

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/08/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220		
(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	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey was initiated on 02/25/14 and concluded on 03/08/14 to investigate KY21369. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified on 02/28/14 and determined to exist on 02/19/14 at 42 CFR 483.20 Resident Assessment, (F281 and F282); and 42 CFR 483.25 Quality of Care, (F333) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 02/28/14.</p> <p>On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name.</p> <p>Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation.</p> <p>Resident #1 was evaluated by the emergency</p>	F 000		

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

*James E. Rife, Jr.*

TITLE

*Interim Executive Director*

(X6) DATE

*3/28/14*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

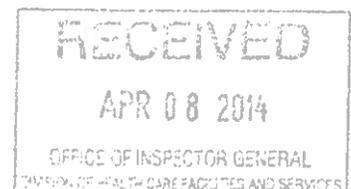
APR 08 2014

*Redisc'd 4/7/14*

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F 000	Continued From page 1 room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), Respiratory Failure and Hypoxia. Resident #1 was hospitalized for three (3) days and expired on 02/21/14.  An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a "D" at 42 CFR 483.20 Services Meet Professional Standards, F281 and F282; and, 42 CFR 483.25 Quality of Care, F333 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.  An additional deficiency was cited at 42 CFR 483.30 Nursing Services (F356) at a S/S of an "E".  The SSA investigated KY21466 in conjunction with KY21369 during the abbreviated survey. The allegation was unsubstantiated with no deficiencies identified.	F 000			
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 281	1. On 2/19/2014 at approximately 9am, Resident #1 received four medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send Resident #1 to the ER at 9:04am. Resident #1 was transported by EMS to Baptist Hospital East.	3/21/14	

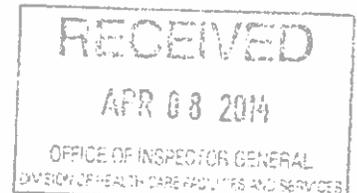


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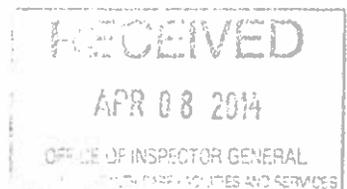
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F 281	<p>Continued From page 2</p> <p>the facility's Investigation Report, Medication Administration Policy and the Licensed Practical Nursing Scope of Practice in Kentucky, it was determined the facility failed to have an effective system to ensure medications were administered according to professional standards for one (1) of ten (10) sampled residents (Resident #1).</p> <p>On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name.</p> <p>Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation.</p> <p>Resident #1 was evaluated by the emergency room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), Respiratory Failure and Hypoxia. Resident #1 was hospitalized for three (3) days and expired on 02/21/14. (Refer to F333)</p>	F 281	<p>Upon arrival at the hospital, he was in stable condition.</p> <p>2. All residents have the potential to be affected. The facility took immediate action to ensure the safety of all residents. The Licensed Practical Nurse who gave resident #1 the medications in error, was removed immediately from the cart. One other Licensed Practical Nurse who had previously worked at the facility for several years was also in orientation. Both Licensed Practical Nurses received education on 2/19/14 on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1, "Nursing Care Center Pharmacy Policy &amp; Procedure Manual - 2007 PharMerica Corp.")</p> <p>3. On 2/19/14, the Director of Clinical Education immediately began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication</p>	



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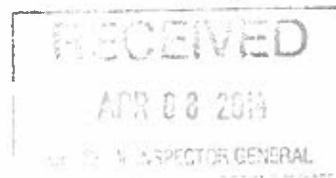
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F 281	<p>Continued From page 3</p> <p>In addition, interview and review of the facility's Nursing Competency revealed LPN #1's competency in medication administration had not been validated per the facility's policy.</p> <p>The facility's failure to ensure medication was administered according to the nursing standards of practice has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/14, and was determined to exist on 02/19/14. The facility was notified of the Immediate Jeopardy on 02/28/14. An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's Licensed Practical Nursing Scope of Practice in Kentucky, dated July 2013, revealed the LPN was required to practice nursing with reasonable skill and safety. Even though the act may be within the scope, if the LPN did not have the training and skills, the act should not be done.</p> <p>Review of the facility's Nursing Competency Checklist revealed an assessment of clinical competency of nursing personnel would be completed during the orientation period. The competency checklist was an on going tool, to be</p>	F 281	<p>Administration are from the "Nursing Care Center Pharmacy Policy &amp; Procedure Manual - 2007 PharMerica Corp.". Initiation of medication observations competencies for all licensed nurses was started first shift on 2/23/2014 by RN Nurse Managers. All nurses who worked had both trainings completed by 2/24/2014. No nurse will be allowed to work after 2/24/2014 unless training is completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and have medication pass observation competencies (see attached Medication Administration Competency Checklist), completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable meds and to ensure resident has an order for "may crush meds." Medication observation competencies will be completed when a medication error is identified, and annually for all licensed nursing staff.</p>		



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F 281	<p>Continued From page 4</p> <p>completed within ninety (90) days of hire. Validation for clinical competency would be completed during orientation with the various assigned staff.</p> <p>Review of the facility's Medication Administration, General Guidelines, dated October 2007, revealed residents were identified prior to administration of medications. Residents should be identified using three (3) identifiers prior to medication administration. Room numbers should not be used as one (1) of two (2) identifiers. The procedure was to use one (1) of the following procedures: check the identification band; check the photograph attached to the medication administration record; and/or verify the resident's identification with other nursing care center personnel.</p> <p>Review of the facility's investigation, undated, revealed Resident #1 received the incorrect medication on 02/19/14. LPN #1 entered the resident's room and called Resident #1 by Resident #2's name and Resident #1 answered and sat up in the bed. LPN #1 administered Resident #2's medications to Resident #1. Further review revealed there was no evidence LPN #1 compared the pictures of Resident #1 or Resident #2 to Resident #1 or asked Resident #1 his/her name.</p> <p>Review of Resident #1's Medication Administration Record (MAR), dated February 2014, revealed on 02/19/14 the medications scheduled for 8:00 AM and 9:00 AM, were coded on the MAR as not administered indicating the documentation would be located in the nurses notes as to why the medications were not administered. Corresponding nurses notes</p>	F 281	<p>On 2/19/2014 at approximately 7pm, the Director of Nursing Services completed an electronic audit to ensure each resident had a current, accurate photograph in the emar/etar. All residents in house on 2/19/14 had a photograph. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 2/27/14.</p> <p>On 2/20/14 at 11am, the Medical Director attended QAPI to discuss the medication error and resident #1 current condition. The Medical Director agreed with plan to address medication errors, which included; immediately removing licensed practical nurse who administered medications in error to resident #1 from the medication cart, education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 2/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy</p>	



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F 281 Continued From page 5  
indicated Resident #1 did not receive his/her ordered medications related to the transfer out to the hospital for an evaluation.

Interview with LPN #3, on 02/25/14 at 11:35 AM and on 02/26/14 at 3:22 PM, revealed LPN #1 was assigned to her for the day shift, on 02/19/14, when the medication error occurred. She stated she had observed LPN #1 preparing and administering medications for another resident just prior to the incident. She had no concerns with LPN #1's ability to perform the task at that time; however, LPN #3 stated she was not familiar with where LPN #1 was in her orientation. LPN #3 revealed the rights of medication administration should be observed; however, LPN #1 did not do this and administered the medications to the wrong resident.

Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed she was hired on 02/10/14 and had been on the unit providing direct resident care for three shifts. She stated, prior to coming to work at this facility, she had worked in a physician's office since October 2013. She revealed she entered Resident #1's room and called the resident by the name of Resident #2. Resident #1 answered and she proceeded to administer the medications to Resident #1 which had been prepared for Resident #2. She stated she had several interruptions during the medication pass. LPN #1 stated she should have gone back and checked the photo in the MAR and had someone else to go with her to identify the resident. She stated she was still in orientation and was not familiar with the residents. LPN #1 revealed she did not follow the nurse practice by not making sure the right resident was administered the right medications. She stated her medication

F 281 6.2 and Medication Administration Policy 7.1, in-service education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1, and auditing all resident photographs in emars/etars. Medical Director also provided information regarding resident #1. The Medical Director stated resident #1 was awake, alert, and oriented, requesting to return to the facility.

On 2/23/2014, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate.

On 2/23/2014, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents with arm bands. The facility decided to implement all residents wearing arm bands as

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F 281	<p>Continued From page 6</p> <p>competency was not completed prior to the medication pass on the morning of 02/19/14.</p> <p>Interview with the Director of Nursing Services (DNS), on 02/26/14 at 5:31 PM, revealed the Licensed Practical Nursing Scope of Practice in Kentucky was the standards of practice used in this facility. The LPN Scope of Nursing was not followed by the nurse administering the medication to the wrong resident. She stated LPN #1 had passed her nursing boards and was an LPN; therefore, she felt that qualified LPN #1 to pass medications. LPN #1 was assigned to a seasoned nurse on the unit during orientation and remained assigned to this nurse. She stated the staff in orientation had ninety (90) days to complete their competency check off list and the medication competency was included in the competency check list to be completed within the ninety (90) days. She revealed the medication error should not have occurred. She further stated the prior nursing administration had stopped using the arm band as a form of identification, however, it remained as an option in the facility's policy and procedure for resident identification. If the identification bracelet had been in place, that would have been an additional layer for identifying the residents and possibly prevented the occurrence of the medication error.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. On 2/19/2014 at approximately 9:00 AM, Resident #1 received five medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the Emergency</li> </ol>	F 281	<p>another form of identification. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 2/27/14.</p> <p>On 2/24/2014, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of identification.</p> <p>On 2/24/2014 at 8am, Ad Hoc QAPI was held to discuss facility's implementation of plan to decrease medication errors which included; immediately removing licensed practical nurse who administered medications in error to resident #1 from the medication cart, education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 2/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy</p>	



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F 281

Continued From page 7  
Room (ER) at 9:04 AM. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital. Upon arrival at the hospital, he/she was in stable condition.

2. All residents had the potential to be affected. The facility took immediate action to ensure the safety of all residents. Licensed Practical Nurse #1, who gave Resident #1 the medications in error, was removed immediately from the cart. Licensed Practical Nurse #2, who had previously worked at the facility for several years, was also in orientation. Both Licensed Practical Nurses received education on 02/19/14 on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1, "Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp."

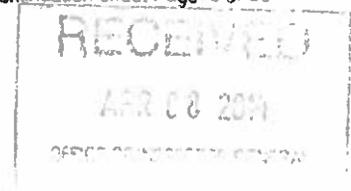
3. On 02/19/14, the Director of Clinical Education immediately began education with all licensed nurses on the 8 rights of medication administration; Medication Error and Adverse Drug Reaction Reporting Policy 6.2; Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the "Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp.". Initiation of medication observations competencies for all licensed nurses was started first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and

F 281

6.2 and Medication Administration Policy 7.1 - PharMerica Nursing Care Center Pharmacy Policy & Procedures, completing medication observation pass competencies by an RN, auditing all records for photographs, implementing use of arm bands as another form of identification, auditing all residents for armbands immediately, auditing resident room doors for correct names, revising orientation process to include medication administration competencies prior to being assigned to the floor, notifying pharmacist of error and requesting assistance with medication pass observations and audits, reviewing previous 6 months medication errors to identify trends, and to conduct medication pass audits weekly.

Orientation for all new licensed nurses hired after 2/24/14 was revised and now includes; medication pass observation competencies by the Director of Clinical Education prior to being assigned to the floor for orientation with another licensed nurse.

Licensed nurses selected by Director of Nursing Services to conduct on



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F 281	Continued From page 8 Medication Administration policy 7.1, and have medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure residents have an order for "may crush meds." Medication observation competencies will be completed when a medication error is identified, and annually for all licensed nursing staff.  4. On 02/19/14 at approximately 7:00 PM, the Director of Nursing Services (DNS) completed an electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 02/27/14.  5. On 02/20/14 at 11:00 AM, the Medical Director attended Quality Assurance Performance Improvement (QAPI) to discuss the medication error and Resident #1's current condition. The Medical Director agreed with the plan/AOC to address medication errors, which included: immediately removing the licensed practical nurse who administered medications in error to Resident #1 from the medication cart; education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration; Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; in-service	F 281	the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, including; defining preceptor/mentor, explaining role of preceptor and preceptees, adult learning principles, strategies for effective precepting, challenges of being a preceptor, goals of program, working with staff at different stages of clinical competence, working with diversity, safe and ethical practice, communication, critical thinking, nursing process to problem solve, assessing preceptor progress, skills objective, knowledge objective, affective objective, continuous interaction and feedback, preceptor/preceptee, preceptor/preceptee/Director of Clinical Education, progress, conflict, and transition, for their role as a preceptor/mentor, prior to orientating any additional licensed nursing staff. Until additional training can be initiated, Director of Clinical Education, will complete on the floor orientation with all new licensed nurses.  In-service education was provided by the Director of Clinical Education and House Supervisors for all		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/08/2014
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F 281

Continued From page 9  
education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; and auditing resident photographs in eMARs/eTARs.

6. On 02/22/14 the DNS contacted the consultant pharmacist regarding the medication error and requested the pharmacy's assistance in medication pass observations. On 03/02/14, the DNS spoke with the consultant pharmacist and discussed notification of the IJs, initial AOC Plan, QAPI to be held on 02/24/14, and the pharmacy plan for the coming week.

Consultant Pharmacist was at the facility on 03/04/14. The DNS reviewed the QAPI meeting, and AOC/plan from 03/04/14. During his visit, the pharmacist also conducted medication reviews. On 03/04/14 additional Pharmacy consultants began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. Any issues identified in review of audits would be tracked and trended with follow-up actions or education for staff completed as needed. No issues were identified at this time.

7. Medication errors for the previous 6 month period were reviewed and analyzed by the DNS and Field Services Clinical Director on 02/26/14 with no trends noted.

8. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing

F 281

licensed nursing staff on the nursing scope of practice on 3/3, 3/4, 3/5, 3/12, 3/13 & 3/16. No nurse will be allowed to work after 3/21/2014 unless training is completed on the nursing scope of practice, prior to the start of a shift.

On 3/3/14, Ad Hoc QAPI meeting was held. One item reviewed was new orientation process with includes:

- New Nurse Orientation process revised to include additional orientation days and training. All clinical competencies, including medication administration competencies to be completed prior to floor orientation. Orientation will go as follows for newly hired nurses:
  - Days one and two will classroom general orientation
  - Day three will be classroom with PCC training and LMS trainings specific to Nursing
  - Day four will be with DCE completing all clinical competencies, including med pass observations and tests.
  - Days 5, 6, and 7 will be floor

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F 281 Continued From page 10 name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate.

9. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents for arm bands. There were one-hundred thirty-nine (139) residents audited and only two (2) had arm bands in place. The facility decided all residents would wear arm bands as another form of identification per the facility's policy. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for the Admission Coordinator, House Supervisors, and Unit Managers was provided by the DNS on 02/27/14.

10. On 02/24/14, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of identification.

11. On 02/24/14 at 8:00 AM, an Ad Hoc QAPI was held to discuss the facility's implementation of their plan to decrease medication errors which included: immediate removal of the licensed practical nurse who administered medications in error to Resident #1 from the medication cart, education for the licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1: completing

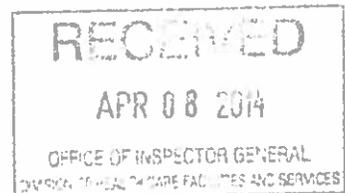
F 281

orientation with designated, trained mentor using the skills check off sheet. (Until additional training can be initiated for licensed nurses selected to conduct on the floor orientation, DCE will complete on the floor orientation with all new licensed nurses.)

- At the end of day 7, conference with Mentor, UM, Orientee, and DCE or designee to review progress, skills check off, and any additional training/orientation needed.
- After day 7, DCE meets with Orientee during the first week and q 30 days thereafter for 90 days.
- Prior to end of 90 day introductory period, Orientee will meet with DCE for evaluation.

This was reviewed with Medical Director on 3/6/14.

4. The Unit Managers began audits on 2/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in



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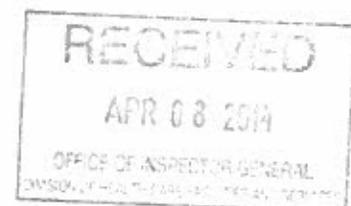
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medication observation pass competencies with an RN, auditing all records for photographs; implementing use of armbands as another form of identification; immediately auditing all residents for armbands; auditing resident room doors for correct names; revising the orientation process to include medication administration competencies prior to being assigned to the floor; notifying the pharmacist of the error and requesting assistance with medication pass observations and audits; reviewing the previous 6 months of medication errors to identify trends; and conducting medication pass audits weekly. The Executive Director, Director of Nursing Services, 2-Unit Managers, Director of Clinical Education, 2-Social Services, Transitional Care Nurse, Business Office Manager, Human Resources Personnel, Medical Records Clerk were present. The meeting minutes were reviewed with the Medical Director.

12. On 03/04/14 the RN Assessment Coordinators began education with all licensed nurses on Care Plans which included: initiating the care plan, how the care plan related to the care of the resident, how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated, care plan criteria, and components of a nursing progress note. The training also included accessing and reviewing care plans in the Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstrations included how to access the plan of care in Point Click Care, and explaining the plan of care is an integral part in performing individualized care for each resident. It was also

F 281 place will immediately have an arm band placed and the reason the arm band is not in place will be investigated by the Unit Manager an/or person conducting the audit. Audits for name bands will be conducted by the Unit manager or designee 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. The results of the audits will be analyzed and trends noted. The results will be discussed weekly in the QAPI meeting.

The Unit Managers began audits on 2/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into PCC. Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo is not in place will be investigated by the Unit Manager and/or person conducting the audit. Audits for photos will be conducted 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. The results of the audits will be analyzed and trends noted. The results will be discussed weekly in the QAPI meeting.



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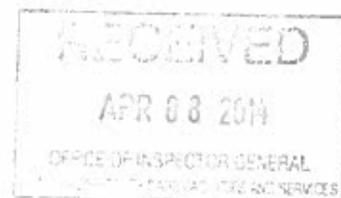
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F 281 Continued From page 12  
explained the nurses must utilize information found in resident's plan of care to provide care every shift. In additional education was provided on how to locate plan of care documentation under the dashboard; medical diagnosis; orders, care plan tabs in the PCC, and also on the MAR. In addition resident's charts have H&Ps and physician progress notes available for reference. All training was performed in small groups or 1:1 by the RN Assessment Coordinators. Participants were allowed to ask questions; verbalized understanding; and, performed return demonstration.

13. Orientation for all new licensed nurses hired after 02/24/14 will include medication pass observation competencies by the Director of Clinical Education (DCE) prior to being assigned to the floor for orientation with another licensed nurse. Licensed nurses selected by Director of Nursing Services to conduct on the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, prior to orientating any additional licensed nursing staff. This training will include: defining preceptor/mentor; explaining the role of preceptor and orientee, adult learning principles; strategies for effective precepting, challenges of being a preceptor; goals of the program; working with staff at different stages of clinical competence; working with diversity; safe and ethical practice; communication; critical thinking; nursing process to problem solve, assessing preceptor progress; skills objective, knowledge objective; affective objective; continuous interaction and feedback on preceptor/orientee, preceptor/orientee/Director of Clinical Education; and progress, conflict, and transition, for their role as a preceptor/mentor. Until additional training

F 281 The DON, ADON, DCE, or RN Supervisors began conducting a medication pass audit on 3/1/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Medication pass audits will be conducted 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Results will be analyzed and trends noted. The results will be reviewed and discussed weekly in QAPI meeting.

A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits weekly/monthly. Audits will be tracked and trended with follow-up actions or education for staff completed as needed to ensure compliance with the plan of correction. If the Medical Director is unavailable in person on a weekly basis, he will review progress by



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F 281 Continued From page 13  
can be initiated, the Director of Clinical Education, will complete on the floor orientation with all new licensed nurses.

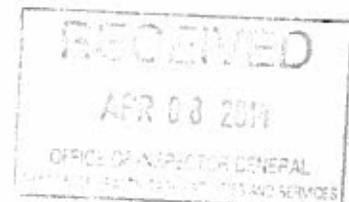
14. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in place will immediately have an arm band placed and the reason the arm band was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Manager and DNS. The results would be discussed weekly in the QAPI meeting.

15. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into Point Click Care (PCC). Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Managers. The results would be discussed weekly in the QAPI meeting.

16. The DNS, ADNS, DCE, & RN Supervisors began conducting a medication pass audit on 03/01/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Results would be analyzed and trends noted weekly by the DNS. The results would be reviewed and discussed weekly in QAPI meeting.

17. On 03/03/14, an Ad Hoc QAPI was held to discuss the facility's monitoring of the plan to

F 281 phone with Executive Director and/or DON.  
  
It is ultimately the Administrator's job to validate all parts of the POC are implemented and compliance are achieved and continues.



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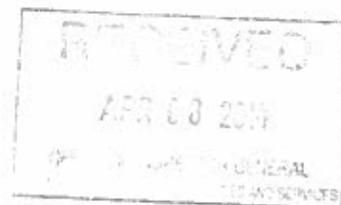
F 281 Continued From page 14  
decrease medication errors. Also, the Pharmacy consultants plan for conducting a 3-way audit of physician orders/medication administration records and medication carts was discussed. Pharmacy consultants also began conducting medication pass observations. Training was also being conducted on narcotic reconciliation and documentation. Audits would also be conducted of the medication rooms and carts. In addition, discussion of the need to begin education with all licensed nurses on Care Plans and how the care plan related to the care of the resident, including training on accessing and reviewing care plans in PCC. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 03/04/14.

18. A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits. Audits will be tracked and trended with follow-up actions or education for staff completed as needed by the QAPI Committee. If the Medical Director is unavailable in person on a weekly basis, he will review progress by phone with Executive Director and/or DNS.

The State Survey Agency validated the AOC on 03/08/14 through observation, interview and record review.

1. Interview with the Director of Nursing Services (DNS), on 03/08/14 at 10:45 AM, revealed she

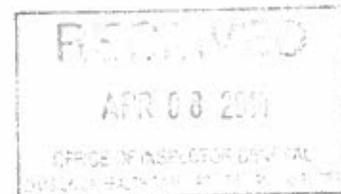
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F 281	<p>Continued From page 15</p> <p>was notified of the medication error shortly after the error occurred. She stated, the staff notified the Advanced Registered Nurse Practitioner (ARNP) via text message per LPN/Unit Manager from 100 Unit, on 02/19/14 at 9:04 AM. The text message, at 9:04 AM, provided the medications involved and the oxygen (O2) levels at 82%. Review of the copied text message, identified with the ARNP's name, date and time, revealed the ARNP returned orders at 9:05 AM via text message to send Resident #1 to the hospital for a medical evaluation. Review of the emergency department records revealed Resident #1's vital signs were not suppressed; however, he/she did have a significantly abnormal chest x-ray.</p> <p>2. Interview with the DNS and record review, on 03/08/14 at 10:45 AM, revealed the initial investigation identified the medication error occurred with a newly licensed, Licensed Practical Nurse (LPN). The nurse was identified as LPN #1. She was removed from the medication cart and medication pass orientation. She was provided education on the 8 rights of medication administration. Review of the education attendance roster recorded dated of 02/19/14, revealed LPN #1 and #2 signed the sheet indicating their attendance. Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provided during the monthly orientation. Review of the staff attendance form validated inservice attendance.</p> <p>Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed once the medication error was identified and reported, she was removed from the</p>	F 281		

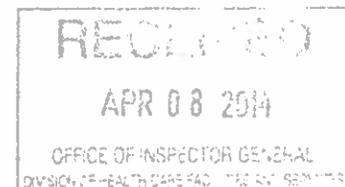


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F 281	<p>Continued From page 16</p> <p>medication cart. She was reassigned with the Director of Clinical Education and Restorative Nursing to become more aquatinted with the residents. She reported her orientation was extended.</p> <p>Review of the statement of occurrence, on 02/19/14, completed by the DNS, dated 02/27/14, revealed LPN #2 was in her fifth (5th) and last day of orientation. She completed an in-service related to the 8 rights of medication administration and medication error, and adverse drug reaction reporting. The statement stated, LPN #2 completed the medication administration competency, on 02/23/14, for E-Kit use and reordering, oral medications, eye medications, enterals, injections and the disposition of controlled medications. She was administered two (2) test for competency verification. She passed both examinations.</p> <p>3. Review of the rights of medication administration education, evidenced by the attendance roster revealed education was completed on 02/19/14, 02/21/14, 02/22/14 and 02/24/14. The Director of Clinical Education began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the "Nursing Care Center Pharmacy Policy &amp; Procedure Manual - 2007 PharMerica Corp.". Initiation of medication administration observation competencies for all licensed nurses was started on the first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse</p>	F 281		



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F 281 Continued From page 17  
would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and had medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure resident has an order for "may crush meds."

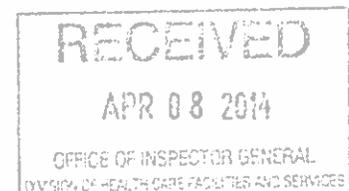
Interview with RN #1 and LPN #4, on 02/27/14 at 7:25 AM and 7:40 AM, respectively, revealed they had received in-servicing on the 8 rights of medication administration.

Interview with House Supervisor #2, on 03/08/14 at 5:20 PM, revealed any staff identified as on leave of absence and had not completed the training by the Director of Clinical Education would receive the education upon their return before they would be allowed to work. There were three (3) on medical leave and four (4) as needed staff who rarely worked a schedule. The House Supervisor had a packet of education materials for each person when any of these individuals worked again.

4. Interview with the DNS, on 03/08/14 at 1:30 PM, revealed she completed the electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR on 02/19/14, prior to her leaving the facility at 7:00 PM.

Review of the audit completed on 02/19/14, by the Director of Nursing Services, revealed it was completed to ensure each resident had a current,

F 281



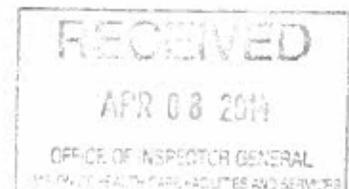
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/08/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220
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F 281	<p>Continued From page 18</p> <p>accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission.</p> <p>Review of the I-pad with the DNS, on 03/08/14 at 1:45 PM, revealed she checked to ensure each resident had a current picture. She stated she did update two (2) of the pictures.</p> <p>Review of the inservice on electronic photos, dated 02/27/14 revealed education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission.</p> <p>Telephone interview with the 200 Unit Manager and 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed they had been trained and directed to ensure each resident had a picture on their electronic record.</p> <p>5. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance. Topics of discussion, included the medication error of 02/19/14, which was identified as a routine monthly meeting.</p> <p>6. Review of the medication pass observations revealed the consultant pharmacist was on</p>	F 281		



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F 281	<p>Continued From page 19</p> <p>location on 03/04/14 and initiated medication pass observations. The pharmacy consultant began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. No issues had been identified with the completed med pass observation; however, this was ongoing and pending review.</p> <p>7. Review and interview with the DNS and Field Services Clinical Director on 03/07/14 at 5:15 PM, revealed medication errors for the previous six (6) month period were reviewed and analyzed on 02/26/14 with no trends identified.</p> <p>8. Observation during tour of twenty-five (25) rooms on the 300 Hall, on 03/08/14 at 5:15 PM, revealed each resident room had a name identification on the outside of the door in the hall.</p> <p>Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the doors (resident rooms) were audited on 02/23/14. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM.</p> <p>Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident photos were completed for of all residents.</p> <p>Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each door for a resident name. There were no doors found without appropriate</p>	F 281		



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F 281	<p>Continued From page 20 names.</p> <p>9. Review of written statements, dated 02/26/14, from the Admission Coordinator and Staffing Coordinator, revealed the arm bands were audited on 02/23/14, and placed on the residents as another form of identification. The audit form used was from the midnight census and included the run date, of 02/22/14 at 11:59 PM.</p> <p>Review of the Admission Coordinator and the Staffing Coordinator's written statements, dated 02/26/14, revealed an audit of resident armbands was completed for of all residents.</p> <p>Interview with the Admission Coordinator and the Staffing Coordinator, on 02/27/14 at 8:25 AM, revealed they utilized the 02/22/14 midnight census to check each resident for an armband. There was a total of one-hundred thirty-nine (139) residents on the census. They found two residents who already had an armband on and the rest were provided a new armband.</p> <p>Review of the inservice staff attendance record revealed an inservice on arm bands was conducted on 02/27/14, with the Admission Coordinator, Staffing Coordinator, House Supervisors and the Unit Managers.</p> <p>10. Observations of fifteen (15) residents on 02/26/14 revealed the residents had arm bands in place.</p> <p>11. Review of the QAPI attendance record, on 03/08/14, verified a regular scheduled monthly meeting was held, on 02/20/14, with the Director of Nursing Services, the Medical Director and three (3) plus Directors in attendance and was a</p>	F 281		

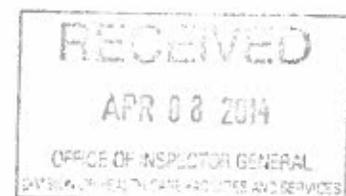
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F 281	<p>Continued From page 21</p> <p>routine monthly meeting. The topic of discussion was the plan to decrease medication errors. An Ad Hoc QAPI meeting was held, on 02/24/14, related to the medication error occurrence, dated 02/19/14, for ongoing auditing, monitoring and re-evaluation.</p> <p>Interview with the Executive Director and The DNS, on 03/08/14 at 2:00 PM, revealed the QAPI meetings are ongoing weekly, with the auditing, reviewing and re-evaluation of the findings of the auditing and on target.</p> <p>12. Review of the education content regarding care plans, completed on 03/04/14, by the RN Assessment Coordinators with all licensed nurses revealed it included: initiating the care plan; how the care plan related to the care of the resident; how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated; care plan criteria; and components of a nursing progress note. It also included training on accessing and reviewing care plans in Point Click Care. Demonstrations included: how to access the plan of care in Point Click Care, and explaining the plan of care was an integral part in performing individualized care for each resident. The nurses must utilize information found in the resident's plan of care to provide care every shift. Education included how to locate plan of care documentation under the dashboard; medical diagnosis; orders; care plan tabs in the PCC; and also on the MAR. In addition the education covered the residents' charts containing H&amp;Ps and physician progress notes that were available for reference. All training was performed in small groups or 1:1 by the RN Assessment Coordinators. Participants asked questions; verbalized understanding and</p>	F 281		



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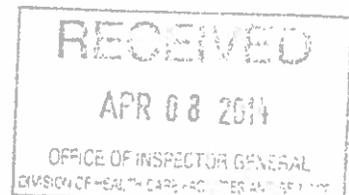
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F 281	<p>Continued From page 22 performed return demonstration.</p> <p>Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM, revealed an in-service was provided by herself, on 03/04/14, to the staff that was in orientation on 02/19/14. She stated, training would be provide during the monthly orientation related to the care plans. She reported she would be providing training with staffing related to the use of the care plans, how to access and update, when needed. Telephone interview with LPNUM 100 Unit, on 03/08/14 at 6:00 PM, revealed she received training last week on the use of care plans. She reported the Director of Resident Assessment Coordinator was on the 100 Unit, on 03/04/14, providing education related to care plan use and how to access to the care plans.</p> <p>13. Review of the hired employee summary with dates of hire, dated 03/04/14, revealed no listed licensed employees hired since 02/24/14.</p> <p>Interview with the DNS, on 03/08/14 at 2:40 PM, revealed there were no new licensed nurses hired since 02/24/14. However, she had identified nursing staff who she would offer the opportunity to be a preceptor for the new staff during orientation.</p> <p>Interview with the Director of Clinical Education, on 03/08/14 at 3:20 PM, revealed she added the staff orientation with all new licensed nurses to her agenda, pending the additional training for the preceptors.</p> <p>14. Review of the arm band education attendance record, dated 02/27/14, identified attendance of</p>	F 281		
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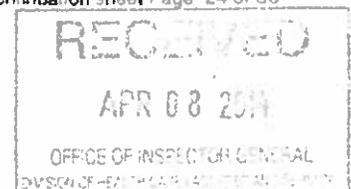


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F 281	<p>Continued From page 23</p> <p>Assistant DNS, Unit Managers, Staffing Coordinator and Admission Coordinator.</p> <p>Review of the audits conducted on 03/01/14 by the Unit Managers revealed on all residents on their assigned units were checked five (5) times per week to ensure all residents had an arm band in place. There were no identified missing or lost arm bands found during these audits.</p> <p>Telephone interview with the 200 Unit Manager and 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed audits were completed five (5) days a week to look for residents who did not have a arm band in place. If the arm band was not there, then one was placed immediately. The reason the arm band was not in place was investigated, by the Unit Manager completing the audit. The results of the audits were discussed weekly in the QAPI meeting by the DNS.</p> <p>15. Review of the resident photo education attendance record, dated 02/27/14, identified attendance of Assistant DNS, Unit Managers, Staffing Coordinator and Admission Coordinator.</p> <p>Review of the resident photo audit revealed it was initiated on 02/28/14. The audits were conducted by the Unit Managers five (5) times per week to ensure all residents had a photo loaded into PCC. Two (2) photos were retaken to update due to the aging process.</p> <p>Telephone interview with the 200 Unit Manager and the 100 Unit Manager, on 03/08/14 at 5:41 PM and 6:00 PM, respectively, revealed audits were completed five (5) days a week to look for residents who did not have a photo in place. If</p>	F 281		



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F 281 Continued From page 24  
the photo was not there, then one was placed immediately. The photos were taken and loaded into the PCC. The reason the photo was not in place was investigated, by the Unit Manager completing the audit. The results of the audits were discussed in the QAPI meeting by the DNS.

16. Review of the medication pass audit initiated on 03/01/14, for five (5) days, revealed they were completed and in a binder. The Assistant Director of Nursing Services (ADNS) provided documentation of six (6) audits that were completed for week one (1).

Interview with the DNS and ADNS, on 03/08/14 at 2:20 PM, revealed all units were audited and these audits were provided to the DNS for review.

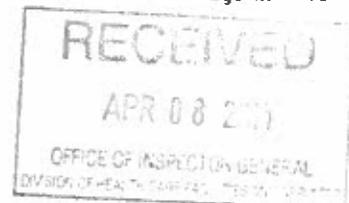
17. A QAPI meeting was held, on 03/03/14. Review of the attendance record revealed the DNS, and the ED were present, plus 10 additional management staff for on going review of auditing and monitoring.

Review of telephonic review notes identified the Medical Director was notified by the DNS, on 03/04/14, of the Ad Hoc QAPI meeting and the topics of discussion.

Interview with the Executive Director and the DNS, on 03/08/14 at 2:00 PM, revealed the QAPI meetings are ongoing weekly, with the auditing, reviewing and re-evaluation of the findings of the auditing and on target.

Interview with the Director of Resident Assessment Coordination, on 03/08/14 at 4:45 PM, revealed an in-service was provided by herself, on 03/04/14, to the staff that was in

F 281



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F 281 Continued From page 25  
orientation on 02/19/14. She stated, training would be provide during the monthly orientation related to the care plans. She reported she would be providing training with staff related to the use of the care plans, how to access and update the care plans when needed.

Telephone interview with LPN/UM 100 Unit, on 03/08/14 at 6:00 PM, revealed she received training last week on the use of care plans. She reported the Director of Resident Assessment Coordinator was on the 100 unit providing education related to care plan use and how to access the care plans.

18. Interview with DNS, on 03/08/14 at 12:00 PM, revealed the next weekly QAPI meeting was scheduled, on 03/10/14, for continued monitoring and ensuring compliance. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication pass audits. Audits would be tracked and trended with follow-up actions or education for staff completed as needed. If the Medical Director was unavailable in person on a weekly basis, he would review the facility's progress by phone with the Executive Director and/or DON.

F 281

F 282 SS-J 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
  
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

F 282 1. On 2/19/2014 at approximately 9am, Resident #1 received four medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the ER at 9:04am. The

3/2/14

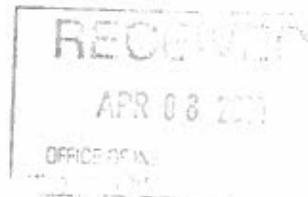
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F 282	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's Investigation, Hospital History and Physical and the facility's Resident Care Plan policy and procedure, it was determined the facility failed to administer medications as ordered per the care plan for one (1) of ten (10) sampled residents (Resident #1).</p> <p>On 02/19/14 at approximately 8:45 AM to 9:00 AM, Licensed Practical Nurse (LPN) #1, who was in orientation with LPN #3, administered Resident #2's medication to Resident #1 without ensuring he/she was the right resident and without LPN #3 being present to supervise the task. Resident #1 was administered five (5) medications that were not prescribed for him/her which included an antihypertensive, an antidepressant, an antiplatelet, and an opioid pain medication. The LPN failed to compare the resident to the resident's picture, and failed to ask the alert and oriented resident his/her name.</p> <p>Resident #1 experienced increased shortness of air between 8:00 AM and 9:00 AM prior to the medication error. The Advanced Registered Nurse Practitioner (ARNP) was notified, on 02/19/14 at 9:04 AM, of the medication error and shortness of air status, and the ARNP ordered the resident be sent to the hospital for a medical evaluation.</p> <p>Resident #1 was evaluated by the emergency room physician and admitted with the clinical impression of Dyspnea, Accidental Overdose (Opiate-Accidental), Respiratory Failure and Hypoxia. Resident #1 was hospitalized for three</p>	F 282	<p>resident #1 was transported by EMS to Baptist Hospital East. Upon arrival at the hospital, he was in stable condition.</p> <p>2. All residents have the potential to be affected. The facility took immediate action to ensure the safety of all residents. The Licensed Practical Nurse who gave resident #1 medications in error, was removed immediately from the cart. The Licensed Practical Nurse who gave resident #1 medications in error and the one other Licenser Practical Nurse who was in orientation on 2/19/14, received in-service education on 3/4/14 provided by the RN Assessment Coordinator on Care Plans including: initiating the care plan, how the care plan relates to the care of the resident, how to utilize the nursing process in the development of the plan of care, when care plan is developed and updated, and care plan criteria, and components of a nursing progress note. Also, training on accessing and reviewing care plans in Point Click Care will be lead by the RN Assessment Coordinators for all licensed nurses.</p>	

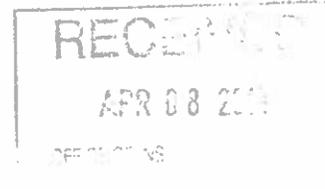


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F 282	<p>Continued From page 27 (3) days and expired on 02/21/14. (Refer to F333)</p> <p>The facility's failure to implement the care plan related to the administration of medications as ordered by the physician has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/28/14, and was determined to exist on 02/19/14. The facility was notified of the Immediate Jeopardy on 02/28/14. An acceptable Allegation of Compliance (AOC) was received on 03/07/14 alleging the removal of the Immediate Jeopardy on 03/05/14. The State Survey Agency (SSA) validated, on 03/08/14, the Immediate Jeopardy had been removed on 03/05/14, as alleged, prior to exit. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Per interview with the Director of Nursing Services (DNS) on 02/27/14 revealed the facility referred to the Federal Regulatory Requirements and the Resident Assessment Instrument (RAI) as their guidance on care planning.</p> <p>Review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) 3.0 Manual, Chapter 1, page 10, revealed residents respond to individualized care. Chapter 4, page 12, revealed approaches serve as instructions for resident care and provide for continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions consistently. Overall care plans</p>	F 282	<p>3. The RN Assessment Coordinators provide in-service education on 3/4, 3/5, 3/7, 3/10, 3/11, 3/12 with all licensed nurses on Care Plans including; initiating the care plan, how the care plan relates to the care of the resident, how to utilize the nursing process in the development of the plan of care, when care plan is developed and updated, and care plan criteria, and components of a nursing progress note. Also, training on accessing and reviewing care plans in Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstration included; how to access the plan of care in Point Click Care, explaining plan of care is integral part in performing individualized care for each resident/rehab. patient. Explaining nurses must utilize information found in resident's plan of care to provide care every shift. Locating plan of care documentation under dashboard; medical diagnosis; orders, car plan tabs in PCC, and also on MAR. In addition resident's charts have H&amp;Ps and physician</p>	

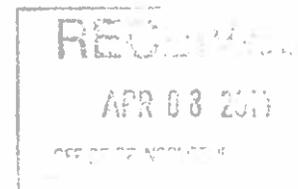


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/08/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3118 BRECKINRIDGE LANE LOUISVILLE, KY 40220	

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F 282	<p>Continued From page 28</p> <p>should be oriented towards applying current standards of practice in the care planning process.</p> <p>Review of the facility's investigation, undated, revealed Resident #1 received the incorrect medication on 02/19/14. LPN #1 entered the resident's room and called Resident #1 by Resident #2's name and Resident #1 answered and sat up in the bed. LPN #1 administered Resident #2's medications to Resident #1. The resident had a change of condition within the hour prior to receiving the wrong medication. Once the Nurse Practitioner was made aware she sent the resident to the hospital where he/she was admitted with Respiratory Failure.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident, on 07/02/12, and re-admitted, on 01/03/14, with diagnoses of Quadriplegia and Quadraparesis C1-C4 Incomplete, Constipation, Post Procedural Aspiration Pneumonia, Acute Respiratory Failure, Cough, Benign Essential Hypertension, Acute Venous Embolism and Thrombosis of Deep Veins of the Upper Extremities, and a History of Urinary Tract Infection. Review of the Quarterly Minimum Data Set Assessment, dated 02/03/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview Mental Status (BIMS) score of fifteen (15) of fifteen (15).</p> <p>Review of Resident #1's, Comprehensive Care Plan revised on 02/27/13, revealed an intervention to provide medications as ordered by the physician.</p> <p>Review of Resident #1's, February 2014 MAR, revealed on 02/19/14, the medications ordered by</p>	F 282	<p>progress notes available to reference.</p> <p>All training performed in small groups or 1:1 by RN Assessment Coordinators. Participants were allowed to ask questions; verbalized understanding and performed return demonstration. No nurse will be allowed to work after 3/21/14 unless training has been received prior to the start of a shift.</p> <p>Orientation for all new licensed nurses hired after 3/4/14 will include RN Assessment Coordinators education on Care Plans including; initiating the care plan, how the care plan relates to the care of the resident, how to utilize the nursing process in the development of the plan of care, when care plan is developed and updated, and care plan criteria, and components of a nursing progress note. Also, training on accessing and reviewing care plans in Point Click Care will be lead by the RN Assessment Coordinators for all licensed nurses.</p> <p>On 3/03/2014, Ad Hoc QAPI was held to discuss facility's implementation of plan to decrease medication errors (AOC). Executive Director and DNS discussed AOC and revisions to be completed. Also,</p>	



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F 282 Continued From page 29  
the physician were scheduled for administration, at 8:00 AM and 9:00 AM, were coded on the MAR as not administered indicating the documentation would be located in the nurses notes as to why the medications were not administered. Corresponding nurses notes dated 02/19/14 indicated Resident #1 did not receive his/her ordered medications related to the transfer out to the hospital for an evaluation. The medications Resident #1 was scheduled to receive, on 02/19/14 at 8:00 AM: were Gabapentin 800 milligram (mg) for Muscle Spasm; and at 9:00 AM: BuSpar 5 milligram (mg) for Depressive Disorder; Docusate Sodium 200 mg for Constipation; Furosemide 20 mg for Diuretic-Essential Hypertension; Klor-Con M20 a Potassium Supplement-Hypertension; Lactulose 20 grams (GM)/30 milliliter (ml) for Constipation; and Metoprolol 12.5 mg an Antihypertensive.

Review of Resident #2's, February 2014 physician orders and MAR, with the Director of Nurses (DON) revealed the medications given to Resident #1 in error were Aggrenox 25-200 mg an Antiplatelet, OxyContin (Oxycodone HCL-Opiate for Pain) 160 mg extended release, Paroxetine HCL 20 mg an Antidepressant, Hydralazine HCL 10 mg an Antihypertensive and Coreg 12.5 mg a Beta Blocker/Heart.

Interview with LPN #3, on 02/25/13 at 11:35 AM and on 02/26/14 at 3:22 PM, revealed she was training LPN #1, on 02/19/14 when the incident occurred. She stated she did not review the care plans with LPN #1 prior to medication pass.

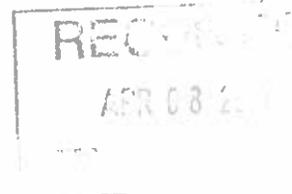
Interview with LPN #1, on 02/26/14 at 1:15 PM, revealed she entered Resident #1's room and called the resident by the name of Resident #2

F 282 F282 was discussed and need to initiate care plan training for all licensed nursing staff including; Care Plans and how the care plan relates to the care of the resident. Also, training on accessing and reviewing care plans in Point Click Care. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 3/4/14 and reviewed during his visit on 3/6/14.

4. The IDT Team will monitor all resident care plans quarterly, with significant changes, or as needed.

DCE meets with new licensed nurses during the first week and q30 days thereafter for 90 days to monitor progress.

A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review compliance with education related to care plan training weekly/monthly to ensure compliance with the plan of correction. If the Medical Director is unavailable in person on a weekly basis, he will review progress by phone with Executive Director and/or DON.



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F 282	<p>Continued From page 30</p> <p>and Resident #1 answered. She administered the medications she had prepared. She stated she started to work on 02/10/14 and was still in orientation and not familiar with the residents.</p> <p>Further interview with LPN #1, on 03/08/14 at 11:45 AM, revealed she did not review the care plan prior to passing medications on 02/19/14. She stated she was assigned with LPN #3 and that was not part of the morning process before starting the morning medication pass. LPN #1 revealed she was not familiar with any of the residents' care plans.</p> <p>Interview with the 200 Unit Manager, on 03/08/14 at 5:45 PM, revealed the purpose of the care plan was to ensure proper care was provided to the correct resident and for each resident to receive the care that was care planned for each resident. The care plan should be reviewed for new and/or changes each shift. She stated each resident had a care plan designed individually for that resident. Per interview, following the care plan for each resident would ensure each resident received the care designed for that resident.</p> <p>Interview with the 100 Unit Manager, on 03/08/14 at 6:00 PM, revealed she received training on the care plans when she was hired at the facility. The staff should be reviewing the care plan and following the care plan. She stated being familiar with the care plans would ensure the residents received the care to meet their needs.</p> <p>Interview with the DNS, on 02/28/14 at 5:00 PM, revealed care planning was not part of the new employee orientation and the facility did not have a policy on care plans. The MDS Coordinators developed the care plans and new orders and</p>	F 282	<p>It is ultimately the Administrator's job to validate all parts of the POC are implemented and compliance are achieved and continues.</p>	

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Continued From page 31

changes were added to the care plan so staff should be looking at the care plans for resident specific care. There had been a short discussion about care plans; however, the focus was more on documentation than the care plan.

The facility implemented the following actions to remove the Immediate Jeopardy:

1. On 2/19/2014 at approximately 9:00 AM, Resident #1 received five medications in error. The error was immediately identified by nursing staff. The ARNP on call was notified and an order was received to send to the Emergency Room (ER) at 9:04 AM. Resident #1 was transported by Emergency Medical Services (EMS) to the hospital. Upon arrival at the hospital, he/she was in stable condition.
2. All residents had the potential to be affected. The facility took immediate action to ensure the safety of all residents. Licensed Practical Nurse #1, who gave Resident #1 the medications in error, was removed immediately from the cart. Licensed Practical Nurse #2, who had previously worked at the facility for several years, was also in orientation. Both Licensed Practical Nurses received education on 02/19/14 on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2, and Medication Administration Policy 7.1, "Nursing Care Center Pharmacy Policy & Procedure Manual - 2007 PharMerica Corp."
3. On 02/19/14, the Director of Clinical Education immediately began education with all licensed nurses on the 8 rights of medication administration, Medication Error and Adverse Drug Reaction Reporting Policy 6.2; Medication

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F 282	<p>Continued From page 32</p> <p>Administration Policy 7.1. Policy 6.2 Medication Error and Adverse Drug Reporting and 7.1 Medication Administration are from the "Nursing Care Center Pharmacy Policy &amp; Procedure Manual - 2007 PharMerica Corp.". Initiation of medication observations competencies for all licensed nurses was started first shift on 02/23/14 by the RN Nurse Managers. All nurses who worked had both trainings completed by 02/24/14. No nurse would be allowed to work after 02/24/14 unless training was completed on medication administration using the 8 rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration policy 7.1, and have medication pass observation competencies completed by an RN, prior to passing any medications. Education included not crushing extended release medications or no crushable medications and to ensure residents have an order for "may crush meds." Medication observation competencies will be completed when a medication error is identified, and annually for all licensed nursing staff.</p> <p>4. On 02/19/14 at approximately 7:00 PM, the Director of Nursing Services (DNS) completed an electronic audit to ensure each resident had a current, accurate photograph in the eMAR/eTAR. All residents in house on 02/19/14 had a photograph. The Admission Coordinator, House Supervisor or Unit Managers are responsible to ensure a new resident has a photo taken and uploaded into the electronic charting system at the time of admission. Education for Admission Coordinator, House Supervisors, and Unit Managers was provided by DNS on 02/27/14.</p> <p>5. On 02/20/14 at 11:00 AM, the Medical Director</p>	F 282		
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F 282 Continued From page 33  
attended Quality Assurance Performance Improvement (QAPI) to discuss the medication error and Resident #1's current condition. The Medical Director agreed with the plan/AOC to address medication errors, which included: immediately removing the licensed practical nurse who administered medications in error to Resident #1 from the medication cart; education for licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration; Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; in-service education for all licensed nurses on using the 8 Rights of Medication Administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; and auditing resident photographs in eMARs/eTARs.

6. On 02/22/14 the DNS contacted the consultant pharmacist regarding the medication error and requested the pharmacy's assistance in medication pass observations. On 03/02/14, the DNS spoke with the consultant pharmacist and discussed notification of the IJs, initial AOC Plan, QAPI to be held on 02/24/14, and the pharmacy plan for the coming week.

Consultant Pharmacist was at the facility on 03/04/14. The DNS reviewed the QAPI meeting, and AOC/plan from 03/04/14. During his visit, the pharmacist also conducted medication reviews. On 03/04/14 additional Pharmacy consultants began conducting a 3-way audit of physician orders/medication administration records and medication carts, along with medication pass observations, in-service education, and medication room audits. Any issues identified in

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F 282 Continued From page 34  
review of audits would be tracked and trended with follow-up actions or education for staff completed as needed. No issues were identified at this time.

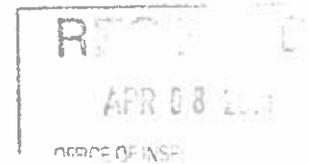
7. Medication errors for the previous 6 month period were reviewed and analyzed by the DNS and Field Services Clinical Director on 02/26/14 with no trends noted.

8. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all doors to ensure the correct resident name was listed. One door on the 300 hall had a missing name. It was replaced immediately. The Admissions Coordinator or Staffing Coordinator is responsible to ensure the names on resident room doors are accurate.

9. On 02/23/14, the Admissions Coordinator and the Staffing Coordinator conducted an audit of all residents for arm bands. There were one-hundred thirty-nine (139) residents audited and only two (2) had arm bands in place. The facility decided all residents would wear arm bands as another form of identification per the facility's policy. The Admission Coordinator, House Supervisor, or Unit Managers are responsible to ensure a new resident has a new arm band placed on the resident at the time of admission and to replace armbands if the armband is missing, becomes soiled or illegible. Education for the Admission Coordinator, House Supervisors, and Unit Managers was provided by the DNS on 02/27/14.

10. On 02/24/14, arm bands were placed on all residents by the Admission Coordinator and Staffing Coordinator as another form of

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F 282	<p>Continued From page 35 identification.</p> <p>11. On 02/24/14 at 8:00 AM, an Ad Hoc QAPI was held to discuss the facility's implementation of their plan to decrease medication errors which included; immediate removal of the licensed practical nurse who administered medications in error to Resident #1 from the medication cart, education for the licensed practical nurse and a second licensed practical nurse who also was in orientation on 02/19/14 on using the 8 Rights of medication administration, Medication Error and Adverse Drug Reporting Policy 6.2 and Medication Administration Policy 7.1; completing medication observation pass competencies with an RN; auditing all records for photographs; implementing use of armbands as another form of identification; immediately auditing all residents for armbands; auditing resident room doors for correct names; revising the orientation process to include medication administration competencies prior to being assigned to the floor; notifying the pharmacist of the error and requesting assistance with medication pass observations and audits; reviewing the previous 6 months of medication errors to identify trends; and conducting medication pass audits weekly. The Executive Director, Director of Nursing Services, 2-Unit Managers, Director of Clinical Education, 2-Social Services, Transitional Care Nurse, Business Office Manager, Human Resources Personnel, Medical Records Clerk were present. The meeting minutes were reviewed with the Medical Director.</p> <p>12. On 03/04/14 the RN Assessment Coordinators began education with all licensed nurses on Care Plans which included: initiating the care plan, how the care plan related to the</p>	F 282		

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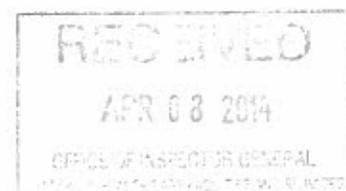
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F 282	<p>Continued From page 36</p> <p>care of the resident, how to utilize the nursing process in the development of the plan of care, when a care plan is developed and updated, care plan criteria, and components of a nursing progress note. The training also included accessing and reviewing care plans in the Point Click Care. By understanding the components and purpose of the care plan, and progress note, all staff members should be able to provide proper and individualized care to each resident. Demonstrations included how to access the plan of care in Point Click Care, and explaining the plan of care is an integral part in performing individualized care for each resident. It was also explained the nurses must utilize information found in resident's plan of care to provide care every shift. In additional education was provided on how to locate plan of care documentation under the dashboard; medical diagnosis; orders, care plan tabs in the PCC, and also on the MAR. In addition resident's charts have H&amp;Ps and physician progress notes available for reference. All training was performed in small groups or 1:1 by the RN Assessment Coordinators. Participants were allowed to ask questions; verbalized understanding; and, performed return demonstration.</p> <p>13. Orientation for all new licensed nurses hired after 02/24/14 will include medication pass observation competencies by the Director of Clinical Education (DCE) prior to being assigned to the floor for orientation with another licensed nurse. Licensed nurses selected by Director of Nursing Services to conduct on the floor orientation with newly hired nurses, will receive additional training provided by Director of Clinical Education, prior to orientating any additional licensed nursing staff. This training will include:</p>	F 282		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/08/2014
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - HILLCREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220	
(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)

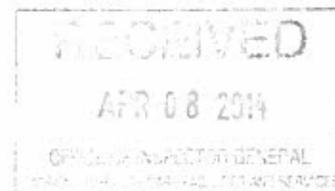
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defining preceptor/mentor; explaining the role of preceptor and orientee; adult learning principles; strategies for effective precepting; challenges of being a preceptor; goals of the program; working with staff at different stages of clinical competence; working with diversity; safe and ethical practice; communication; critical thinking; nursing process to problem solve; assessing preceptor progress; skills objective; knowledge objective; affective objective; continuous interaction and feedback on preceptor/orientee, preceptor/orientee/Director of Clinical Education; and progress, conflict, and transition, for their role as a preceptor/mentor. Until additional training can be initiated, the Director of Clinical Education, will complete on the floor orientation with all new licensed nurses.

14. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have an arm band in place. Any resident who does not have an arm band in place will immediately have an arm band placed and the reason the arm band was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and trends noted weekly by the Unit Manager and DNS. The results would be discussed weekly in the QAPI meeting.

15. The Unit Managers began audits on 02/28/14 of all residents 5 times per week to ensure all residents have a photo loaded into Point Click Care (PCC). Any resident who does not have a photo in place will immediately have a photo taken and loaded into PCC and the reason the photo was not in place would be investigated, by the Unit Manager conducting the audit. The results of the audits would be analyzed and

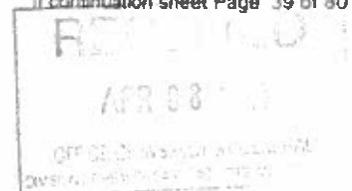
F 282



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

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F 282	<p>Continued From page 38</p> <p>trends noted weekly by the Unit Managers. The results would be discussed weekly in the QAPI meeting.</p> <p>16. The DNS, ADNS, DCE, &amp; RN Supervisors began conducting a medication pass audit on 03/01/14, 5 times per week, to ensure continued effectiveness of the plan to reduce errors. Results would be analyzed and trends noted weekly by the DNS. The results would be reviewed and discussed weekly in QAPI meeting.</p> <p>17. On 03/03/14, an Ad Hoc QAPI was held to discuss the facility's monitoring of the plan to decrease medication errors. Also, the Pharmacy consultants plan for conducting a 3-way audit of physician orders/medication administration records and medication carts was discussed. Pharmacy consultants also began conducting medication pass observations. Training was also being conducted on narcotic reconciliation and documentation. Audits would also be conducted of the medication rooms and carts. In addition, discussion of the need to begin education with all licensed nurses on Care Plans and how the care plan related to the care of the resident, including training on accessing and reviewing care plans in PCC. The meeting minutes were reviewed with the Medical Director by DNS via telephone on 03/04/14.</p> <p>18. A QAPI Committee meeting will be held weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly thereafter. The committee will review effectiveness and compliance with the plan to decrease medication errors, and will review, revise, update, and develop action plans, based on any issues identified in review of audits including arm bands, photos, and medication</p>	F 282			



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F 282	<p>Continued From page 39</p> <p>pass audits. Audits will be tracked and trended with follow-up actions or education for staff completed as needed by the QAPI Committee. If the Medical Director is unavailable in person on a weekly basis, he will review progress by phone with Executive Director and/or DNS.</p> <p>The State Survey Agency validated the AOC on 03/08/14 through observation, interview and record review.</p> <p>1. Interview with the Director of Nursing Services (DNS), on 03/08/14 at 10:45 AM, revealed she was notified of the medication error shortly after the error occurred. She stated, the staff notified the Advanced Registered Nurse Practitioner (ARNP) via text message per LPN/Unit Manager from 100 Unit, on 02/19/14 at 9:04 AM. The text message, at 9:04 AM, provided the medications involved and the oxygen (O2) levels at 82%. Review of the copied text message, identified with the ARNP's name, date and time, revealed the ARNP returned orders at 9:05 AM via text message to send Resident #1 to the hospital for a medical evaluation. Review of the emergency department records revealed Resident #1's vital signs were not suppressed; however, he/she did have a significantly abnormal chest x-ray.</p> <p>2. Interview with the DNS and record review, on 03/08/14 at 10:45 AM, revealed the initial investigation identified the medication error occurred with a newly licensed, Licensed Practical Nurse (LPN). The nurse was identified as LPN #1. She was removed from the medication cart and medication pass orientation. She was provided education on the 8 rights of medication administration. Review of the</p>	F 282		

