STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185470		C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT HAMBURG	2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated/Partial Extended Survey investigating KY#00019742 was initiated on 02/08/13 and was concluded on 02/15/13. KY#00019742 was substantiated with deficiencies identified. Immediate Jeopardy (IJ) was identified on 02/09/13 and was determined to exist on 02/02/13 with deficiencies cited at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-333; and, 42 CFR 483.75 Administration, F-514 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F-333. The facility was notified of the Immediate Jeopardy (IJ) on 02/09/13. The facility failed to ensure all residents were free of significant medication errors. On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Staff interviews revealed RN #1 had not been observed administering medications by any of her mentors prior to her administering medications to	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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	residents on 02/02/13, per facility policy. Interviews further revealed, Licensed Practical Nurse (LPN) #1 was to be observing RN #1 administer medications on 02/02/13; however, she left the unit and never observed RN #1 administer any medications. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. An acceptable Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 02/14/13, with the facility alleging the Immediate Jeopardy had been removed on 02/14/13. On 02/15/13 the State Survey Agency verified the Immediate Jeopardy was removed on 02/14/13 as alleged, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-333; and, 42 CFR 483.75 Administration, F-514 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors the effectiveness of the systemic changes.			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		

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F 157	Continued From page 2 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the Physician and the resident's Power of	F 157		

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F 157	Continued From page 3 Attorney (POA) were notified in a timely manner, for one (1) of six (6) sampled residents, (Resident #1). The facility failed to immediately notify the Physician and the POA for Resident #1, after Resident #1 received the wrong medications on 02/02/13. In addition, when the Nurse Practitioner was initially notified, she was given insufficient information regarding the medications Resident #1 was given, therefore delaying Resident #1 being sent to the hospital. On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. Interview with the Nurse Practitioner revealed she had been notified at approximately 10:00 AM of	F 157		

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the medication error; however, she was not given the entire list of medications Resident #1 had received nor had she been given vital signs taken after the medication error had occurred. She further stated at approximately 11:00 AM, LPN #1 sent her a text stating Resident #1's blood pressure (BP) had dropped and he/she had became increasingly lethargic, and the family had requested Resident #1 be sent to the hospital. She stated she gave LPN #1 the order to send Resident #1 to the hospital at that time; however, had she been given the correct information the first time LPN #1 notified her at 10:00 AM, she would have sent Resident #1 to the hospital immediately. Interview with the POA revealed the facility did not notify her of the incorrect medications given to Resident #1; she was notified by Resident #1's sitter.

The facility's failure to ensure an effective system was in place to ensure timely Physician and responsible party notification of a change in condition, which was likely to cause a risk for serious injury, harm, or impairment or death. The Immediate Jeopardy was identified on 02/09/13, and was determined to exist on 02/02/13. The facility was notified of the Immediate Jeopardy on 02/09/13.

The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157 at a S/S of a "D" while the facility develops and implements the facility's Plan of Correction (POC) and the facility's Quality

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F 157	Continued From page 5 Assurance Program continues to monitor to ensure the Physicians and the residents' responsible party are notified in a timely manner of any changes in conditions. The findings include: Review of the facility policy titled, "Guidelines for Medication Error Reporting", dated 11/2010, revealed in the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare, and notify the Physician promptly of the error. Further review revealed, nursing staff should also notify the resident's responsible party. Review of the Medication Error Circumstance, Assessment and Intervention sheet, dated 02/02/13 at 8:00 AM, revealed Resident #1 received the wrong medication. Further review revealed, the section staff was to write the name and dose of the wrong medication, LPN #1 had written "see the MAR" for Resident #2. Further review revealed LPN #1 wrote Resident #1 was sedated and had a low blood pressure, and was lethargic. Review of the Fire and Emergency Services report, dated 02/02/13, revealed at 11:30 AM they arrived at the facility. Further review revealed the facility had reported Resident #1 was mistakenly given another resident's medications at 9:00 AM, which included Lisinopril 30 mg and long acting insulin. It was further reported Resident #1 demonstrated a decreased level of consciousness and had a decreased blood pressure from his/her baseline, and the resident	F 157		

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F 157	Continued From page 6 was placed in a modified trendelenburg position. Further review revealed Resident #1's blood pressure was 82/40 and heart rate of fifty-six (56), upon Emergency Medical Service (EMS) arrival and upon arrival to the hospital, Resident #1's blood pressure was 78/30 and a heart rate of fifty (50). Review of the hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension) 1 MG and 400 Milliliters (ML) of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor; the resident's oxygen saturation dropped to eighty-nine (89) percent, and he/she was placed on a non-rebreather at ten (10) liters of oxygen. Record review revealed Resident #1's blood sugar was 119 when he/she first arrived to the Emergency Department at 11:50 AM and at 2:30 PM his/her blood sugar had dropped to ninety-three (93). The resident was admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation. Review of Resident #1's medical chart revealed the facility admitted Resident #1 on 01/13/13 with diagnosis which included Hypertension, Tachy/Brady Syndrome, Congestive Heart Failure, and Dementia. Review of the admission	F 157		

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F 157	Continued From page 7 Minimal Data Set (MDS) Assessment, dated 01/25/13, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15), indicating the resident was cognitively impaired. Interview on 02/08/13 at 3:30 PM with Resident #1's roommate, Resident #3, whom the facility had assessed being cognitive intact with a BIMS of 15, revealed on 02/02/13 he/she went to the bathroom at approximately 9:00 AM. Resident #3 stated he/she overheard the nurse tell Resident #1 she was going to give the resident an insulin shot and his/her other medications. She further stated it was about 9:45 AM, when Resident #1's sitter arrived at the facility and she asked the sitter if Resident #1 took insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she arrived at the facility at approximately 9:45 AM on 02/02/13. She stated as soon as she walked in the room, Resident #3 asked her if Resident #1 took insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She stated she had gone out into the hall way and asked LPN #1 if she had given Resident #1 an insulin shot, and it was approximately ten (10) minutes later when LPN #1 came to the room and stated Resident #1 had received an insulin shot. Further interview revealed, she was the one who notified Resident #1's POA about the medication error as well as the change in Resident #1's condition. Interview with Resident #1's daughter, on	F 157		

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F 157	Continued From page 8 02/08/13 at 6:00 PM, revealed Resident #1's sitter called her at approximately 10:00 AM and informed her Resident #1 had received an insulin shot. She stated the sitter was the only person who called her related to the medication error and the change in condition. Interview with RN #1, on 02/09/13 at 10:00 AM, revealed 02/02/13, at approximately 9:00 AM she entered Resident #1's room without looking at the name on the door, and proceeded to administer Resident #2's medications to Resident #1, without asking Resident #1 what his/her name was. She stated she could not recall how long it was before LPN #1 came to her and asked if she had given Resident #1 an insulin shot, but this was when they realized the medication error had occurred. She stated LPN #1 took over and instructed her to bring her a set of vital signs. She stated the Certified Nursing Assistants (CNA) had taken Resident #1's vital signs prior to the medication administration (approximately 8:00 AM), and these were the vital signs given to the Nurse Practitioner when she was notified by LPN #1 at approximately 9:45 AM. She further stated she should have taken a new set of vital signs before calling the Nurse Practitioner. She stated everything happened so fast and she could not remember exactly when Resident #1's vital signs were taken or when the POA was notified. She further stated the Nurse Practitioner should have been given the entire list of medications Resident #1 received and the POA should have been notified by the nursing staff. Interview with LPN #1, on 02/09/13 at 11:00 AM, revealed she was going to answer the call light in Resident #1's room when Resident #1's sitter	F 157		

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F 157	Continued From page 9 asked her if Resident #1 had received an insulin shot. She stated she asked RN #1 if she had given Resident #1 an insulin shot and at this time RN #1 stated she had given Resident #2 his/her medications, and it was at this time they realized she had given Resident #1 all of Resident #2's morning medications. She stated she thought RN #1 had taken Resident #1's vital signs after they had discovered he/she had received the wrong medications. She stated she notified the Director of Health Services (DHS) of the medication error and then she sent the Nurse Practitioner a text stating Resident #1 had been given Resident #2's medications. She stated she then called the Nurse Practitioner and reported to her the medications Resident #1 received and the vital signs that RN #1 had given her. She stated she thought she had given the entire list of medications administered to Resident #1 to the Nurse Practitioner; however, she could not say for sure. Further interview revealed, LPN #1 could not give any of the times in which she notified the Nurse Practitioner and performed an assessment of Resident #1, which she said included blood sugar check and vital signs check; however, there was no documented evidence of the notification or any type of assessments in Resident #1's medical record. Further interview revealed, at no time did LPN #1 call Resident #1's POA, but had been handed the sitter's cell phone when the POA requested to speak with her. She further stated she should have called the POA before that time. Interview with the DHS, on 02/09/13 at 9:00 PM, revealed LPN #1 called her at home and reported to her Resident #1 had received all of Resident #2's medications, as soon as the medication error	F 157		

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was identified, which was at approximately 10:00 AM, and she came straight to the facility. Further interview revealed, when a nurse calls a physician about a medication error, the nurse should have named all of the medications the resident received as well as give vital signs taken after the medication error occurred. She further stated after a medication error has occurs and the Physician has been notified, staff should have notified the resident's POA.

Interview with the Nurse Practitioner, on 02/11/13 at 9:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin, and the vital signs the nurse gave her was normal; therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to check his/her blood sugar before lunch, dinner, and before bed time. She stated she was not notified of any changes in Resident #1's condition until approximately 11:00 AM, when she received a text from the facility stating Resident #1's blood pressure had dropped and the daughter was wanting the resident sent to the hospital. She stated had she been informed of all of the medications Resident #1 had received and been given the first set of vital signs taken after the medication error occurred (which were B/P of 79/38, Respirations of 16 and Heart Rate of 80), she would have given the order to send Resident #1 out right then. She further stated at no time did LPN #1 state Resident #1 had received all of Resident #2's medications. She further stated

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F 157	Continued From page 11 she did not feel she was completely informed of the medication error and the change in Resident #1's status, and she was not notified in a timely manner considering the error occurred at approximately 9:00 AM and the first text she received was approximately 10:00 AM. Review of the Physician Orders, dated 02/02/12 at 9:45 AM, revealed a telephone order to monitor Resident #1's vital signs every four (4) hours for twenty-four (24) hours and to test Resident #1's blood sugar before lunch, dinner, and bed time. Further review of the Physician Orders, dated 02/02/13 at 11:00 AM, revealed a telephone order from the Nurse Practitioner to send Resident #1 to the hospital. Interview with Resident #1's Primary Physician/Medical Director, on 02/11/13 at 10:05 AM, revealed had he been made aware of all the medications Resident #1 was given, he would have given the order to send the resident to the hospital at that time. The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following: All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline.	F 157		

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F 157	Continued From page 12 On 02/02/13 the DHS ensured that RN #1 did not administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on MAR/TAR, name on door and name on MAR/TAR were present. The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements on the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock"	F 157		

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F 157	Continued From page 13 timely Physician notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation. A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DHS, ADHS, Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above	F 157		

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F 157	Continued From page 14 will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday). The State Survey Agency validated the implementation of the facility's AOC as follows: Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DHS or the ADNS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a	F 157		

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F 157	Continued From page 15 medication error, which included the nurses being given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error prevention post test in order to validate skill competency. Further interview revealed, all nurses interviewed participated in a discussion and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DHS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of	F 157		

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F 157	Continued From page 16 resident clinical records for accuracy, and on the timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made. Interview with the ED, on 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	F 157		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 17 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 policy, it was determined the facility failed to have an effective system to ensure services provided met professional standards for one (1) of six (6) sampled residents, (Resident #1). The facility failed to ensure staff completed their Job Specific Orientation Checklist, prior to administering medications to residents, per facility policy. Review of Registered Nurse (RN) #1 Job Orientation Checklist, not dated, revealed Licensed Practical Nurse (LPN) #1's initials were next to the task of administering oral medications, performing a subcutaneous injection, and performing an accu-check. However, interview with LPN #1 revealed she had never observed RN #1 administer any route of medication and she did not remember initialing the Job Specific Orientation Checklist. On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a	F 281		

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F 281	Continued From page 18 medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Staff interviews revealed RN #1 had not been observed administering medications by any of her mentors prior to her administering medications to residents on 02/02/13, per facility policy. Interviews further revealed, LPN #1 was to be observing RN #1 administer medications on 02/02/13; however, she left the unit and never observed RN #1 administer any medications. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. The facility further failed to timely inform the Physician of all the medications Resident #1 received when RN #1 administered Resident #2's medications to Resident #1, which delayed emergency treatment for Resident #1. The facility further failed to assess Resident #1 and check his/her blood sugar after he/she received the wrong medications, including a long acting insulin, using professional standards. Review of	F 281		

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F 281	Continued From page 19 the medical records revealed no documented evidence assessments were performed on Resident #1 except for vital signs, which were documented but not timed. The facility's failure to ensure services provided met professional standards was likely to cause a risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 02/09/13, and was determined to exist on 02/02/13. The facility was notified of the Immediate Jeopardy on 02/09/13. The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F-281 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program continues to monitor to ensure the residents receive care and service that meet professional standards of practice. The findings include: Review of the facility's policy, titled "Nursing Services-Licensed Staff", dated 10/13/2008, revealed all residents' safety would be maintained as much as possible through risk assessments, preventive interventions, monitoring, and education. Further review revealed, timely and correct completion of required documentation was not negotiable and must be kept up to date at all times to provide a record of care and service delivery and meet regulatory	F 281		

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F 281	Continued From page 20 requirements. Further review revealed, staff was to provide communication to the Physician and responsible party to keep them abreast of condition changes and serviced delivered. Review of the facility's policy, titled "Preparation and General Guidelines", dated 02/01/10, revealed under the documentation section, the staff who administered the medication should document on the resident's Medication Administration Record (MAR) directly after the medication was given. Further review revealed the resident's MAR was initialed by the person administering the medication, in the space provided under the date, and on the line for the specific medication dose administered. Further review revealed, medications were administered in accordance with the written order of the attending Physician, and were administered without unnecessary interruption, and staff was to identify the resident before the medication was administered, using one of these forms of identifications: A) Checking the identification band. B) Checking the photograph. C) Calling the resident by name. D) If necessary, verifying resident identification with other facility personnel. Review of the facility's policy, titled "Guidelines for Medication Error Reporting", dated 11/2010, revealed staff was to document a description of the error, name of the Physician and time notified, and the Physician's subsequent orders, in the resident's clinical record. Review of the Board of Nursing Standards of Practice, used by the facility, revealed under KRS 314.011 Licensed Nurses were to be able to observe, record, and report untoward reactions	F 281		

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F 281	Continued From page 21 and side effects of drug therapy. Interview with the Executive Director (ED), on 02/15/13 at 10:00 AM, revealed the facility used the Lippincott Standards of Nursing Practice, the Briggs Standards of Nursing Practice, the Board of Nursing Standards of Practice, the Regulatory Standards of Practice, Taber's Medical Dictionary, and the PCA Pharmacy as sources for standards of nursing and professional standards. Review of RN #1's Job Specific Orientation Checklist, not dated, revealed LPN #1's initials next to Medication Administration on day two (2) of oral medications, Subcutaneous Injections, and Accu-Checks, not dated. Interview with LPN #1, on 02/09/13 at 8:00 PM, revealed she did not recall signing off on the Job Specific Orientation Checklist for RN #1. Interview with LPN #10, on 02/09/13 at 12:20 PM, revealed she worked with RN #1 on 02/01/13, which was RN #1's first day on the floor. She stated at no time did she observe RN #1 administer any oral medications nor had she observed RN #1 give any types of injections nor accu-checks. She further stated as a mentor, she had been trained to observe a new orientee when they administered any form of medication on their first and their second day on the floor, and then after the second day it would be up to the mentor and the orientee if they needed further one (1) on one (1) with the mentor when administering medications. Interview with LPN #1, on 02/08/12 at 3:30 PM, revealed she was assigned as RN #1's mentor on 02/02/13. She stated RN #1 had told her it was	F 281		

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her third (3) day on the floor; therefore, she left the unit and did not observe RN #1 administer any medications. She further stated she could not recall a picture of Resident #1 on the MAR.

Interview with RN #1, on 02/09/13 at 9:30 AM, revealed on 02/02/13 LPN #1 had not observed her administering medications prior to leaving the unit. She further stated she did not recall a picture of Resident #1 on the MAR; however, she stated she did not look at the pictures when administering medications, she would look at the names on the MAR and the names on the doors. She further stated she did not look at the name on the door before entering Resident #1's room and prior to administering the medications she stated Resident #2's name and when Resident #1 smiled she assumed he/she was Resident #2. She further stated this had been the first time she had worked on this hall and was not familiar with the resident's and she should have asked Resident #1 his/her name prior to administering the medications. Further interview revealed, the blood pressure reading 140/62 had been taken prior to the medication error.

Interview with the Director of Health Services (DHS), on 02/09/13 at 8:45 PM, revealed she had been under the assumption that LPN #1 had observed RN #1 administer medications prior to leaving the unit to go to the dinning room. She further stated before an orientee administered medications alone, they must first be observed by a mentor administering medications. She further stated she was unable to locate a photograph of Resident #1. She further stated, stating a resident's name was not an appropriate identifier for staff to use prior to administering a

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medication, and staff were to use at least two (2) of the approved identifiers prior to administering a medication, and RN #1 had not used two (2) acceptable identifiers prior to administering medications to Resident #1. Further interview revealed, she had observed RN #1 administer medications; however, she was unable to say when she had observed RN #1 administer medications and to which resident's she had observed RN #1 administer medications to.

Review of Resident #2's MAR, dated 02/02/13, revealed RN #1 signed out Propafenone HCL (a medication given for Atrial Fibrillation) 225 milligrams (MG) per oral (PO), Tramadal (a controlled medication given for mild to moderate pain) 50 MG two (2) tablets PO, Coreg (a medication given for Hypertension (HTN)) 12.5 MG PO, Gabapentin (a medication given for nerve pain) 600 MG PO, Imdur (a medication given for HTN) 15 MG PO, Lisinopril (a medication given for HTN) 15 MG PO, Lorazepam (a controlled medication given for anxiety) 0.5 MG PO, and Levumir (a long acting insulin) 25 Units Subcutaneous.

Interview with RN #1, on 02/09/13 at 9:30 AM, revealed she gave Resident #1 all of Resident #2's morning medications. She further stated once the medication error was discovered, LPN #1 was the one who notified the on call Physician.

Interview with LPN #1, on 02/08/13 at 4:30 PM, revealed after the medication error was discovered she notified the Nurse Practitioner who was on call and reported Resident #1 had received Resident #2's morning medications. She further stated she thought she had told the

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F 281	Continued From page 24 Nurse Practitioner every medication Resident #1 had received. She further stated the vital signs given to the Nurse Practitioner had been given to her by RN #1, and she had assumed the vital signs had been taken after the medication error had occurred. She further stated once the medication error had been identified, she and RN #1 assessed Resident #1 and placed him/her in a modified Trendelenburg position and checked Resident #1's blood sugar, she stated at this time Resident #1 was alert and oriented and his/her vital signs were within normal limits. Review of Resident #1's medical record revealed no documented blood sugar nor any documentation of assessments performed or interventions put into place. LPN #1 stated she must not have documented the blood sugar and she could not recall who had taken the vital signs or when the vital signs had been take. She further stated she had not documented in the Nurses Notes any of the assessments done on Resident #1 nor had she documented any of the interventions that were put into place. Further interview revealed, a member of the staff was in the room with Resident #1 at all times; however, she could not remember who had been in the room and when they had been in the room. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she could not remember the names of the staff who were in Resident #1's room; however, she could say there had been long periods of times where a staff member was not in the room. She stated she could recall three (3) times staff had taken Resident #1's vital signs but she could not recall anyone testing Resident #1's blood sugar. Further interview revealed, the	F 281		

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F 281	Continued From page 25 only time she left Resident #1's room was when she went out into the hallway to ask LPN #1 if she had given Resident #1 an insulin shot. Interview with the Nurse Practitioner, on 02/11/13 at 9:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin, and his/her blood pressure was 140/62; therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to check his/her blood sugar before lunch, dinner, and before bed time. She stated she was not notified of any changes in Resident #1's condition until approximately 11:00 AM, when she received a text from the facility stating Resident #1's blood pressure had dropped and the daughter was wanting the resident sent to the hospital. Further interview revealed, had she been given the correct list of medications Resident #1 had received and been given the first set of vital signs taken after the medication error occurred (blood pressure of 79/38, heart rate of 80 and respirations of 16) she would have given the order to send Resident #1 out right then. She further stated at no time did LPN #1 state Resident #1 had received all of Resident #2's medications. She further stated she did not feel she was completely informed of the medication error and of the change in Resident #1's status. Review of the Physician Orders, dated 02/02/12 at 9:45 AM, revealed a telephone order to monitor Resident #1's vital signs every four (4) hours for	F 281		

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	185470		C 02/15/2013

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F 281	Continued From page 26 twenty-four (24) hours and to test Resident #1's blood sugar before lunch, dinner, and bed time. Review of the Vital Sign form, dated 02/02/12 with no time documented, revealed Resident #1's vital signs were: blood pressure 140/62, heart rate sixty-six (66), oxygen saturation of ninety-four (94) percent on three (3) liters of oxygen; blood pressure 78/38, heart rate eighty (80), oxygen saturation of eighty-nine (89) percent on three (3) liters of oxygen. Review of the Nurse Notes, dated 02/02/13 but not timed, revealed Licensed Practical Nurse (LPN) #1 documented Resident #1 had a blood pressure of 79/38 a heart rate of eighty (80) and respirations of sixteen (16). It stated the resident was lethargic and was being transferred to the hospital. Review of the Transfer Form, dated 02/02/13 at 11:30 AM, revealed Resident #1 had a blood pressure of 81/38, heart rate of fifty-eight (58), respirations of fourteen (14). Interview with the Medical Director, on 02/11/13 at 10:05 AM, revealed had he been made aware of all the medications Resident #1 was given, he would have given the order to send the resident to the hospital when first notified of the medication error. He further stated, he would expect a new orientee would be monitored by an experienced staff when administering medications on their second day. Review of the Hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including	F 281		

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F 281	Continued From page 27 respiratory depression, sedation and hypotension) 1 MG and 400 Milliliters of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Further review revealed Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor. Further review revealed Resident #1 was admitted to the Intensive Care Unit (ICU). The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following: All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline. On 02/02/13 the DHS ensured that RN #1 did not administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on MAR/TAR, name on door and name on MAR/TAR were present.	F 281		

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F 281	Continued From page 28 The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements on the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely Physician notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining	F 281		

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F 281	Continued From page 29 complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation. A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DHS, Assistant Director of Nursing Services (ADHS), Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday). The State Survey Agency validated the implementation of the facility's AOC as follows:	F 281		

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F 281	Continued From page 30 Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DHS or the ADHS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a medication error, which included the nurses being given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error prevention post test in order to validate skill competency. Further interview revealed, all	F 281		

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F 281	Continued From page 31 nurses interviewed participated in a discussion and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DHS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of resident clinical records for accuracy, and on the timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made. Interview with the Executive Director (ED), on	F 281		

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F 281	Continued From page 32 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	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 interview, record review, review of the facility policy and Medication Error Circumstance,	F 333		

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F 333	Continued From page 33 Assessment and Intervention sheet, and review of the hospital records, it was determined the facility failed to have an effective system to ensure all resident's were free of significant medication errors for one (1) of six (6) samples resident's (Resident #1). On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnoses of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. Based on the above findings it was determined the facility's failure to ensure residents remained	F 333		

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F 333	Continued From page 34 free of significant medication errors was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy (IJ) was identified on 02/09/13, and was determined to of existed on 02/02/13. The facility was notified of the IJ on 02/09/13. The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13 with remaining non-compliance at 42 CFR 483.25 Quality of Care, F-333 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program continues to monitor to ensure the residents are free from significant medication errors. The finding included: Review of the facility's policy, titled "Specific Medication Administration Procedures", dated 02/01/2010, revealed staff was to identify residents using two (2) identification methods before administering medications. Review of the facility's policy, titled "Preparation and General Guidelines", dated 02/01/10, revealed under the documentation section, the staff who administered the medication should document on the resident's Medication Administration Record (MAR) directly after the medication was given. Further review revealed the resident's MAR was initialed by the person administering the medication, in the space provided under the date, and on the line for the	F 333		

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F 333	Continued From page 35 specific medication dose administered. Further review revealed, medications were administered in accordance with the written order of the attending Physician, and were administered without unnecessary interruption, and staff was to identify the resident before the medication was administered, using one of these forms of identifications: A) Checking the identification band. B) Checking the photograph. C) Calling the resident by name. D) If necessary, verifying resident identification with other facility personnel. Review of the facility's policy, titled "Nursing Services-Licensed Staff", dated 10/13/2008, revealed resident's would receive the correct medications, type, dosage, and route at the appropriate times. Review of the Medication Error Circumstance, Assessment and Intervention sheet, dated 02/02/13 at 8:00 AM, revealed Resident #1 received the wrong medication. Further review revealed, the section staff was to write the name and dose of the wrong medication, LPN #1 had written "see the MAR" for Resident #2. Further review revealed LPN #1 wrote Resident #1 was sedated and had a low blood pressure, and was lethargic. Review of the Fire and Emergency Services report, dated 02/02/13, revealed at 11:30 AM they arrived at the facility. Further review revealed the facility had reported Resident #1 was mistakenly given another resident's medications at 9:00 AM, which included Lisinopril 30 mg and long acting insulin. It was further reported Resident #1 demonstrated a decreased level of consciousness and had a decreased blood	F 333		

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F 333	Continued From page 36 pressure from his/her baseline, and the resident was placed in a modified trendelenburg position. Further review revealed Resident #1's blood pressure was 82/40 and heart rate of fifty-six (56), upon Emergency Medical Service (EMS) arrival and upon arrival to the hospital, Resident #1's blood pressure was 78/30 and a heart rate of fifty (50). Review of the hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension) 1 MG and 400 Milliliters (ML) of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor; the resident's oxygen saturation dropped to eighty-nine (89) percent, and he/she was placed on a non-rebreather at ten (10) liters of oxygen. Record review revealed Resident #1's blood sugar was 119 when he/she first arrived to the Emergency Department at 11:50 AM and at 2:30 PM his/her blood sugar had dropped to ninety-three (93). The resident was admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation. Record review revealed the facility admitted Resident #1 on 01/13/13 with diagnoses which included Hypertension, Tachy/Brady Syndrome, Congestive Heart Failure, and Dementia. Review	F 333		

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F 333	Continued From page 37 of the Admission Minimal Data Set (MDS) Assessment, dated 01/25/13, revealed the facility assessed Resident #1 had a Brief Interview for Mental Status (BIMS) of three (3), which indicated the resident was cognitively impaired. Review of Resident #1's Comprehensive Care Plan, dated 01/30/13, revealed Resident #1 had a Care Plan for communication, which stated Resident #1 suffered from Dementia with behavior disturbance which caused the resident to have difficulty understanding and being understood. Further review revealed, Resident #1 would miss some parts/intents of messages at times and required simple, direct communication. Interview on 02/08/13 at 3:30 PM with Resident #1's roommate, Resident #3, whom the facility had assessed being cognitive intact with a BIMS of 15, revealed on 02/02/13 at approximately 9:00 AM while Resident #3 was in the bathroom, he/she overheard the nurse tell Resident #1 she was going to give the resident an insulin shot and his/her other medications. Resident #3 further stated he/she thought this was strange because he/she had never seen Resident #1 receive an insulin shot or heard Resident #1's family say he/she had "sugar". She further stated it was about 9:45 AM, when Resident #1's sitter arrived at the facility and she asked the sitter if Resident #1 received insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She further stated the sitter stated Resident #1 did not receive insulin shots. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she arrived at the facility at approximately 9:45 AM on 02/02/13. She stated	F 333		

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Resident #3 asked her if Resident #1 took insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She stated it was at this time she looked down and saw an alcohol swab in Resident #1's trash can and it had blood on it. She stated she went out into the hall way and asked LPN #1 if she had given Resident #1 an insulin shot. She stated LPN #1 stated she had not administered the medications but would ask the nurse who had. She further stated approximately five (5) minutes later LPN #1 came into Resident #1's room and stated Resident #1 had received an insulin shot. She stated at that time Resident #1 became more lethargic, unable to hold his/her head up and kept his/her eyes open. She stated she asked LPN #1 to help her get Resident #1 into the bed and LPN #1 assisted her with Resident #1. She further stated, after Resident #1 was back in his/her bed, RN #1 came into the room and stated Resident #1 had also received a "nerve pill", and proceeded to take Resident #1's vital signs, and then she stated Resident #1's blood pressure was very low.

Interview with Resident #1's daughter, on 02/08/13 at 6:00 PM, revealed Resident #1's sitter called her at approximately 10:00 AM and informed her Resident #1 had received an insulin shot. She stated she had been on the phone with the sitter when she heard the nurse say Resident #1's blood pressure had dropped. She asked to speak to the nurse, and asked the nurse if she had called 911 and when the nurse stated she had not, Resident #1's daughter told her she needed to hang up the phone and she wanted 911 called immediately and the resident sent out

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as soon as possible. She further stated she arrived at the facility at around 11:15 AM and Resident #1 was in the bed with his/her eyes closed, mouth gaped open, and non-responsive.

Interview with RN #1, on 02/09/13 at 10:00 AM, revealed 02/02/13 was her second day on the floor, and she was administering medications by herself. She stated she had the MAR opened to Resident #2's medications; however, she was in front of Resident #1's door. She stated at approximately 9:00 AM she entered Resident #1's room without looking at the name on the door, calling the resident's name, or identifying the resident, and proceeded to administer Resident #2's medications to Resident #1. She stated she was not for sure how long it was before LPN #1 came to her and asked if she had given Resident #1 an insulin shot, but this was when they realized the medication error had occurred.

Review of Resident #2's MAR, dated 02/2013, revealed Resident #2 was prescribed the following: Propafenone HCL (a medication given for Atrial Fibrillation) 225 milligrams (MG) per oral (PO), Tramadal (a controlled medication given for mild to moderate pain) 50 MG two (2) tablets PO, Coreg (a medication given for Hypertension (HTN)) 12.5 MG PO, Gabapentin (a medication given for nerve pain) 600 MG PO, Imdur (a medication given for HTN) 15 MG PO, Lisinopril (a medication given for HTN) 15 MG PO, Lorazepam (a controlled medication given for anxiety) 0.5 MG PO, and Levumir (a long acting insulin) 25 Units Subcutaneous.

Interview with LPN #1, 02/09/13 at 11:30 AM, revealed on 02/02/13 at approximately 9:45 AM

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she was going to answer a call light in Resident #1's room when Resident #1's sitter asked her if Resident #1 had received an insulin shot. She stated she asked RN #1 if she had given Resident #1 an insulin shot and at this time RN #1 stated she had given Resident #2 his/her medications, and it was at this time they realized she had given Resident #1 all of Resident #2's morning medications. She stated she notified the Director of Nursing Services (DNS) of the medication error and then she sent the Nurse Practitioner a text stating Resident #1 had been given Resident #2's medications. She further stated at approximately 11:00 AM she text the Nurse Practitioner and informed her Resident #1's blood pressure had dropped and the POA wanted him/her sent to the hospital and she stated she was given the order to send the resident to the hospital and she immediately picked up the red phone, which is a direct line to dispatch, and they took her information and stated they would send an ambulance right away. Further interview revealed Resident #1 had become increasingly lethargic and his/her blood pressure had dropped to 78/38 with a heart rate of sixty-six (66).

Interview with the Nurse Practitioner, on 02/11/13 at 9:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin; however, the vital signs the nurse gave her were normal; therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to

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check his/her blood sugar before lunch, dinner, and before bed time. She stated she was not notified of any changes in Resident #1's condition until approximately 11:00 AM, when she received a text from the facility stating Resident #1's blood pressure had dropped and the daughter was wanting the resident sent to the hospital. She stated had she been given the correct list of medications Resident #1 had received and been given the first set of vital signs taken after the medication error occurred, she would have given the order to send Resident #1 out right then. She further stated at no time did LPN #1 state Resident #1 had received all of Resident #2's medications. She further stated she did not feel she was completely informed of the medication error and the change in Resident #1's status.

Review of the Vital Sign and Weight Record sheet, dated 02/02/12 with no time documented, revealed Resident #1's vital signs were: blood pressure 140/62, heart rate sixty-six (66), oxygen saturation of ninety-four (94) percent on three (3) liters of oxygen; blood pressure 78/38, heart rate eighty (80), oxygen saturation of eighty-nine (89) percent on three (3) liters of oxygen.

Interview with the DNS, on 02/09/13 at 9:00 PM, revealed LPN #1 called her at home and reported to her Resident #1 had received all of Resident #2's medications, as soon as the medication error was identified, which was at approximately 10:00 AM. She stated that all residents had vital signs taken every shift; therefore, there was no other vital signs taken after the medication error occurred. Further interview revealed staff should always use two (2) approved identifiers before administering medications to a resident and RN

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F 333	Continued From page 42 #1 did not use two (2) approved identifiers prior to administering the medications. Per interview, RN #1 stating a resident's name versus asking the resident to state his/her name, was not appropriate considering she was not familiar with the residents. Interview with the Executive Director (ED), on 02/09/13 at 3:30 PM, revealed if a nurse was not familiar with the residents, stating the residents' name versus asking the resident to give their name, would not have been an appropriate identifier to use prior to administering medications. The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following: All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline. On 02/02/13 the DHS ensured that RN #1 did not administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on MAR/TAR, name on door and name on MAR/TAR were present.	F 333		

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F 333	Continued From page 43 The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements on the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely Physician notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining	F 333		

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F 333	Continued From page 44 complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation. A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DNS, Assistant Director of Nursing Services (ADHS), Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday). The State Survey Agency validated the implementation of the facility's AOC as follows:	F 333		

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F 333	Continued From page 45 Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DNS or the ADNS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a medication error, which included the nurses being given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error prevention post test in order to validate skill competency. Further interview revealed, all	F 333		

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F 333	Continued From page 46 nurses interviewed participated in a discussion and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DNS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of resident clinical records for accuracy, and on the timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made. Interview with the Executive Director (ED), on	F 333		

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F 333	Continued From page 47 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	F 333		
F 514 SS=J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 48 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure clinical records were maintained in accordance with accepted professional standards and practices for two (2) of six (6) sampled residents, (Resident #1 and Resident #2). On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. The facility failed to ensure the clinical record contained documentation of times vital signs were taken for Resident #1 on 02/02/13, per physician orders, as well as documented evidence of assessments performed on Resident #1 after	F 514		

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he/she had been given the wrong medications and exhibited a change in condition. Record review and interview revealed the facility also failed to ensure staff accurately documented the times medications were administered and their initials on the Medication Administration Records (MAR) for Resident #1 and Resident #2, as well as on the narcotic sign out sheet for Resident #2.

Based on the above findings it was determined the facility's failure to ensure a system was in place to ensure clinical records were maintained in accordance with accepted professional standards and practices and was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy (IJ) was identified on 02/09/13, and was determined to of existed on 02/02/13. The facility was notified of the IJ on 02/09/13.

The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13, with remaining non-compliance at 42 CFR 483.75 Administration, F-514 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program continues to monitor to ensure clinical records on each resident are maintained in accordance with accepted professional standards of practice and that the clinical records are accurately documented.

The findings include:

Review of the facility policy, titled "Nursing

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F 514	Continued From page 50 Services-Licensed Staff", dated 10/13/08, revealed timely and correct completion of required documentation was not negotiable and must be kept up to date at all times to provide a record of care and service delivery and meet regulatory requirements. Review of facility's policy titled "Medication Administration Times Procedural Guidelines", (no date) revealed the nurse administering the medications shall record the time the medication was administered along with his/her initials. 1. Record review revealed the facility admitted Resident #1 on 01/13/13 with diagnosis which included Hypertension, Tachy/Brady Syndrome, Congestive Heart Failure, and Dementia. Review of Resident Admission Minimal Data Set (MDS) Assessment, dated 01/25/13, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15), which meant the resident was cognitively impaired. Interview with RN #1, on 02/09/13 at 9:30 AM, revealed on 02/02/13 at approximately 9:00 AM she administered Resident #2's medications to Resident #1. She stated she could not remember who assessed Resident #1 after the medication error occurred nor could she remember when Resident #1's vital signs had been taken. She stated everything happened so fast, and after review of the medical records, she was still unable to say what type of assessments were done and when, as well as what time vital signs were taken and by whom. Review of Resident #1's Medication Administration Record (MAR), dated 02/02/13,	F 514		

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F 514	Continued From page 51 revealed LPN #1's initials with a circle around the initials indicating the medication were no administered; however, further review of the MAR revealed no documentation on the back of the MAR to explain the reason for the circled initials. Interview with LPN #1, on 02/09/13 at 9:30 AM, revealed if initials on a MAR were circled, this meant the medications were not given. She further stated she had not documented in the nurses notes about Resident #1 not receiving his/her medications, but she should have documented the medication error in the nurses notes, as per the facility's policy. Interview with LPN #1, on 02/08/13 at 3:30 PM, revealed she thought she had come back to the unit from the dining room at approximately 9:45 AM; however, she was unable to say for sure. She further stated after she discovered Resident #1 had received Resident #2's medications, she assessed Resident #1; however, after review of the medical record she was unable to say when she assessed Resident #1 and when his/her vital signs had been taken. She stated Resident #1 was never left alone after the medication error had been identified; however, she was unable to say who was with Resident #1 and when. Interview with LPN #1, on 02/08/13 at 3:30 PM, revealed she had documented the incident on the Medication Error Circumstance Assessment and Intervention form. She further stated there was not a place on the Medication Error Circumstance Assessment and Intervention form to document all of the vital signs which had been taken, and there was not a place to document the assessments performed. She further stated she should have documented in the Nurses Notes	F 514		

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	185470		C 02/15/2013

NAME OF PROVIDER OR SUPPLIER
THE WILLOWS AT HAMBURG

STREET ADDRESS, CITY, STATE, ZIP CODE
2531 OLD ROSEBUD ROAD
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F 514	Continued From page 52	F 514		

what assessments were done as well as the times the vital signs were taken. Further interview revealed, LPN #1 was unable to remember what times Resident #1's vital signs were taken or who had taken Resident #1's vital signs after the medication error occurred. She further stated she also could not remember who had performed the assessments on Resident #1 after he/she had received the wrong medications, but whoever did the assessment should have documented those assessments. Further interview revealed, LPN #1 stated she had taken Resident #1's blood sugar; however, there was no documented evidence a blood sugar had been obtained.

Interview with Registered Nurse (RN) #1, on 02/09/13 at 10:00 AM, revealed she had not documented any assessments done on Resident #1 after she gave him/her the wrong medications. She further stated she knew Resident #1's vital signs had been taken; however, she did not know who had taken the vital signs or when. She further stated she should have documented the assessments she did on Resident #1 and she should have documented the vital signs and the time they were taken. She stated at no time was Resident #1 left alone; however, she was unable to say who was in the room with Resident #1 and when.

Interview with the Nurse Practitioner, on 02/11/13 at 09:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin, and the vital signs the nurse gave her were normal;

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F 514	Continued From page 53 therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to check his/her blood sugar before lunch, dinner, and before bed time. However, review of the Physician Orders, dated 02/02/13, revealed at 09:45 AM, LPN #1 wrote an order for Resident #1's vital signs to be checked every four (4) hours for the next twenty-four (24) hours and to check Resident #1's blood sugar at lunch, dinner, and at bedtime. Further review revealed on 02/02/13 at 11:00 AM, LPN #1 wrote an order to send Resident #1 to the hospital. Further review revealed no Physician's signature on either order and no Physician's name was documented on either order by LPN #1. Review of the Vital Signs Record, dated 02/02/13 no time documented, revealed Resident #1 had two (2) sets of vital signs documented; however, there was no time documented. Review of the Nurse Notes, dated 02/02/13 at 10:00 AM, revealed Licensed Practical Nurse (LPN) #1 documented Resident #1 had a blood pressure of 79/38 a heart rate of eighty (80) and respirations of sixteen (16). Interview with LPN #1, on 02/08/13 at 3:30 PM, revealed she should have written the Nurse Practitioners name on the order. She further stated she had not written the times on the orders and was not aware of who wrote the times on the orders. Further interview revealed she thought the Nurse Practitioner had given the order to check Resident #1's vital signs as she wrote in	F 514		

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F 514	Continued From page 54 the order, but she might have misunderstood. Interview with the DNS, on 02/09/13 at 9:00 PM, revealed LPN #1 called her at home and reported to her Resident #1 had received all of Resident #2's medications, as soon as the medication error was identified, which was at approximately 10:00 AM and she went straight to the facility. Further interview revealed, staff was to document the medication error and the assessments on the Medication Error Circumstance Assessment and Intervention form. After review of the Medication Error Circumstance Assessment and Intervention form and the Nurses Notes, she stated LPN #1 should have documented further what assessments had been done and the times the vital signs had been taken. 2. Review of medical record for Resident #2 revealed the facility admitted the resident on 12/30/12, with diagnoses which include Heart Block, Arrhythmia, Atrial Fibrillation, Heart Murmur, Diabetes, Osteoarthritis, Hypertension (HTN), Pernicious Anemia, Hypothyroidism, Chronic Back Pain and Anxiety. Review of Resident #2's Physician's Orders, starting 02/01/13 and ending 02/28/13, revealed the following medications: Aspirin (use to prevent heart attack or stroke) 81 milligrams (mg) orally every morning, Azo Cranberry (reduce risk for urinary tract infection) 450 mg, 2 tablets daily, Carvedilol (for HTN) 12.5 mg tablet given twice a day, Citrucel Orange (for prevention of constipation) 1 scoop in 8 ounces of water, Docusate Sodium (prevention of constipation) 100 mg, dose of 2 tablets twice a day, Floranex (probiotic to aid in digestion) one tablet twice	F 514		

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F 514	Continued From page 55 daily, Gabapentin (pain relief) 600 mg, one tablet orally, twice a day, Isosorbide (for HTN) 30 mg tablet, ½ tablet orally twice a day, Levothyroxine (for hypothyroidism) 175 Microgram (MCG) tablet once daily, Lisinopril (for HTN) 30 mg tablet, ½ tablet twice a day, Lorazepam (narcotic anxiety medication) 0.5 mg, one tablet to be given three times a day at 09:00 AM, Megace (to stimulate appetite) 40 mg/milliliter (ml) liquid, 10 ml, Multivitamin given daily for dietary supplement, Oyst-Cal 500+D (calcium and vitamin D combination) 200 International Units (IU), 2 tablets (400 IU) once a day for treatment of osteoporosis, Pancreaze 10500 Unit, 1 capsule 3 times a day for pancreatitis, Pantoprazole (treatment of hiatal hernia) 40 mg, 1 tablet daily, Propafenone (prevention of serious heart rhythm disorders), 225 MG, 1 capsule twice a day, Senna-Laxative (prevention of constipation), 2 tablets at bedtime,Tramadol (narcotic for pain control) 50 mg tablet, 2 tablets 4 times a day, Levemir (long-acting form of insulin to treat diabetes) 25 Units injected subcutaneously every morning, Temazepam (narcotic medication for insomnia) 15 mg as needed for insomnia. Interview with RN #1, on 02/09/13 at 09:30 AM, revealed she had mistakenly administered all of Resident #2's medication to Resident #1, including checking finger stick blood sugar, injecting insulin, and administration of controlled medications, the morning of 02/02/13. RN #1 further stated she did not administer any medications to Resident #2. Interview with LPN #1, on 02/08/13 at 3:15 PM, revealed RN #1 did not administer any other medications nor perform treatments once	F 514		

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discovering the medication error. Further, LPN#1 stated she administered all of Resident #2's medications "once everything calmed down", indicating after Resident #1 left the facility via ambulance to hospital. Review of Emergency Medical Services (EMS) run sheet, dated 02/02/13, revealed Resident #1 left facility at 11:45 AM.

Review of Resident #2's MAR, for February 2013, revealed all of Resident #2's medications were documented as being administered at 9:00 AM on 02/02/13, with initials of what appeared to be those of RN #1. Further, Resident #2's MAR did not have any additional documentation indicating morning medications were administered at any other time than 9:00 AM by what appeared to be RN #1's initials.

Review of the Controlled Drug Record (Controlled substances are any drug or therapeutic agent with a potential for abuse or addiction which is held under strict government control) for Resident #2, revealed RN #1 documented she administered doses of controlled medications Tramadol and Lorazepam on 02/02/13 at 9:00 AM, which, as previously stated, was given to Resident #1. However, further review of Controlled Drug Record (CDR) revealed no other doses of controlled medication Tramadol and Lorazepam were signed out as administered to Resident #2 until Resident #2 received his/her next dose of Tramadol documented on 02/02/13 at 6:00 PM, and Lorazepam documented on 02/02/13 at 10:00 PM.

Interview with the DHS, on 02/13/13 at 3:15 PM, revealed she was not able to identify her nursing

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staff's initials responsible for administering the morning medications as recorded on Resident #2's MAR on 02/02/13 at 09:00 AM. Additionally, the DNS was unable to provide a current, up to date, Master Signature Log of nursing staff which identified the individuals by printed name, signature, initials, and license designation. Further, the DNS stated the CDR, which was verified by both the off going and on coming nurses at the end of each shift for accuracy, was not a definite measure to indicate whether a controlled medication was administered or not, and felt verbal verification from the nurses involved would be a better measure to determine whether or not controlled medications were administered.

The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following:

All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline.

On 02/02/13 the DHS ensured that RN #1 did not administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on

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F 514	Continued From page 58 MAR/TAR, name on door and name on MAR/TAR were present. The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements was the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely Physician notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and	F 514		

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resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation.

A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DNS, Assistant Director of Nursing Services (ADHS), Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday).

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F 514	Continued From page 60 The State Survey Agency validated the implementation of the facility's AOC as follows: Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DNS or the ADNS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a medication error, which included the nurses being given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error	F 514		

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F 514	Continued From page 61 prevention post test in order to validate skill competency. Further interview revealed, all nurses interviewed participated in a discussion and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DNS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of resident clinical records for accuracy, and on the timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made.	F 514		

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F 514	Continued From page 62 Interview with the Executive Director (ED), on 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	F 514		

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

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F 000	INITIAL COMMENTS	F 000	DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE ALLEGED DEFECIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF MULTIPLE INTERVIEWS, THE TRAINING AND EXPERIENCE OF STAFF INVOLVED, THE TIMING SEQUENCE OF EVENTS AND CONTACT WITH HEALTH CARE PROFESSIONALS AND THE CARE AND SUPREVISION PROVIDED TO THE RESIDENTS. THE FACILITY PRESENTED CONTRARY EVIDENCE DURING THE SURVEY ITSELF WHICH WAS NOT ACKNOWLEDGED BY THE CABINET AND WILL DO SO THROUGH THE DISPUTE RESOLUTION PROCESS AS WELL.	3/13/13
	An Abbreviated/Partial Extended Survey investigating KY#00019742 was initiated on 02/08/13 and was concluded on 02/15/13. KY#00019742 was substantiated with deficiencies identified. Immediate Jeopardy (IJ) was identified on 02/09/13 and was determined to exist on 02/02/13 with deficiencies cited at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-333; and, 42 CFR 483.75 Administration, F-514 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F-333. The facility was notified of the Immediate Jeopardy (IJ) on 02/09/13.			
	The facility failed to ensure all residents were free of significant medication errors. On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Staff interviews revealed RN #1 had not been observed administering medications by any of her mentors prior to her administering medications to		**F157** 1. On 2-2-13 Resident #1 received the wrong medication at around 9:45 a.m. per nurse interview, documented time on MAR is	3/13/13

RECEIVED MAR 11 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Hallina, Executive Director — (X6) DATE: 3/11/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185475		C 02/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT HAMBURG	2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509

(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	Continued From page 1 residents on 02/02/13, per facility policy. Interviews further revealed, Licensed Practical Nurse (LPN) #1 was to be observing RN #1 administer medications on 02/02/13; however, she left the unit and never observed RN #1 administer any medications. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. An acceptable Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 02/14/13, with the facility alleging the Immediate Jeopardy had been removed on 02/14/13. On 02/15/13 the State Survey Agency verified the Immediate Jeopardy was removed on 02/14/13 as alleged, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-281; 42 CFR 483.25 Quality of Care, F-333; and, 42 CFR 483.75 Administration, F-514 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program monitors the effectiveness of the systemic changes.	F 000	incorrectly listed as 9 a.m. Nurse #1 and #2 reviewed both residents MARs. Nurse RN #1 obtained a set of vitals of 110/60 and blood sugar of 123 and nurse LPN#1 contacted APRN with above information for orders at (10:07 a.m.) per APRN's phone record and interview. APRN gave orders to monitor vital signs q 4 hrs x 24 hours and obtain blood sugar at lunch, dinner and hours of sleep. Per APRN phone record at 10:57 a.m. nurse RN #1 called back and stated that while she was obtaining another set of vital signs, the daughter called and stated she wanted res. sent to hospital. RN#1stated she had informed the residents husband right when the error occured and she was on her way to contact the ARNP to report drop in b/p when the daughter called. APRN gave order to send resident to hospital. Resident #1 was transported to hospital. Nurse LPN #1 stated on interview to the DHS on and with the DHS and CNC (Corporate Nurse Consultant) on 2/4/13, that she had administered resident #2's medications as ordered at approximately 10 a.m., although she failed to document on the MAR. A Medication Error Circumstance Form was completed on 2/13/13	RJS 3/13/13 3/13/13
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		

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	185470		C 02/15/2013

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THE WILLOWS AT HAMBURG	2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509

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F 157	Continued From page 2 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the Physician and the resident's Power of Attorney (POA) were notified in a timely manner,	F 157	related to the Medications not being documented. **2.** Per Nurse RN #1 the Director of Health Services (DHS) was notified of the medication error at approximately 11:15 a.m. came to the facility. The DHS initiated the following interventions: all residents, including the residents that Nurse #1 had given medications to, were observed by the DHS on for any signs and symptoms different from their baseline. DHS interviewed all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline. There were no changes noted. DHS interviewed Nurse RN #1 and Nurse LPN #1 regarding the sequence of events. DHS conducted a 100% review of all current residents clinical record to verify that all methods of resident identification: photo and name on MAR/TAR and name on door were present. DHS initiated in-service education of all licensed staff regarding the "medication error circumstance assessment and intervention" and the "Specific Medication Admin. Procedures," to include noting the correct: time, dose, route, medication	3/13/13

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F 157	Continued From page 3 for one (1) of six (6) sampled residents, (Resident #1). The facility failed to immediately notify the Physician and the POA for Resident #1, after Resident #1 received the wrong medications on 02/02/13. In addition, when the Nurse Practitioner was initially notified, she was given insufficient information regarding the medications Resident #1 was given, therefore delaying Resident #1 being sent to the hospital. On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. Interview with the Nurse Practitioner revealed she had been notified at approximately 10:00 AM of the medication error; however, she was not given	F 157	and resident identification prior to giving medication. The DHS also included specific instructions that once medications have been prepared, the nurse must continue through with administration to the resident. All licensed nurses had to attend the in-service education prior to their next scheduled shift. The DHS and ADHS observed all residents for any signs and symptoms different from their baseline. DHS and ADHS conducted interviews of all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline. There were no changes noted. On 2/4/2013 Nurse RN #1 resigned. 3. The DHS, CCS, ADHS and others initiated other in-service education. This in-service for all licensed nurses included the following: "Specific Medication Admin. Procedures" to include noting the correct: time, dose, route, medication and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including	

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F 157	Continued From page 4 the entire list of medications Resident #1 had received nor had she been given vital signs taken after the medication error had occurred. She further stated at approximately 11:00 AM, LPN #1 sent her a text stating Resident #1's blood pressure (BP) had dropped and he/she had became increasingly lethargic, and the family had requested Resident #1 be sent to the hospital. She stated she gave LPN #1 the order to send Resident #1 to the hospital at that time; however, had she been given the correct information the first time LPN #1 notified her at 10:00 AM, she would have sent Resident #1 to the hospital immediately. Interview with the POA revealed the facility did not notify her of the incorrect medications given to Resident #1; she was notified by Resident #1's sitter. The facility's failure to ensure an effective system was in place to ensure timely Physician and responsible party notification of a change in condition, which was likely to cause a risk for serious injury, harm, or impairment or death. The Immediate Jeopardy was identified on 02/09/13, and was determined to exist on 02/02/13. The facility was notified of the Immediate Jeopardy on 02/09/13. The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157 at a S/S of a "D" while the facility develops and implements the facility's Plan of Correction (POC) and the facility's Quality Assurance Program continues to monitor to	F 157	verifying resident's name on door, MAR/TAR, review photo, have resident tell the nurse their name or have facility personnel identify the resident. A "Specific Medication Admin. Clinical Competency" was completed on all nurses with mock resident demonstration using at least two forms of identification prior to medication administration. On 2-10-13 and 2-11-13 nurses were also observed while completing their medication pass and this is on-going. Assessment, monitoring and documentation requirements in the event that a medication error has occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test," in order to validate skill competency. Discussion/Review of the facility policy and procedure for timely Notification. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and	

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F 157 Continued From page 5

ensure the Physicians and the residents' responsible party are notified in a timely manner of any changes in conditions.

The findings include:

Review of the facility policy titled, "Guidelines for Medication Error Reporting", dated 11/2010, revealed in the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare, and notify the Physician promptly of the error. Further review revealed, nursing staff should also notify the resident's responsible party.

Review of the Medication Error Circumstance, Assessment and Intervention sheet, dated 02/02/13 at 8:00 AM, revealed Resident #1 received the wrong medication. Further review revealed, the section staff was to write the name and dose of the wrong medication, LPN #1 had written "see the MAR" for Resident #2. Further review revealed LPN #1 wrote Resident #1 was sedated and had a low blood pressure, and was lethargic.

Review of the Fire and Emergency Services report, dated 02/02/13, revealed at 11:30 AM they arrived at the facility. Further review revealed the facility had reported Resident #1 was mistakenly given another resident's medications at 9:00 AM, which included Lisinopril 30 mg and long acting insulin. It was further reported Resident #1 demonstrated a decreased level of consciousness and had a decreased blood pressure from his/her baseline, and the resident was placed in a modified trendelenburg position.

F 157

Intervention Form" has been modified to accommodate frequent vital sign documentation.

4. A Quality Assurance discussion was conducted to discuss the details of the action items. The ED, DHS, ADHS, Consultant Pharmacist, APRN and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place.

The "Documentation Audit Tool" was used to audit 100% of resident clinical records for accuracy. This audit will be conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit will focus on timely and thorough notification and documentation. This audit tool was used to conduct audits on 100% of residents clinical record on 2-13-13 with no errors noted. This audit will continue three times weekly by reviewing 10% of residents' clinical records.

The QA committee will review results of all audits weekly for three months. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any problems identified through audits

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F 157	Continued From page 6 Further review revealed Resident #1's blood pressure was 82/40 and heart rate of fifty-six (56), upon Emergency Medical Service (EMS) arrival and upon arrival to the hospital, Resident #1's blood pressure was 78/30 and a heart rate of fifty (50). Review of the hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension) 1 MG and 400 Milliliters (ML) of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor; the resident's oxygen saturation dropped to eighty-nine (89) percent, and he/she was placed on a non-rebreather at ten (10) liters of oxygen. Record review revealed Resident #1's blood sugar was 119 when he/she first arrived to the Emergency Department at 11:50 AM and at 2:30 PM his/her blood sugar had dropped to ninety-three (93). The resident was admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation. Review of Resident #1's medical chart revealed the facility admitted Resident #1 on 01/13/13 with diagnosis which included Hypertension, Tachy/Brady Syndrome, Congestive Heart Failure, and Dementia. Review of the admission Minimal Data Set (MDS) Assessment, dated	F 157	The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director will review the progress with the Administrator on a weekly basis. After weekly meetings for three consecutive months, QA meeting will return to monthly. 5. March 13, 2013 **F281** **1**. On 2-2-13Resident #1 received the wrong medication at around 9:45 a.m. per nurse interview, documented time on MAR is incorrectly listed as 9 a.m. Nurse #1 and #2 reviewed both residents MARs. Nurse RN #1 obtained a set of vitals of 110/60 and blood sugar of 123 and nurse LPN#1 contacted APRN with above information for orders at (10:07 a.m.) per APRN's phone record and interview. APRN gave orders to monitor vital signs q 4 hrs x 24 hours and obtain blood sugar at lunch, dinner and hours of sleep. Per APRN phone record at 10:57 a.m. nurse RN #1 called back and stated that while she was obtaining another set of vital signs, the daughter called and stated she wanted res. sent to hospital. RN#1stated she had informed the	3/13/13

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F 157	Continued From page 7 01/25/13, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15), indicating the resident was cognitively impaired. Interview on 02/08/13 at 3:30 PM with Resident #1's roommate, Resident #3, whom the facility had assessed being cognitive intact with a BIMS of 15, revealed on 02/02/13 he/she went to the bathroom at approximately 9:00 AM. Resident #3 stated he/she overheard the nurse tell Resident #1 she was going to give the resident an insulin shot and his/her other medications. She further stated it was about 9:45 AM, when Resident #1's sitter arrived at the facility and she asked the sitter if Resident #1 took insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she arrived at the facility at approximately 9:45 AM on 02/02/13. She stated as soon as she walked in the room, Resident #3 asked her if Resident #1 took insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She stated she had gone out into the hall way and asked LPN #1 if she had given Resident #1 an insulin shot, and it was approximately ten (10) minutes later when LPN #1 came to the room and stated Resident #1 had received an insulin shot. Further interview revealed, she was the one who notified Resident #1's POA about the medication error as well as the change in Resident #1's condition. Interview with Resident #1's daughter, on 02/08/13 at 6:00 PM, revealed Resident #1's	F 157	residents husband right when the error occured and she was on her way to contact the ARNP to report drop in b/p when the daughter called. APRN gave order to send resident to hospital. Resident #1 was transported to hospital. Nurse LPN #1 stated on interview to the DHS on and with the DHS and CNC (Corporate Nurse Consultant) on 2/4/13, that she had administered resident #2's medications as ordered at approximately 10 a.m., although she failed to document on the MAR. A Medication Error Circumstance Form was completed on 2/13/13 related to the Medications not being documented. **2.** Per Nurse RN #1 the Director of Health Services (DHS) was notified of the medication error at approximately 11:15 a.m. came to the facility. The DHS initiated the following interventions: all residents, including the residents that Nurse #1 had given medications to, were observed by the DHS on for any signs and symptoms different from their baseline. DHS interviewed all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline.	

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F 157	Continued From page 8 sitter called her at approximately 10:00 AM and informed her Resident #1 had received an insulin shot. She stated the sitter was the only person who called her related to the medication error and the change in condition. Interview with RN #1, on 02/09/13 at 10:00 AM, revealed 02/02/13, at approximately 9:00 AM she entered Resident #1's room without looking at the name on the door, and proceeded to administer Resident #2's medications to Resident #1, without asking Resident #1 what his/her name was. She stated she could not recall how long it was before LPN #1 came to her and asked if she had given Resident #1 an insulin shot, but this was when they realized the medication error had occurred. She stated LPN #1 took over and instructed her to bring her a set of vital signs. She stated the Certified Nursing Assistants (CNA) had taken Resident #1's vital signs prior to the medication administration (approximately 8:00 AM), and these were the vital signs given to the Nurse Practitioner when she was notified by LPN #1 at approximately 9:45 AM. She further stated she should have taken a new set of vital signs before calling the Nurse Practitioner. She stated everything happened so fast and she could not remember exactly when Resident #1's vital signs were taken or when the POA was notified. She further stated the Nurse Practitioner should have been given the entire list of medications Resident #1 received and the POA should have been notified by the nursing staff. Interview with LPN #1, on 02/09/13 at 11:00 AM, revealed she was going to answer the call light in Resident #1's room when Resident #1's sitter asked her if Resident #1 had received an insulin	F 157	There were no changes noted. DHS interviewed Nurse RN #1 and Nurse LPN #1 regarding the sequence of events. DHS conducted a 100% review of all current residents clinical record to verify that all methods of resident identification: photo and name on MAR/TAR and name on door were present. DHS initiated in-service education of all licensed staff regarding the "medication error circumstance assessment and intervention" and the "Specific Medication Admin. Procedures," to include noting the correct: time, dose, route, medication and resident identification prior to giving medication. The DHS also included specific instructions that once medications have been prepared, the nurse must continue through with administration to the resident. All licensed nurses had to attend the in-service education prior to their next scheduled shift. The DHS and ADHS observed all residents for any signs and symptoms different from their baseline. DHS and ADHS conducted interviews of all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 9 shot. She stated she asked RN #1 if she had given Resident #1 an insulin shot and at this time RN #1 stated she had given Resident #2 his/her medications, and it was at this time they realized she had given Resident #1 all of Resident #2's morning medications. She stated she thought RN #1 had taken Resident #1's vital signs after they had discovered he/she had received the wrong medications. She stated she notified the Director of Health Services (DHS) of the medication error and then she sent the Nurse Practitioner a text stating Resident #1 had been given Resident #2's medications. She stated she then called the Nurse Practitioner and reported to her the medications Resident #1 received and the vital signs that RN #1 had given her. She stated she thought she had given the entire list of medications administered to Resident #1 to the Nurse Practitioner; however, she could not say for sure. Further interview revealed, LPN #1 could not give any of the times in which she notified the Nurse Practitioner and performed an assessment of Resident #1, which she said included blood sugar check and vital signs check; however, there was no documented evidence of the notification or any type of assessments in Resident #1's medical record. Further interview revealed, at no time did LPN #1 call Resident #1's POA, but had been handed the sitter's cell phone when the POA requested to speak with her. She further stated she should have called the POA before that time. Interview with the DHS, on 02/09/13 at 9:00 PM, revealed LPN #1 called her at home and reported to her Resident #1 had received all of Resident #2's medications, as soon as the medication error was identified, which was at approximately 10:00	F 157	There were no changes noted. On 2/4/2013 Nurse RN #1 resigned. **3**. The DHS, CCS, ADHS and others initiated other in-service education. This in-service for all licensed nurses included the following: "Specific Medication Admin. Procedures" to include noting the correct: time, dose, route, medication and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying resident's name on door, MAR/TAR, review photo, have resident tell the nurse their name or have facility personnel identify the resident. A "Specific Medication Admin. Clinical Competency" was completed on all nurses with mock resident demonstration using at least two forms of identification prior to medication administration. On 2-10-13 and 2-11-13 nurses were also observed while completing their medication pass and this is on-going. Assessment, monitoring and documentation requirements in the event that a medication error has occurred. This included the nurses being given a hypothetical medication error scenario and having	

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	185470		C 02/15/2013

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F 157	Continued From page 10 AM, and she came straight to the facility. Further interview revealed, when a nurse calls a physician about a medication error, the nurse should have named all of the medications the resident received as well as give vital signs taken after the medication error occurred. She further stated after a medication error has occurs and the Physician has been notified, staff should have notified the resident's POA. Interview with the Nurse Practitioner, on 02/11/13 at 9:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin, and the vital signs the nurse gave her was normal; therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to check his/her blood sugar before lunch, dinner, and before bed time. She stated she was not notified of any changes in Resident #1's condition until approximately 11:00 AM, when she received a text from the facility stating Resident #1's blood pressure had dropped and the daughter was wanting the resident sent to the hospital. She stated had she been informed of all of the medications Resident #1 had received and been given the first set of vital signs taken after the medication error occurred (which were B/P of 79/38, Respirations of 16 and Heart Rate of 80), she would have given the order to send Resident #1 out right then. She further stated at no time did LPN #1 state Resident #1 had received all of Resident #2's medications. She further stated she did not feel she was completely informed of	F 157	them complete "mock" timely notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test," in order to validate skill competency. Discussion/Review of the facility policy and procedure for timely Notification. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Form" has been modified to accommodate frequent vital sign documentation. **4.** A Quality Assurance discussion was conducted to discuss the details of the action items. The ED, DHS, ADHS, Consultant Pharmacist, APRN and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was used to audit 100% of resident clinical records for accuracy. This audit will be conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit will focus on timely	

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F 157 Continued From page 11

the medication error and the change in Resident #1's status, and she was not notified in a timely manner considering the error occurred at approximately 9:00 AM and the first text she received was approximately 10:00 AM.

Review of the Physician Orders, dated 02/02/12 at 9:45 AM, revealed a telephone order to monitor Resident #1's vital signs every four (4) hours for twenty-four (24) hours and to test Resident #1's blood sugar before lunch, dinner, and bed time. Further review of the Physician Orders, dated 02/02/13 at 11:00 AM, revealed a telephone order from the Nurse Practitioner to send Resident #1 to the hospital.

Interview with Resident #1's Primary Physician/Medical Director, on 02/11/13 at 10:05 AM, revealed had he been made aware of all the medications Resident #1 was given, he would have given the order to send the resident to the hospital at that time.

The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following:

All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline.

On 02/02/13 the DHS ensured that RN #1 did not

F 157

and thorough notification and documentation. This audit tool was used to conduct audits on 100% of residents clinical record on 2-13-13 with no errors noted. This audit will continue three times weekly by reviewing 10% of residents' clinical records.

The QA committee will review results of all audits weekly for three months. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any problems identified through audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director will review the progress with the Administrator on a weekly basis. After weekly meetings for three consecutive months, QA meeting will return to monthly.

5. March 13, 20131.

F333 3/13/13

1. On 2-2-13Resident #1 received the wrong medication at around 9:45 a.m. per nurse interview, documented time on MAR is incorrectly listed as 9 a.m. Nurse #1 and #2 reviewed both residents

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F 157	Continued From page 12 administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on MAR/TAR, name on door and name on MAR/TAR were present. The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements on the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely Physician notification, assessment and	F 157	MARs. Nurse RN #1 obtained a set of vitals of 110/60 and blood sugar of 123 and nurse LPN#1 contacted APRN with above information for orders at (10:07 a.m.) per APRN's phone record and interview. APRN gave orders to monitor vital signs q 4 hrs x 24 hours and obtain blood sugar at lunch, dinner and hours of sleep. Per APRN phone record at 10:57 a.m. nurse RN #1 called back and stated that while she was obtaining another set of vital signs, the daughter called and stated she wanted res. sent to hospital. RN#1stated she had informed the residents husband right when the error occured and she was on her way to contact the ARNP to report drop in b/p when the daughter called. APRN gave order to send resident to hospital. Resident #1 was transported to hospital. Nurse LPN #1 stated on interview to the DHS on and with the DHS and CNC (Corporate Nurse Consultant) on 2/4/13, that she had administered resident #2's medications as ordered at approximately 10 a.m., although she failed to document on the MAR. A Medication Error Circumstance Form was completed on 2/13/13 related to the Medications not being documented.	

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F 157	Continued From page 13 monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation. A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DHS, ADHS, Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above will be tracked and trended with follow up actions	F 157	**2.** Per Nurse RN #1 the Director of Health Services (DHS) was notified of the medication error at approximately 11:15 a.m. came to the facility. The DHS initiated the following interventions: all residents, including the residents that Nurse #1 had given medications to, were observed by the DHS on for any signs and symptoms different from their baseline. DHS interviewed all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline. There were no changes noted. DHS interviewed Nurse RN #1 and Nurse LPN #1 regarding the sequence of events. DHS conducted a 100% review of all current residents clinical record to verify that all methods of resident identification: photo and name on MAR/TAR and name on door were present. DHS initiated in-service education of all licensed staff regarding the "medication error circumstance assessment and intervention" and the "Specific Medication Admin. Procedures," to include noting the correct: time, dose, route, medication and resident identification prior to giving medication. The DHS also	

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F 157	Continued From page 14 or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday). The State Survey Agency validated the implementation of the facility's AOC as follows: Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DHS or the ADNS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a medication error, which included the nurses being	F 157	included specific instructions that once medications have been prepared, the nurse must continue through with administration to the resident. All licensed nurses had to attend the in-service education prior to their next scheduled shift. The DHS and ADHS observed all residents for any signs and symptoms different from their baseline. DHS and ADHS conducted interviews of all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline. There were no changes noted. On 2/4/2013 Nurse RN #1 resigned. 3. The DHS, CCS, ADHS and others initiated other in-service education. This in-service for all licensed nurses included the following: "Specific Medication Admin. Procedures" to include noting the correct: time, dose, route, medication and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying resident's name on door, MAR/TAR, review of photo, have	

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F 157	Continued From page 15 given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error prevention post test in order to validate skill competency. Further interview revealed, all nurses interviewed participated in a discussion and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DHS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of resident clinical records for accuracy, and on the	F 157	resident tell the nurse their name or have facility personnel identify the resident. A "Specific Medication Admin. Clinical Competency" was completed on all nurses with mock resident demonstration using at least two forms of identification prior to medication administration. On 2-10-13 and 2-11-13 nurses were also observed while completing their medication pass and this is on-going. Assessment, monitoring and documentation requirements in the event that a medication error has occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test," in order to validate skill competency. Discussion/Review of the facility policy and procedure for timely Notification. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Form" has been	

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F 157	Continued From page 16 timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made. Interview with the ED, on 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	F 157	modified to accommodate frequent vital sign documentation. **4.** A Quality Assurance discussion was conducted to discuss the details of the action items. The ED, DHS, ADHS, Consultant Pharmacist, APRN and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was used to audit 100% of resident clinical records for accuracy. This audit will be conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit will focus on timely and thorough notification and documentation. This audit tool was used to conduct audits on 100% of residents clinical record on 2-13-13 with no errors noted. This audit will continue three times weekly by reviewing 10% of residents' clinical records. The QA committee will review results of all audits weekly for three months. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any problems identified through audits. The results of the above will be	
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 17 must meet professional standards of quality.	F 281	tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director will review the progress with the Administrator on a weekly basis. After weekly meetings for three consecutive months, QA meeting will return to monthly.	

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility policy, it was determined the facility failed to have an effective system to ensure services provided met professional standards for one (1) of six (6) sampled residents, (Resident #1).

The facility failed to ensure staff completed their Job Specific Orientation Checklist, prior to administering medications to residents, per facility policy. Review of Registered Nurse (RN) #1 Job Orientation Checklist, not dated, revealed Licensed Practical Nurse (LPN) #1's initials were next to the task of administering oral medications, performing a subcutaneous injection, and performing an accu-check. However, interview with LPN #1 revealed she had never observed RN #1 administer any route of medication and she did not remember initialing the Job Specific Orientation Checklist.

On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a

5. March 13, 2013

F514 3/13/13

1. On 2-2-13Resident #1 received the wrong medication at around 9:45 a.m. per nurse interview, documented time on MAR is incorrectly listed as 9 a.m. Nurse #1 and #2 reviewed both residents MARs. Nurse RN #1 obtained a set of vitals of 110/60 and blood sugar of 123 and nurse LPN#1 contacted APRN with above information for orders at (10:07 a.m.) per APRN's phone record and interview. APRN gave orders to monitor vital signs q 4 hrs x 24 hours and obtain blood sugar at lunch, dinner and hours of sleep. Per APRN phone record at 10:57 a.m. nurse RN #1 called back and stated that while she was obtaining another set of vital signs, the daughter called and stated she wanted res. sent to hospital. RN#1stated she had informed the residents husband right when the

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F 281	Continued From page 18 controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Staff interviews revealed RN #1 had not been observed administering medications by any of her mentors prior to her administering medications to residents on 02/02/13, per facility policy. Interviews further revealed, LPN #1 was to be observing RN #1 administer medications on 02/02/13; however, she left the unit and never observed RN #1 administer any medications. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility. The facility further failed to timely inform the Physician of all the medications Resident #1 received when RN #1 administered Resident #2's medications to Resident #1, which delayed emergency treatment for Resident #1. The facility further failed to assess Resident #1 and check his/her blood sugar after he/she received the wrong medications, including a long acting insulin, using professional standards. Review of the medical records revealed no documented	F 281	error occured and she was on her way to contact the ARNP to report drop in b/p when the daughter called. APRN gave order to send resident to hospital. Resident #1 was transported to hospital. Nurse LPN #1 stated on interview to the DHS on and with the DHS and CNC (Corporate Nurse Consultant) on 2/4/13, that she had administered resident #2's medications as ordered at approximately 10 a.m., although she failed to document on the MAR. A Medication Error Circumstance Form was completed on 2/13/13 related to the Medications not being documented. **2.** Per Nurse RN #1 the Director of Health Services (DHS) was notified of the medication error at approximately 11:15 a.m. came to the facility. The DHS initiated the following interventions: all residents, including the residents that Nurse #1 had given medications to, were observed by the DHS on for any signs and symptoms different from their baseline. DHS interviewed all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline. There were no changes noted. DHS	

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F 281	Continued From page 19 evidence assessments were performed on Resident #1 except for vital signs, which were documented but not timed. The facility's failure to ensure services provided met professional standards was likely to cause a risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 02/09/13, and was determined to exist on 02/02/13. The facility was notified of the Immediate Jeopardy on 02/09/13. The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F-281 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program continues to monitor to ensure the residents receive care and service that meet professional standards of practice. The findings include: Review of the facility's policy, titled "Nursing Services-Licensed Staff", dated 10/13/2008, revealed all residents' safety would be maintained as much as possible through risk assessments, preventive interventions, monitoring, and education. Further review revealed, timely and correct completion of required documentation was not negotiable and must be kept up to date at all times to provide a record of care and service delivery and meet regulatory requirements. Further review revealed, staff was	F 281	interviewed Nurse RN #1 and Nurse LPN #1 regarding the sequence of events. DHS conducted a 100% review of all current residents clinical record to verify that all methods of resident identification: photo and name on MAR/TAR and name on door were present. DHS initiated in-service education of all licensed staff regarding the "medication error circumstance assessment and intervention" and the "Specific Medication Admin. Procedures," to include noting the correct: time, dose, route, medication and resident identification prior to giving medication. The DHS also included specific instructions that once medications have been prepared, the nurse must continue through with administration to the resident. All licensed nurses had to attend the in-service education prior to their next scheduled shift. The DHS and ADHS observed all residents for any signs and symptoms different from their baseline. DHS and ADHS conducted interviews of all licensed staff to confirm that no other residents had experienced any inadvertent medication error and that none were exhibiting any signs or symptoms different from their normal baseline.	

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F 281	Continued From page 20 to provide communication to the Physician and responsible party to keep them abreast of condition changes and serviced delivered. Review of the facility's policy, titled "Preparation and General Guidelines", dated 02/01/10, revealed under the documentation section, the staff who administered the medication should document on the resident's Medication Administration Record (MAR) directly after the medication was given. Further review revealed the resident's MAR was initialed by the person administering the medication, in the space provided under the date, and on the line for the specific medication dose administered. Further review revealed, medications were administered in accordance with the written order of the attending Physician, and were administered without unnecessary interruption, and staff was to identify the resident before the medication was administered, using one of these forms of identifications: A) Checking the identification band. B) Checking the photograph. C) Calling the resident by name. D) If necessary, verifying resident identification with other facility personnel. Review of the facility's policy, titled "Guidelines for Medication Error Reporting", dated 11/2010, revealed staff was to document a description of the error, name of the Physician and time notified, and the Physician's subsequent orders, in the resident's clinical record. Review of the Board of Nursing Standards of Practice, used by the facility, revealed under KRS 314.011 Licensed Nurses were to be able to observe, record, and report untoward reactions and side effects of drug therapy.	F 281	There were no changes noted. On 2/4/2013 Nurse RN #1 resigned. **3**. The DHS, CCS, ADHS and others initiated other in-service education. This in-service for all licensed nurses included the following: "Specific Medication Admin. Procedures" to include noting the correct: time, dose, route, medication and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying resident's name on door, MAR/TAR, review photo, have resident tell the nurse their name or have facility personnel identify the resident. A "Specific Medication Admin. Clinical Competency" was completed on all nurses with mock resident demonstration using at least two forms of identification prior to medication administration. On 2-10-13 and 2-11-13 nurses were also observed while completing their medication pass and this is on-going. Assessment, monitoring and documentation requirements in the event that a medication error has occurred. This included the nurses being given a hypothetical medication error scenario and having	

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F 281	Continued From page 21 Interview with the Executive Director (ED), on 02/15/13 at 10:00 AM, revealed the facility used the Lippincott Standards of Nursing Practice, the Briggs Standards of Nursing Practice, the Board of Nursing Standards of Practice, the Regulatory Standards of Practice, Taber's Medical Dictionary, and the PCA Pharmacy as sources for standards of nursing and professional standards. Review of RN #1's Job Specific Orientation Checklist, not dated, revealed LPN #1's initials next to Medication Administration on day two (2) of oral medications, Subcutaneous Injections, and Accu-Checks, not dated. Interview with LPN #1, on 02/09/13 at 8:00 PM, revealed she did not recall signing off on the Job Specific Orientation Checklist for RN #1. Interview with LPN #10, on 02/09/13 at 12:20 PM, revealed she worked with RN #1 on 02/01/13, which was RN #1's first day on the floor. She stated at no time did she observe RN #1 administer any oral medications nor had she observed RN #1 give any types of injections nor accu-checks. She further stated as a mentor, she had been trained to observe a new orientee when they administered any form of medication on their first and their second day on the floor, and then after the second day it would be up to the mentor and the orientee if they needed further one (1) on one (1) with the mentor when administering medications. Interview with LPN #1, on 02/08/12 at 3:30 PM, revealed she was assigned as RN #1's mentor on 02/02/13. She stated RN #1 had told her it was her third (3) day on the floor; therefore, she left	F 281	them complete "mock" timely notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test," in order to validate skill competency. Discussion/Review of the facility policy and procedure for timely Notification. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Form" has been modified to accommodate frequent vital sign documentation. **4.** A Quality Assurance discussion was conducted to discuss the details of the action items. The ED, DHS, ADHS, Consultant Pharmacist, APRN and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was used to audit 100% of resident clinical records for accuracy. This audit will be conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit will focus on timely	

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F 281	Continued From page 22 the unit and did not observe RN #1 administer any medications. She further stated she could not recall a picture of Resident #1 on the MAR. Interview with RN #1, on 02/09/13 at 9:30 AM, revealed on 02/02/13 LPN #1 had not observed her administering medications prior to leaving the unit. She further stated she did not recall a picture of Resident #1 on the MAR; however, she stated she did not look at the pictures when administering medications, she would look at the names on the MAR and the names on the doors. She further stated she did not look at the name on the door before entering Resident #1's room and prior to administering the medications she stated Resident #2's name and when Resident #1 smiled she assumed he/she was Resident #2. She further stated this had been the first time she had worked on this hall and was not familiar with the resident's and she should have asked Resident #1 his/her name prior to administering the medications. Further interview revealed, the blood pressure reading 140/62 had been taken prior to the medication error. Interview with the Director of Health Services (DHS), on 02/09/13 at 8:45 PM, revealed she had been under the assumption that LPN #1 had observed RN #1 administer medications prior to leaving the unit to go to the dinning room. She further stated before an orientee administered medications alone, they must first be observed by a mentor administering medications. She further stated she was unable to locate a photograph of Resident #1. She further stated, stating a resident's name was not an appropriate identifier for staff to use prior to administering a medication, and staff were to use at least two (2)	F 281	and thorough notification and documentation. This audit tool was used to conduct audits on 100% of residents clinical record on 2-13-13 with no errors noted. This audit will continue three times weekly by reviewing 10% of residents' clinical records. The QA committee will review results of all audits weekly for three months. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any problems identified through audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director will review the progress with the Administrator on a weekly basis. After weekly meetings for three consecutive months, QA meeting will return to monthly. 5. March 13, 2013	

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F 281	Continued From page 23 of the approved identifiers prior to administering a medication, and RN #1 had not used two (2) acceptable identifiers prior to administering medications to Resident #1. Further interview revealed, she had observed RN #1 administer medications; however, she was unable to say when she had observed RN #1 administer medications and to which resident's she had observed RN #1 administer medications to. Review of Resident #2's MAR, dated 02/02/13, revealed RN #1 signed out Propafenone HCL (a medication given for Atrial Fibrillation) 225 milligrams (MG) per oral (PO), Tramadal (a controlled medication given for mild to moderate pain) 50 MG two (2) tablets PO, Coreg (a medication given for Hypertension (HTN)) 12.5 MG PO, Gabapentin (a medication given for nerve pain) 600 MG PO, Imdur (a medication given for HTN) 15 MG PO, Lisinopril (a medication given for HTN) 15 MG PO, Lorazepam (a controlled medication given for anxiety) 0.5 MG PO, and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview with RN #1, on 02/09/13 at 9:30 AM, revealed she gave Resident #1 all of Resident #2's morning medications. She further stated once the medication error was discovered, LPN #1 was the one who notified the on call Physician. Interview with LPN #1, on 02/08/13 at 4:30 PM, revealed after the medication error was discovered she notified the Nurse Practitioner who was on call and reported Resident #1 had received Resident #2's morning medications. She further stated she thought she had told the Nurse Practitioner every medication Resident #1	F 281		

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F 281	Continued From page 24 had received. She further stated the vital signs given to the Nurse Practitioner had been given to her by RN #1, and she had assumed the vital signs had been taken after the medication error had occurred. She further stated once the medication error had been identified, she and RN #1 assessed Resident #1 and placed him/her in a modified Trendelenburg position and checked Resident #1's blood sugar, she stated at this time Resident #1 was alert and oriented and his/her vital signs were within normal limits. Review of Resident #1's medical record revealed no documented blood sugar nor any documentation of assessments performed or interventions put into place. LPN #1 stated she must not have documented the blood sugar and she could not recall who had taken the vital signs or when the vital signs had been take. She further stated she had not documented in the Nurses Notes any of the assessments done on Resident #1 nor had she documented any of the interventions that were put into place. Further interview revealed, a member of the staff was in the room with Resident #1 at all times; however, she could not remember who had been in the room and when they had been in the room. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she could not remember the names of the staff who were in Resident #1's room; however, she could say there had been long periods of times where a staff member was not in the room. She stated she could recall three (3) times staff had taken Resident #1's vital signs but she could not recall anyone testing Resident #1's blood sugar. Further interview revealed, the only time she left Resident #1's room was when	F 281		

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F 281	Continued From page 25 she went out into the hallway to ask LPN #1 if she had given Resident #1 an insulin shot. Interview with the Nurse Practitioner, on 02/11/13 at 9:55 AM, revealed on 02/02/13 at approximately 10:00 AM she received a text from the facility stating Resident #1 had received two (2) blood pressure medications he/she did not normally take and a slow acting insulin, and his/her blood pressure was 140/62; therefore, she was not concerned. She stated she gave an order to monitor Resident #1's vital signs every hour for four (4) hours and then every four (4) hours for twenty-four (24) hours, and to check his/her blood sugar before lunch, dinner, and before bed time. She stated she was not notified of any changes in Resident #1's condition until approximately 11:00 AM, when she received a text from the facility stating Resident #1's blood pressure had dropped and the daughter was wanting the resident sent to the hospital. Further interview revealed, had she been given the correct list of medications Resident #1 had received and been given the first set of vital signs taken after the medication error occurred (blood pressure of 79/38, heart rate of 80 and respirations of 16) she would have given the order to send Resident #1 out right then. She further stated at no time did LPN #1 state Resident #1 had received all of Resident #2's medications. She further stated she did not feel she was completely informed of the medication error and of the change in Resident #1's status. Review of the Physician Orders, dated 02/02/12 at 9:45 AM, revealed a telephone order to monitor Resident #1's vital signs every four (4) hours for twenty-four (24) hours and to test Resident #1's	F 281		

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F 281	Continued From page 26 blood sugar before lunch, dinner, and bed time. Review of the Vital Sign form, dated 02/02/12 with no time documented, revealed Resident #1's vital signs were: blood pressure 140/62, heart rate sixty-six (66), oxygen saturation of ninety-four (94) percent on three (3) liters of oxygen; blood pressure 78/38, heart rate eighty (80), oxygen saturation of eighty-nine (89) percent on three (3) liters of oxygen. Review of the Nurse Notes, dated 02/02/13 but not timed, revealed Licensed Practical Nurse (LPN) #1 documented Resident #1 had a blood pressure of 79/38 a heart rate of eighty (80) and respirations of sixteen (16). It stated the resident was lethargic and was being transferred to the hospital. Review of the Transfer Form, dated 02/02/13 at 11:30 AM, revealed Resident #1 had a blood pressure of 81/38, heart rate of fifty-eight (58), respirations of fourteen (14). Interview with the Medical Director, on 02/11/13 at 10:05 AM, revealed had he been made aware of all the medications Resident #1 was given, he would have given the order to send the resident to the hospital when first notified of the medication error. He further stated, he would expect a new orientee would be monitored by an experienced staff when administering medications on their second day. Review of the Hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including respiratory depression, sedation and	F 281		

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hypotension) 1 MG and 400 Milliliters of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Further review revealed Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor. Further review revealed Resident #1 was admitted to the Intensive Care Unit (ICU).

The facility provided an acceptable AOC on 02/14/13 that alleged the removal of the IJ was effective on 02/14/13. Review of the AOC revealed the facility implemented the following:

All residents, including Resident #1 were observed by the DHS on 02/02/13 for any signs and symptoms different from their baseline. The DHS interviewed all licensed staff on duty on 02/02/13 to confirm no other residents had experienced an inadvertent medication error and that none were exhibiting an signs of symptoms different from their normal baseline.

On 02/02/13 the DHS ensured that RN #1 did not administer any additional medications following the medication error and initiated an investigation related to the medication error. In addition, on 02/02/13, the DHS conducted a 100% review of all current residents' clinical records to verify that all methods of resident identification: photos on MAR/TAR, name on door and name on MAR/TAR were present.

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F 281	Continued From page 28 The DHS, Clinical Campus Support (CCS), Assistant Director of Health Service (ADHS), and the DHS, initiated in-service education on 02/10/13 at 12:00 PM and completed on 02/11/13 at 2:00 PM. This in-service for all licensed nurses included the following: 1) "Specific Medication Administration Procedures" to include noting the correct time, dose, route, medication, and resident identification. 2) "Specific Medication Administration Procedures" related to identification of correct resident. This included discussion of all available identification resources for resident identification including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. 3) A "Specific Medication Administration Clinical Competency" was completed on all nurses with a mock resident demonstration using at least two (2) forms of identification prior to medication administration. On 02/11/13 the nurses were also observed while completing their medication pass and this is on going. 4) Assessment, monitoring, and documentation requirements on the evening that a medication error occurred. This included the nurses being given a hypothetical medication error scenario and having them complete "mock" timely Physician notification, assessment and monitoring documentation and "Medpass Error Prevention Post Test", in order to validate skill competency. 5) Discussion/Review of the facility policy and procedure for timely Physician Notification was reviewed. This included discussion of critical labs, normal labs, and resident change of condition. In-service education provided related to maintaining complete and accurate clinical records to include	F 281		

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F 281	Continued From page 29 documentation of medication errors. The "Medication Error Circumstance Assessment and Intervention Forms" had been modified to accommodate frequent vital sign documentation. A Quality Assurance (QA) discussion was conducted on 02/11/13 at 9:00 AM to discuss the details of the action items contained in the AOC. The Executive Director (ED), DHS, Assistant Director of Nursing Services (ADHS), Consultant Pharmacist, Advanced Practice Registered Nurse (APRN), and CCS were present. The ED via phone with Medical Director discussed the action items that were put into place. The "Documentation Audit Tool" was be used to audit 100% of resident clinical records for accuracy until abatement was achieved. This audit was conducted by the DHS, ADHS, Medical records nurse, and CCS. This audit focused on timely and thorough notification of the Physician and POA and documentation. This audit tool was used to conduct audits on 100% of resident clinical records on 02/13/13 with no errors noted. The QA committee will review results of all audits weekly until substantial compliance is obtained. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action related to any and all problems identified though audits. The results of the above will be tracked and trended with follow up actions or education for staff completed as necessary. The Medical Director if unavailable in person will review the progress by phone with the Administrator on a weekly basis (Wednesday). The State Survey Agency validated the implementation of the facility's AOC as follows:	F 281		

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	185470	A. BUILDING B. WING	C 02/15/2013

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F 281	Continued From page 30 Interviews with licensed nursing staff on 02/15/13 at 8:00 AM with LPN #6, at 8:15 AM with LPN #7, at 9:00 AM with LPN #8, at 9:15 AM with RN #2, at 9:30 AM with LPN #2, at 10:00 AM with LPN #3, at 1:40 PM with LPN #9, at 2:00 PM with RN #3, at 2:30 PM with LPN #4, and at 3:00 PM with LPN #5 revealed they all attended in-services which covered: "Specific Medication Administration Procedures" which included noting the correct time, dose, route, medication, and resident identification. "Specific Medication Administration Procedures" related to identification of correct resident, including discussions on all of the acceptable identification methods, including verifying residents names on the door, MAR/TAR, review of the photo, have resident tell the nurse their name or have another facility personnel identify the resident. Further interview revealed all nurses interviewed had completed a medication administration competency, which consisted of a mock resident demonstration using at least two (2) forms of identification prior to medication administration, and were observed by the DHS or the ADHS completing their medication pass before they were able to accept the keys to a medication cart on the floor. Further interview revealed staff was in-serviced on the assessment, monitoring, and documentation requirements in the event of a medication error, which included the nurses being given a hypothetical medication error scenario and having to complete a "mock" timely Physician and POA/family notification, assessment and monitoring documentation, and then each nurse had to take and pass a medication error prevention post test in order to validate skill competency. Further interview revealed, all nurses interviewed participated in a discussion	F 281		

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F 281	Continued From page 31 and review discussion of the facility policy and procedures for timely Physician and POA/family notification, which included discussion of critical labs, normal labs, and resident change of condition, education related to maintaining complete and accurate clinical records to include documentation of medication errors, and review of the new "Medication Error Circumstance Assessment and Intervention Forms". Review of the in-service sign in sheet revealed all nursing staff attended all in-services provided. Interview with DHS, on 02/15/13 at 3:00 PM, revealed she had participated in all the in-services provided to all licensed nursing staff and had conducted a hypothetical medication error scenario with all licensed nursing staff and completed a "mock" timely Physician and POA/family notification, assessment and monitoring documentation scenario. She further stated she also conducted a "mock" medication administration scenario with each licensed nursing staff, prior to observing each licensed nursing staff administer medications to actual residents. She further stated no licensed nursing staff had been allowed to take the medication cart prior to completing these tasks. Further interview revealed, she had conducted audits using the "Documentation Audit Tool" to audit 100% of resident clinical records for accuracy, and on the timely and thorough notification of the Physician and POA/family, and documentation. She further stated she had attended the QA meeting when all the components of the AOC were discussed and recommendations were made. Interview with the Executive Director (ED), on 02/15/13 at 3:30 PM, revealed he had	F 281		

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F 281	Continued From page 32 participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	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 interview, record review, review of the facility policy and Medication Error Circumstance, Assessment and Intervention sheet, and review	F 333		

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F 333	Continued From page 33	F 333		

of the hospital records, it was determined the facility failed to have an effective system to ensure all resident's were free of significant medication errors for one (1) of six (6) samples resident's (Resident #1).

On 02/02/13 at approximately 9:00 AM, Registered Nurse (RN) #1 administered Resident #2's medications to Resident #1, which included Propafenone HCL (a medication given for Atrial Fibrillation), Tramadal (a controlled medication given for mild to moderate pain), Coreg (a medication given for Hypertension (HTN), Gabapentin (a medication given for nerve pain), Imdur (a medication given for HTN), Lisinopril (a medication given for HTN), Lorazepam (a controlled medication given for anxiety), and Levumir (a long acting insulin) 25 Units Subcutaneous. Interview revealed RN #1 did not look at the name on the door before she entered Resident #1's room, and she did not ask the resident his/her name before administering the medications to Resident #1. Interview and record review revealed the significant medication error was identified at approximately 9:45 AM after a change in Resident #1's alertness was noted by the resident's sitter. On 02/02/13 at 11:30 AM, Resident #1 was transferred to the hospital by Emergency Medical Services and admitted to the Intensive Care Unit (ICU) with a diagnoses of Hypotension and Atrial Fibrillation after ingestion of toxic/overdose of the wrong medications. The resident was hospitalized for three (3) days and discharged on 02/05/13 to another nursing facility.

Based on the above findings it was determined the facility's failure to ensure residents remained free of significant medication errors was likely to

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F 333	Continued From page 34 cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy (IJ) was identified on 02/09/13, and was determined to of existed on 02/02/13. The facility was notified of the IJ on 02/09/13. The facility provided an acceptable Allegation of Compliance (AOC) on 02/14/13, with the facility alleging removal of the Immediate Jeopardy on 02/14/13. The Immediate Jeopardy was verified to be removed on 02/15/13 with remaining non-compliance at 42 CFR 483.25 Quality of Care, F-333 at a S/S of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance program continues to monitor to ensure the residents are free from significant medication errors. The finding included: Review of the facility's policy, titled "Specific Medication Administration Procedures", dated 02/01/2010, revealed staff was to identify residents using two (2) identification methods before administering medications. Review of the facility's policy, titled "Preparation and General Guidelines", dated 02/01/10, revealed under the documentation section, the staff who administered the medication should document on the resident's Medication Administration Record (MAR) directly after the medication was given. Further review revealed the resident's MAR was initialed by the person administering the medication, in the space provided under the date, and on the line for the specific medication dose administered. Further	F 333		

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F 333	Continued From page 35	F 333		

review revealed, medications were administered in accordance with the written order of the attending Physician, and were administered without unnecessary interruption, and staff was to identify the resident before the medication was administered, using one of these forms of identifications: A) Checking the identification band. B) Checking the photograph. C) Calling the resident by name. D) If necessary, verifying resident identification with other facility personnel.

Review of the facility's policy, titled "Nursing Services-Licensed Staff", dated 10/13/2008, revealed resident's would receive the correct medications, type, dosage, and route at the appropriate times.

Review of the Medication Error Circumstance, Assessment and Intervention sheet, dated 02/02/13 at 8:00 AM, revealed Resident #1 received the wrong medication. Further review revealed, the section staff was to write the name and dose of the wrong medication, LPN #1 had written "see the MAR" for Resident #2. Further review revealed LPN #1 wrote Resident #1 was sedated and had a low blood pressure, and was lethargic.

Review of the Fire and Emergency Services report, dated 02/02/13, revealed at 11:30 AM they arrived at the facility. Further review revealed the facility had reported Resident #1 was mistakenly given another resident's medications at 9:00 AM, which included Lisinopril 30 mg and long acting insulin. It was further reported Resident #1 demonstrated a decreased level of consciousness and had a decreased blood pressure from his/her baseline, and the resident

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was placed in a modified trendelenburg position. Further review revealed Resident #1's blood pressure was 82/40 and heart rate of fifty-six (56), upon Emergency Medical Service (EMS) arrival and upon arrival to the hospital, Resident #1's blood pressure was 78/30 and a heart rate of fifty (50).

Review of the hospital records, dated 02/02/13, revealed Resident #1 received Narcan (prevents or reverses the effects of opioids including respiratory depression, sedation and hypotension) 1 MG and 400 Milliliters (ML) of normal saline via Intravenous Infusion (IV) in the ambulance in route to the hospital. Resident #1 was started on a Dopamine drip (Suddenly Serious Symptoms of Heart Failure, Decrease in the Amount of Work the Heart Does, Sudden Drop in Blood Pressure) which was titrated from 3 MG to 12 MG to maintain Resident #1's blood pressure. Further review revealed Resident #1 showed Atrial Fibrillation on the cardiac monitor; the resident's oxygen saturation dropped to eighty-nine (89) percent, and he/she was placed on a non-rebreather at ten (10) liters of oxygen. Record review revealed Resident #1's blood sugar was 119 when he/she first arrived to the Emergency Department at 11:50 AM and at 2:30 PM his/her blood sugar had dropped to ninety-three (93). The resident was admitted to the Intensive Care Unit (ICU) with a diagnosis of Hypotension and Atrial Fibrillation.

Record review revealed the facility admitted Resident #1 on 01/13/13 with diagnoses which included Hypertension, Tachy/Brady Syndrome, Congestive Heart Failure, and Dementia. Review of the Admission Minimal Data Set (MDS)

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F 333	Continued From page 37 Assessment, dated 01/25/13, revealed the facility assessed Resident #1 had a Brief Interview for Mental Status (BIMS) of three (3), which indicated the resident was cognitively impaired. Review of Resident #1's Comprehensive Care Plan, dated 01/30/13, revealed Resident #1 had a Care Plan for communication, which stated Resident #1 suffered from Dementia with behavior disturbance which caused the resident to have difficulty understanding and being understood. Further review revealed, Resident #1 would miss some parts/intents of messages at times and required simple, direct communication. Interview on 02/08/13 at 3:30 PM with Resident #1's roommate, Resident #3, whom the facility had assessed being cognitive intact with a BIMS of 15, revealed on 02/02/13 at approximately 9:00 AM while Resident #3 was in the bathroom, he/she overheard the nurse tell Resident #1 she was going to give the resident an insulin shot and his/her other medications. Resident #3 further stated he/she thought this was strange because he/she had never seen Resident #1 receive an insulin shot or heard Resident #1's family say he/she had "sugar". She further stated it was about 9:45 AM, when Resident #1's sitter arrived at the facility and she asked the sitter if Resident #1 received insulin shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She further stated the sitter stated Resident #1 did not receive insulin shots. Interview with Resident #1's sitter, on 02/08/13 at 5:30 PM, revealed she arrived at the facility at approximately 9:45 AM on 02/02/13. She stated Resident #3 asked her if Resident #1 took insulin	F 333		

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F 333	Continued From page 38 shots because he/she had overheard the nurse tell Resident #1 she was going to give him/her an insulin shot. She stated it was at this time she looked down and saw an alcohol swab in Resident #1's trash can and it had blood on it. She stated she went out into the hall way and asked LPN #1 if she had given Resident #1 an insulin shot. She stated LPN #1 stated she had not administered the medications but would ask the nurse who had. She further stated approximately five (5) minutes later LPN #1 came into Resident #1's room and stated Resident #1 had received an insulin shot. She stated at that time Resident #1 became more lethargic, unable to hold his/her head up and kept his/her eyes open. She stated she asked LPN #1 to help her get Resident #1 into the bed and LPN #1 assisted her with Resident #1. She further stated, after Resident #1 was back in his/her bed, RN #1 came into the room and stated Resident #1 had also received a "nerve pill", and proceeded to take Resident #1's vital signs, and then she stated Resident #1's blood pressure was very low. Interview with Resident #1's daughter, on 02/08/13 at 6:00 PM, revealed Resident #1's sitter called her at approximately 10:00 AM and informed her Resident #1 had received an insulin shot. She stated she had been on the phone with the sitter when she heard the nurse say Resident #1's blood pressure had dropped. She asked to speak to the nurse, and asked the nurse if she had called 911 and when the nurse stated she had not, Resident #1's daughter told her she needed to hang up the phone and she wanted 911 called immediately and the resident sent out as soon as possible. She further stated she	F 333		

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F 514	Continued From page 62 Interview with the Executive Director (ED), on 02/15/13 at 3:30 PM, revealed he had participated in the development of the AOC and the implementation of the AOC. He further stated he had also assisted in the "Documentation Audit Tool" which was done on 100% of resident clinical records, as well as observed the licensed nursing staff administer medications to the residents. He further stated he had attended the QA meeting when all of the components of the AOC were discussed and recommendations made, and he had also contacted the Medical Director for his input on the AOC as well as communicated with him via phone during the QA meeting. He further stated that each morning, during the morning stand up meetings attended by all department heads, the results of the audits were reviewed by all in attendance. Interview with the Medical Director, on 02/15/13 at 4:30 PM, revealed he had been included in the completion of the AOC and had given his input and had approved the AOC. He further stated the ED had remained in contact with him via the telephone with all aspects of the implementation of the AOC and during the QA meeting when the results of the AOC and the audits were discussed.	F 514		