

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
NAME OF PROVIDER OR SUPPLIER HOPKINS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 460 SOUTH COLLEGE STREET WOODBURN, KY 42170	
(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>Amended</p> <p>A Recertification Survey was conducted on 04/08/14 through 04/12/14 to determine the facility's compliance with Federal requirements. Immediate Jeopardy was identified on 04/12/14, and determined to exist on 02/16/14, at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F281; and 42 CFR 483.25 Quality of Care, F-329; 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 04/12/14.</p> <p>On 02/15/14, the facility received a telephone physician's order for Resident #8 for Biaxin (an antibiotic) 1000 milligrams (mg) daily for seven (7) days. Review of the February 2014 Medication Administration Record (MAR) revealed the nurse transcribed the order as Biaxin 1000 mg daily for seven (7) days; however, the administration times had been transcribed as three (3) times a day, instead of daily. Resident #8 received the medication one (1) time for a total of 1000 mg on 02/15/14, three (3) times for a total of 3000 mg on 02/16/14, and two (2) times for a total of 2000 mg on 02/17/14. The staff who administered the medication failed to use the five rights (right resident, right time, right drug, right dose, and right route) of medication administration to identify the transcription error. In addition, 24 hour physician order checks were not conducted each night to compare the orders with the MAR to identify any transcription errors. Interview with the Director of Nursing (DON)</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hopkins Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> 	

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

Jennifer D. Hwa, RMA

TITLE

(X6) DATE

6/10/14

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

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F 000	Continued From page 1 revealed there was no policy and procedure to perform the 24 hour chart checks; however, it was the facility's practice and her expectation. On 02/17/14 at 10:00 PM, Registered Nurse (RN) #1 identified the transcription error and withheld the medication, but failed to notify the physician, family and the Director of Nursing (DON); and, failed to complete an incident report for the medication error. The DON and the Physician were not made aware of the incident until the next day (02/18/14). Interview with the Advanced Practitioner Registered Nurse (APRN), revealed the doses of Blaxin could have resulted in kidney and/or liver failure, and/or gastro-intestinal disorders. An acceptable Allegation of Compliance (AoC) was received on 04/22/14, alleging the removal of Immediate Jeopardy on 04/17/14. The State Survey Agency validated, on 04/24/14, the Immediate Jeopardy was removed on 04/17/14, as alleged. The Scope and Severity was lowered to a "D" at 483.10 Resident Rights, F-157; 483.20 Resident Assessment, F-281; and, 483.25 Quality of Care, F-329; while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes. Deficiencies continue at F-241, F-309, F-314, F-332 and F-441 at a Scope and Severity of a "D".	F 000			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	F 157			

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F 157	<p>Continued From page 2</p> <p>or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's "Medication Error" policy and procedure, it was determined the facility failed to notify the physician and the resident's family member in a timely manner, for one (1) of thirteen (13) sampled residents (Resident #8), related to an excessive dose medication error, resulting in the resident receiving two (2) times the</p>	F 157	<p>Resident # 8 was ordered Biaxin XL 500mg 2 tabs every day x 7 days on 2/15/14. The order was transcribed to the MAR as q 8 hours with times 6AM, 2PM, 10PM. On 2/17/14, the MAR was corrected to reflect the physician order. Upon notification of the transcription error on 2/18/14 the DNS notified the physician/NP with orders received and initiated. The DNS completed medication error report and ensured it was transcribed correctly on MAR with remainder of doses given as ordered. The resident was assessed by the NP on 2/17/14 and again on 2/24/14 and the resident did not have any negative effects from the additional antibiotic.</p> <p>An audit of the 24-hour report and the event log for the dates of 3/15/14 – 4/16/14 was completed on 4/17/14 by the area support staff including 2 RN Nurses. Audits validated physician & responsible party notification of a change in condition; no concerns were identified as the physician/NP and the responsible party had been immediately notified of all events.</p>		

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F 157	<p>Continued From page 3</p> <p>medication dose ordered by the physician over a three (3) day period.</p> <p>On 02/15/14 at approximately 3:15 PM, the facility received a telephone order from the physician, for Resident #8 to be administered Biaxin (an antibiotic) 500 milligrams (mg), two (2) tablets once daily for seven (7) days. Registered Nurse (RN) #3 received the telephone order and transcribed the order on the Medication Administration Record (MAR). The medication was ordered to be given once a day, however, RN #3 transcribed the administration times for three (3) times a day, at 6:00 AM, 2:00 PM, and 10:00 PM. On 02/15/14 at 10:00 PM, Resident #8 received the first dose of medication. On 02/16/14, the resident received the antibiotic three (3) times at 6:00 AM, 2:00 PM, and 10:00 PM, for a total dose of 3000 mg, instead of the 1000 mg per day the physician had ordered. On 02/17/14, the resident received the medication two (2) times at 6:00 AM and 2:00 PM, for a total of 2000 mg, instead of the 1000 mg ordered by the physician.</p> <p>On 02/17/14 at approximately 10:00 PM, RN #1 noted the medication error resulting from the failure to correctly transcribe the times the medication was to have been administered; however, RN #1 failed to notify the physician, the Director of Nursing (DON) or the resident's family. The RN notified the oncoming nurse, Licensed Practical Nurse (LPN) #1, during shift change report, who also failed to notify the physician, the DON, and the resident's family. LPN #1 informed the oncoming shift, the next day on 02/18/14, of the error. On 02/18/14 at approximately 8:00 AM, ten (10) hours after the medication error was</p>	F 157	<p>17 of 21 Licensed nurses were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or the RN Nurse Practice Educator regarding immediate notification of physician/NP upon identification of medication error or other change of resident status.</p> <p>Four Licensed Nurses not working during this time frame and future new nurses and/or new medication aides during orientation will have reeducation/education before returning to work and during orientation by the DNS or ADNS.</p> <p>The DON/ADON/ or RN Manager will audit the 24 hour report for change in condition to validate the physician was immediately notified. This audit will be completed at least daily including weekends for 2 weeks then 5 times per week for 30 days then no less than 3 times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly</p>		

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F 157	<p>Continued From page 4</p> <p>noted, the DON was made aware of the medication error and notified Resident #8's physician and family. This error resulted in the resident receiving two (2) times the ordered dose of the antibiotic over the three (3) day period. There was no documented evidence that RN #1 or LPN #1 assessed Resident #8 after they became aware of the medication error. Interview with the Advanced Practitioner Registered Nurse (APRN), revealed the doses of Biaxin could have resulted in kidney and/or liver failure, and/or gastro-intestinal disorders.</p> <p>The facility's failure to ensure the physician and family member were made aware of the medication error has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/12/14 and was determined to exist on 02/16/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Errors", policy and procedure, last revised 01/02/14, revealed upon discovery of a medication error, the staff would evaluate the patient for adverse effects, report immediately to the DON, and notify the physician, patient, and responsible party.</p> <p>Record review revealed the facility admitted Resident #8 on 06/10/09 with diagnoses which included Dementia with Behavioral Disturbance, Cognitive Deficits, Depressive Disorder, Unspecified Heart Disease, Unspecified Hypothyroidism, and Gastro-Esophageal Reflux Disorder. Review of the Annual Minimum Data Set (MDS) assessment, dated 03/08/14, revealed the facility assessed Resident #8's cognitive</p>	F 157	<p>QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>05/14/2014</p>	05/14/14

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F 157	<p>Continued From page 5</p> <p>status as severely impaired with a Brief Interview Mental Status (BIMS) score of three (3), indicating the resident was not interviewable.</p> <p>Review of a Physician's Order, dated 02/15/14, revealed an order for Biaxin 500 mg, two (2) tabs once daily for seven (7) days; however, review of the February 2014 MAR revealed the order was transcribed on the MAR with administration times of 6:00 AM, 2:00 PM, and 10:00 PM, which was three (3) times a day rather than once a day that was ordered by the physician. Further review revealed the resident received the first dose of the medication on 02/15/14 at 10:00 PM. On 02/16/14, the resident received three (3) doses of medication: 1000 mg at 6:00 AM, 2:00 PM, and 10:00 PM, three (3) times the amount ordered by the physician. On 02/17/14, Resident #8 received two (2) doses of medication, 1000 mg at 6:00 AM and 2:00 PM, two (2) times the amount ordered by the physician.</p> <p>Interview with RN #1, on 04/12/14 at 10:20 AM, revealed she was the first staff member who noted the discrepancy on the MAR, on 02/17/14 at approximately 10:00 PM. She stated she did not administer the 10:00 PM dose. The RN stated she did not call the resident's physician and family but stated she reported to LPN #1, the oncoming nurse, at shift change, that the medication had not been administered and the medication error had been discovered.</p> <p>Interview with LPN #1, on 04/12/14 at 10:30 AM, revealed she was told by RN #1 in report about the error and stated RN #1 said she had reported it to the DON. LPN #1 stated she "assumed it was being taken care of" and, "I didn't follow up on it, I was under the impression that she (RN #1)</p>	F 157			

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F 157	<p>Continued From page 6 had taken care of it".</p> <p>Interview with the DON, on 04/11/14 at 4:00 PM, revealed she was not called regarding the incident and was not made aware of the incident until 02/18/14 at approximately 8:00 AM, after six (6) doses of the medication had been administered.</p> <p>Interview with the current DON on 04/12/14 at 4:20 PM, revealed her expectation, was the RN should have notified the DON, physician, and the resident's family when the medication error was identified.</p> <p>Interview with the Advanced Practitioner Registered Nurse (APRN), on 04/11/14 at 12:55 PM, revealed the doses of Biaxin could have resulted in kidney and/or liver failure, and/or gastro-intestinal disorders. She stated she was not made aware of the medication error until 02/18/14.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The resident was assessed by the APRN on 02/17/14 and 02/24/14 with no negative side effects from the antibiotic identified.</p> <p>An audit of the current MARs and Physician/APRN orders, was completed on 04/16/14 with no errors identified.</p> <p>A MAR to medication cart audit was completed by the Licensed Pharmacy Technician, on 04/14/14 and all MAR orders and medication times were correct.</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>All current residents were reassessed on 04/12/14, by two (2) licensed staff, for signs and symptoms of medication reactions and none were identified.</p> <p>Seventeen (17) of twenty-one (21) Licensed Nurses and three (3) of four (4) Certified Medication Aides (CMAs) were re-educated by the DON/ADON, and or the Nurse Educator on 04/16/14, regarding the appropriate transcription of physician medication orders, checking residents for allergies, the five (5) rights of medication administration, immediate notification of the physician/ARNP/DON and responsible party, upon identification of a medication error and staff completed clinical competencies and return demonstration on medication passes and transcription of physician orders. Four (4) Licensed Nurses and one CMA were to have this training prior to working the floor, as some of these staff were either on sick leave, vacation or worked as needed.</p> <p>The DON, ADON and Administrative RNs audited current MARs and Physician Orders, MARs to chart reviews, allergies and physician/responsible party notifications, every day, beginning 04/14/14, for fourteen (14) days, then five (5) days a week for sixty (60) days, then no less than three (3) times a week for an additional thirty (30) days. No discrepancies were identified and the audits were on-going. Additional audits will be determined by the monthly Quality Improvement (QI) Committee and corrective action and /or re-education will be provided at the point of discovery. Licensed Pharmacists or Licensed Pharmacy Technicians will complete MAR to chart checks monthly, with corrective action, if indicated and findings reported to the DON and</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>ADON. Audit tools will be brought to the monthly QI meetings, by the ADM/DON and or ADON for review with additional plans put into place as warranted by the QI Committee.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review on 04/24/14 revealed Resident #8 had no negative outcome from the event and a review of the clinical record, MARs and Physician Orders on 04/23/14, revealed no concerns.</p> <p>Review of the MARs and Physician Orders for five (5) residents (Residents #1, #9, #11, #12 and #19), on 04/24/14, revealed there were no medication transcription errors.</p> <p>Review of the MAR and Physician Orders audit list and the pharmacy audit list, dated 04/15-16/14, revealed on 04/24/14 the DON and Administrative RNs completed fifty (50) of fifty (50) resident audits of MARs and Orders reviews with no transcription or medication errors identified.</p> <p>Review of the Inservice log, dated 04/13-16/14, on 04/24/14 revealed all but five (5) licensed staff and CMAs were inserviced and a post test and repeat demonstration was completed to verify competency of transcription of physician orders and ensure documentation on the MAR was correct. Any other staff working as needed or staff on vacation or sick leave, were to be re-educated prior to working the floor and this was verified by interview with one CMA and review of the CMA's training record. She had been re-educated on 04/21/14, prior to work that day.</p>	F 157			

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F 157	Continued From page 9 Interviews with RN #1, LPN #4, LPN #5, CMA #1, CMA #3, and CMA #4 on 04/24/14 at 12:50 PM, 1:00 PM, 1:15 PM, 1:20 PM, 1:36 PM and 2:10 PM and review of the training logs, dated 04/13-16/14, revealed training was completed by the DON/ADON and Administrative RNs, which included transcription of physician orders to the MARs, immediate Physician/APRN/DON/ responsible party notification, training on monitoring for any reaction to a medication order, checking for allergies and the five (5) rights of medication administration. Review of the Quality Improvement (QI) audits and interviews conducted with the ADON and DON, on 04/24/14 at 10:40 AM, revealed results of the audits were discussed in the QI meetings, as stated in the AoC, training was provided to licensed nursing staff as well as the CMAs and the auditing was ongoing.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Patient's Bill of Rights and Responsibilities document, it was determined the facility failed to promote care for one (1) of thirteen (13) sampled residents (Resident #1), in a manner that maintains and enhances a	F 241	The Administrator and Social Services Director, assessed resident #1 for dignity on 04/09/14 and 04/10/14. Resident interview and assessment identified the resident did not have concerns related to the event. Alert/Oriented residents were interviewed by the Social Services Director or Administrator beginning on 04/09/14 to determine if residents		

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F 241	<p>Continued From page 10</p> <p>resident's dignity and respect related to a harsh remark made by a staff member.</p> <p>On 04/09/14, Registered Nurse (RN) #1 was told by Resident #1 that he/she needed to use the rest room and RN #1 told the resident that "he/she should have told them before they laid him/her down" and to "go ahead and go" (void in the bed).</p> <p>The findings include:</p> <p>Review of a document titled, "Patient's Bill of Rights and Responsibilities", last revised 09/01/13, revealed its purpose was to assure that the patient's personal dignity, well-being, and self-determination is maintained and to assure that patients are knowledgeable of their responsibilities in this regard." Further review of the policy and procedure revealed staff will be in-serviced on Patient's Rights and Responsibilities at orientation and annually thereafter.</p> <p>Record review revealed the facility readmitted Resident #1 on 03/12/14 with diagnoses which included Parkinson's Disease, Anemia, Peripheral Neuropathy, Pressure Ulcer Buttock, Stage II, Generalized Pain, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated the resident was interviewable.</p> <p>Observation, on 04/09/14 at 3:06 PM, revealed Resident #1 stated to RN #1, "I have to go pee".</p>	F 241	<p>had dignity concerns related to care/services. No other concerns were identified.</p> <p>Re-education was provided to facility staff by the Assistant Director of Nursing (ADNS) beginning on 4/9/14 to include appropriate response to a resident, staff treatment and care of residents in a manner and an environment that maintains or enhances each resident's dignity and respect. Facility staff will have this education provided during orientation by the ADNS, Administrator or Social Service Director.</p> <p>The Social Services Director, Director of Nursing, ADNS or Administrator will interview residents, family members, or visitors regarding dignity and respect towards our residents. This will include at least 5 residents per week for 30 days followed by 3 residents per week for 60 additional days. Corrective action and/or re-</p>	

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F 241	Continued From page 11 RN #1 replied to Resident #1, "You should have told us that before we laid you down, you might as well go on and go." The resident stated, "I don't know I have to go until the last minute, I just hate to pee in the bed." Interview with RN #1, on 04/09/14 at 3:25 PM, revealed Resident #1 had never used a urinal and always said he/she had to go after he/she had gone. RN #1 stated, "I thought (he/she) said (he/she) had peed" when asked about remark related to "you should have told us before we laid you down." When asked about the remark telling the resident, "you might as well go on and go" she only replied, "huh", with no other response. Interview with Resident #1, on 04/09/14 at 4:00 PM, revealed he/she had little warning before he/she had to urinate. When the resident was asked how it made him/her feel to be told, "you might as well go ahead and go", the resident stated "I don't care anymore", with no emotion and expression on his/her face. Interview with the Administrator, on 04/09/14 at 4:45 PM, revealed RN #1 should have offered Resident #1 a urinal or to go to the bathroom. The Administrator further stated the comments made to the resident were unacceptable and an investigation would be conducted.	F 241	education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager. May 14, 2014	05/14/14	
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	F 281			

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F 281	<p>Continued From page 12</p> <p>by: Based on observation, interview, record review, review of the facility's policy and procedures, review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 "Patient Care Orders", and Lippincott Manual of Nursing Practice, 10th Edition, copyright 2014, it was determined the facility failed to provide services in accordance with acceptable standards of practice, for two (2) of thirteen (13) sampled residents (Resident #8). The facility failed to administer medication according to the five (5) rights (right resident, right medication, right time, right dose, right route); failed to report a medication error in a timely manner; and, failed to investigate the incident to determine if any other medication errors were made and to inservice staff members to prevent a reoccurrence of these type of errors. In addition, the facility failed to ensure wound care was provided according to Nursing Practice guidelines for Resident #1 when a Licensed Nurse failed to wash her hands and change gloves after the glove became contaminated with feces and prior to providing wound care.</p> <p>On 02/15/14, Resident #8 was ordered Biaxin XL 500 milligrams (mg,) two (2) tabs by mouth once daily for seven (7) days. Registered Nurse (RN) #3 received the order and transcribed the order on the resident's Medication Administration Record (MAR). The medication was ordered to be given once a day; however, the RN transcribed administration times as 6:00 AM, 2:00 PM, and 10:00 PM, three times a day. On 02/15/14, Resident #8 received the first dose of 1000 mg of Biaxin, at 10:00 PM. On 02/16/14, the resident received 1000 mg doses at 6:00 AM, 2:00 PM, and 10:00 PM, for a total of 3000 mg,</p>	F 281	<p>Resident # 8 was ordered Biaxin XL 500mg 2 tabs every day x 7 days on 2/15/14. The order was transcribed to the MAR as q 8 hours with times 6AM, 2PM, 10PM. Three extra doses were given until 2/17/14, when the MAR was corrected to reflect the physician order. Upon notification of the transcription error on 2/18/14 the DNS notified the physician/NP with orders received and initiated. The DNS completed medication error report and ensured it was transcribed correctly on MAR with remainder of doses given as ordered. The resident was assessed by the NP on 2/17/14 and again on 2/24/14 and the resident did not have any negative effects from the additional antibiotic.</p> <p>All Current residents (50 of 50) were reassessed on 4/12/14 by two licensed nurses for signs and symptoms of medication reactions; none were identified.</p> <p>An audit of current Medication Administration Records (MARS) and physician/Nurse Practitioner orders was completed by the DNS or an RN</p>		

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F 281	<p>Continued From page 13</p> <p>instead of the 1000 mg per day, ordered by the physician. On 02/17/14, the resident received 1000 mg doses at 6:00 AM and 2:00 PM, for a total of 2000 mg that day instead of the ordered amount of 1000 mg a day. The Licensed Practical Nurse (LPN) and two (2) Certified Medication Aides (CMAs), who administered the medications, failed to identify the transcription error. On 02/17/14 at approximately 10:00 PM, Registered Nurse (RN) #1 identified the transcription error. Interview with the Advanced Practice Registered Nurse (APRN) revealed the doses of Blaxin could have resulted in kidney and/or liver failure and/or gastro-intestinal disorders.</p> <p>The facility's failure to ensure medication was transcribed correctly and 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 04/12/14 and was determined to exist on 02/16/14. The facility was notified of Immediate Jeopardy on 04/12/14.</p> <p>The findings include:</p> <p>Review of a Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14, last revised 10/2010, revealed nurses are individually held responsible and accountable for rendering safe, effective nursing care to clients and for judgments exercised and actions taken in the course of providing care. Registered Nurses and Licensed Practical Nurses' nursing practice includes the administration of medication and treatment prescribed by a physician which are consistent with the recognized standards of practice. The</p>	F 281	<p>Area Support Personnel beginning on 4/15/14 and finished on 4/16/14. 50 of 50 resident MARS were reviewed. No medication errors were identified. No transcription errors were identified.</p> <p>A MAR to cart audit was completed by the Licensed Pharmacist and a Licensed Pharmacy Technician on 4/15/14. 3 of 3 medication carts were audited. All MAR orders and medication times matched pharmacy labels for 50 out of 50 residents.</p> <p>17 of 21 Licensed nurses and 3 of 4 medication aides were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or the RN Nurse Practice Educator regarding the following with return demonstration:</p> <ul style="list-style-type: none"> · Appropriate transcription of physician medication orders; · Medication pass including the 5 rights of med pass; 	

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F 281	<p>Continued From page 14</p> <p>components of medication administration includes but is not limited to preparing and giving medication in the prescribed dosage, route, and frequency and the supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care.</p> <p>Review of the facility's policy and procedure titled, "Medication Administration," last revised 01/02/14, revealed the purpose was to provide a safe, effective medication administration process. Further review revealed the accepted standard of practice would be followed. Review of the facility's "Clinical Competency Validation", dated 03/20/11, revealed the standards included for staff administering medications to check orders on the MAR carefully, check specific administration directions, clarify the medication order when necessary, check the label on the medication, calculate the correct dose, administer the routes of medication properly, document appropriately on the MAR, and report and record any side effect, error, or unusual information regarding the medication.</p> <p>Record review revealed the facility admitted Resident #8 on 10/06/09 with diagnoses which included Dementia with Behavioral Disturbance, Cognitive Deficits, Depressive Disorder, Unspecified Heart Disease, Unspecified Hypothyroidism, and Gastro-Esophageal Reflux Disorder. Review of the Annual Minimum Data Set (MDS) assessment, dated 03/08/14, revealed the facility had assessed Resident #8's cognitive status as severely impaired with a Brief Interview Mental Status (BIMS) score of three (3).</p> <p>Review of a Physician's Order, dated 02/15/14 at approximately 3:15 PM, revealed an order for</p>	F 281	<ul style="list-style-type: none"> · Immediate notification of physician/NP upon identification of medication error; · Notification of responsible party/resident; · Notification of the Director of Nursing Services and /or other Management Nurses as appropriate; <p>17 of 21 Licensed nurses and 3 of 4 medication aides were re-educated beginning on 4/13/14 and completed on 4/16/14 by the Director of Nursing or the Assistant Director of Nursing or the RN Nurse Practice Educator regarding Clinical Competency Validation for Medication Administration (see Attachment A.) Transcription competencies were also completed by return demonstration utilizing sample order with licensed nurse transcribing to sample MAR.</p> <p>Medication pass observations were completed for 17 of 21 Licensed nurses and 3 of 4 medication aides, including 3 administrative nurses by the DNS or ADNS or RN Nurse Practice Educator during each shift beginning on 4/13/14 through 4/16/14.</p>	

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F 281	<p>Continued From page 15</p> <p>Biaxin XL 500 mg two (2) tabs daily for seven (7) days. Review of the February 2014 MAR revealed Biaxin 500 mg two (2) tabs daily for seven (7) days, for a daily dose of 1000 mg. However, administration times were transcribed as 6:00 AM, 2:00 PM, and 10:00 PM.</p> <p>Interview with RN #3, on 04/11/14 at 4:00 PM, and review of a Nurse's Note, dated 02/15/14, revealed RN #3 obtained the new telephone order on 02/15/14 at 3:15 PM and transcribed it onto the MAR. RN #3 stated she wrote the times down on the MAR as 6:00 AM, 2:00 PM, and 10:00 PM, as she had confused this with another order she was working on at the time.</p> <p>Further review of the February 2014 MAR revealed the resident received the first dose of Biaxin 1000 mg at 10:00 PM on 02/15/14. On 02/16/14, the resident received three (3) doses, 1000 mg at 6:00 AM, 2:00 PM and 10:00 PM for a total of 3000 mg instead of the 1000 mg a day. On 02/17/14, the resident received two (2) doses, 1000 mg at 6:00 AM and 1000 mg at 2:00 PM for a total of 2000 mg instead of the 1000 mg a day. The LPN and two (2) CMAs administering the medication at these times failed to identify the transcription error.</p> <p>Interview with CMA #1, on 04/12/14 at 11:15 AM, revealed she administered the medication on 02/17/14 at 2:00 PM and should have caught the error. She stated, "I usually look to see if the MAR matches the label on the medication and I missed it".</p> <p>Interview with LPN #2, on 04/12/14 at 11:30 AM, revealed she administered Biaxin XL 500 mg two (2) tablets on 02/15/14 at 10:00 PM, on 02/16/14</p>	F 281	<p>Four Licensed Nurses & one medication aide not working during this time frame and future new nurses and/or new medication aides during orientation will have reeducation/education and be competency tested before returning to work and during orientation by the DNS or ADNS.</p> <p>The Director of Nursing, the Assistant Director of Nursing, the RN Clinical Case Manager or the RN Area Support Personnel will audit all new physician/NP medication orders including:</p> <ul style="list-style-type: none"> · MAR matches the physician order · Time of the medication administration on MAR matches physician order · If medication error identified, physician notified immediately · If medication error identified, medical record corrected per physician orders · This audit will be completed daily 	

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F 281	<p>Continued From page 16</p> <p>at 6:00 AM, and at 10:00 PM, and on 02/17/14 at 6:00 AM. She further stated it was the facility's policy and procedure to check the medication label against the order to ensure accuracy with right medication, dose and time. She stated she was not sure what happened because she always checked the medication label against the order to ensure it was accurate.</p> <p>Interview with the current Director of Nursing (DON), on 04/12/14 at 4:20 PM, revealed the LPN and two (2) Certified Medication Aides (CMAs) who administered the six (6) doses of the medication, should have verified the order on the Medication Administration Record (MAR) and the times of administration with the physician's order and the pharmacy prescription. She stated they should have noted the error before six (6) doses were given improperly.</p> <p>Interview with the APRN, on 04/11/14 at 12:55 PM, revealed the doses of Biaxin could have resulted in kidney and/or liver failure and/or gastro-intestinal disorders.</p> <p>2. Review of the Lippincott Manual of Nursing Practice, 10th Edition, copyright 2014, page 1083, revealed hand hygiene is the single most recommended measure to reduce the risks of transmitting infection. Hand hygiene should be performed in between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control. It may also be necessary to clean hands in between tasks on the same patient to prevent cross-contamination of different body sites.</p>	F 281	<p>beginning on 4/14/14 for at least 14 days including weekends then 5 days a week for 60 days then no less than 3 times per week for 30 additional days. Additional audits will be determined by the monthly QI/PI committee. Corrective action and/or re-education will be provided at point of discovery including physician notification and re-education of involved nurse.</p> <p>The Licensed Pharmacist or Licensed Pharmacy Technician will complete 3 of 3 MAR to cart checks monthly x 3 with corrective action if indicated and report findings to DNS or ADNS.</p> <p>The audit tools will be brought to the monthly QI/PI meeting by the Administrator or DNS or ADNS for review with addition plans put into place as warranted by the Quality Improvement committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p>		

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F 281	<p>Continued From page 17</p> <p>Review of the facility's "Aseptic Wound Dressings" policy and procedure, last revised 01/02/14, revealed if a break in aseptic technique occurs, stop the procedure, remove gloves, cleanse hands, and apply clean gloves. In addition, it stated that wound dressings were performed using aseptic technique to decrease the risk of wound contamination and cross-contamination during dressing changes.</p> <p>Record review revealed the facility readmitted Resident #1 on 03/12/14 with diagnoses which included Peripheral Neuropathy, Pressure Ulcer Buttock, Stage II, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Observation of incontinent care and wound care provided by LPN #3 to Resident #1, on 04/09/14 at 9:25 AM, revealed LPN #3 donned clean gloves and used disposable moist towelettes located on the bedside table to clean stool off the resident's buttocks. The stool was noted to contaminate her glove. Further observation revealed the LPN did not change her gloves or perform hand hygiene but obtained a fresh moist towelette from the bedside table to clean the wound bed of the resident's pressure ulcer. She then removed a container of prescribed Calazime (skin protectant paste) from the resident's bedside table, opened the container wearing the same visibly contaminated glove and applied the medication to the wound bed with the finger of the contaminated glove. The LPN failed to wash her hands and change glove between providing the incontinent care and the wound care.</p> <p>Interview with LPN #3, on 04/09/14 at 9:36 AM, revealed she always changed gloves between incontinent care and wound care and stated she</p>	F 281	<p>Resident #1 was reassessed by a licensed nurse for pressure sores and signs/symptoms of infection on 4/28/14.</p> <p>The other resident with a peri/anal pressure sores was reassessed by a licensed nurse for signs/symptoms of infection on 4/28/14 with no concerns were identified. As of 05/01/14 this area was healed.</p> <p>Re-education was provided to licensed nurses by the Assistant Director of Nursing, Director of Nursing or RN Educator beginning on 4/28/14 to include aseptic techniques during wound dressing including appropriate glove usage and hand hygiene. Licensed nurses will have this training provided during orientation by ADNS/DNS or a RN.</p>	

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F 281	<p>Continued From page 18</p> <p>thought she did. She stated it was good nursing practice to ensure gloves were changed and hands washed to prevent infection.</p> <p>Interview with the Director of Nursing and Administrator, on 04/09/14 at 10:45 AM, revealed the LPN should have changed gloves and washed her hands according to the facility's policy and procedure and should not have provided wound care with the soiled gloves.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The resident was assessed by the APRN on 02/17/14 and 02/24/14 with no negative side effects from the antibiotic identified.</p> <p>An audit of the current MARs and Physician/APRN orders, was completed on 04/16/14 with no errors identified.</p> <p>A MAR to medication cart audit was completed by the Licensed Pharmacy Technician, on 04/14/14 and all MAR orders and medication times were correct.</p> <p>All current residents were reassessed on 04/12/14, by two (2) licensed staff, for signs and symptoms of medication reactions and none were identified.</p> <p>Seventeen (17) of twenty-one (21) Licensed Nurses and three (3) of four (4) Certified Medication Aides (CMA) were re-educated by the DON/ADON and or the Nurse Educator on 04/16/14, regarding the appropriate transcription of physician medication orders, checking</p>	F 281	<p>The DNS, ADNS or RN will observe dressing or treatment to validate aseptic techniques including appropriate glove usage and hand hygiene were followed across all shifts at least 4 times per week for 30 days then no less than 2 times per week for 60 additional days. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>May 14, 2014</p>	05/14/14	

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F 281	<p>Continued From page 19</p> <p>residents for allergies, the five (5) rights of medication administration, immediate notification of the physician/ ARNP/DON and responsible party, upon identification of a medication error and staff completed clinical competencies and return demonstration on medication passes and transcription of physician orders. Four (4) Licensed Nurses and one CMA were to have this training prior to working the floor, as some of these staff were either on sick leave, vacation or worked as needed.</p> <p>The DON, ADON and Administrative RNs audited current MARs and Physician Orders, MARs to chart reviews, allergies and physician/responsible party notifications, every day, beginning 04/14/14, for fourteen (14) days, then five (5) days a week for sixty (60) days, then no less than three (3) times a week for an additional thirty (30) days. No discrepancies were identified and the audits were on-going. Additional audits will be determined by the monthly Quality Improvement (QI) Committee and corrective action and /or re-education will be provided at the point of discovery. Licensed Pharmacists or Licensed Pharmacy Technicians will complete MAR to chart checks monthly, with corrective action, if indicated and findings reported to the DON and ADON. Audit tools will be brought to the monthly QI meetings, by the ADM/DON and or ADON for review with additional plans put into place as warranted by the QI Committee.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review on 04/24/14 revealed Resident #8 had no negative outcome from the event and a review of the clinical record, MARS and physician</p>	F 281			

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F 281	<p>Continued From page 20 orders on 04/23/14, revealed no concerns.</p> <p>Review of the MARs and physician orders for five residents (Residents #1, #9, #11, #12 and #19), on 04/24/14, revealed there were no medication transcription errors.</p> <p>Review of the MAR and physician orders audit list and the pharmacy audit list, dated 04/15-16/14, revealed on 04/24/14 the DON and Administrative RNs completed fifty (50) of 50 resident audits of MARS and Orders reviews with no transcription or medication errors identified.</p> <p>Review of the inservice log, dated 04/13-16/14, on 04/24/14 revealed all but five (5) licensed staff and CMAs were inserviced and a post test and repeat demonstration was completed to verify competency of transcription of physician orders and ensure documentation on the MAR was correct. Any other staff working as needed or staff on vacation or sick leave, were to be re-educated prior to working the floor and this was verified by interview with one CMA and a review of the CMA's training record and stated she had been re-educated on 04/21/14, prior to work that day.</p> <p>Interviews with RN #1, LPN #4, LPN #5, CMA #1, CMA #3, and CMA #4 on 04/24/14 at 12:50 PM, 1:00 PM, 1:15 PM, 1:20 PM, 1:36 PM and 2:10 PM and review of the training logs, dated 04/13-16/14, revealed training was completed by the DON/ADON and Administrative RNs, which included transcription of physician orders to the MARs, immediate physician/APRN/DON/responsible party notification, training on monitoring for any reaction to a medication order, checking for</p>	F 281			

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F 281	Continued From page 21 allergies and the five rights of medication administration. Review of the Quality Improvement (QI) audits and interviews conducted with the ADON and DON, on 04/24/14 at 10:40 AM, revealed results of the audits were discussed in the QI meetings, as stated in the AoC, training was provided to licensed nursing staff as well as the CMAs and the auditing was ongoing.	F 281			
F 282 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide a pain assessment and interventions for pain according to the care plan for for one (1) of thirteen (13) sampled residents (Resident #1) related to pain. On 04/09/14, Registered Nurse (RN) #1 was told by Resident #1 his/her toe was hurting. RN #1 replied to Resident #1, "It is hard for it not to hurt when it is infected". RN #1 left the room and did not perform a pain assessment or offer the resident any comfort measures for pain control per the resident's care plan. The findings include:	F 282	Resident #1 was assessed for pain on 04/09/14 and provided PRN pain medication per orders at 3:35pm and again at 11:00pm on 4/9/14 for the resident's complaint of toe pain. Resident #1's nurse practitioner reassessed resident on 04/25/14. New orders were received for additional pain management. Resident's #1 care plan was updated by the licensed nurse. All residents were re-assessed for pain on 4/10/14 by a licensed nurse with follow up and pain medication administration and documentation completed as needed. Another audit was initiated and completed on 4/16/14 by a licensed nurse to include all residents with new		

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F 282	<p>Continued From page 22</p> <p>Review of the facility's policy and procedure titled, "Pain Management", last revised 01/02/14, revealed staff was to maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain and to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with patient directed goals. In addition, if the Nursing Assessment indicated pain, the nurse would obtain treatment orders as indicated and at a minimum of daily, patients would be evaluated for the presence of pain by making an inquiry of the patient or by observing for signs of pain.</p> <p>Record review revealed Resident #1 was readmitted on 03/12/14 with diagnoses which included Parkinson's Disease, Anemia, Peripheral Neuropathy, Pressure Ulcer Buttock, Stage Two (2), Generalized Pain, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of "12", which indicated the resident was interviewable. The resident was assessed to have the presence of pain with the pain occurring frequently.</p> <p>Review of the Comprehensive Care Plan for Pain, dated 03/21/14, revealed interventions to monitor pain on a scale of zero to ten (0-10); administer pain medication per physician's orders; note effectiveness and notify physician if not effective, give as needed (PRN) medication for breakthrough as per physician's order; note effectiveness and notify physician if ineffective,</p>	F 282	<p>orders for pain management since 4/10/14, any resident with an event since 3/15/14 and any resident identified at risk for pain per the 24-hour report review between 4/10/14 – 4/16/14.</p> <p>Licensed nurses were re-educated on 4/16/14 by the ADNS or the RN Nurse Educator regarding pain management assessment including when resident states pain is not relieved and physician notification if indicated, treatment and documentation including care plan revision if indicated. New licensed nurses will have education provided regarding pain management during orientation by the DNS, ADNS or an RN.</p> <p>The DNS, ADNS, or charge nurse will audit the 24-hour report for change in condition to validate that pain management was completed including care plan revision if indicated for any resident with an</p>		

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F 282	<p>Continued From page 23</p> <p>document and report complaints and non-verbal signs of pain, and assist to reposition for comfort.</p> <p>Observation on 04/09/14 at 3:06 PM, revealed Resident #1 stated to RN #1, "My toe on my left foot hurts." RN #1 stated to Resident #1, "It's hard for it not to hurt when it is infected." Further observation revealed the RN did not assess the resident's level of pain and did not offer any comfort measures for the resident's pain.</p> <p>Review of Resident #1's Physician Orders, dated 03/13/14, revealed an order for Acetaminophen (pain medication) 650 milligrams (mg) as needed four (4) times a day for pain; however, there was no documentation the resident was administered the pain medication related to his/her complaints of pain on 04/09/14 at 3:06 PM.</p> <p>Interview with Resident #1, on 04/09/14 at 4:00 PM, revealed his/her Cellulitis (infection/inflammation of deep tissue) of the foot caused him/her pain and when the staff moved him/her it would cause him/her pain and it would take a while for the pain to go away.</p> <p>Interview with RN #1, on 04/09/14 at 3:25 PM, revealed she had not assessed the resident's pain and had checked to see if there were any orders for pain medication but she would now.</p> <p>Interview with the Director of Nursing (DON) and the Administrator, on 04/09/14 at 10:45 AM, revealed when the resident complained of pain they expected the nurse to have assessed the resident's pain, checked the physician's orders, and to have offered pain medication, as per the plan of care.</p>	F 282	<p>event or new complaint of pain. This audit will be completed daily for 2 weeks then 5 days per week for 30 days then no less than 3 times per week for 60 additional days. Additional audits will be determined by the monthly QI/PI committee. Corrective action and/or re-education will be provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.</p> <p>05/14/2014</p>	05/14/14	

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F 309 F 309 SS=G	Continued From page 24 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's "Pain Management" policy and procedure, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing according to the comprehensive assessment and plan of care for one (1) of thirteen (13) sampled residents (Resident #1) related to pain. During an observation on 04/09/14, Registered Nurse (RN) #1 was told by Resident #1 his/her toe was hurting. RN #1 replied to Resident #1, "It is hard for it not to hurt when it is infected". RN #1 left the room and did not perform a pain assessment or offer the resident any comfort measures for pain control. The findings include: Review of the facility's policy and procedure titled, "Pain Management", last revised 01/02/14, revealed staff was to maintain the highest	F 309 F 309	Resident #1 was assessed for pain on 04/09/14 and provided PRN pain medication per orders at 3:35pm and again at 11:00pm on 4/9/14 for the resident's complaint of toe pain. Resident #1's nurse practitioner reassessed resident on 04/25/14. New orders were received for additional pain management. Resident's #1 care plan was updated by the licensed nurse. All residents were re-assessed for pain on 4/10/14 by a licensed nurse with follow up and pain medication administration and documentation completed as needed. Another audit was initiated and completed on 4/16/14 by a licensed nurse to include all residents with new orders for pain management since 4/10/14, any resident with an event since 3/15/14 and any resident identified at risk for pain per the 24-hour report review between 4/10/14 – 4/16/14.		

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F 309	<p>Continued From page 25</p> <p>possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain and to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with patient directed goals. In addition, if the Nursing Assessment indicated pain, the nurse would obtain treatment orders as indicated and at a minimum of daily, patients would be evaluated for the presence of pain by making an inquiry of the patient or by observing for signs of pain.</p> <p>Record review revealed Resident #1 was readmitted on 03/12/14 with diagnoses which included Parkinson's Disease, Anemia, Peripheral Neuropathy, Pressure Ulcer Buttock, Stage Two (2), Generalized Pain, Infection to Left Foot, Second Toe, and Restless Leg Syndrome.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of "12", which indicated the resident was interviewable. The resident was assessed to have the presence of pain with the pain occurring frequently.</p> <p>Review of the Comprehensive Care Plan for Pain related to Arthritis, pressure points, skin breakdown and Peripheral Neuropathy, dated 03/21/14, revealed interventions to monitor pain on a scale of zero to ten (0-10); administer pain medication per physician's orders; note effectiveness and notify physician if not effective, give as needed (PRN) medication for breakthrough as per physician's order; note effectiveness and notify physician if ineffective, document and report complaints and non-verbal</p>	F 309	<p>Licensed nurses were re-educated on 4/16/14 by the ADNS or the RN Nurse Educator regarding pain management assessment including when resident states pain is not relieved and physician notification if indicated, treatment and documentation including care plan revision if indicated. New licensed nurses will have education provided regarding pain management during orientation by the DNS, ADNS or an RN.</p> <p>The DNS, ADNS, or charge nurse will audit the 24-hour report for change in condition to validate that pain management was completed including care plan revision if indicated for any resident with an event or new complaint of pain. This audit will be completed daily for 2 weeks then 5 days per week for 30 days then no less than 3 times per week for 60 additional days. Additional audits will be determined by the monthly QI/PI committee. Corrective action and/or re-education will be</p>		

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F 309	Continued From page 26 signs of pain, and assist to reposition for comfort. Review of Resident #1's Physician Orders, dated 03/13/14, revealed an order for Acetaminophen (pain medication) 650 milligrams (mg) as needed four (4) times a day for pain. Observation on 04/09/14 at 3:06 PM, revealed Resident #1 stated to RN #1, "My toe on my left foot hurts." RN #1 stated to Resident #1, "It's hard for it not to hurt when it is infected." Further observation revealed the RN did not assess the resident's level of pain and did not offer any comfort measures for the resident's pain. Interview with Resident #1, on 04/09/14 at 4:00 PM, revealed he/she had pain due to Cellulitis (infection/inflammation of deep tissue) of the foot and when staff moved him/her it would cause him/her pain and it would take a while for the pain to go away. During interview with RN #1, on 04/09/14 at 3:25 PM, she stated she had not checked the resident's orders for pain but stated, "I will now". Interview with the Director of Nursing (DON) and the Administrator, on 04/09/14 at 10:45 AM, revealed their expectation would have been for the nurse to have assessed the resident's pain, checked the physician's orders, and to have offered pain medication, as per the plan of care.	F 309	provided at point of discovery. Additional audits will be determined by the monthly QI/PI committee. The Quality Improvement committee includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, the Social Services Director, the Maintenance Director, the Dietary Manager and the Business Office Manager.	05/14/2014	05/14/14
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314			

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F 314	<p>Continued From page 27</p> <p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's "Hand Hygiene" and "Aseptic Wound Dressings" policies and procedures, it was determined the facility failed to ensure a resident received the necessary services to prevent infection and promote healing for one (1) of thirteen (13) sampled residents (Resident #1), related to improper wound care for a Stage II pressure ulcer. Licensed Practical Nurse (LPN) #3 failed to change gloves and wash her hands between touching feces during incontinent care and cleaning a wound during wound care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Hand Hygiene", last revised 10/01/13, revealed its purpose was to improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Further review revealed it was the process of the facility to use soap and water in the following situations: After removing gloves or other personal protective equipment (PPE), immediately after contact with blood, body fluids, or other potentially infectious materials, and when hands were visibly soiled or contaminated.</p> <p>Review of the facility's policy titled, "Aseptic</p>	F 314	<p>Resident #1 was reassessed by a licensed nurse for pressure sores and signs/symptoms of infection on 4/28/14.</p> <p>The other resident with a peri/anal pressure sores was reassessed by a licensed nurse for signs/symptoms of infection on 4/28/14 with no concerns were identified. As of 05/01/14 this area was healed.</p> <p>Re-education was provided to licensed nurses by the Assistant Director of Nursing, Director of Nursing or RN Educator beginning on 4/28/14 to include aseptic techniques during wound dressing including appropriate glove usage and hand hygiene. Licensed nurses will have this training provided during orientation by ADNS/DNS or a RN.</p>		