identified to be used by the Director of Nursing. It will be reviewed as part of the Abbreviated Quality Assurance meeting [consisting of the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Director, Activity Director, MDS Coordinator, Plant Services Director, and Admissions Director Monday-Friday and</p>	2/5/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 12/23/2014
NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754		
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F 333	<p>Continued From page 18</p> <p>5. The facility developed a process to ensure staff members were provided education/counseling to address the root cause of the error to prevent re-occurrence. The facility's Department Leaders consisting of the DON, Unit Managers, Dietary Supervisor, Activity Director, Social Service Director, Human Resource Director, and the Minimum Data Set (MDS) Coordinators were educated on the process on 12/11/14 and 12/12/14 by the Administrator.</p> <p>6. Medication Administration observations for all nurses and CMTs were completed by the Regional Resource Nurse, DON and Unit Managers on 12/10/14 through 12/13/14.</p> <p>7. Medication errors previously identified for 2014 were audited to verify that appropriate actions had been taken. The audit was completed on 12/12/14 by the Administrator, Regional Director of Operations and the Human Recourse Director.</p> <p>8. On 12/11/14, the Regional Resource Nurse conducted training for the Quality Assurance (QA) Team Members which included the Administrator, Director of Nursing, Unit Managers, MDS Coordinators, Social Service Director, Activity Director, Maintenance Director, Human Resources Director and the Medical Records Director regarding Root Cause Analysis.</p> <p>9. The QA committee, which includes the Administrator, Director of Nursing, Unit Managers, MDS Coordinators, Social Service Director, Activity Director, Maintenance Director, Human Resources Director and the Medical Records Director will track medication pass observation findings for six (6) months to verify that proper administration technique is being</p>	F 333	<p>led by the Administrator.]</p> <p><u>Monitoring Measures To Maintain On-Going Compliance:</u></p> <p>[1] The Director of Nurses and Assistant Director of Nurses will be responsible for the monitoring of the medication administration observations. The Director of Nurses will bring the results of the observations to the Quality Assurance committee [consisting of the Administrator, Director of Nursing, Dietary Manager, Social Services Director, Activity Director, MDS Coordinator, Business Office Manager, Plant Services Director, Medical Director, Unit Managers, Staff Development Coordinator and Admissions Director] for development of action plan to ensure medication errors are investigated thoroughly with education/correction provided times six months.</p>	2/5/15	

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F 333	<p>Continued From page 19 followed. The QA Committee will also confirm that measurable goals are presented on all medication error counseling to create follow up monitoring to evaluate the ongoing compliance with policies. Trends will also be reviewed in the monthly QA meeting in conjunction with the Medical Director.</p> <p>10. The facility modified the process for responding and recording Medication Errors to include implementation of corrective measures based on the root cause analysis findings. The facility will maintain a record of education and performance correction actions conducted with employees involved with medication errors. Employees involved in medication errors will be subject to progressive disciplinary actions.</p> <p>11. The facility modified the new employee orientation education to included the proper way to prepare and administer medication and the six (6) rights of medication administration. In addition, all new medication errors are now brought to the daily QA meetings Monday-Friday to discuss the root cause analysis and ensure employee follow up. The Administrator and DON or, the On Call Administrative Nurse will be notified when a medication error occurs. Additionally, on 12/12/14, a checklist was implemented to guide the staff through the appropriate steps following a medication error.</p> <p>12. The facility developed and implemented a log on 12/15/14 to assist in monitoring the implementation of corrective actions and to assist in trending errors identified which will be reviewed as part of the Abbreviated Quality Assurance Meeting.</p>	F 333		2/5/15	

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F 333	<p>Continued From page 20</p> <p>13. The QA Committee will review medication errors/performance correction to identify trends conduct root cause analysis and ensure appropriate interventions added to prevent re-occurrence.</p> <p>14. The DON, Unit Managers, and the Resource Nurses will conduct medication pass observations on all nurses and CMTs each month for six (6) months and then quarterly. Results of the observations will be reviewed at the monthly QA Committee meeting.</p> <p>15. Monthly post testing on the six (6) rights of medication administration, preparation of medication for one resident at a time, and resident identification will be completed for six (6) months and then reduced to quarterly.</p> <p>The State Survey Agency validated the Corrective Action taken by the facility as follows:</p> <p>1. Interview with RN #1 on 12/23/14 at 10:55 AM, revealed she was re-educated to prepare medication for one resident at a time and was instructed never to pre-fill insulin syringes for multiple residents. In addition, RN #1 stated she was re-educated on following the "Six Rights of Medication Administration" and to review the resident's photo in the MAR prior to administering medications. RN #1 stated she was observed by the Regional Resource Nurse during administration of insulin to verify competency and was suspended for three (3) days. Review of a "Staff Development Attendance Record" dated 12/10/14 validated RN #1 received the education.</p> <p>2. Interview with the DON on 12/23/14 at 11:05 AM, revealed she was trained by the Regional</p>	F 333		2/5/15	

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F 333	<p>Continued From page 21</p> <p>Recourse Nurse on preparation of medication for only one resident at a time.</p> <p>Interviews on 12/23/14 with Unit Manager, LPN #3 at 9:35 AM and Unit Manager, LPN #4 at 10:09 AM, revealed they were trained by the Regional Recourse Nurse on preparation of medication for only one resident at a time on 12/10/14 and on 12/11/14.</p> <p>Review of the facility's attendance records dated 12/10/14 and 12/11/14 verified training was conducted.</p> <p>3. Interview on 12/23/14 with LPN #2 at 10:00 AM, LPN #5 at 7:39 AM, LPN #6 at 7:29 AM, LPN #7 at 11:02 AM, and LPN #8 at 10:55 AM revealed they had been re-educated on the "Six Rights of Medication Administration" and preparation of medication for only one resident at a time.</p> <p>Interviews on 12/23/14 with CMT #2 at 9:18 AM and CMT #3 at 10:35 AM, revealed they had been re-educated on the "Six Rights of Medication Administration" and preparation of medication for only one resident at a time.</p> <p>4. Interview with the DON, on 12/23/14 at 11:05 AM, revealed she was educated by the Regional Resource Nurse regarding the need to thoroughly investigate medication errors and to identify the root cause of the error.</p> <p>5. Interview on 12/23/14, with the Dietary Manager at 6:55 AM, the Activity Director at 9:30 AM, and the Social Service Director at 9:12 AM, revealed they had received education on the facility's new process to address the root cause of</p>	F 333		2/5/15	

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F 333	<p>Continued From page 22</p> <p>medication errors to prevent re-occurrence. The facility's Department Leaders were educated on the process on 12/11/14 and 12/12/14 by the Administrator.</p> <p>6. Interviews on 12/23/14, with LPN #2 at 10:00 AM, LPN #5 at 7:39 AM, LPN #8 at 7:29 AM, LPN #7 at 11:02 AM, and LPN #8 at 10:55, revealed they had been observed during medication administration and received a check off for competency.</p> <p>7. Interview with the Administrator on 12/23/14 at 9:40 AM, revealed the facility reviewed all medication errors previously identified for 2014 and performed an audit to verify appropriate actions were taken.</p> <p>8. Interview on 12/23/14, with the Dietary Manager at 6:55 AM, the Activity Director at 9:30 AM, and the Social Service Director at 9:12 AM, revealed they received training conducted by the Regional Resource regarding Root Cause Analysis.</p> <p>9. Interview with the DON on 12/23/14 at 11:05 AM revealed the facility was performing audits and competency testing to confirm that proper medication administration techniques were followed. She stated that competencies audits were done randomly and included all nursing staff.</p> <p>Interview with the Administrator on 12/23/14 at 9:40 AM, revealed the QA committee continues to meet monthly and the facility was evaluating for potential trends.</p> <p>Interview with the Medical Director on 12/23/14 at</p>	F 333		2/5/15	

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F 333	<p>Continued From page 23</p> <p>12:00 PM revealed medication errors were a big concern for him. He stated the facility had implemented new processes to better determine the root cause of all medication errors and the QA committee will continue to evaluate for any potential trends.</p> <p>10. Interview with the Administrator on 12/23/14 at 9:40 AM, revealed the facility modified the process for responding and recording Medication Errors to include implementation of corrective measures based on the root cause analysis findings.</p> <p>11. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed education regarding the proper way to prepare and administer medication and the six (6) rights of medication administration was now included in the New Employee Orientation. Further interview revealed the facility had a daily Abbreviated Quality Assurance meeting Monday-Friday to determine the root cause for all medication errors. The DON stated that both she and the Administrator were notified immediately when a medication error occurred.</p> <p>12. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they each keep a log to monitor medication errors and ensure implementation of appropriate corrective actions.</p> <p>13. Interview on 12/23/14, with the Dietary Manager at 6:55 AM; the Activity Director at 9:30 AM; and, the Social Service Director at 9:12 AM, revealed as part of the QA Committee they now review medication errors/performance corrections each month during the QA meetings to identify</p>	F 333		2/5/15	

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F 333	Continued From page 24 trends, conduct root cause analysis, and ensure appropriate interventions were added to prevent further errors.  14. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they will continue to conduct Medication Pass Observations on all nurses and CMTs each month for six (6) months and then quarterly.  15. Interview with the Administrator on 12/23/14 at 9:40 AM and the DON at 11:05 AM, revealed they will continue to conduct monthly post testing on the six (6) rights of medication administration, preparation of medication for one resident at a time, and resident identification for all nurses and CMTs for six (6) months and then reduce to quarterly.	F 333		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection	F 441	<b><u>F 441 483.65 Infection Control, Prevent Spread, Linens</u></b>  <b><u>Corrective Measures for Resident(s) Identified in the Deficient Practice:</u></b> [1] Resident #4 was assessed by a licensed nurse and found to have no signs or symptoms of bilateral eye infection related to eye drop administration on 1/20/2015. Infection Control Nurse reviewed antibiotic usage from September 2014 thru January 20, 2015 and found no evidence of an eye infection related to eye drop administration  [2] Resident #4 and unsampled residents A,B,C,D were assessed by a Licensed Nurse on 1/27/2015 for signs and symptoms of infection related to nursing	2/5/15

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F 441	<p>Continued From page 25</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures it was determined the facility failed to maintain an infection control program for one (1) of four (4) sampled residents (Resident #4); and, four (4) unsampled residents (Unsampled Residents #A, #B, #C and #D). The facility staff failed to wear gloves during administration of eye drops for Resident #4; failed to wash their hands after performing blood glucose monitoring checks for Unsampled Residents B and C; failed to clean the blood glucose monitoring machine after use on Resident #4 and Unsampled Residents A, B, C and D; and, disposed of a used lancet (pricking needle used to obtain drops of blood for testing) and a blood glucose test strip in a resident's garbage for Unsampled resident A.</p>	F 441	<p>not washing her hands following blood glucose monitoring. Infection Control Nurse reviewed antibiotic usage from September 2014 thru January 20, 2015 and found no evidence of infections related to nurse not washing her hands and not cleaning the blood glucose monitor after resident procedure was concluded..</p> <p>[3] Licensed nurses and Certified Medication Aides were re-educated on 12/10/2014 by the Director of Nurses on [1] eye drop administration and the [2] wearing of gloves and [3]washing of hands.</p> <p>[4] Licensed nurses and Certified Medication Aides was re-educated on 12/9/2014 by the Director of Nurses on the cleaning/disinfection of the blood glucose monitor.</p> <p><u>How Other Residents Who May Have Been Affected By This Practice Were Identified:</u></p> <p>[1] Residents receiving Eye Drops Administration were assessed by licensed nurses for signs/symptoms of eye infection on 1/20/2015. Infection Control Nurse reviewed antibiotic usage from September 2014 thru January 20, 2015 and found no evidence of infections related to eye drop administration.</p> <p>[2] Residents requiring blood glucose monitoring were assessed by Licensed nurses on 1/27/2015 for signs and symptoms of skin infections due to finger sticks related to nurse not cleaning blood glucose monitor. No infections identified. Infection Control Nurse reviewed antibiotic usage from September 2014 thru</p>	2/5/15	

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F 441	Continued From page 26  The findings include:  Review of the facility's policy and procedure titled, "Infection Control, Handwashing" dated 01/27/11, revealed its goal was to prevent the spread of infection. Further review revealed handwashing should be done before and after caring for each resident and after handling equipment that was contaminated.  Review of the facility's user guide for the "Medline Professional Blood Glucose Monitoring System", not dated, revealed standard precautions were to be used when handling or using the device, and all parts of the glucose monitoring system should be considered potentially infectious and were capable of transmitting blood borne pathogens between patients and health care professionals. Further review revealed the blood glucose monitoring system should be disinfected after use on each patient, and may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures were followed. Additional review revealed lancets were to be disposed of properly in biohazard waste.  1. Observation during a medication pass on 12/08/14 at 6:30 PM, revealed Certified Medication Assistant (CMA) #1 placed one (1) drop of Latanoprost (eye drops) into Resident #4's right eye and one drop in the resident's left eye. Further observation revealed CMA #1 was not wearing gloves. Additional observation revealed CMA #1 returned to the medication cart where the lid to the eye drops was on the medication cart. She placed the lid on the eyedrops and placed the eye drops back in the storage drawer in the medication cart.	F 441	January 20, 2015 and found no evidence of infections related to nurse not cleaning the blood glucose monitor.  <u>Measures Implemented or Systems altered to Prevent Re-Occurrence:</u> [1] Licensed nurses and Certified Medication Aides were re-educated by the Director of Nurses on 12/10/2014 on The Proper Management of Eye Drop Administration to include washing hands after removing gloves [2] Licensed nurses and Certified Medication Aides were re-educated by the Director of Nurses on 12/9/2014 regarding the the cleaning of the blood glucose monitor. [3] Licensed nurses and Certified Medication Aides were re-educated on 1/27/2015 by the Director of Nurses on the disposal of lancets following blood glucose monitoring. [4] Medication Pass Observations by the Director of Nurses, Assistant Director of Nurses, Unit Managers and/or Regional Resource Nurse on following Standards of Practice addressing the management of eye drops and their containers, management of lancets following use for blood glucose monitoring, cleaning of the blood glucose monitoring machines and hand washing prior to, during and upon completion of procedures were initiated and completed for the month of January 2015 and will be completed monthly for 12 months. [5] Any variances will be addressed immediately with the DON and the employee.	2/5/15	

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F 441	<p>Continued From page 27</p> <p>Interview with CMA #1, on 12/10/14 at 3:40 PM, revealed she should have been wearing gloves during the medication pass on 12/09/14 while administering the eye drops. She further stated she left the lid to the eye drops on the medication cart and should not have left the lid there. She stated she was nervous and made a mistake.</p> <p>2. Observation during a blood glucose monitoring procedure on 12/09/14 at 10:17 AM, revealed Licensed Practical Nurse (LPN) #1 placed a used lancet and a used blood glucose test strip inside the gloves she was wearing and discarded them in the resident's garbage can.</p> <p>Observation during blood glucose monitoring, on 12/09/14 at 10:19 AM, revealed LPN #1 placed the blood glucose monitoring machine on the medication cart in a storage basket (which also contained lancets) after the device was used on Resident #4, Unsampld Resident A, Unsampld Resident B, Unsampld Resident C, and Unsampld Resident D. LPN #1 failed to clean/disinfect the blood glucose monitor machine after each use per the facility's policy and procedures. Further observation revealed LPN #1 did not perform hand hygiene (hand washing or use of an alcohol based hand gel) after removing her gloves after she obtained Resident #B's and #C's blood glucose level.</p> <p>Interview with LPN #1, on 12/09/14 at 10:42 AM, revealed she was a new employee at the facility; however, she had been a nurse for fourteen (14) years. LPN #1 stated the facility's policy and procedure was to only clean the blood glucose monitoring machine before she used it. However, review of the facility's user guide for the "Medline</p>	F 441	<p><u>Monitoring Measures To Maintain On-going Compliance:</u></p> <p>[1] The Director of Nurses, the Assistant Director of Nurses, the Unit Managers or the Regional Resource Nurse will be responsible for the monitoring of the medication administration observations, in regards to eye drop administration, and the cleaning of glucometers. The Director of Nurses will bring the findings of the observations monthly times 6 months to the Quality Assurance Committee[consisting of the Administrator, Director of Nursing, Dietary Manager, Social Services Director, Activity Director, MDS Coordinator, Human Resources Director, Plant Services Director, Medical Records, Unit Managers, Staff Development Coordinator and Admissions Director] Meeting for review to develop an action plan as indicated to ensure the prevention/spread of infection in maintained.</p>	2/5/15	

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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 441	<p>Continued From page 28</p> <p>Professional Blood Glucose Monitoring System", not dated, revealed the blood glucose monitoring system should be disinfected after use on each patient, and may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed.</p> <p>Continued interview with LPN #1, on 12/09/14 at 10:42 AM, stated the facility's policy and procedure was to perform hand hygiene every third resident. However, review of the facility's policy and procedure titled, "Infection Control, Handwashing" dated 01/27/11, revealed handwashing should be done before and after caring for each resident and after handling equipment that was contaminated. Additionally, she stated she should not have put the used lancet and test strip in the garbage can in the resident's room. She stated they should have been disposed of in the sharps' container.</p> <p>Interview with the Director of Nursing (DON), on 12/10/14 at 5:20 PM, revealed it was her expectation that the facility staff follow the Centers for Disease Control (CDC) guidelines, the facility's policy and procedures and to utilize good judgement related to infection control practices.</p> <p>Interview with the Administrator, on 12/10/14 at 6:00 PM, revealed it was her expectation the facility staff should know and follow the facility's policies and procedures.</p>	F 441		2/5/15