

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170		
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F 314	<p>Continued From page 28</p> <p>Wound Dressings", last revised 01/02/14, revealed if a break in aseptic technique occurs, stop the procedure, remove gloves, cleanse hands, and apply clean gloves. In addition it stated that wound dressings were performed using aseptic technique to decrease the risk of wound contamination and cross-contamination during dressing changes.</p> <p>Record review revealed the facility readmitted Resident #1 on 03/12/14 with diagnoses which included Pressure Ulcer Buttock, Stage II, Generalized Pain, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of "12", which indicated the resident was interviewable. The facility also assessed the resident to have a Stage II pressure ulcer present on re-admission.</p> <p>Observation, on 04/09/14 at 9:25 AM, revealed LPN #3 performed incontinent care before performing wound care to Resident #1's pressure ulcer to his/her right buttock. LPN #3 donned clean gloves and used disposable moist towelettes located on the bedside table to clean the bowel movement. A brown substance was observed on her gloves. She continued to obtain the disposable moist towelettes from the bedside table until the resident's buttock was free of the brown substance. Further observation revealed the LPN did not change her gloves or perform hand hygiene. LPN #3 then obtained a fresh moist towelette from the bedside table and cleaned the wound bed of the pressure ulcer.</p>	F 314	<p>The DNS, ADNS or RN will observe dressing or treatment to validate aseptic techniques including appropriate glove usage and hand hygiene were followed across all shifts at least 4 times per week for 30 days then no less than 2 times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>May 14, 2014</p>	05/14/14	

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F 314	Continued From page 29 She obtained a container of Physician prescribed Calazime (skin protectant paste) from the resident's bedside table, opened the container wearing the same visibly soiled gloves, obtained the medication on the finger of the soiled glove and placed the medication onto the wound bed. The LPN did not change her gloves and did not wash her hands after the incontinent care. Interview, on 04/09/14 at 9:36 AM with LPN #3, revealed she normally would change gloves between incontinent care and wound care. She stated she thought she did. Review of the Skin Integrity Report, with the last weekly data collection date of 04/02/14, revealed the wound had measured 0.4 centimeters (cm) length, 0.3 cm width, 0.0 cm depth. Observation on 04/09/14 at 3:12 PM, revealed LPN #3 measured the wound to the right buttock and the wound measured 0.3 cm length, 0.3 cm width and 0.1 cm depth. Interview with the Director of Nursing (DON) and Administrator, on 04/09/14 at 10:45 AM, revealed their expectation was the LPN should have changed gloves and performed hand hygiene as the facility's policy and procedure stated and should not have continued with wound care with the visibly soiled gloves.	F 314			
F 329 SS=J	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329			

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F 329	<p>Continued From page 30</p> <p>indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's " Medication Administration", "Clinical Competency Validation" and "Medication Errors" policies and procedures, and Event Report, it was determined the facility failed to have an effective system to ensure one (1) of thirteen (13) sampled residents (Resident #8), was free of excess dosing of medication and received only the medication in doses clinically indicated to treat the resident's condition.</p> <p>Record review revealed on 02/15/14, Registered Nurse (RN) #3 received an order for Resident #8 to be administered Biaxin (an antibiotic) 500 milligrams (mg), two (2) tablets, for a total of 1000 mg, once daily for seven (7) days. RN #3</p>	F 329	<p>Resident # 8 was ordered Biaxin XL 500mg 2 tabs every day x 7 days on 2/15/14. The order was transcribed to the MAR as q 8 hours with times 6AM, 2PM, 10PM. On 2/17/14, the MAR was corrected to reflect the physician order. Upon notification of the transcription error on 2/18/14 the DNS notified the physician/NP with orders received and initiated. The DNS completed medication error report and ensured it was transcribed correctly on MAR with remainder of doses given as ordered. The resident was assessed by the NP on 2/17/14 and again on 2/24/14 and the resident did not have any negative effects from the additional antibiotic.</p> <p>All Current residents (50 of 50) were reassessed on 4/12/14 by two licensed nurses for signs and symptoms of medication reactions; none were identified.</p> <p>The Licensed Pharmacist evaluated all resident medications on 4/24/14 to validate that all resident's drug</p>		

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F 329	<p>Continued From page 31</p> <p>transcribed the order on the Medication Administration Record (MAR). The medication was ordered to be given once a day and RN #3 transcribed the order as once a day. However, she transcribed the administration times as 6:00 AM, 2:00 PM, and 10:00 PM; three (3) times a day instead of the once daily time, as ordered.</p> <p>Further review revealed on 02/15/14, Resident #8 received the first dose of 1000 mg of the medication at 10:00 PM. On 02/16/14, the resident received the antibiotic three (3) times at 6:00 AM, 2:00 PM, and 10:00 PM, for a total dose that day of 3000 mg, instead of the 1000 mg per day, as ordered. On 02/17/14, the resident received the medication two (2) times at 6:00 AM and 2:00 PM, for a total of 2000 mg. During the time the medication was administered, from 02/15/14 through 02/17/14, one Licensed Practical Nurse (LPN) and two Certified Medication Aides (CMAs) failed to follow the Five Rights of Medication Administration, (right dose, time, resident, drug and route,) and failed to identify the transcription error. In addition, the twenty-four (24) hour checks for new physician orders were not completed each night to ensure there was not a transcription error, as per facility policy.</p> <p>On the evening of 02/17/14, at approximately 10:00 PM, RN #1 noted the medication error and did not administer the medication. However, RN #1 failed to notify the physician, the Director of Nursing (DON) or the resident's family, per facility policy, of the Medication Errors. She notified LPN #1, the oncoming nurse, in shift change report, on 02/17/14 at approximately 10:00 PM; however, LPN #1 also failed to notify the physician, the DON, or the resident's family. LPN #1 notified the</p>	F 329	<p>regimens are free from unnecessary drugs. No issues were identified.</p> <p>An audit of current Medication Administration Records (MARS) and physician/Nurse Practitioner orders was completed by the DNS or an RN Area Support Personnel beginning on 4/15/14 and finished on 4/16/14. 50 of 50 resident MARS were reviewed. No medication errors were identified. No transcription errors were identified.</p> <p>A MAR to cart audit was completed by the Licensed Pharmacist and a Licensed Pharmacy Technician on 4/15/14. 3 of 3 medication carts were audited. All MAR orders and medication times matched pharmacy labels for 50 out of 50 residents.</p> <p>17 of 21 Licensed nurses and 3 of 4 medication aides, including 3 administrative nurses were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or the RN Nurse Practice</p>	

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F 329	<p>Continued From page 32</p> <p>oncoming shift supervisor, the next day, on 02/18/14, at approximately 8:00 AM and the Director of Nursing (DON) was made aware of the medication error. The DON then notified Resident #8's physician and family.</p> <p>In addition, the Clinical Committee failed to notice the error during the weekend review of physician orders on Monday morning (02/18/14). Interview with the Advanced Practice Registered Nurse (APRN) on 04/11/14 at 12:55 PM, revealed the doses of Biaxin could have resulted in kidney and/or liver failure and/or gastro-intestinal disorders.</p> <p>The facility's failure to have an effective system to ensure the resident was free from excessive doses of a medication caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/12/14 and was determined to exist on 02/16/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Administration" policy and procedure, last revised 01/02/14, revealed its purpose was to provide a safe, effective medication administration process. Further review revealed the accepted standard of practice would be followed. In addition, a review of the "Clinical Competency Validation" dated 03/20/11, revealed the standards were for Licensed Staff and Certified Medication Assistants (CMAs) to check orders in the MAR carefully, check specific administration directions, clarify the medication order when necessary, check the label on the medication, calculate the correct dose, administer the routes of medication</p>	F 329	<p>Educator regarding the following with return demonstration:</p> <ul style="list-style-type: none"> • Appropriate transcription of physician medication orders; • Medication pass including the 5 rights of med pass; • Immediate notification of physician/NP upon identification of medication error; • Notification of responsible party/resident; • Notification of the Director of Nursing Services and /or other Management Nurses as appropriate; <p>17 of 21 Licensed nurses and 3 of 4 medication aides, including 3 administrative nurses were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or the RN Nurse Practice Educator regarding Clinical Competency Validation for Medication Administration (see Attachment A.) Transcription competencies were also completed by return demonstration utilizing sample order with licensed nurse transcribing</p>		

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F 329	<p>Continued From page 33</p> <p>properly, document appropriately on the MAR, and report and record any side effect, error, or unusual information regarding the medication.</p> <p>Review of the facility's "Medication Errors" policy and procedure, last revised 01/02/14, revealed upon discovery of a medication error, the staff would evaluate the patient for adverse effects, report immediately to the DON, and notify the physician, patient, and responsible party. In addition, the person discovering the incident will complete a Resident/Patient Incident Report. Further review revealed the facility would investigate the incident and implement interventions to prevent further errors.</p> <p>Record review revealed the facility admitted Resident #8, on 06/10/09 with diagnoses which included Dementia, with Behavioral Disturbance, Cognitive Deficits, Depressive Disorder, Unspecified Heart Disease, Unspecified Hypothyroidism, and Gastro-Esophageal Reflux Disorder. Review of the Annual Minimum Data Set (MDS) assessment, dated 03/08/14, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable.</p> <p>Review of Resident #8's Physician's Order and a Nursing Note, dated 02/15/14, revealed a telephone order was received for Biaxin 500 mg, two (2) tablets by mouth every day for seven (7) days, at approximately 3:15 PM.</p> <p>Review of the February 2014 MAR revealed an order for Biaxin 500 mg, two (2) tabs by mouth every day for seven (7) days with the scheduled times of administration documented as 6:00 AM,</p>	F 329	<p>to sample MAR.</p> <p>Medication pass observations were completed for 17 of 21 Licensed nurses and 3 of 4 medication aides, including 3 administrative nurses by the DNS or ADNS or RN Nurse Practice Educator during each shift beginning on 4/13/14 through 4/16/14. Four Licensed Nurses & one medication aide not working during this time frame and future new nurses and/or new medication aides during orientation will have reeducation/education and be competency tested before returning to work and during orientation by the DNS or ADNS.</p> <p>The Director of Nursing, the Assistant Director of Nursing, the RN Clinical Case Manager or the RN Area Support Personnel will audit all new physician/NP medication orders including:</p> <ul style="list-style-type: none"> • MAR matches the physician order • Time of the medication administration on MAR matches 	

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F 329	<p>Continued From page 34</p> <p>2:00 PM, and 10:00 PM, which was three (3) times a day. Further review of the MAR revealed staff administered Biaxin XL 1000 mg at 10:00 PM on 02/15/14, at 6:00 AM, 2:00 PM, and 10:00 PM on 02/16/14 and at 6:00 AM and 2:00 PM on 02/17/14. This resulted in Resident #8 receiving two (2) times the amount of Biaxin (6000 mg) over three days, instead of the 1000 mg per day that was ordered.</p> <p>Interview with the Advanced Practice Registered Nurse (APRN) on 04/11/14 at 12:55 PM, revealed the doses of Biaxin could have resulted in kidney and/or liver failure and/or gastro-intestinal disorders.</p> <p>Interview with RN #3, on 04/11/14 at 4:00 PM, revealed she obtained the new telephone order on 02/15/14 at 3:15 PM and transcribed it onto the MAR. RN #3 stated she wrote the times down on the MAR as 6:00 AM, 2:00 PM, and 10:00 PM, as she had confused this with another order she was working on at the time.</p> <p>Interview with LPN #2, on 04/12/14 at 11:30 AM, revealed she administered Biaxin XL 500 mg 2 tablet on 02/15/14 at 10:00 PM, on 02/16/14 at 6:00 AM, and at 10:00 PM, and on 02/17/14 at 6:00 AM. She further stated it was the facility's policy and procedure to check the medication label against the order to ensure accuracy with the right medication, dose and time. She stated she was not sure what happened as this was her customary practice.</p> <p>Interview with CMA #1, on 04/12/14 at 11:15 AM, revealed she administered the medication on 02/17/14 at 2:00 PM and should have caught the error. She stated, "I usually look to see that the</p>	F 329	<p>physician order</p> <ul style="list-style-type: none"> · If medication error identified, physician notified immediately · If medication error identified, medical record corrected per physician orders · This audit will be completed daily including weekends beginning on 4/14/14. Then 5 days a week for 60 days then no less than 3 times per week for 30 additional days. Additional audits will be determined by the monthly QI/PI committee. Corrective action and/or re-education will be provided at point of discovery including physician notification and re-education of involved nurse. <p>The Licensed Pharmacist or Licensed Pharmacy Technician will complete 3 of 3 MAR to cart checks monthly x 3 with corrective action if indicated and report findings to DNS or ADNS.</p> <p>The audit tools will be brought to the monthly QI/PI meeting by the Administrator or DNS or ADNS for review with addition plans put into place as warranted by the Quality Improvement committee. The Quality Improvement committee includes the</p>		

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F 329	<p>Continued From page 35</p> <p>MAR matches the label on the medication and I missed it".</p> <p>Interview with RN #1, on 04/12/14 at 10:20 AM, revealed she was the first staff member who noted the discrepancy on the MAR, on 02/17/14 at approximately 10:00 PM, and did not administer the 10:00 PM dose. The RN stated she did not call the DON, the physician, or the resident's family. Furthermore, she did not follow the facility's policy and procedure and complete an incident report for the medication errors. She stated she reported it to LPN #1, the oncoming nurse, at approximately 10:00 PM during shift change report.</p> <p>Interview with LPN #1, on 04/12/14 at 10:30 AM, revealed she was told by RN #1 in report about the error and stated RN #1 stated she had reported it to the DON. LPN #1 stated she "assumed it was being taken care of" and stated, "I didn't follow up on it, I was under the impression that she (RN #1) had taken care of it".</p> <p>Review of the documentation of the twenty-four (24) hour chart reviews, for the front and back hall nursing stations, revealed the 24 hour chart checks had not been completed on the front hall, where the incident occurred, since 02/10/14.</p> <p>Interview with the current DON, on 04/12/14 at 10:50 AM and 4:20 PM, revealed the staff administering the medication should have followed the facility's policy and procedure on Medication Administration, to include the five rights. The DON stated her expectation was the RN should have notified the DON, Physician, and the resident's family when the medication error was identified. The DON stated the RN should</p>	F 329	<p>Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>05/14/2014</p>	05/19/14	

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F 329	<p>Continued From page 36</p> <p>have followed the policy and procedure and should have completed an incident report for the medication error. In addition, the DON revealed the midnight shift nurses should have completed twenty-four hour chart checks to assess for new orders and verify the correctness of the transcription of the orders. She stated this was an ongoing process to ensure orders were not missed and were correct. The DON stated an investigation was not conducted to identify why the facility's procedures of 24 hour chart reviews and following the five (5) rights of medications administration were not followed by staff, and how the clinical team had failed to identify the transcription error.</p> <p>Interview with the Interim DON, on 04/11/14 at 4:00 PM, revealed the Clinical Team's process was to gather all newly written physician orders, every morning, Monday through Friday, for verification of correctness. For orders written on the weekend, the Clinical Team met on Monday morning to gather and verify the correctness of the orders written over the weekend and checked them against the MAR for accuracy. The DON stated on 02/17/14, she reviewed the order against the MAR, for Biaxin 1000 mg every day and stated "I overlooked it myself". She revealed she was not called or made aware of the incident until 02/18/14, at approximately 8:00 AM, the day after the error was found.</p> <p>Review of the facility's Event Report, dated 02/18/14, revealed the facility had identified a physician's order received on 02/15/14 for Biaxin XL 500 mg, two (2) tabs by mouth daily was not transcribed correctly on the MAR. Further review of the Event Report revealed there was no documented evidence the facility had completed</p>	F 329			

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F 329	<p>Continued From page 37</p> <p>an investigation to identify the failures related to this incident and implemented interventions to prevent further errors.</p> <p>Interview with the Administrator, on 04/11/14 at 11:00 AM, revealed the facility had not conducted an investigation, as it was determined the incident was a transcription error.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The resident was assessed by the APRN on 02/17/14 and 02/24/14 with no negative side effects from the antibiotic identified.</p> <p>An audit of the current MARs and Physician/APRN orders, was completed on 04/16/14 with no errors identified.</p> <p>A MAR to medication cart audit was completed by the Licensed Pharmacy Technician, on 04/14/14 and all MAR orders and medication times were correct.</p> <p>All current residents were reassessed on 04/12/14, by two (2) licensed staff, for signs and symptoms of medication reactions and none were identified.</p> <p>Seventeen (17) of twenty-one (21) Licensed Nurses and three (3) of four (4) Certified Medication Aides (CMA) were re-educated by the DON/ADON and or the Nurse Educator on 04/16/14, regarding the appropriate transcription of physician medication orders, checking residents for allergies, the five (5) rights of medication administration, immediate notification of the physician/ ARNP/ DON and responsible</p>	F 329			

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F 329	<p>Continued From page 38</p> <p>party, upon identification of a medication error and staff completed clinical competencies and return demonstration on medication passes and transcription of physician orders. Four (4) Licensed Nurses and one CMA were to have this training prior to working the floor, as some of these staff were either on sick leave, vacation or worked as needed.</p> <p>The DON, ADON and Administrative RNs audited current MARs and Physician Orders, MARs to chart reviews, allergies and physician/responsible party notifications, every day, beginning 04/14/14, for fourteen (14) days, then five (5) days a week for sixty (60) days, then no less than three (3) times a week for an additional thirty (30) days. No discrepancies were identified and the audits were on-going. Additional audits will be determined by the monthly Quality Improvement (QI) Committee and corrective action and /or re-education will be provided at the point of discovery. Licensed Pharmacists or Licensed Pharmacy Technicians will complete MAR to chart checks monthly, with corrective action, if indicated and findings reported to the DON and ADON. Audit tools will be brought to the monthly QI meetings, by the ADM/ DON and or ADON for review with additional plans put into place as warranted by the QI Committee.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review on 04/24/14 revealed Resident #8 had no negative outcome from the event and a review of the clinical record, MARS and physician orders on 04/23/14, revealed no concerns.</p> <p>Review of the MARs and physician orders for five</p>	F 329			

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F 329	<p>Continued From page 39</p> <p>residents (Residents #1, #9, #11, #12 and #19), on 04/24/14, revealed there were no medication transcription errors.</p> <p>Review of the MAR and physician orders audit list and the pharmacy audit list, dated 04/15-16/14, revealed on 04/24/14 the DON and Administrative RNs completed fifty (50) of 50 resident audits of MARS and Orders reviews with no transcription or medication errors identified.</p> <p>Review of the inservice log, dated 04/13-16/14, on 04/24/14 revealed all but five (5) licensed staff and CMAs were inserviced and a post test and repeat demonstration was completed to verify competency of transcription of physician orders and ensure documentation on the MAR was correct. Any other staff working as needed or staff on vacation or sick leave, were to be re-educated prior to working the floor and this was verified by interview with one CMA and a review of the CMA's training record and stated she had been re-educated on 04/21/14, prior to work that day.</p> <p>Interviews with RN #1, LPN #4, LPN #5, CMA #1, CMA #3, and CMA #4 on 04/24/14 at 12:50 PM, 1:00 PM, 1:15 PM, 1:20 PM, 1:36 PM and 2:10 PM and review of the training logs, dated 04/13-16/14, revealed training was completed by the DON/ADON and Administrative RNs, which included transcription of physician orders to the MARs, immediate physician/ APRN/ DON/ responsible party notification, training on monitoring for any reaction to a medication order, checking for allergies and the five rights of medication administration.</p> <p>Review of the Quality Improvement (QI) audits</p>	F 329			

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F 329	Continued From page 40 and interviews conducted with the ADON and DON, on 04/24/14 at 10:40 AM, revealed results of the audits were discussed in the QI meetings, as stated in the AoC, training was provided to licensed nursing staff as well as the CMAs and the auditing was ongoing.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's "Medication Administration" policy and procedure, it was determined the facility failed to ensure it was free of a medication error rate of 5% or greater. Observation of a medication pass revealed there were twenty-six (26) opportunities with two (2) medication errors which resulted in a seven percent (7%) medication error rate. Resident #18 was administered a medication that was ordered to be given with food; however, it was given without food. Resident #12 was given a medication that should not have been crushed. The findings include: Review of the facility's policy and procedure titled, "Medication Administration," last revised 01/02/14, revealed the purpose was to provide a safe, effective medication administration process. In addition, review of the facility's "Clinical Competency Validation," dated 03/20/11, revealed	F 332	Resident #12 and Resident #18's physicians were notified on 4/9/14. Resident #12 had new orders received and implemented on that date. Both residents were reassessed by licensed nurses on 4/12/14 for signs and symptoms of medication reactions; none were identified. All residents were reassessed on 4/12/14 by the two licensed nurses for signs and symptoms of medication reactions; none were identified. 17 of 21 Licensed nurses and 3 of 4 medication aides were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or	

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F 332	<p>Continued From page 41</p> <p>Licensed Staff and CMAs (Certified Medication Aides) were to check orders in the MAR carefully, check specific administration directions, clarify the medication order when necessary, check the label on the medication, calculate the correct dose, administer the routes of medication properly, document appropriately on the MAR, and report and record any side effect, error, or unusual information regarding the medication.</p> <p>Observation of a medication pass, on 04/09/14 from 8:35 AM until 10:45 AM, revealed twenty-six (26) medications were administered to five (5) residents with two (2) medication errors made as follows:</p> <p>1. Review of Resident #18's April 2014 Physician Orders revealed orders for Meloxicam (an anti-inflammatory medication) 15 milligrams (mg,) one tablet daily with food.</p> <p>Observation of a medication pass, on 04/09/14 at 9:00 AM, revealed Certification Medication Aide #3 administered the above medication at 9:00 AM which was one (1) hour and fifty (50) minutes after the facility's breakfast was served in that area.</p> <p>Interview with CMA #3, on 04/09/14 at 3:00 PM, revealed the medication should have been administered with breakfast, at 7:10 AM.</p> <p>2. Observation of a medication pass, on 04/09/14 at 10:15 AM, revealed Registered Nurse (RN) #3 administered a Nitrofurantoin (an antibacterial agent) 100 mg capsule, by opening the capsule and taking three (3) of three (3) tablets out of the capsule and mixing them in water in an attempt to dissolve the tablets, so the medication could be</p>	F 332	<p>the RN Nurse Practice Educator regarding Clinical Competency Validation for Medication Administration. Medication pass observations were completed for 17 of 21 Licensed nurses and 3 of 4 medication aides by the DNS or ADNS or RN Nurse Practice Educator during each shift beginning on 4/13/14 through 4/16/14.</p> <p>The DNS, ADNS or RN Manager or pharmacy personnel will audit via observation medication pass for meds that are to be given with food and randomly for medications that are to be administered to be crushed at least 4 times per week for 30 days then no less than two times per week for 60 additional days. Additional audits will be determined by the monthly QI/PI committee. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the</p>		

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F 332	Continued From page 42 administered through Resident #12's gastrostomy tube (G-tube). Interview with RN #3, on 04/09/14 at 10:45 AM, revealed the RN was still attempting to dissolve the medication in water by mashing the medication against the side of a cup with a spoon. She stated the pharmacy usually sends the pill in a crystallized form that dissolves much easier in water. The RN did not call the pharmacy to verify the correct dosage to be given; the medication was administered per G-tube. Interview with RN #3, on 04/09/14 at 2:15 PM, revealed she had researched the medication and the form of Nitrofurantoin sent from pharmacy was not to be crushed. Interview with the Director of Nursing, on 04/09/14 at 2:45 PM, revealed the medication should not have been crushed and stated she would have expected the RN to have "looked it up."	F 332	Maintenance Director, the Dietary Manager and the Business Office Manager. May 14, 2014	05/14/14	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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,	F 441	Resident #1 was reassessed by a licensed nurse for pressure sores and signs/symptoms of infection on 4/28/14. The other resident with a peri/anal pressure sores was reassessed by a licensed nurse for signs/symptoms of infection on 4/28/14 with no concerns		

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F 441	<p>Continued From page 43</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</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</p> <p>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:</p> <p>Based on observation, interview and record review, and review of the facility's Infection Control Program and policy and procedures, it was determined the facility failed to ensure a safe, sanitary and comfortable environment and failed to ensure the prevention of the development and transmission of disease and infection for one (1) of thirteen (13) sampled residents (Resident #1), related to improper incontinent care and improper wound care for a Stage II pressure ulcer.</p>	F 441	<p>were identified. As of 05/01/14 this area was healed.</p> <p>Re-education was provided to licensed nurses by the Assistant Director of Nursing, Director of Nursing or RN Educator beginning on 4/28/14 to include aseptic techniques during wound dressing including appropriate glove usage and hand hygiene. Licensed nurses will have this training provided during orientation by ADNS/DNS or a RN.</p> <p>The DNS, ADNS or RN will observe dressing or treatment to validate aseptic techniques including appropriate glove usage and hand hygiene were followed across all shifts at least 4 times per week for 30 days then no less than 2 times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality</p>	

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F 441	<p>Continued From page 44</p> <p>On 04/09/14, Licensed Practical Nurse #3 failed to change gloves and wash her hands after providing incontinent care which resulted in her gloves being contaminated with stool. Observation revealed the LPN performed wound care to Resident #1's Stage II pressure ulcer to his/her right buttock, while wearing the contaminated gloves.</p> <p>The findings include:</p> <p>Review of the facility's "Infection Control Program, (not dated), revealed the goals of the Infection Control Program had been developed to provide staff with a coordinated organizational structure, technical procedures, comprehensive work practices, and guidelines to reduce the risk of transmission of infection. The Infection Control Program encompasses both employee health and patient care practices with goals to provide a safe and sanitary environment and to decrease the risk of infection to patients and staff.</p> <p>Review of the facility's "Hand Hygiene" policy and procedure, last revised 10/01/13, revealed its purpose was to improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Further review revealed it was the process of the facility to use soap and water in the following situations: After removing gloves or other personal protective equipment, immediately after contact with blood, body fluids, or other potentially infectious materials, and when hands were visibly soiled or contaminated.</p> <p>Review of the facility's "Aseptic Wound Dressings" policy and procedure, last revised 01/02/14, revealed if a break in aseptic technique occurs, stop the procedure, remove gloves,</p>	F 441	<p>Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>May 14, 2014</p>	05/14/14	

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F 441	<p>Continued From page 45</p> <p>cleanse hands, and apply clean gloves. In addition, it stated that wound dressings were performed using aseptic technique to decrease the risk of wound contamination and cross-contamination during dressing changes.</p> <p>Record review revealed the facility readmitted Resident #1 on 03/12/14 with diagnoses which included Peripheral Neuropathy, Pressure Ulcer Buttock, Stage II, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Observation of LPN #3 providing incontinent care and wound care for Resident #1, on 04/09/14 at 9:25 AM, revealed LPN #3 donned clean gloves and used disposable moist towelettes located on the bedside table to clean stool off the resident's buttocks. The stool was noted to contaminate her glove. The LPN continued to obtain the disposable moist towelettes from the bedside table until the resident's buttock was free of stool. Further observation revealed the LPN did not change her gloves or perform hand hygiene. The LPN then used a fresh moist towelette from the bedside table to clean the wound bed of the pressure ulcer. She then obtained a container of prescribed Calazime (skin protectant paste) from the resident's bedside table, opened the container wearing the same visibly contaminated glove, obtained the medication on the finger of the contaminated glove and placed the medication onto the wound bed. The LPN did not change gloves and did not wash her hands after the incontinent care.</p> <p>Interview with LPN #3, on 04/09/14 at 9:36 AM, revealed she always changed gloves between incontinent care and wound care and stated she thought she did.</p>	F 441			

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F 441	Continued From page 46 Interview with the Director of Nursing and Administrator, on 04/09/14 at 10:45 AM, revealed their expectation was the LPN should have changed gloves and performed hand hygiene as the facility's policy and procedure stated and should not have continued with wound care with the visibly soiled gloves.	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1960 & 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978, with 4 duct smoke detectors and 114 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1978 and upgraded in 1997.</p> <p>GENERATOR: Type II generator installed in 2000. Fuel source is Propane.</p> <p>A Standard Life Safety Code Survey was conducted on 04/08/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty (50) beds with a census of forty-nine (49) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hopkins Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	



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

Jennifer S. [Signature]

TITLE

Administrator

(X6) DATE

05/16/14

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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K 000	Continued From page 1 Fire).	K 000			
K 017 SS=D	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, sixteen (16) residents, staff and visitors. The facility has the capacity for fifty (50) beds and at the time of the survey, the	K 017	The Maintenance Director reconfigured front porch space on 05/09/14 to eliminate office use and utilize area as resident common space. Hopkins Center has no additional porches that are utilized as office space. The Regional Property Manager reeducated Maintenance Director on 04/08/14 regarding an office space requiring an automatic smoke detection system and therefore the front porch could not be utilized in this way. The Maintenance Director or Administrator will review front porch space to ensure it is not used as office space at least once weekly for 30 days. Corrective action will be completed immediately upon discovery. Results will be reported to the QI/PI Committee by the Maintenance Director and additional audits will be determined based on audit results.		

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K 017	<p>Continued From page 2 census was forty-nine (49).</p> <p>The findings include:</p> <p>Observation, on 04/08/14 at 3:44 PM with the Maintenance Supervisor, revealed the front porch was part of the exit corridor at the front of the facility. The area was being used for office space and was not equipped with an automatic smoke detection system.</p> <p>Interview, on 04/08/14 at 3:45 PM with the Maintenance Supervisor, revealed it was not possible to have an automatic smoke detection system on the porch that was part of the exit corridor. He stated he was unaware this meant the office area could not be located in the exit corridor.</p> <p>The census of forty-nine (49) was verified by the Administrator on 04/08/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/08/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.</p>	K 017	05/14/2014	05/14/14	

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K 017	Continued From page 3 (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The door to room #16, #24 and #26 were adjusted on 4/9/14 by the Maintenance Director to ensure each latched properly. On 4/9/14, the Maintenance Director completed a 100% audit on all resident corridor doors to verify each latched properly. No other issues were identified. The Regional Property Manager re-educated the Maintenance Director on	

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K 018	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-two (22) residents, staff and visitors. The facility has the capacity for fifty (50) beds and at the time of the survey, the census was forty-nine (49). The findings include: Observations, on 04/08/14 at 2:02 PM with the Maintenance Supervisor, revealed the corridor door to room #24 would not latch properly. Interview, on 04/08/14 at 2:03 PM with the Maintenance Supervisor, revealed he was unaware the door was not latching. He stated he checked the resident doors weekly to ensure the doors latch and stated the weather affects the doors. Observations, on 04/08/14 at 2:05 PM with the Maintenance Supervisor, revealed the corridor door to room #26 would not latch properly. Interview, on 04/08/14 at 2:06 PM with the Maintenance Supervisor, revealed he was	K 018	the requirement that all doors must properly latch on 4/8/14. The Maintenance Director or Administrator will audit all resident doors at least 3 times per week for 60 days and at least 1 time per week for 30 additional days during preventative maintenance rounds to validate all doors latch properly. Corrective action will be completed immediately upon discovery. Results will be reported to the QI/PI Committee by the Maintenance Director and additional audits will be determined based on audit results.	05/14/14

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K 018	<p>Continued From page 5</p> <p>unaware the door was not latching. He stated he checked the resident doors weekly to ensure the doors latch and stated the weather affects the doors.</p> <p>Observations, on 04/08/14 at 2:15 PM with the Maintenance Supervisor, revealed the corridor door to room #16 would not latch properly.</p> <p>Interview, on 04/08/14 at 2:16 PM with the Maintenance Supervisor, revealed he was unaware the door was not latching. He stated he checked the resident doors weekly to ensure the doors latch and stated the weather affects the doors.</p> <p>The census of forty-nine (49) was verified by the Administrator on 04/08/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/08/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms,</p>	K 018		

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K 018	Continued From page 6 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144	Review of the maintenance log by the Maintenance Director revealed that the generator was inspected weekly including all pertinent components, but not every 7 days. The Maintenance Director inspected the generator on 04/14/2014 with required documentation completed. The Maintenance Director contacted the generator vendor to request the transfer switch to be programmed to exercise in 7 day intervals automatically.	

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K 144	<p>Continued From page 7</p> <p>Based on review of generator test logs and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty (50) beds and at the time of the survey, the census was forty-nine (49).</p> <p>The findings include:</p> <p>Generator test log review, on 04/08/14 at 12:15 PM with the Maintenance Supervisor, revealed the facility could not prove through documentation the generator was being checked on a weekly basis.</p> <p>Interview, on 04/08/14 at 12:16 PM with the Maintenance Supervisor, revealed he was unaware the documentation did not properly show when the generator was being checked. He stated the program only documents when he logs in the checks and he could not tell from the data when the generator was actually checked.</p> <p>The census of forty-nine (49) was verified by the Administrator on 04/08/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/08/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the</p>	K 144	<p>The Regional Property Manager re-educated the Maintenance Director on 4/8/14 regarding requirements to inspect the generator every 7 days.</p> <p>The Maintenance Director will review findings of the weekly generator inspection log with the Administrator weekly for 30 days and then bi-weekly for an additional 30 days then as determined by the monthly QI/PI committee to validate timely generator inspections. Corrective action will be completed immediately upon discovery. Results will be reported by the Maintenance Director to the QI/PI Committee and additional audits will be determined based on audit results.</p> <p>05/14/2014</p>	05/14/14

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K 144	Continued From page 8 minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144			