

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2014
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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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<p>F 000 INITIAL COMMENTS</p> <p>**Amended**</p> <p>An Abbreviated Survey investigating complaint #KY22011, and a Partial Extended Survey was conducted on 07/28/14 through 08/06/14. Complaint #KY22011 was substantiated with related deficiencies cited at a Scope and Severity of a "K".</p> <p>After consultation with CMS and Supervisory review, the survey was reopened to obtain additional information on 09/02/14 through 09/12/14.</p> <p>On 03/16/14, Resident #2 received an order for Lisinopril (anti-hypertensive) 40 milligrams (mg) daily. On 03/21/14, Licensed Practical Nurse (LPN) #2 received a telephone order for Lisinopril 20 mg twice a day. LPN #2 transcribed the order for the Lisinopril 20 mg onto the March 2014 Medication Administration Record (MAR) and discontinued the Lisinopril 40 mg daily order. During the monthly MAR review, the MARs for May 2014 were verified for accuracy; however, Resident #2's Lisinopril 20 mg twice daily was transcribed onto Resident #3's MAR in error. Resident #2 received Lisinopril 40 mg daily from 05/01/14 through 05/17/14. Resident #3 received thirty-three (33) doses of the wrong anti-hypertensive medication from 05/01/14 to 05/17/14, which resulted in a significant medication error. Although LPN #1 identified the significant medication error on 05/17/14, she failed to clarify the order for Resident #2's Lisinopril. LPN #1 added the Lisinopril 20 mg order back onto Resident #2's MAR, leaving both orders for Lisinopril 40 mg daily and Lisinopril 20</p>	<p>F 000 DISCLAIMER:</p> <p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> 
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE NHA	(X6) DATE 10/23/14 10/10/2014
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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	<p>Continued From page 1</p> <p>mg twice daily on the resident's MAR which resulted in another significant medication error. Resident #2 received 80 mg of Lisinopril from 05/18/14 through 05/30/14.</p> <p>Additionally, the facility failed to conduct a thorough investigation of the significant medication error as it was determined by the facility to be a transcription error. Although Resident #3 did not have an order for the Lisinopril, the resident received thirty-three (33) doses of the medication. The facility failed to investigate how the Lisinopril was obtained for the resident without an order, as the medication did not come from the pharmacy.</p> <p>Immediate Jeopardy (IJ) was identified in the areas of CFR 483.20 Resident Assessment at F281 and F282; CFR 483.25 Quality of Care at F309 and F333; and, CFR 483.75 Administration at F490 and F514 at a Scope and Severity of a "K". Substandard Quality of Care was identified at CFR 483.25 Quality of Care at F309 and F333. Immediate Jeopardy was identified on 07/30/14 and was determined to exist on 05/01/14. The facility was notified of the Immediate Jeopardy on 07/30/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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>It was determined even though the facility conducted audits on 07/28/14 and 08/04/14 to ensure accurate reflection of the current</p>	F 000	

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F 000	Continued From page 2 physician's orders per the facility's AoC, the facility failed to identify that Resident #5 was receiving Lisinopril after the medication had been discontinued. On 05/02/14, the facility received orders to discontinue Resident #5's Lisinopril 10 mg every day order; however, the facility failed to ensure the medication was discontinued on the June, July, August and September 2014 MARs during the monthly MAR checks which resulted in the resident receiving ninety-five (95) doses of Lisinopril between 06/01/14-09/03/14. The facility alleged removal of Jeopardy on 08/06/14; however, it was determined the Immediate Jeopardy was not removed until 09/09/14.	F 000	
F 281 SS=K	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, review of the facility's policy/procedure, review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14 and the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Survey and Certification Group, S&C:13-02-NH, dated 11/02/12; standards of practice, Section II item B, it was determined the facility failed to have an effective system to ensure medication was administered according to the professional standards of quality for eight (8) of twenty-one (21) sampled residents (Resident #2, Resident #3, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10).	F 281	<u>F 281: 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u> It is the practice of Princeton Health and Rehab Center, Inc. to provide or arrange services that must meet professional standards of practice. <u>Corrective Measures for Residents Identified in the deficient practice:</u> Resident # 2 & Resident #3 were assessed by a R.N. on July 30, 2014. Physicians were notified with no new orders for Res.#2 and Res.#3. Resident #2 & Resident #3 's clinical records were audited by the Director of Nursing (DON) and their plans of care were reviewed on 7/30/14. The physician for Resident #5 was contacted on 9/3/14, and an order was obtained to discontinue Lisinopril. He was assessed by unit nurse for signs/symptoms associated with medication, for three shifts, with no adverse effects noted. Resident #11 and Resident #12 experienced no adverse effects from medications delivered outside standard parameters. Education was provided to CMA #11 and CMA #12 who delivered the medication on 9/6/14 and 9/21/14. Administration of narcotic pain patches Resident #6, Resident #7, Resident #8, Resident #9 and

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F 281	<p>Continued From page 3</p> <p>The facility failed to have an effective system in place to ensure medications were transcribed correctly on the Medication Administration Record (MAR) for Resident #2 and Resident #3, failed to ensure a Physician's Telephone Order to discontinue a medication for Resident #5 was carried out, and failed to ensure narcotic pain patches were disposed of by two (2) nurses per facility policy for Resident #6. Resident #7, Resident #8, Resident #9 and Resident #10.</p> <p>On 03/16/14, Resident #2's Physician ordered Lisinopril 40 milligrams (mg) daily for Hypertension, and on 03/21/14, an order was received for Lisinopril 20 mg twice daily. LPN #2 documented on the March and April 2014 MAR that the resident's Lisinopril 40 mg daily had been "changed", with the initiation of the Lisinopril 20 mg twice daily even though the physician's order did not indicate to discontinue the 40 mg order.</p> <p>During the May 2014 review of the MARs for accuracy, Resident #2's Lisinopril 20 mg twice daily was transcribed onto Resident #3's MAR, in error. From 05/01/14 through 05/17/14, Resident #2 received Lisinopril 40 mg daily, and Resident #3 received thirty-three (33) doses of Lisinopril 20 mg twice a day without a physician's order. LPN #1 identified the medication error on 05/17/14; however, she failed to clarify the order for Resident #2's Lisinopril, leaving both orders, Lisinopril 40 mg daily and Lisinopril 20 mg twice daily, on the resident's MAR. The resident received 80 mg daily from 05/18/14 through 05/30/14. Refer to F333, F309, F514.</p> <p>On 05/02/14, the facility received orders to discontinue Resident #5's Lisinopril 10 mg every day order; however, the facility failed to ensure</p>	F 281	<p><u>F 201 cont'd:</u></p> <p>Resident #10 was relocated to the Licensed Nurse MAR, by DON & CCC on 9/5/14, with prompting to dispose with a second nurse.</p> <p><u>How other residents were identified who may have been impacted by the practice:</u></p> <p>100% audit identified one other resident (in addition to residents' #6,#7,#8,#9,#10) who received a narcotic pain patch. He/she had his/her narcotic pain patch relocated to the Licensed Nurse MAR by DON & CCC on 9/5/14, with prompting to dispose with a second nurse.</p> <p>100 % of all residents' Medication Administration Records (MAR) were audited by DON, Staff Development Coordinator (SDC), Clinical Care Coordinator (CCC), MDS coordinator & MDS nurse, and Unit Managers (UM) on July 29, 2014 to ensure accurate reflection of current Physicians' Orders for the July and August MARs. A second 100% audit was conducted on August 4, 2014 by the DON and the Regional Quality Management Nurse (RQMN) for the August MARs. One medication error was identified with a telephone order and corrected. Additional audits were completed of the orders, MARs and TARs, of current residents reviewing records from April 2014 to the date of review, for accurate transcription of medication orders on the POS and MARs. The audit was completed primarily utilizing the services of qualified outside RN's and LPN's w known performance credentials. The errors identified in this audit originated in April & May before new processes were implemented.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>RQMN in serviced the DON, SDC, CCC, MDS UM and Administrator on 7/30/14 regarding:</p>	

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the medication was discontinued on the June, July, August and September 2014 MAR during the checking of MARs for the new month which resulted in the resident receiving ninety-five (95) doses of Lisinopril between 06/01/14-09/03/14. Refer to F333.

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 07/30/14, and was determined to exist on 05/01/14. The facility was notified of the Immediate Jeopardy on 07/30/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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.

Even though 100% resident MAR to physician orders audits were conducted on 07/29/14 and 08/04/14 to ensure accurate reflection of the current physician's orders per the AoC, the facility failed to identify another example (Resident #5). This error was identified by the State Survey Agency. Therefore, it was determined the Immediate Jeopardy was not removed on 08/06/14, as alleged. The facility conducted additional audits and training related to ensuring the residents' MARs were an accurate reflection of the current physician's orders. After validation of the facility's actions, the State Survey Agency determined the Immediate Jeopardy was

F 281 F 281 cont'd:

proper medication administration techniques; accuracy of transcribing medications; correct process for month end transcriptions & validation of physician orders & MARs; obtaining blood pressure prior to administration of anti hypertensive medication, accurate & consistent documentation of blood pressure reading prior to administration of anti-hypertensive medication, administration of medication, transcription of orders & assessment findings; and to ensure that staff administering medications are aware of care plan interventions for hypertension.

On July 31, 2014, SDC re-educated Licensed Nurses regarding: accurate transcription of telephone orders to the MAR, read back order to prescribing physician, verify documents belonging to the correct resident when transcribing order onto the MAR/TAR, and to clearly discontinue existing orders that is stopped or modified by a new order. Telephone orders from the previous day are reviewed by the CCC to verify accuracy. On weekends, the night shift nurse will review new orders to verify that they have been accurately transcribed.

The end of month procedure for reviewing MARs was modified to designate one specific nurse to be removed from additional duties other than MAR change over at the end of the month. The nurse was designated as the Order Validation Nurse (OVN). The OVN was trained by the SDC on 7/31/14 regarding the process which included comparing the previous month's orders and subsequent telephone orders to ensure new orders contained all changes that occurred since the previous month began. The reviewed orders are utilized to verify that the MARs / TARs accurately reflect those orders. All new orders obtained after the OVM reviews but prior to the end of the month, will be added to both the current and upcoming months MAR / TAR and the upcoming months POS, by

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removed on 09/09/14.

The findings include:

Review of the facility's policy titled, "General Dose Preparation and Medication Administration", last revised 01/01/13, revealed facility staff should verify each time a medication was administered that it was the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident. Confirm that the MAR reflected the most recent medication order.

Review of the facility's policy titled, "Documentation Standards", last revised 01/02/14, revealed documentation standards would follow established professional ethics and practices. Prior to documenting, always check the identifying information to verify and authenticate it was the correct medical record for charting.

Review of the facility's "Protocol for Checking MARs for the New Month", dated 07/30/14, revealed to check the new physician's orders and update with any telephone orders since the last physician's orders were checked. Check the new physician's orders against the new MARs, check the new MARs against the current month's MARs, and check new physician's orders against the previous month's physician's orders.

Review of the KBN Advisory Opinion, AOS #14, last revised 10/2010, revealed Registered Nurses (RN) and Licensed Practical Nurses (LPN) were required to administer medications and treatments prescribed by the physician, physician assistant, dentist and advanced practice registered nurse. Components of medication

F 281 F 281 cont'd:

the nurse receiving the order. The CCC will review both the current and upcoming records in her verification. On the last day of the month, prior to utilization, the night nurse will compare the upcoming MAR which had been checked against the new orders to the MAR currently being utilized, to identify any discrepancies between the two.

Education was provided to licensed nurses and CMTs regarding proper medication administration practice on 7/31/14, and again on 9/6/14. Med Pass Administration Observations conducted for all nurses CMTs currently working beginning on 8/5/14, and with remaining nurses and CMTs at the beginning of their next scheduled shift. These were completed by the SDC and Unit Managers. Repeat Med Pass Observations were conducted throughout the month of September on 9/3, 9/6, 9/18, 9/21, 9/24, 9/25, 9/27, 9/29, and 9/30/14. Further education was provided on 10/8/14 and 10/9/14, by a Quality Management Specialist, regarding prevention of Medication Errors, and proper medication delivery such as adhering to scheduled times, and administering in correct form.

A Policy & Procedure was developed regarding disposal of topical narcotic patches. When a patch is removed or is to be wasted, nurses were trained to fold the used or discarded patch in half with the medicated sides folded together. With a second nurse as a witness, the folded patch is to be placed into the sharps container that is locked inside a secured holder anchored to the medication cart. Both nurses are to sign for the disposal. Procedure was developed by Regional Resource Team Nurse and training was initiated with Licensed Nurses and Certified Medication Technicians on 9/5/14 by the SDC and continued with oncoming shifts until all had been trained. The administration and removal of topical narcotic patches was placed on the

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administration included preparing and giving medication in the prescribed dosage, route, and frequency.

1. Record review revealed the facility admitted Resident #2 on 07/02/13 with diagnoses which included Hypertension and Congestive Heart Failure (CHF). Review of the Quarterly Minimum Data Set (MDS), dated 06/18/14, revealed the facility assessed Resident #2 as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15), indicating the resident was interviewable.

Review of the Physician's Orders, dated 03/16/14, revealed an order for Lisinopril 40 mg daily for Hypertension. Further review revealed a Physician's Order, dated 03/21/14, for Lisinopril 20 mg twice daily for Hypertension.

Review of Resident #2's March 2014 MARs revealed the order for Lisinopril 40 mg daily had been marked as "changed", with the last dose initialed as being administered on 03/21/14 at 8:00 AM. Further review revealed the Lisinopril 20 mg twice daily had been transcribed onto the MAR with the first dose initialed indicating it had been administered on 03/21/14 at 8:00 PM.

Review of Resident #2's April 2014 MAR revealed an order for Lisinopril 20 mg twice daily with Lisinopril 40 mg daily marked as "changed" on the MAR. However, review of the May 2014 MAR revealed the Lisinopril 40 mg once daily was not marked as changed; it was initialed indicating it had been administered from 05/01/14 through 05/31/14. In addition, the Lisinopril 20 mg twice daily was also initialed as been administered 05/18/14 through 05/30/14

F 281 F 281 cont'd:
Nurses Medication Administration Record by the DON & CCC on 9/5/14, with a prompt to have a second nurse for disposal.

Orientation program for newly hired Medication Techs and Licensed Nurses has been revised to reflect the changes with post testing to confirm understanding and one on one training with the SDC prior to working with a mentor as of 8/05/14 with additional revision on 10/9/14, by the Regional Quality Management Nurse.

Monitoring Measures to Maintain On-going Compliance:

100% of all medication errors will be brought through the morning Abbreviated Quality Assurance meeting for the review of the completion of the RCA and the assessment of the resident for a minimum of 24 hours after the medication error is identified. Each month, the CCC and the Quality Assurance Committee will review the medication errors for further opportunities for training or correction. The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director, MDS Coordinator, Plant Management, Medical Records, Social Services Director, Dietary Manager, Unit Managers and Clinical Care Coordinator.

After the Order Validation Nurse completes end of month order, MAR, TAR review, the DON, CCC, UM, SDC or MDS will conduct a second audit of 100% of new month's orders and MARs for the next three months. If no errors are identified, a transition to auditing 50% of new month's orders, MARs and TARs by the DON, CCC, UM, SDC, or MDS. The DON or CCC will report the results of audits to the Quality Assurance Committee meeting. After the conclusion of six months, the Quality Assurance

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F 281	Continued From page 7 Phone interview with LPN #2, on 07/28/14 at 3:10 PM; and, on 07/29/14 at 10:40 AM, revealed she received a telephone order from Physician #1 for Lisinopril 20 mg twice daily on 03/21/14. She stated Resident #2 had been having an increase in his/her blood pressure in the evening or the morning (she could not remember which one). She stated Physician #1 ordered the divided dose of Lisinopril so the medication would be evenly distributed throughout the day. LPN #2 further stated if the previous order of Lisinopril had been replaced, it should have been documented as "discontinued" on the telephone order. Interview with LPN #1, on 07/28/14 at 3:30 PM, revealed she had identified, on 05/17/14, that the order for Lisinopril 20 mg twice daily order had been transcribed onto the wrong MAR (Resident #3's May 2014 MAR). LPN #1 stated after the error was found, she added the medication to Resident #2's MAR; however, she did not discontinue the order for the Lisinopril 40 mg daily which resulted in the resident receiving 80 milligrams of Lisinopril daily from 05/18/14 through 05/30/14. LPN #1 stated she did not notify the physician to verify the order. She stated she "assumed" the resident was supposed to have both orders, Lisinopril 40 mg and Lisinopril 20 mg twice daily. Interview with Physician #1, on 07/28/14 at 3:45 PM; and, on 07/29/14 at 10:15 AM, revealed if he gave an order for Lisinopril 20 mg twice daily, he would not have intended for the resident to remain on Lisinopril 40 mg daily. Physician #1 verified the maximum dose of Lisinopril for an elderly resident was 40 mg daily. He stated if a resident received 80 mg daily, there was a	F 281	<u>F 281 cont'd:</u> Committee will determine sample size for further audits. The SDC will continue to in-service, conduct medication pass observations, and conduct post testing of Licensed Nurses and CMT's quarterly & report results to the Quality Assurance Committee meeting for twelve months. Blood pressure audits to be conducted by the Unit Nurse / Unit Manager to ensure that blood pressures are being taken before anti-hypertensive medications are given. The MARs will be audited to verify vital signs that are indicated prior to medication administration have been recorded. The audit will be conducted seven times a week for four weeks, three times a week for four weeks, one time a week for four weeks, every other week for four weeks, then monthly for 3 months. The results of the audit will be reported during the Quality Assurance Committee meeting for seven months unless the Committee identifies areas of concern. An audit will be conducted by the Clinical Care Coordinator or Director of Nursing weekly, to verify that there is documentation validating that two nurses have witnessed the disposal of all transdermal narcotic patches. The audit will be conducted weekly x 4 to verify that the practice is being consistently followed. After 4 successful weeks of auditing, audits may be decreased in frequency to every other week for 8 weeks, then monthly if no issues are identified. The findings of the audit will be communicated to the QA Committee for review. The monitoring process will be modified as indicated by the committee based on findings. In the event the designated staff assigned a monitoring task, the Administrator will assign a qualified individual, with appropriate training to complete the monitoring assignment. If concerns are identified in any of the monitoring processes, additional training and performance

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F 281	<p>Continued From page 8</p> <p>potential to lower the resident's blood pressure too much, causing fatigue, dizziness, lightheadedness when standing, weakness, and an increased risk for falling.</p> <p>2. Record review revealed the facility admitted Resident #3 on 11/28/05 with diagnoses which included Hypertension. Review of the Quarterly MDS, dated 07/17/14, revealed the facility assessed Resident #3 as cognitively intact with a BIMS score of fifteen (15).</p> <p>Review of the May 2014 MAR revealed an entry for Lisinopril 20 mg twice daily. The Lisinopril was initialed indicating it was administered thirty-three (33) times from 05/01/14 through 05/17/14. Review of the May 2014 Physician's Orders revealed an order for Cozaar 25 mg tablet every morning for Hypertension; and, Norvasc (antihypertension medication) 10 mg tablet once daily; however, there was no order for Lisinopril. When the nurse reconciled the physician's orders to the May 2014 MARs, the nurse documented the Lisinopril order on Resident #3's May 2014 MAR instead of Resident #2's May 2014 MAR.</p> <p>Interview with the Director of Nursing (DON), on 07/29/14 at 10:55 AM, 12:00 PM, 2:30 PM; and, on 07/30/14 at 10:30 AM, revealed it was expected for licensed staff to discontinue the previous order if an order change was received. She stated staff should have received clarification for the two (2) Lisinopril orders written for Resident #2, as common practice for licensed staff. The process for verifying accuracy of a resident's MAR each month included comparison of the resident's current physician's orders with the resident's new MAR. The DON verified LPN #2 was most likely the nurse reviewing the May</p>	F 281	<p><u>F 281 cont'd:</u></p> <p>correction will be provided as indicated.</p>	<u>10/13/14</u>

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2014 MAR for Resident #3. She stated they were reviewed by one licensed staff, but not double checked by a second licensed staff member.

3. Record review revealed the facility admitted Resident #5 on 02/05/13 with diagnoses which included Hypertension and Cerebral Artery Occlusion with Infarct.

Review of a Physician's Order, dated 02/05/13, revealed an order for Lisinopril 10 mg once daily. Review of a Physician's Order, dated 05/02/14 at 5:35 PM, revealed an order to discontinue the Lisinopril.

Review of the May 2014 MAR revealed the Lisinopril was discontinued on 05/02/14; however review of the June, July, August, and and September 2014 MARs revealed ninety-five (95) doses were administered between 06/01/14 and 09/03/14. The 02/05/13 order for Lisinopril 10 mg daily remained on the MARs.

Interview with the DON, on 09/02/14 at 11:15 AM, revealed she was unaware of another significant medication error involving Lisinopril. She stated the month end change-over of 08/31/14 and the September 2014 MAR to medication cart audit conducted as part of the AoC did not reveal any discrepancies.

Interview with the Clinical Care Coordinator, on 09/12/14 at 8:25 AM, revealed an audit was conducted on all resident MARs on 07/29/14 and a second audit was conducted on 08/04/14 as part of the facility's AoC to ensure accurate reflection of the physician's orders; however, staff failed to identify that Resident #5's Lisinopril 10 mg daily order remained on the MARs with no

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F 281	<p>Continued From page 10</p> <p>physician's order. She stated Resident #5 received Lisinopril 10 mg daily from 06/01/14 through 09/03/14 in error.</p> <p>Interview on 09/02/14 at 1:55 PM with the Medical Director, who was also Resident #5's Primary Care Provider, revealed she knew Resident #5 well and had stopped the Lisinopril 10 mg daily on 05/02/14 probably due to his/her B/P being low and renal insufficiency. Further interview revealed she would have expected the resident's B/P to remain low when the medication was continued, and due to the resident's renal insufficiency she would not have restarted the medication at all as that could cause further renal compromise.</p> <p>4. Record review revealed the facility admitted Resident #11 on 08/20/13 with diagnoses which included Osteoarthritis (OA), and weakness with multiple falls. Review of the Physician's Orders, dated 08/25/14, revealed an order for Alendronate Sodium (Fosamax) seventy (70) milligrams (mg), give one (1) tablet orally once a week with six to eight (6-8) ounces of water in the morning before meal/medication administration. Review of the September 2014 MAR revealed the Fosamax administration time was 7:00 AM.</p> <p>Observation of the medication pass, on 09/05/14 at 7:53 AM, revealed Resident #11 was administered his/her Fosamax after breakfast at 7:53 AM. The resident was noted to have his/her breakfast tray in front of him/her with most of the food eaten. The Fosamax was given by Certified Medication Aide (CMA) #12 with the resident's morning medications.</p> <p>Interview with CMA #12 on 09/05/14 at 10:35 AM,</p>	F 281	

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revealed she was forty-five (45) minutes late giving the resident his/her Fosamax and was aware the medication was for brittle bones and was to be given on an empty stomach at least thirty (30) minutes before the first food or drink of the day.

5. Record review revealed the facility admitted Resident #12 on 05/24/12 with diagnoses which included Gastroesophageal Reflux. Review of the September 2014 MAR revealed an order for Lansoprazole (anti-ulcer) Extended Release (ER) thirty (30) mg orally every morning before breakfast, "DO NOT CRUSH" with an administration time of 6:30 AM.

Observation of a medication pass, on 09/05/14 at 8:05 AM, revealed CMA #11 administered the Lansoprazole by sprinkling the medication on applesauce. The medication was administered after breakfast.

Interview with CMA #11, on 09/05/14 at 10:35 AM, revealed she was not aware that she had given the medication after the resident's breakfast.

Interview with the DON, on 09/05/14 at 3:35 PM, revealed she expected staff to contact the physician prior to administering a late medication and get instructions.

6. Review of the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Survey and Certification Group, S&C:13-02-NH, dated 11/02/12, standards of practice, Section II item B, revealed staff should dispose of Fentanyl patches in the same manner as wasting of any other controlled substance. Wasting involved a secure and safe

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method so divers on and/or accidental exposure were minimized

Review of the facility's policy entitled "LTC Facilities Receiving Pharmacy Products and Services from Pharmacy", last revised 01/01/13, revealed wasting of controlled medications should be destroyed by two (2) licensed nurses employed by the facility, and the disposal should be documented on the accountability record on the line representing that dose.

Record review revealed the facility admitted Resident #6 on 03/31/13 with diagnoses which included Dementia with behavior, Encephalopathy, Osteoporosis and Motor Restlessness

Review of the Physician's Order, dated 07/29/14, revealed an order for Duragesic twelve (12) micrograms per hour (mcg/hr.) patch apply one (1) patch every seventy-two (72) hours.

Review of the August 2014 Medication Administration Record (MAR) revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on ten (10) out of 10 days the patch was changed between 08/01/14 through 08/31/14. Review of the September 2014 MAR revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal destruction of the patch two (2) days between 09/01/14 and 09/05/14.

7. Record review revealed the facility admitted Resident #7 on 10/01/13 with diagnoses which included Arthritis, History of cancer of the breast, and partial left mastectomy.

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F 281	Continued From page 13 Review of the Physician's Order, dated 07/29/14, revealed an order for Duragesic twelve (12) mcg/hr patch apply one (1) patch every 72 hours. Review of the August 2014 Medication Administration Record (MAR) revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on ten (10) out of 10 days between 08/01/14 through 08/31/14. Review of the September 2014 MAR revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on two (2) days between 09/01/14 and 09/05/14. 8. Record review revealed the facility admitted Resident #8 on 08/04/11 with diagnoses which included Paralysis Agitans, Bipolar Disorder, Chronic Airway Obstruction, and Hypertension. Review of the Physician's Order, dated 07/22/14, revealed an order for Duragesic seventy-five (75) mcg/hr patch apply one (1) patch topically every 72 hours. Review of the August 2014 Medication Administration Record (MAR) revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on five (5) out of fifteen (15) days between 08/01/14 through 08/15/14; and, six (6) out of 6 days between 08/15/14 and 08/31/14 . Review of the September 2014 MAR revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on two (2) days between 09/01/14 and 09/05/14.	F 281		

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F 281	<p>Continued From page 14</p> <p>9. Record review revealed the facility admitted Resident #9 on 05/22/13 with diagnoses which included Hemiplegia Dominant Side, Cerebral Embolism with infarct, and Generalized Pain.</p> <p>Review of the Physician's Order, dated 07/10/14, revealed an order for Duragesic fifty (50) mcg/hr patch apply one (1) patch topically every 72 hours.</p> <p>Review of the August 2014 Medication Administration Record (MAR) revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on ten (10) out of 10 days between 08/01/14 through 08/31/14. Review of the September 2014 MAR revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch two (2) days between 09/01/14 and 09/05/14.</p> <p>10. Record review revealed the facility admitted Resident #10 on 02/07/13 with diagnoses which included Multiple Sclerosis, Congestive Heart Failure, Cerebral Palsy, and General Osteoarthritis.</p> <p>Review of the Physician's Order, dated 07/10/14, revealed an order for Duragesic fifty (50) mcg/hr patch apply one (1) patch topically every 72 hours.</p> <p>Review of the August 2014 Medication Administration Record (MAR) revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on ten (10) out of 10 days</p>	F 281		

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F 281	<p>Continued From page 15</p> <p>between 08/01/14 through 08/31/14. Review of the September 2014 MAR revealed there was no documented evidence indicating two (2) licensed nurses had verified the removal and destruction of the patch on two (2) days between 09/01/14 and 09/05/14.</p> <p>Interview with Certified Medication Aide (CMA) #1, on 09/05/14 at 1:06 PM, revealed she would apply the patch, and label it with the date and her initials. She stated when she removed a patch she would take off the old patch and discard it in the sharps' container. She was not aware that two (2) licensed nurses were supposed to dispose of the used patches.</p> <p>Interview with CMA #7, on 09/05/14 at 3:00 PM, revealed she would follow the MAR for putting the pain patches on a resident and then label the patches with her initials and the date. She stated when she removed a patch, she folded it together and put it in the sharps' container in the resident's room. She was not aware that two (2) licensed nurses were supposed to dispose of the used patches.</p> <p>Interview with CMA #9, on 09/05/14 at 3:18 PM, revealed she would follow the MAR when she applied a pain patch to a resident. She stated when she removed a patch she would fold the patch up in her glove and place it in the sharps' container in the resident's room. She was not aware that two (2) licensed nurses were supposed to dispose of the used patches.</p> <p>Interview with Unit Manager #1 on 09/07/14 at 5:07 PM; Registered Nurse (RN) #1 on 09/12/14 at 3:00 PM, and RN #2 on 09/05/14 at 12:25 PM revealed they were aware the CMAs had applied,</p>	F 281	

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F 281	<p>Continued From page 16</p> <p>removed and disposed of the pain patches. They were not aware of the facility's policy that two (2) nurses were supposed to witness the disposal of the patch.</p> <p>Interview with the DON, on 09/05/14 at 3:35 PM, revealed she was not aware that two (2) licensed nurses were supposed to dispose of used pain patches and she thought there was no medication left in the patch when the CMAs removed it.</p> <p>Interview with the Pharmacist in Charge from the contracted facility pharmacy vendor, on 09/05/14 at 2:00 PM, revealed a Duragesic or Fentanyl patch was a controlled substance and when the used patch was removed from a resident it should be wasted "just like any other controlled substance".</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. Resident #3's blood pressure was monitored three (3) times on 05/17/14, two (2) times on 05/18/14 and then daily for the next five (5) days. The Nurse Practitioner assessed the resident on 06/18/14 and an RN assessed the resident on 07/30/14 with no indications of any adverse effect. <p>On 07/29/14, all resident Medication Administration Records (MARs) were audited to ensure accurate reflection of the current physician's orders. A second audit was conducted, on 08/04/14, by the DON and the Regional Quality Management Nurse. After the audit, the facility implemented a revised process for faxing telephone orders to the pharmacy. Education was provided to licensed staff of the</p>	F 281		

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F 281	<p>Continued From page 17</p> <p>new process, which included the attachment of the fax verification to the telephone order. The Clinical Care Coordinator (CCC) or the weekend monitor would verify the fax confirmation was present for all new orders</p> <p>The end of the month procedure for reviewing MARs was modified to designate one specific nurse to be removed from additional duties other than MAR revision at the end of the month. The nurse was designated as the "Order Validation Nurse". That nurse was trained by the Staff Development Coordinator (SDC) on 07/31/14, on the process which included comparing the previous month's orders and subsequent telephone orders to ensure new orders contained all changes that occurred since the previous month began. The new orders would be utilized to verify that the MARs accurately reflected those orders. On the last day of the month, prior to utilization, the night nurse would compare the new MAR which had been checked against the new orders to the MAR currently being utilized.</p> <p>The process for reviewing new orders was revised to include the CCC validating accurate transcription of new orders on the correct MAR on weekdays. The night shift nurse would validate on the weekends and holidays. The DON would assign responsibility or complete the reviews in the absence of the CCC. The process included implementation of a task list to utilize when reviewing orders to guide the reviewer through the process</p> <p>2. Education was provided, on 07/30/14 to the Administrator, DON, CCC, SDC, Unit Managers, and MDS Nurses by the Regional Resource Team Nurse regarding proper administration</p>	F 281	
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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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F 281	Continued From page 18 techniques utilizing the "rights" of medication administration to prevent errors, accuracy of transcribing medications, correct process for month end transcription and validation of physician's orders and MARs, administration of medication, and transcription of orders. On 07/31/14, the Regional Resource Nurse educated the Administrative Team on root cause analysis. On 07/31/14, education was provided by the SDC to licensed staff and CMAs regarding accurate medication administration, obtaining vital signs as indicated by medication and as directed on the MAR, and the prohibition of borrowing medication from another resident. If a medication was not available, the pharmacy should be contacted regarding the medication. The physician should be notified for clarification if there were any discrepancies. Education was provided to licensed nurses by the SDC on 07/31/14 regarding accurate transcription of telephone orders onto the MAR. The education included to read back the order to the prescriber to ensure the initial order reflects his/her verbal order correctly, transcribe the order onto the correct MAR, clearly discontinue existing orders that may be stopped or modified due to the new order. Nurses were educated on 07/31/14 by the SDC that a resident was to have a complete assessment each shift for a minimum of twenty-four hours after identification of a medication error. The assessment would be documented in the clinical record. Education was provided to licensed nurses by the SDC on 07/31/14 regarding accurate transcription of telephone orders onto the MAR. The education included to read back the order to the prescriber to ensure the initial order reflected his/her verbal	F 281			

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F 281	<p>Continued From page 19</p> <p>order correctly, transcribe the order onto the correct MAR, clearly discontinue existing orders that may be stopped or modified due to the new order. Nurses were educated on 07/31/14 by the SDC that a resident was to have a complete assessment each shift for a minimum of twenty-four hours after identification of a medication error. The assessment would be documented in the clinical record.</p> <p>On 07/31/14, the Regional Director of Operations educated the Administrator on utilizing the Abbreviated Quality Assurance processes, a review of the previous day's events, with focus on unusual events or deviation from normal. The process included audits of documents and departmental reports of activities and findings that may prompt the need for additional review, identify any weaknesses in processes as they relate to medication or other facility operations and systems.</p> <p>3. Training would be provided to all staff currently working and would continue with oncoming staff, prior to beginning duty, until completed by the SDC.</p> <p>After the State Survey Agency identified the facility failed to remove the Jeopardy on 08/06/14, the facility implemented the following actions:</p> <p>4. Resident #5's physician was notified and an order was obtained to discontinue the medication. The resident was assessed by the nurse, with her findings noted in the clinical record. The assessment was repeated each shift for the next twenty-four (24) hours then daily for the next two (2) days. No adverse effects were identified. All the resident's blood pressure obtained during the</p>	F 281		

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F 281	<p>Continued From page 20</p> <p>time the resident was receiving the medication were within the physician's parameters for administration.</p> <p>5. The facility revised the process for the handling of medication discontinue orders to include the placement of a "Discontinue" sticker on the medication cards containing the remainder of the medication and remove that medication from the medication cart at that time. The facility conducted an additional one-hundred percent (100%) resident record review audit on 09/05/14 through 09/07/14; which included Physician Telephone Orders and MAR/TAR from 04/01/14 through 09/07/14 which revealed no errors related to transcription, communication with the pharmacy or removal of discontinued medications and no further medication order to MAR discrepancies. A re-audit was conducted by the Director of Nursing (DON), Clinical Care Coordinator (CCC), Staff Development Coordinator (SDC), Unit Managers (UM), Regional Quality Control Specialist (RQMS), and Minimum Data Set (MDS) Coordinator, utilizing the services of outside Registered Nurses (RNs) with known performance credentials, on 09/05/14 through 09/07/14 of all the residents' records which included; the Physician Orders, the Medication Administration Records (MAR) and Treatment Administration Records (TAR) and Telephone Physician Orders dating from 04/01/14 to 09/07/14 to identify problems associated with order transcription and/or communication with the Pharmacy.</p> <p>6 The facility conducted re-education and in-servicing on 09/04/14 with all licensed staff related to the discontinuation of medications. The education included; write the order for the</p>	F 281		

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F 281	Continued From page 21 discontinued medication, make the correction on the MAR, pull medication from medication cart, scan the barcode for return, place "discontinued" stickers on each of the discontinued medication cards, and place the medication in the tote to be returned to the Pharmacy or if the medication was a controlled substance secure for destruction. 7. The Regional Resource Team Nurse and the DON educated and in-serviced the licensed nurses and CMAs on 09/05/14 related to the facility's policy for the removal and disposal of narcotic patches by two (2) licensed nurses and that the CMAs should not dispose of the narcotic patches. 8. The facility reviewed and revised the medication administration schedule on the MAR for all residents; a revised administration time schedule was noted for daily routine medications and the special administration times (before breakfast, before meals, after meals, or with food) were noted and located on the MAR in a specific group for each type, the as needed (PRN) medications will be kept separated from the routine and special schedule medications. Nurses were monitored during medication administration on 09/07/14 and is ongoing; the DON, SDC, UM and CCC ensured the observations will continue to include; observations of appropriate technique, including securing medications when the cart is unattended, proper storage of supplies, administering medications as ordered and scheduled in the appropriate time frame, and is an ongoing Quality Control process. ** The State Survey Agency validated the	F 281	

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F 281	Continued From page 22			
	corrective action taken by the facility as follows:		F 281	

1. Review of facility's documentation revealed each resident's August MAR was reviewed for accuracy, reflecting the resident's current orders 07/31/14, with all blood pressure parameters listed on the MARs.

2. Review of the in-service form, dated 07/30/14, revealed administrative staff was in-serviced on the rights of medication, receiving new orders/transcription, end of the month MAR review, medication administration, and medication errors. Review of the in-service form, dated 07/31/14, revealed the administrative team was educated on root cause analysis.

Review of the in-service form dated 07/31/14, revealed licensed nurses and CMAs were in-serviced on the "rights" of medication administration, unavailable medications, borrowing medication, medication errors/assessment of the resident, blood pressures obtained prior to administration of anti-hypertensive medications, what to do if the blood pressure was outside the written parameters, and care plans.

Interviews with RN #1, LPN #2, LPN #3, and LPN #4, on 08/06/14 at 3:40 PM, 5:05 PM, 4:55 PM, and 5:30 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, receiving new orders/transcription of new orders, end of the month MAR review, obtaining blood pressures before administering anti-hypertensive medications, identification of medication errors and assessment of the resident afterwards, and care plans.

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F 281 Continued From page 23 F 281

Interviews with CMA #10, CMA #4, and CMA #3 on 08/06/14 at 4:25 PM, 5:15 PM, and 5:45 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, not borrowing medication for a resident, obtaining blood pressures before administering anti-hypertensive medications, and care plans.

3. Verified with the SDC all medication observations and in-servicing of staff was completed with the exception of 2-3 weekend staff who would receive their training/testing prior to starting their shift.

4. Review on 09/12/14 of Resident #5's September MAR and Physician's Orders revealed the Lisinopril order was discontinued. Review of a Nursing Assessments revealed the resident was assessed each shift for twenty-four hours then daily for two days.

5. Observation of the medication room, on 09/12/14 at 8:15 AM, revealed a medication box designated for medications to be sent back to the pharmacy containing a medication card with a "Discontinued" sticker attached below the resident's identifying information, a roll of stickers imprinted "Discontinued", and a copy of the Staff Development Attendance Record dated 09/04/14 for education on writing medication orders, affixing the sticker to discontinued medications, removal of discontinued medications from the medication carts, and the designated location to place the medications for return to the pharmacy. Review of facility audit reports, dated 09/05-07/14, revealed audits were conducted to ensure the MARs only contained current physician orders and discontinued medications

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F 281 Continued From page 24
were removed from the cart.

F 281

6. Observation of a medication pass conducted on 09/12/14 beginning at 8:25 AM, on halls one-hundred (100), two-hundred (200) and three-hundred (300) respectively revealed no medication errors. Review of the in-service records, dated 09/04/14 and signed by all licensed staff and CMAs, education was provided related to discontinuation of medications. Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM, revealed they were in-serviced related to the actions to take when a medication was discontinued.

7. Review of inservice records dated 09/05/14, revealed the Regional Quality Control Specialist (RQMS) and the DON provided all licensed staff and CMAs education on "Destroying Narcotics including Fentanyl Patches". Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM revealed the CMAs no longer removed or disposed of the pain patches only the licensed nurses do that now, that they were provided education related to the policy of two (2) licensed nurses witnessing the removal and disposal of the pain patches. Review of the MARs of Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10 revealed two (2) licensed nurses initials as witnesses to the removal and disposal of the pain patches.

Interview with the DON and Administrator, on 09/12/14 at 9:00 AM revealed both were provided education by the Regional Resource Team Nurse on 09/05/14 and they in turn provided re-education and testing for all licensed nurses

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F 281	Continued From page 25 and CMA's starting on 09/06/14 related to the confirmation that two (2) licensed nurses removed patches and signed as witnesses of disposal. 8. Observation of a medication pass on all three halls, on 09/12/14 at 7:12 AM, which included the administration of oral, inhaled, topical eye drops, and insulin injection which no medication errors identified.	F 281			
F 282 SS=K	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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with the resident's written plan of care for two (2) of five (5) sampled residents (Resident #2 and Resident #3). The facility failed to administer anti-hypertensive medications as ordered and evaluate the resident's blood pressure, per the care plan for Resident #2 and Resident #3. Resident #2's Care Plan for Hypertension revealed staff should administer anti-hypertensive medications as ordered and evaluate the resident's blood pressure per the physician's orders and as needed. On 03/16/14, an order was received for Lisinopril 40 mg (milligrams)	F 282	<u>F282: 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN:</u> It is the practice of Princeton Health and Rehab Center, Inc. to provide or arrange services by qualified persons in accordance with each resident's written plan of care. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 2 & Resident #3 were assessed by a R.N. on July 30, 2014. Physicians were notified with no new orders or medication changes. Resident #2 & Resident #3's clinical records were audited by the Director of Nursing (DON) and Care Plans were reviewed with no changes on 7/30/14. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> The facility identified 100 % of the residents receiving anti-hypertensive medication. Those residents' care plans and MARs were reviewed by the DON, UM, CCC, SDC, and/or MDS on July 31, 2014. Hypertension care plans were placed in front of each resident's MAR as of 7/31/14 and medication related care plans for other medications were placed in the Medication Care Plan Book on the medication carts on 8/05/14. On 7/31/14 SDC in-serviced CMTs and Licensed Nurses on any resident receiving an anti-hypertensive, their care plan will be in front of the each MAR and to ensure interventions listed on the care plan are being followed.		

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F 282 Continued From page 26
daily for Hypertension, and on 03/21/14, Licensed Practical Nurse (LPN) #2 received and transcribed an order for Resident #2 for Lisinopril 20 mg twice daily; however, Lisinopril 40 mg daily was not discontinued. On the March and April 2014 MAR, Lisinopril 40 mg daily had been changed to Lisinopril 20 mg twice daily, and blood pressures were to be obtained when administered.

Upon verification of the May 2014 MARs, Resident #2's Lisinopril 20 mg twice daily was transcribed onto Resident #3's May 2014 MAR, resulting in Resident #2 receiving Lisinopril 40 mg daily from 05/01/14 through 05/17/14 instead of Lisinopril 20 mg twice a day as ordered by the physician. Review of Resident #2's MAR revealed thirteen (13) doses of Lisinopril were administered without obtaining the resident's blood pressure. On 05/17/14, LPN #1 identified the medication error; however, she failed to clarify the order. This resulted in the resident receiving Lisinopril 80 mg from 05/18/14 through 05/30/14.

Resident #3's Care Plan for Hypertension revealed staff should administer anti-hypertensive medications as ordered and evaluate the blood pressure per the physician's orders and as needed. Review of the Physician's Orders, dated May 2014, revealed for staff to check and record a blood pressure every shift and to administer Cozaar 25 mg tablet every morning and Norvasc 10 mg tablet once daily for Hypertension. However, there was no order for Lisinopril. The facility determined Resident #2's order for Lisinopril 20 mg twice a day was transcribed to Resident #3's May 2014 MAR. It was determined Resident #3 received thirty-three (33) doses of anti-hypertensive medication not ordered for

F 282

F 282 cont'd:

Measures Implemented or Systems Altered to Prevent Re-occurrence:

On July 31, 2014, SDC re-educated Licensed Nurses regarding: accurate transcription of telephone orders to the MAR, read back order to prescribing physician, verify documents belonging to the correct resident when transcribing order onto the MAR/TAR, and to clearly discontinue existing orders that are stopped or modified by a new order.

Telephone orders from the previous day are reviewed by the CCC to verify accuracy. On weekends, the night shift nurse will review new orders to verify that they have been accurately transcribed as of August 1, 2014.

Each resident receiving anti-hypertensive medication has a copy of his/her hypertension care plan in front of his/her MAR as of July 31, 2014. These were placed by the MDS Nurses who are also responsible to replace / revise / add care plans as changes occur.

Education was provided by the SDC to all CMT's and Licensed Nurses on the hypertensive care plan placed in front of the MAR on 7/31/14, blood pressures are to be taken before an anti-hypertensive medication is given, and if blood pressure is outside the parameters, hold the medication (unless higher) and notify the nurse, and then the physician when assessment is completed.

Medication related care plans other than hypertension are located in a medication care plan book on the medication carts.

On August 5, 2014, the DON/ CCC's admission checklist was revised to include: check blood pressure on MAR, blood pressure parameter on

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him/her from 05/01/14 to 05/17/14 with staff stating they borrowed the medication from other residents. In addition the resident received twelve (12) doses of medication without his/her blood pressure being obtained.

The facility's failure to ensure services were provided in accordance with the resident's care plan has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/30/14, and was determined to exist on 05/01/14. The facility was notified of the Immediate Jeopardy on 07/30/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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.

However, the survey was reopened and it was determined the IJ was removed on 09/09/14.

The findings include:

Review of the facility's "Comprehensive Care Plans" policy/procedure, last revised 04/03/13, revealed a care plan would be developed based on assessed needs. Care plan approaches would be communicated to staff for use in providing direction for care.

Review of the facility's "General Dose Preparation and Medication Administration" policy/procedure, last revised 01/01/13, revealed prior to administration of medication, facility staff should

F 282: F 282 cont'd:

MAR, and green hypertension care plan in MAR. The medication related care plans will be updated with any change by the MDS coordinator or nurse.

On August 5, 2014, the Orientation Program has been revised specifically for newly hired Medication Techs and Licensed Nurses to include awareness of the location of the hypertension on the MAR and medication related care plans on cart, for quick reference.

Monitoring Measures to Maintain On-going Compliance:

The Licensed Nurse conducting the third check of the MAR to MAR on change over night will ensure the hypertension care plans are placed in front of each residents' MAR each month.

The DON/CCC will continue to conduct the revised admission checklist on each new admission. DON/CCC will check new admission charts to ensure care plans pertaining to medications have been placed in the medication care plan book located on the medication cart. DON/CCC will check all new admissions having a hypertension diagnosis to ensure a hypertension care plan has been placed in front of the resident's MAR. Audits will be reported in the Quality Assessment Committee meeting for twelve months. The results of the findings will be reported in the Quality Assurance Committee for twelve months. The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director, MDS Coordinator, Plant Management, Medical Records, Social Services Director, Dietary Manager, Unit Managers and Clinical Care Coordinator.

SDC will conduct medication administration observations on all Medication Techs and

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obtain vital signs, if necessary.

1. Record review revealed the facility admitted Resident #2 on 07/02/13 with diagnoses which included Hypertension and Congestive Heart Failure (CHF).

Review of the Interdisciplinary Care Plan for Hypertension, dated 01/16/14, revealed to administer anti-hypertensive medications as ordered and evaluate blood pressure per the physician's orders and, as needed.

Review of the Physician's Orders, dated 03/16/14, revealed an order for Lisinopril 40 mg daily for Hypertension. Further review revealed a Physician's Order, dated 03/21/14, for Lisinopril 20 mg twice daily for Hypertension.

Review of the MAR, dated March 2014, revealed the order for Lisinopril 40 mg daily was marked on the MAR as "changed", with the last dose initiated as administered on 03/21/14 at 8:00 AM. Lisinopril 20 mg twice daily was transcribed onto the MAR with the first dose initiated as administered on 03/21/14 at 8:00 PM. Review of the MAR, dated April 2014, revealed an order for Lisinopril 20 mg twice daily with Lisinopril 40 mg daily indicated as "changed" on the MAR. However, review of the MAR, dated May 2014, revealed the Lisinopril 40 mg once daily was initiated as administered from 05/01/14 through 05/31/14 with Lisinopril 20 mg twice daily initiated as administered starting on 05/18/14 through 05/30/14. After the medication was initiated on 05/18/14, thirteen (13) doses were documented in (May 2014) as administered without obtaining the resident's blood pressure.

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Licensed Nurses monthly for three months and then quarterly for nine months. Results of the post testing and the medication observation will be reported in the Quality Assurance Committee meeting for the next twelve months.

Blood pressure and vital sign audit results ensuring blood pressures and vital signs are being taken before anti-hypertensive medication or medication that is indicated are given will be conducted seven times a week for four weeks, three times a week for four weeks, one time a week for four weeks, every other week for four weeks, then monthly for 3 months. The results of the audit will be reported during the Quality Assurance Committee meeting.

Any concerns identified in the monitoring/auditing process will be immediately addressed based on the issue noted and the corrective action commensurate with the issue will be implemented as recommended by the Quality Assurance Committee.

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NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
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F 282	<p>Continued From page 29</p> <p>Phone interview with LPN #2, on 07/28/14 at 3:10 PM; and, on 07/29/14 at 10:40 AM, revealed she received the telephone order from Physician #1 for Lisinopril 20 mg twice daily on 03/21/14. She stated if the previous order was replaced, it should have been discontinued on the telephone order.</p> <p>Interview with Physician #1, on 07/28/14 at 3:45 PM and on 07/29/14 at 10:15 AM, revealed if he gave an order for Lisinopril 20 mg twice daily, he would not have intended for the resident to remain on Lisinopril 40 mg daily. Physician #1 stated there was a potential to lower the resident's blood pressure too much, causing fatigue, dizziness, lightheadedness when standing, weakness, and an increased risk for falling.</p> <p>Interview with LPN #1, on 07/28/14 at 3:30 PM, revealed she identified the medication error involving Resident #2, on 05/17/14. She stated the resident's Lisinopril 20 mg twice daily order was transcribed onto the wrong MAR (Resident #3's May 2014 MAR). After the error was found, Lisinopril 20 mg twice daily was transcribed onto Resident #2's MAR; however, there had been no discontinue order for the Lisinopril 40 mg daily. She "assumed" the resident was supposed to have both orders (Lisinopril 40 mg and Lisinopril 20 mg twice daily).</p> <p>2. Record review revealed the facility admitted Resident #3 on 11/28/05 with diagnoses which included Hypertension.</p> <p>Review of the Interdisciplinary Care Plan for Hypertension, dated 02/18/14, revealed to administer anti-hypertensive medications as</p>	F 282	

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ordered and evaluate the blood pressure per the physician's orders and, as needed.

Review of the MAR, dated May 2014, revealed an entry for Lisinopril 20 mg twice daily. The Lisinopril was initiated as being administered thirty-three (33) times from 05/01/14 through 05/17/14 with twelve (12) doses administered to Resident #3 without obtaining the resident's blood pressure. Review of the Physician's Orders, dated (May 2014), revealed to check and record a blood pressure every shift. Orders also included Cozaar 25 mg tablet every morning for Hypertension and Norvasc 10 mg tablet once daily; however, there was no order for Lisinopril.

Phone interview with Certified Medication Aide (CMA) #6, on 07/29/14 at 3:00 PM, revealed she was supposed to obtain and document a resident's blood pressure before administering anti-hypertensive medication. However, when she was busy, she did not always document the blood pressures. She stated the care plans were not utilized, as she administered medications per the MAR.

Interview with CMA #9, on 07/30/14 at 10:00 AM, revealed she was trained to obtain a resident's blood pressure prior to administering anti-hypertensive medications. However, the blood pressure reading did not have to be documented if it was "normal." She stated she was not aware of a specific care plan to monitor blood pressures or medications.

Interview with the Director of Nursing (DON), on 07/30/14 at 10:30 AM, revealed the CMAs, who were responsible for administering medications, were not expected to utilize the resident's care

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plan, they administered medications per the MAR. She stated licensed staff updated the care plans with new physician's orders; however, the name of the anti-hypertension medications were not indicated on the care plan. She stated staff was expected to obtain and document a resident's blood pressure on the MAR prior to administration of an anti-hypertensive medication.

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

1. Resident #3's blood pressure was monitored three (3) times on 05/17/14, two (2) times on 05/18/14 and then daily for the next five (5) days. The Nurse Practitioner assessed the resident on 06/18/14 and an RN assessed the resident on 07/30/14 with no indications of any adverse effect.

On 07/31/14, care plan interventions, relating to medication administration, were placed with each specific resident's MAR.

2. Education was provided, on 07/30/14 to the Administrator, DON, CCC, SDC, Unit Managers, and MDS Nurses by the Regional Resource Team Nurse regarding the need to ensure staff administering medications were aware of care plan interventions for hypertension.

On 07/31/14, education was provided that the interventions for residents receiving anti-hypertension medications would be located in the MAR and were to be followed.

3. Training would be provided to all staff currently working and would continue with oncoming staff,

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F 282	<p>Continued From page 32</p> <p>prior to beginning duty, until completed by the SDC.</p> <p>** The State Survey Agency validated the corrective action taken by the facility as follows:</p> <ol style="list-style-type: none"> 1. Review of each hall's MAR book revealed Hypertension care plans on all resident's receiving anti-hypertensive medications. They were with each specific resident's MAR, on "green" paper for easy detection. Medication related care plans, other than Hypertension, were located in a book on the medication cart. 2. Review of the in-service form, dated 07/31/14, revealed licensed nurses and CMAs were in-serviced on following the care plans. <p>Interviews with RN #1, LPN #2, LPN #3, and LPN #4, on 08/06/14 at 3:40 PM, 5:05 PM, 4:55 PM, and 5:30 PM, respectively, revealed they were in-serviced related to care plans.</p> <p>Interviews with CMA #10, CMA #4, and CMA #3, on 08/06/14 at 4:25 PM, 5:15 PM, and 5:45 PM, respectively, revealed they were in-serviced related to care plans. There were Hypertension care plans in front of each resident's specific MAR, if they had the diagnosis. They were on "green" paper, making it easily accessible. Other medical care plans for residents were in a book on the medicine cart, for reference.</p> <ol style="list-style-type: none"> 3. Verified with the SDC all medication observations and in-servicing of staff was completed with the exception of 2-3 weekend staff who would receive their training/testing prior to starting their shift. 	F 282		

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F 309	Continued From page 33 F 309 483.25 PROVIDE CARE/SERVICES FOR SS=K 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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of five (5) sampled residents (Resident #2 and Resident #3). The facility failed to ensure appropriate monitoring of a resident's blood pressure before administration of anti-hypertensive medications and failed to conduct an assessment of Residents #2 and #3's for twenty-four hours after the identification of a significant medication error, per the facility policy. Licensed Practical Nurse (LPN) #1 identified a significant medication error for both residents on 05/17/14. Resident #2 did not receive an anti-hypertensive medication as ordered from 05/01/14 through 05/30/14; and thirteen (13) of the doses were administered without obtaining a blood pressure. Resident #3 received thirty-three (33) doses of the wrong anti-hypertensive medication from 05/01/14 through 05/17/14.	F 309 F 309	<u>F309: 483.25 PROVIDECARE/SERVICES FOR HIGHEST WELL BEING:</u> It is the practice of Princeton Health and Rehab Center, Inc. for each resident to 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. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 2 & Resident #3 were assessed by a R.N. on July 30, 2014, including blood pressure. Physicians were notified with no new orders or medication changes for either resident. Resident #2 & Resident #3's clinical records were audited by the Director of Nursing (DON) and their individual care plans reviewed with no changes. <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u> Audited all Medication Administration Records to verify that residents who have medications for which vital signs should be obtained, have parameters listed and that appropriate vital signs are being obtained. This audit was conducted by DON, Clinical Care Coordinator, Unit Managers on 7/31/14 for August orders and MARs. The Director of Nursing audited records of residents having had Medication Errors for the past 30 days to assure that assessments of condition have been completed and have had followup assessments with focus on potential for adverse conditions that may be associated with the medication involved in the error. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>

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F 309	<p>Continued From page 34</p> <p>Twelve (12) of the doses were administered to Resident #3 without obtaining the resident's blood pressure. In addition, there was no evidence of an assessment for either resident following the medication error with follow-up assessment for a minimum of twenty-four (24) hours, per the facility's policy. Refer to F333, F514, F281</p> <p>The facility's failure to ensure appropriate monitoring of a resident's blood pressure while on anti-hypertensive medications and failure to conduct on-going assessments of the residents' for twenty-four (24) hours after a significant medication error was identified has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/30/14, and was determined to exist on 05/01/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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>However, after supervisory review, the survey was reopened and it was determined the IJ was removed on 09/09/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Error" policy/procedure, last revised 05/19/14, revealed the licensed staff member would conduct an assessment of the resident where appropriate and document follow-up assessments in the Nurse's Notes for a minimum of twenty-four (24)</p>	F 309	<p><u>F 309 Cont'd:</u></p> <p>SDC in-serviced Certified Medication Techs and Licensed Nurses on 7/31/14 that blood pressures are to be taken before an anti-hypertensive medication is given. If the blood pressure is outside of the physician's specified parameter, the CMT will notify the Nurse. The Nurse is to give the medication if the blood pressure is higher than the parameter, assess the resident and notify the MD with the blood pressure and assessment results for further orders.</p> <p>The Medication Error Policy from 5/19/14 was revised on 7/31/14 to define the assessment as being associated with the medication involved. On 7/31/14 the SDC educated Nurses that in the event a medication error is identified, an assessment of the resident will be conducted in regard to the medication involved & documented in the resident's Nurses Notes for a minimum of every shift for 24 hours. A root cause analysis will be conducted to identify causative/contributing factors of the error and corrective measures implemented. The Director of Nursing or Clinical Care Coordinator in her absence is responsible to assure that the Med Error & RCA process is completed.</p> <p>Nurses were also educated by the Staff Development Coordinator, that they were to notify the on call administrative person of the medication error. The administrative person will contact the facility to confirm that assessment of resident condition related to the medication and that appropriate corrective measures were initiated. This education was initiated on 8/11/14 and continued with oncoming nurses until all were trained.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>The record of a resident experiencing a medication error will be reviewed to validate that the root cause of the error is identified and</p>

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F 309	<p>Continued From page 35</p> <p>hours.</p> <p>Review of the facility's "General Dose Preparation and Medication Administration" policy/procedure, last revised 01/01/13, revealed prior to administration of medication, facility staff should obtain vital signs if necessary.</p> <p>1. Record review revealed the facility admitted Resident #2 on 07/02/13 with diagnoses which included Hypertension and Congestive Heart Failure (CHF). Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/18/14, revealed the facility assessed the resident as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15).</p> <p>Review of a Physician's Order, dated 03/21/14, revealed an order for Lisinopril 20 mg (milligrams) twice daily for Hypertension. However, review of the May 2014 MAR, revealed the Lisinopril 20 mg twice daily was not administered from 05/01/14 through 05/17/14; however, the resident received 80 mg of Lisinopril from 05/18/14 through 05/30/14. Further review revealed when the medication was added on 05/17/14 after the medication error was identified, thirteen (13) doses were documented as being administered without obtaining the resident's blood pressure.</p> <p>Review of the Nurse's Notes for Resident #2, dated 05/17/14 at 5:00 PM, revealed a blood pressure reading of 166/78 mm/hg when the medication error was identified; and, review of the Nurse's Notes, dated 05/18/14 at 9:00 AM, revealed a blood pressure reading of 136/78 mm/hg sixteen hours after the medication error was identified; however, there was no documented evidence of further assessments for</p>	F 309	<p><u>F 309 Cont'd:</u></p> <p>that an assessment of the condition impacted by the involved medication was conducted. The record will be reviewed in the next Abbreviated Quality Assurance meeting conducted on routine business days, by the Administrator, Director of Nursing or Clinical Care Coordinator. On weekends the administrative staff member on call will validate that the assessment was completed. This monitoring will continue for three months. If no concerns identified, Med Errors may be reviewed by the DON or Clinical Care Coordinator and reported to the QAA committee monthly for review.</p> <p>The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director, MDS Coordinator, Plant Management, Medical Records, Social Services Director, Admissions Coordinator, Dietary Manager, Staff Development Coordinator, Unit Managers and Clinical Care Coordinator.</p> <p>The DON/CCC will review 100% of the medication errors for the month, the documentation of assessments, root cause analysis' and review of measures implemented. The CCC will bring the report results through the Quality Assurance Committee monthly for twelve months.</p> <p>Blood pressure audits to be conducted to ensure that blood pressures are being taken before anti-hypertensive medications are given. The MARs will be audited to verify vital signs that are indicated prior to medication administration have been recorded. The audit will be conducted seven times a week for four weeks, three times a week for four weeks, one time a week for four weeks, every other week for four weeks, then monthly for 3 months by the Unit Nurse/ Unit Manager. The results of the audit will be reported during the Quality Assurance Committee meeting.</p>
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F 309	Continued From page 36 twenty-four hours after the medication error per the facility's policy. 2. Record review revealed the facility admitted Resident #3 on 11/28/05 with diagnoses which included Hypertension. Review of the Quarterly MDS, dated 07/17/14, revealed the facility identified the resident as cognitively intact with a BIMS score of fifteen (15). Review of the May 2014 MAR revealed an entry for Lisinopril 20 mg twice daily; however, review of the Physician's Orders, dated May 2014, revealed there was no order for Lisinopril. The orders revealed to check the resident's blood pressure every shift. Review of the MAR revealed the Lisinopril was initiated as being administered thirty-three (33) times from 05/01/14 through 05/17/14 (when the medication error was identified). Further review of the MAR revealed twelve (12) doses of the medication were administered without obtaining the resident's blood pressure. Review of Resident #3's Nurse's Notes dated 05/17/14 at 5:00 PM, revealed a blood pressure reading of 135/76 mm/hg at the time the medication error was identified; and on 05/19/14 at 8:00 AM, the resident's B/P was 118/72 mm/hg fifteen (15) hours after the medication was identified. However, there was no documented evidence of further assessments conducted for twenty-four hours (24) after the medication error was identified per the facility's policy. Phone interview with Certified Medication Aide (CMA) #7, on 07/29/14 at 3:10 PM, revealed she was a previous employee of the facility, her last day working at the facility was on 05/12/14. She	F 309	

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F 309	<p>Continued From page 37</p> <p>stated she had administered medication to Resident #3 during May 2014. CMA #7 stated she "probably borrowed" the Lisinopril from another resident and did not report it to the nurse. She stated staff was supposed to report missing medication to the nurse, who would then notify the pharmacy.</p> <p>Interview with the Director of Nursing (DON), on 07/29/14 at 3:40 PM, revealed a medication error report was initiated on 05/17/14 at approximately 9:00 AM, involving Residents #2 and #3. She stated the Lisinopril 20 mg twice daily ordered for Resident #2 had been transcribed on the MAR for Resident #3, it was a "human error."</p> <p>Interview with LPN #1, on 07/29/14 at 2:35 PM, revealed she identified the medication error on 05/17/14. She stated it was the first time she had identified an error and was not sure what the facility's policy specified as far as assessment of the resident. Review of the "Medication Error" policy revealed the licensed staff member was to conduct an assessment of the resident and document any follow-up assessments in the Nurse's Notes for a minimum of twenty-four (24) hours. She stated her assessment of each resident included a blood pressure reading; however, it was not documented. Further interview with the DON revealed no increased monitoring of either resident was initiated after the medication error.</p> <p>Interview with Physician #2, on 07/29/14 at 2:15 PM, revealed he was the primary physician for Resident #3. Further interview revealed he had been made aware Resident #3 received Lisinopril 20 mg twice daily without an order. He stated there was a potential for the resident to have a</p>	F 309		

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"lower" blood pressure than usual, syncope, and an increased risk of falls. He expected facility staff to monitor the resident's blood pressure 2-3 times daily for 5-7 days after the error was identified.

Phone interview with Certified Medication Aide (CMA) #6, on 07/29/14 at 3:00 PM, revealed she was supposed to obtain and document a resident's blood pressure before administering anti-hypertensive medication; however, she was busy in the evening and "did not always document".

Phone interview with CMA #8, on 07/30/14 at 11:45 AM, revealed she did not document "normal" blood pressure readings on the MAR.

Interview with CMA #9, on 07/30/14 at 10:00 AM, revealed she was trained to obtain a resident's blood pressure prior to administering anti-hypertensive medications; however, the reading did not have to be documented if "normal." She stated some of the resident's blood pressure parameters were indicated on the MAR.

Further interview with the DON, on 07/29/14 at 3:40 PM and on 07/30/14 at 10:30 AM, revealed she expected staff to obtain a blood pressure reading for each resident following the medication error. She stated staff obtained a blood pressure reading on the next 12-hour shift which covered the twenty-four (24) period per the facility's policy and procedure. She stated she felt that was an adequate assessment of each resident as the error involved anti-hypertensive medications. She revealed staff was expected to obtain and document a resident's blood pressure on the MAR prior to administration of an

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F 309	<p>Continued From page 39</p> <p>anti-hypertensive medication, however, there was no system in place to ensure compliance.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>1. On 07/31/14, the August MARs were audited to verify that residents who have medications for which vital signs should be obtained, have parameters listed and that the appropriate vital signs were being obtained. The August MARs were revised to clearly connect vital signs with medication administration.</p> <p>2. Education was provided, on 07/30/14 to the Administrator, DON, CCC, SDC, Unit Managers, and MDS Nurses by the Regional Resource Team Nurse regarding proper administration techniques utilizing the "rights" of medication administration to prevent errors, need for obtaining blood pressure prior to administration of anti-hypertensive medication, need for assessment following identification of a medication error, need for accurate and consistent documentation of blood pressure reading prior to administration of anti-hypertensive medication.</p> <p>Licensed nurses and CMAs were educated on 07/30/14 by the SDC regarding obtaining a blood pressure before an anti-hypertensive medication was administered. If the blood pressure was outside the established parameters on the MAR, the CMA would notify the nurse, who would notify the physician.</p> <p>On 07/31/14, education was provided by the SDC to licensed staff and CMAs regarding accurate medication administration and obtaining vital</p>	F 309	

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signs as indicated by medication and as directed on the MAR. Nurses were educated on 07/31/14 by the SDC that a resident was to have a complete assessment each shift for a minimum of twenty-four hours after identification of a medication error. The assessment would be documented in the clinical record.

3. Training would be provided to all staff currently working and would continue with oncoming staff, prior to beginning duty, until completed by the SDC.

4. The MARs would be audited to verify vital signs that were indicated prior to medication administration have been recorded. The audits would be completed daily for four weeks, then three times per week for four weeks, then one week for four weeks, then every other week for four weeks, then monthly for three months.

When a medication error was identified, the record would be reviewed to validate that the root cause of the error was identified and an assessment of the condition impacted by the involved error was conducted. The monitoring would continue for three months. If no concerns, medication errors would be reviewed by the DON or CCC and reported to the QAA monthly.

The Regional Director of Operations would review the quality assurance records of medication errors monthly for three months.

** The State Survey Agency validated the corrective action taken by the facility as follows:

1. Review of facility documentation revealed each resident's August MAR was reviewed for

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F 309	<p>Continued From page 41</p> <p>accuracy, reflecting the resident's current orders 07/31/14, with all blood pressure parameters listed on the MARs.</p> <p>2. Review of the in-service form, dated 07/30/14, revealed administrative staff was in-serviced on the rights of medication, anti-hypertensive medications, and medication errors/resident assessment. Review of the in-service form, dated 07/31/14, revealed the administrative team was educated on root cause analysis</p> <p>Review of the in-service form dated 07/31/14, revealed licensed nurses and CMAs were in-serviced on the "rights" of medication administration, medication errors/assessment of the resident, blood pressures obtained prior to administration of anti-hypertensive medications, and what to do if the blood pressure was outside the written parameters.</p> <p>Interviews with RN #1, LPN #2, LPN #3, and LPN #4, on 08/06/14 at 3:40 PM, 5:05 PM, 4:55 PM, and 5:30 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, obtaining blood pressures before administering anti-hypertensive medications, identification of medication errors and assessment of the resident afterwards.</p> <p>Interviews with CMA #10, CMA #4, and CMA #3 on 08/06/14 at 4:25 PM, 5:15 PM, and 5:45 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, obtaining blood pressures before administering anti-hypertensive medications, and documenting them on the MAR.</p> <p>3. Verified with the SDC all medication</p>	F 309		

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F 309	Continued From page 42 observations and in-servicing of staff was completed with the exception of 2-3 weekend staff who would receive their training/testing prior to starting their shift. 4. Interview with the DON, on 08/06/14 at 7:27 PM, revealed daily audits were being conducted to ensure vital signs were obtained and documented correctly. She stated the audits would be conducted daily times four (4) weeks, then three (3) a week times four (4) weeks, then one (1) time a week times four (4) weeks, then every other week times four (4) weeks, then monthly times three (3). She revealed when a medication error was identified staff would conduct a root cause analysis. The DON stated they had audit tool to use to ensure all aspects were covered (MD notification, assessment of resident, immediate corrective action, systemic problems, etc) She revealed it would be taken through the next QA meeting and talked about as a group.	F 309	
F 333 SS=K	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure three (3) of twenty-one (21) sampled residents (Resident #2, Resident #3 and Resident #5) were free of significant	F 333	<u>F 333: 483.25(m)(2)RESIDENTS FREE OF SIGNIFICANT MED ERRORS:</u> It is the practice of Princeton Health and Rehab Center, Inc. to ensure that residents are free of any significant medication errors. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident # 2 & Resident #3 were assessed by a R.N. on July 30, 2014. Physicians were notified with no new orders or medication changes for either resident. Resident #2 & Resident #3 's clinical records were audited by the Director of Nursing (DON) including each resident's plan of care. The physician for Resident # 5

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medication errors. The facility failed to have an effective system in place to ensure medications were transcribed correctly on the Medication Administration Record (MAR) for Resident #2 and Resident #3 and failed to ensure a medication was discontinued on the MAR for Resident #5.

On 03/21/14, Licensed Practical Nurse (LPN) #2 received an order for Lisinopril 20 mg twice a day for Resident #2, and transcribed the order on the March MAR leaving a previous order for Lisinopril (anti-hypertensive) 40 milligrams (mg) daily on the MAR. When the May 2014 MARs were verified for accuracy, Resident #2's Lisinopril 20 mg twice daily was transcribed onto Resident #3's MAR. This resulted in Resident #2 receiving Lisinopril 40 mg daily from 05/01/14 through 05/17/14, and Resident #3 incorrectly received thirty-three (33) doses of Lisinopril 20 mg from 05/01/14 to 05/17/14, resulting in a significant medication error. LPN #1 identified the significant medication error on 05/17/14; however, she failed to clarify the order for Resident #2's Lisinopril with the physician which resulted in Resident #2 receiving 80 mg of Lisinopril from 05/18/14 through 05/30/14. Additionally, the facility failed to conduct an investigation to determine how the Lisinopril was obtained for Resident #3 when he did not have an order. Refer to F281, F309, F514

On 05/02/14, the facility received orders to discontinue Resident #5's Lisinopril 10 mg every day order; however, the facility failed to ensure the medication was discontinued on the June, July, August and September 2014 MAR during the monthly checks. This resulted in Resident #5 receiving ninety-five doses of Lisinopril between 06/01/14-09/03/14 which resulted in a significant medication error. Refer to F281.

F 333 F 333 cont'd:

was notified of the error. He/She was assessed by the nurse, with her findings noted on the clinical record. The assessment was repeated by the unit nurse on each shift for the next 24 hours then daily for the next two days. No adverse effects were identified. During the time he/she received the Lisinopril from June 1 through Sept 3, his /her blood pressure was taken daily, with the exception of one omission on 7/27/14. All blood pressure readings remained within the physician's established parameters for administration.

How Other Residents Were Identified Who May Have Been Impacted by the Practice:

100 % of all residents' Medication Administration Records (MAR) were audited by DON, Staff Development Coordinator (SDC), Clinical Care Coordinator (CCC), MDS coordinator & MDS nurse, and Unit Managers (UM) on July 29, 2014 to ensure accurate reflection of current Physicians' Orders for the July and August MARs. A second 100% audit was conducted on August 4, 2014 by the DON and the Regional Quality Management Nurse (RQMN) for the August MARs. One medication error was identified with a telephone order and corrected.

From 9/5/14 through 9/8/14 the facility re-audited the orders, MARs and TARs from April 2014 to the date of review, for current residents, reviewing for accurate transcription of medication orders on the POS and MARs. For additional validation, the audit was completed primarily utilizing the services of qualified outside RN's and LPN's with known performance credentials. The errors identified in this audit originated in April & May before new processes were implemented.

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The facility's failure to ensure that residents were free from significant medication errors has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/30/14, and was determined to exist on 05/01/14. The facility was notified of the Immediate Jeopardy on 07/30/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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.

Even though 100% resident MAR to physician orders audits were conducted on 07/29/14 and 08/04/14 to ensure accurate reflection of the current physician's orders; another example (Resident #5) was found. Therefore, it was determined the Immediate Jeopardy was not removed on 08/06/14, as alleged. The facility conducted additional audits and training related to ensuring the residents' MARs were an accurate reflection of the current physician's orders. After validation of the facility's actions, the State Survey Agency determined the Immediate Jeopardy was removed on 09/09/14.

The findings include:

Review of the facility's "General Dose Preparation and Medication Administration" policy, last revised 01/01/13, revealed facility staff should verify each time a medication was administered that it was the correct medication, at the correct dose, at the

F 333 F 333 cont'd:

Measures Implemented or Systems Altered to Prevent Re-occurrence:

The Medication Error policy was revised to include an assessment of the resident's condition, focusing on potential adverse effects from the involved medications. The assessment is to be completed upon identification of the error and again of each shift for at least the next 24 hours. Nurses were educated in this process on 7/31/14 by the SDC. Additionally the administrative team, including the DON, CCC, SDC, Unit Managers, along with other members of the Quality Assurance and Assessment Committee, were educated on conducting a Root Cause Analysis (RCA) by Risk Management on July 30, 2014. They were trained to apply this process to Medication Errors to determine underlying cause of errors so that corrective measures may be developed and implemented to avoid recurrence.

On July 31, 2014 the SDC re-educated CMTs and Licensed Nurses on: when administering medications always follow your five rights, if a medication is unavailable, it cannot be borrowed from another resident, check the EDK and if the medication is not available in the EDK, have the nurse call the pharmacy for the medication to be sent from back up, and always report to your supervisor when a medication is not available to be given.

On July 31, 2014, SDC re-educated Licensed Nurses regarding: accurate transcription of telephone orders to the MAR, read back order to prescribing physician, verify documents belonging to the correct resident when transcribing order onto the MAR/TAR, and to clearly discontinue existing orders that are stopped or modified by a new order. Monitoring for ongoing accuracy in order transcription will be accomplished through telephone orders from the previous day are being

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correct route, at the correct rate, at the correct time, for the correct resident. Confirm that the MAR reflected the most recent medication order.

Review of the facility's "Protocol for Checking MARs for the New Month", dated 07/30/14, revealed to check the new Physician's Orders and update with any telephone orders since the last physician's orders were checked. Check the new physician's orders against the new MARs, check the new MARs against the current month's MARs, and check new physician's orders against the previous month's physician's orders.

1. Record review revealed the facility admitted Resident #2 on 07/02/13 with diagnoses which included Hypertension and Congestive Heart Failure (CHF).

Review of a Physician's Order, dated 03/21/14, revealed an order for Lisinopril 20 mg twice daily for Hypertension. Review of the MAR, dated March 2014, revealed the order for Lisinopril 40 mg daily was marked on the MAR as "changed", with the last dose initialed as administered on 03/21/14 at 8:00 AM. Lisinopril 20 mg twice daily was transcribed on the MAR with the first dose initialed as administered on 03/21/14 at 8:00 PM. Review of the MAR, dated April 2014, revealed an order for Lisinopril 20 mg twice daily with Lisinopril 40 mg daily indicated as "changed" on the MAR. Review of the MAR, dated (May 2014), revealed the Lisinopril 40 mg once daily was not marked as changed but was initialed as administered from 05/01/14 through 05/31/14 and Lisinopril 20 mg twice daily initialed as administered from 05/18/14 through 05/30/14.

Phone interview with LPN #2, on 07/28/14 at 3:10

F 333 F 333 cont'd:

reviewed by the Clinical Care Coordinator(CCC) to verify accuracy of transcription. On weekends, the night shift nurse will review new orders to verify that they have been accurately transcribed. The CCC and night/weekend nurses were educated in this process on by the Director of Nursing on 7/31/14.

The end of month procedure for reviewing MARs was modified to designate one specific nurse to be removed from additional duties other than MAR change over at the end of the month. The nurse was designated as the Order Validation Nurse (OVN). The OVN was trained by the SDC on 7/31/14 on the process which included comparing the previous month's orders and subsequent telephone orders to ensure new orders contained all changes that occurred since the previous month began. The new orders would be utilized to verify that the MARs accurately reflected those orders. On the last day of the month, prior to utilization, the night nurse will compare the new MAR which had been checked against the new orders to the MAR currently being utilized.

A new process for validating that medication orders received were transmitted to pharmacy was modified to include attaching fax transmission results to the orders transmitted to the pharmacy. This process was implemented on 8/05/14. Licensed nurses were educated on the process on 8/04/14 by SDC.

The process for managing and implementing discontinued medication orders was modified on 9/4/14 to include the following actions by the nurse: Write the telephone order for the discontinued medication, Note the discontinuation on the current MAR., Remove the discontinued medication cards from the medication cart, Fax the physician's telephone order to the pharmacy and staple the

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F 333	<p>Continued From page 46</p> <p>PM and on 07/29/14 at 10:40 AM, revealed she received the order from Physician #1 for Lisinopril 20 mg twice daily on 03/21/14. She stated Resident #2 had been having an increase of blood pressure in the evening or the morning (she could not remember which one). Physician #1 ordered the divided dose of Lisinopril as it would evenly distribute the medication throughout the day, as best she could remember. She stated if the previous order was replaced, it should have been discontinued.</p> <p>Interview with Physician #1, on 07/28/14 at 3:45 PM, and on 07/29/14 at 10:15 AM, revealed if he gave an order for Lisinopril 20 mg twice daily, he would not have intended for the resident to remain on Lisinopril 40 mg daily. He verified the maximum dose of Lisinopril for an elderly resident was forty (40) mg daily. Physician #1 stated if a resident received eighty (80) mg daily, there was a potential to lower the resident's blood pressure too much, causing fatigue, dizziness, lightheadedness when standing, weakness, and an increased risk for falling.</p> <p>Interview with LPN #1, on 07/28/14 at 3:30 PM, revealed she identified the medication error involving Resident #2, on 05/17/14. She stated the resident's Lisinopril 20 mg twice daily order was transcribed onto the wrong MAR. After the error was found, Lisinopril 20 mg twice daily was transcribed to Resident #2's MAR; however, there had been no discontinue order for the Lisinopril 40 mg daily. LPN #1 stated she "assumed" the resident was supposed to have both orders, Lisinopril 40 mg and Lisinopril 20 mg twice daily.</p> <p>2. Review of the "Medication Error" policy, revised 05/19/11, revealed the Director of Nursing</p>	F 333	<p><u>F 333 cont'd:</u></p> <p>confirmation to the order, Scan the bar code on the medication card for return to pharmacy, Place a "discontinue" sticker on all discontinued medication cards, Place the discontinued medication cards in the pharmacy tote for "return to pharmacy" or or if a controlled substance secure for destruction. Licensed nurses were provided education regarding this new process beginning on 9/4/14 and continuing with nurses prior to starting their next shift.</p> <p>Orientation program for newly hired Medication Techs and Licensed Nurses has been revised by the DON to reflect the changes with post testing to confirm understanding on August 5, 2014.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>For ongoing monitoring of avoidance of significant medication errors, the record will be reviewed to validate that the root cause of the error is identified and an assessment of the condition impacted by the involved medication will be conducted. The record will be reviewed in the next Abbreviated Quality Assurance meeting conducted on routine business days, by the Administrator, Director of Nursing or Clinical Care Coordinator. On weekends the administrative staff member on call will validate that the assessment was completed. This monitoring will continue for three months. If no concerns identified, Med Errors may be reviewed by the DON or Clinical Care Coordinator and reported to the QAA committee monthly for review. The DON or CCC will report errors in the monthly QAA Committee for analysis and review of measures implemented to address root causes identified.</p> <p>The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director,</p>

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(DON) would follow-up on all medication errors that have occurred.

Review of the facility's "Medication Shortages/ Unavailable Medications" policy/procedure, revised 01/13/13, revealed if upon delivery the facility had an inadequate supply of medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy.

Record review revealed Resident #3 was admitted to the facility on 11/28/05, with diagnoses which included Hypertension. Review of the MAR, dated May 2014, revealed an entry for Lisinopril 20 mg twice daily. The Lisinopril was initiated indicating it had been administered thirty-three (33) times from 05/01/14 through 05/17/14. Review of the Physician's Orders, dated May 2014, revealed an order for Cozaar 25 mg tablet every morning for Hypertension and Norvasc 10 mg tablet once daily; however, there was no order for Lisinopril. Further record review revealed there was no documented evidence the facility conducted a thorough investigation to identify how Resident #3 received thirty-three (33) doses of a medication without an order, and pharmacy did not deliver the medications.

Phone interview with Certified Medication Aide (CMA) #7, on 07/29/14 at 3:10 PM, revealed she was a previous employee of the facility, her last day working at the facility was on 05/12/14. She stated she had administered medication to Resident #3 during May 2014. CMA #7 stated she "probably borrowed" the Lisinopril from another resident and did not report it to the nurse. She stated staff was supposed to report missing medication to the nurse, who would then notify

F 333 F 333 cont'd:

MDS Coordinator, Plant Management, Medical Records, Social Services Director, Admissions Coordinator, Dietary Manager, Staff Development Coordinator, Staff Development Coordinator, Unit Managers and Clinical Care Coordinator.

To monitor for accuracy of end of month transcription, POS/ MAR/TARs that have been reviewed for accuracy by the Order Validation Nurses will also have a MAR to MAR check completed on the last night of the month, to check for any discrepancies between the two which might suggest an error or omission of a new order. A designated nurse who has been educated in the end of month review process will conduct this review each month. An additional review of 100% of POS/MARs/ TARs will be completed by the DON, CCC, UM, MDS, or SDC prior to use. The review will be completed monthly for the first three months. If the results reported by the CCC in the Quality Assurance Committee meeting demonstrate no errors in physician orders, MARs / TARs, the second audit will be reduced to 50% of resident population for the next three months. If no further problems are identified, the Quality Assurance Committee will determine the sample size for further audits.

Monitoring to assure that all telephone orders for medication are being transmitted will be accomplished by review through validation by the CCC on weekdays and by weekend night nurse on weekends, that the transmission document accompanied the telephone orders. The CCC will also validate that the weekend nurse reviewed the weekend transmissions. The findings of the CCC's review will be reported in Abbreviated Quality Assurance meeting held on routine workdays.

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the pharmacy.

Observation of the Facility's Emergency Drug Kit (EDK), on 09/02/14 at 3:00 PM revealed Lisinopril 5 mg. times four (4) tablets was kept in the EDK. Review of the EDK Logs revealed the Lisinopril tablets were not used during the timeframe Resident #2 and #3 were receiving the Lisinopril.

Interview with the Pharmacist in Charge, on 09/05/14 at 2:00 PM, revealed when monthly pharmacy reviews conducted they compare MARs to MARs. He stated they did not compare physician's order to MARs. He stated they did not catch the Lisinopril error between the April and May 2014 MAR. He revealed the Pharmacy did not do a medication cart count until 08/04/14 and found no discrepancies at that time. He stated Resident #2's Lisinopril 40 mg tablets were delivered but the pharmacy had never received the order for the Lisinopril 20 mg tablets.

Phone interview with Physician #2, on 07/29/14 at 2:15 PM, revealed he was made aware Resident #3 received Lisinopril 20 mg twice daily without an order. Physician #2 stated there was a potential for the resident to have a "lower" blood pressure than usual, syncope, and an increased risk of falls.

Interview with the Director of Nursing (DON), on 07/29/14 at 10:55 AM, 12:00 PM, 2:30 PM and, on 07/30/14 at 10:30 AM, revealed she was not aware Resident #2 had two (2) different Lisinopril orders until 07/28/14. She stated it was expected for licensed staff to discontinue the previous order if an order change was received. The DON stated staff should have received clarification for the two

F 333 F 333 cont'd:

The MARs will be audited by the Unit Nurse, Unit Manager or alternate QAA Committee representative in their absence, to verify vital signs that are indicated prior to medication administration have been recorded. The audits will be conducted seven times a week for four weeks, three times a week for four weeks, one time a week for four weeks, every other week for four weeks, then monthly for 3 months. The results of the audits will be reported during the Quality Assurance Committee meeting. Based on findings, QAA committee may alter frequency of audits.

The SDC will continue to conduct medication administration observations and post tests on all CMTs and Licensed Nurses monthly for the first three months and quarterly for nine months. Results will be reported through the Quality Assurance Committee meeting by the SDC.

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F 333	<p>Continued From page 49</p> <p>(2) Lisinopril orders, as common practice. The process for verifying accuracy of a resident's MAR each month included comparison from the resident's current physician's orders with the resident's new MAR. She verified the MARs were reviewed by one licensed staff, but not double checked. The DON verified LPN #2 was most likely the nurse reviewing the (May 2014) MAR for Resident #3. She stated the investigation of the medication error concluded that the order for Lisinopril 20 mg twice daily was written on the wrong resident's MAR; she stated it was "human error". The DON stated both residents' physicians were notified. The DON's follow-up to the error included review of both resident's blood pressures later in the shift, which were normal. She stated there was no in-servicing conducted directly related to the medication error. She further stated the CMAs were not questioned about the Lisinopril for Resident #3 until 07/30/14, at which time the CMAs verified they "borrowed" the medication from one (1) resident for another resident. She revealed staff was expected to check for the medication in the Emergency Drug Kit (EDK) and have the nurse call the pharmacy for timely delivery.</p> <p>Further interview with the Administrator, on 07/30/14 at 2:00 PM, revealed the medication error involving Resident #2 and Resident #3 was discussed in the Quality Assurance meeting, where it was determined LPN #2 had written an order on the wrong MAR. She stated it was discussed to have licensed staff "double check" the MAR for the right resident's name when reviewing at the end of the month. She stated there was no need for follow-up after the meeting on 05/20/14, as there was no change in either resident's condition. She revealed it was not</p>	F 333	

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F 333	<p>Continued From page 50</p> <p>discussed how Resident #3 received the Lisinopril, as "borrowing" medication had not happened in years.</p> <p>3. Record review revealed the facility admitted Resident #5 on 02/05/13 with diagnoses which included Hypertension and Cerebral Artery Occlusion with Infarct.</p> <p>Review of a Physician's Order, dated 05/02/14 at 5:35 PM, revealed an order to discontinue Lisinopril. Review of the May 2014 MAR revealed a Lisinopril 10 mg every day order, dated 02/05/13, which was discontinued on 05/02/14. However, review of the June, July, August, and September 2014 MARs revealed the 02/05/13 Lisinopril order remained on the MARS and the resident received Lisinopril 10 mg for ninety-five (95) doses between 06/01/14 and 09/03/14 which resulted in a significant medication error.</p> <p>Interview, on 09/02/14 at 1:55 PM with the Medical Director/Resident #5's Primary Care Provider, revealed she discontinued the Lisinopril 10 mg daily on 05/02/14 probably due to the resident's blood pressure being low and renal insufficiency. She stated she would have expected the resident's blood pressure to remain low if the medication continued and due to the resident's renal insufficiency she would not have restarted the medication as that could cause further renal compromise.</p> <p>Interview with the DON, on 09/02/14 at 11:15 AM, revealed she was aware the month end change-over of 08/31/14 and the MAR to medication cart audit conducted as part of the AoC did not reveal any discrepancies.</p>	F 333	
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F 333	<p>Continued From page 51</p> <p>Interview with the Clinical Care Coordinator (CCC), on 09/12/14 at 8:25 AM, revealed an audit was conducted on all resident MARs on 07/29/14 and a second audit was conducted on 08/04/14 as part of the facility's AoC to ensure accurate reflection of the physician's orders; however, staff failed to identify that Resident #5's Lisinopril 10 mg daily order remained on the MARs after the medication was discontinued. She stated Resident #5 received Lisinopril 10 mg daily from 06/01/14 through 09/03/14 in error.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. On 07/31/14, the August MARs were audited to verify that residents who have medications for which vital signs should be obtained, have parameters listed and that the appropriate vital signs were being obtained. The August MARs were revised to clearly connect vital signs with medication administration. 2. Education was provided, on 07/30/14 to the Administrator, DON, CCC, SDC, Unit Managers, and MDS Nurses by the Regional Resource Team Nurse regarding proper administration techniques utilizing the "rights" of medication administration to prevent errors, need for obtaining blood pressure prior to administration of anti-hypertensive medication, need for assessment following identification of a medication error, need for accurate and consistent documentation of blood pressure reading prior to administration of anti-hypertensive medication. <p>Licensed nurses and CMAs were educated on 07/30/14 by the SDC regarding obtaining a blood</p>	F 333	

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F 333	<p>Continued From page 52</p> <p>pressure before an anti-hypertensive medication was administered. If the blood pressure was outside the established parameters on the MAR, the CMA would notify the nurse, who would notify the physician.</p> <p>On 07/31/14, education was provided by the SDC to licensed staff and CMAs regarding accurate medication administration and obtaining vital signs as indicated by medication and as directed on the MAR. Nurses were educated on 07/31/14 by the SDC that a resident was to have a complete assessment each shift for a minimum of twenty-four hours after identification of a medication error. The assessment would be documented in the clinical record.</p> <p>3. Training would be provided to all staff currently working and would continue with oncoming staff, prior to beginning duty, until completed by the SDC.</p> <p>4. The MARs would be audited to verify vital signs that were indicated prior to medication administration have been recorded. The audits would be completed daily for four weeks, then three times per week for four weeks, then one week for four weeks, then every other week for four weeks, then monthly for three months.</p> <p>When a medication error was identified, the record would be reviewed to validate that the root cause of the error was identified and an assessment of the condition impacted by the involved error was conducted. The monitoring would continue for three months. If no concerns, medication errors would be reviewed by the DON or CCC and reported to the QAA monthly.</p>	F 333	

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F 333	<p>Continued From page 53</p> <p>The Regional Director of Operations would review the quality assurance records of medication errors monthly for three months.</p> <p>After the State Survey Agency identified the facility failed to remove the Jeopardy on 08/06/14, the facility implemented the following actions:</p> <p>5. Resident #5's physician was notified and an order was obtained to discontinue the medication. The resident was assessed by the nurse, with her findings noted in the clinical record. The assessment was repeated each shift for the next twenty-four (24) hours then daily for the next two (2) days. No adverse effects were identified. All the resident's blood pressure obtained during the time the resident was receiving the medication were within the physician's parameters for administration.</p> <p>6. The facility revised the process for the handling of medication discontinue orders to include the placement of a "Discontinue" sticker on the medication cards containing the remainder of the medication and remove that medication from the medication cart at that time. The facility conducted an additional one-hundred percent (100%) resident record review audit on 09/05/14 through 09/07/14; which included Physician Telephone Orders and MAR/TAR from 04/01/14 through 09/07/14 which revealed no errors related to transcription, communication with the pharmacy or removal of discontinued medications and no further medication order to MAR discrepancies. A re-audit was conducted by the Director of Nursing (DON), Clinical Care Coordinator (CCC), Staff Development Coordinator (SDC), Unit Managers (UM), Regional Quality Control Specialist (RQMS), and</p>	F 333	

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F 333	Continued From page 54 Minimum Data Set (MDS) Coordinator, utilizing the services of outside Registered Nurses (RNs) with known performance credentials, on 09/05/14 through 09/07/14 of all the residents' records which included; the Physician Orders, the Medication Administration Records (MAR) and Treatment Administration Records (TAR) and Telephone Physician Orders dating from 04/01/14 to 09/07/14 to identify problems associated with order transcription and/or communication with the Pharmacy. 7. The facility conducted re-education and in-servicing on 09/04/14 with all licensed staff related to the discontinuation of medications. The education included; write the order for the discontinued medication, make the correction on the MAR, pull medication from medication cart, scan the barcode for return, place "discontinued" stickers on each of the discontinued medication cards, and place the medication in the tote to be returned to the Pharmacy or if the medication was a controlled substance secure for destruction. 8. The Regional Resource Team Nurse and the DON educated and in-serviced the licensed nurses and CMAs on 09/05/14 related to the facility's policy for the removal and disposal of narcotic patches by two (2) licensed nurses and that the CMAs should not dispose of the narcotic patches. 9. The facility reviewed and revised the medication administration schedule on the MAR for all residents; a revised administration time schedule was noted for daily routine medications and the special administration times (before breakfast, before meals, after meals, or with food) were noted and located on the MAR in a	F 333	

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F 333	<p>Continued From page 55</p> <p>specific group for each type, the as needed (PRN) medications will be kept separated from the routine and special schedule medications. Nurses were monitored during medication administration on 09/07/14 and is ongoing; the DON, SDC, UM and CCC ensured the observations will continue to include; observations of appropriate technique, including securing medications when the cart is unattended, proper storage of supplies, administering medications as ordered and scheduled in the appropriate time frame, and is an ongoing Quality Control process.</p> <p>** The State Survey Agency validated the corrective action taken by the facility as follows:</p> <ol style="list-style-type: none"> 1. Review of facility documentation revealed each resident's August MAR was reviewed for accuracy, reflecting the resident's current orders 07/31/14, with all blood pressure parameters listed on the MARs 2. Review of the in-service form, dated 07/30/14, revealed administrative staff was in-serviced on the rights of medication, anti-hypertensive medications, and medication errors/resident assessment. Review of the in-service form, dated 07/31/14, revealed the administrative team was educated on root cause analysis. <p>Review of the in-service form dated 07/31/14, revealed licensed nurses and CMAs were in-serviced on the "rights" of medication administration, medication errors/assessment of the resident, blood pressures obtained prior to administration of anti-hypertensive medications,</p>	F 333	
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F 333	<p>Continued From page 56</p> <p>and what to do if the blood pressure was outside the written parameters.</p> <p>Interviews with RN #1, LPN #2, LPN #3, and LPN #4, on 08/06/14 at 3:40 PM, 5:05 PM, 4:55 PM, and 5:30 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, obtaining blood pressures before administering anti-hypertensive medications, identification of medication errors and assessment of the resident afterwards.</p> <p>Interviews with CMA #10, CMA #4, and CMA #3 on 08/06/14 at 4:25 PM, 5:15 PM, and 5:45 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, obtaining blood pressures before administering anti-hypertensive medications, and documenting them on the MAR.</p> <p>3. Verified with the SDC all medication observations and in-servicing of staff was completed with the exception of 2-3 weekend staff who would receive their training/testing prior to starting their shift.</p> <p>4. Interview with the DON, on 08/06/14 at 7:27 PM, revealed daily audits were being conducted to ensure vital signs were obtained and documented correctly. She stated the audits would be conducted daily times four (4) weeks, then three (3) a week times four (4) weeks, then one (1) time a week times four (4) weeks, then every other week times four (4) weeks, then monthly times three (3). She revealed when a medication error was identified staff would conduct a root cause analysis. The DON stated they had audit tool to use to ensure all aspects were covered (MD notification, assessment of</p>	F 333	

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resident, immediate corrective action, systemic problems, etc.) She revealed it would be taken through the next QA meeting and talked about as a group

5. Review on 09/12/14 of Resident #5's September MAR and Physician's Orders revealed the Lisinopril order was discontinued. Review of a Nursing Assessments revealed the resident was assessed each shift for twenty-four hours then daily for two days.

6. Observation of the medication room, on 09/12/14 at 8:15 AM, revealed a medication box designated for medications to be sent back to the pharmacy containing a medication card with a "Discontinued" sticker attached below the resident's identifying information, a roll of stickers imprinted "Discontinued", and a copy of the Staff Development Attendance Record dated 09/04/14 for education on writing medication orders, affixing the sticker to discontinued medications, removal of discontinued medications from the medication carts, and the designated location to place the medications for return to the pharmacy. Review of facility audit reports, dated 09/05-07/14, revealed audits were conducted to ensure the MARs only contained current physician orders and discontinued medications were removed from the cart.

7. Observation of a medication pass conducted on 09/12/14 beginning at 8:25 AM, on halls one-hundred (100), two-hundred (200) and three-hundred (300) respectively revealed no medication errors. Review of the in-service records, dated 09/04/14 and signed by all licensed staff and CMAs, education was provided related to discontinuation of medications.

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Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM, revealed they were in-serviced related to the actions to take when a medication was discontinued.

8. Review of inservice records dated 09/05/14, revealed the RQMS and the DON provided all licensed staff and CMAs education on "Destroying Narcotics including Fentanyl Patches". Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM revealed the CMAs no longer removed or disposed of the pain patches only the licensed nurses do that now, that they were provided education related to the policy of two (2) licensed nurses witnessing the removal and disposal of the pain patches. Review of the MARs of Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10 revealed two (2) licensed nurses initials as witnesses to the removal and disposal of the pain patches.

Interview with the DON and Administrator, on 09/12/14 at 9:00 AM revealed both were provided education by the Regional Resource Team Nurse on 09/05/14 and they in turn provided re-education and testing for all licensed nurses and CMA's starting on 09/06/14 related to the confirmation that two (2) licensed nurses removed patches and signed as witnesses of disposal

9. Observation of a medication pass on all three halls, on 09/12/14 at 7:12 AM, which included the administration of oral, inhaled, topical eye drops, and insulin injection which no medication errors identified.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2014
NAME OF PROVIDER OR SUPPLIER PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
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F 490 483.75 EFFECTIVE
SS=K ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on interview and review of the facility's Administrator's Job Description, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to investigate to determine how medication was obtained to administer without a physician's order related to a significant medication error involving three (3) of five (5) sampled residents (Resident #2, Resident #3 and Resident #5).

On 05/17/14, the facility identified an order for Lisinopril (anti-hypertension) 20 mg (milligrams) twice daily was transcribed on the wrong resident's MAR. The facility determined that during the May 2014 review of the Medication Administration Records (MARs) for accuracy, Resident #2's order for Lisinopril 20 mg twice daily was transcribed onto the MAR for Resident #3. The order was discontinued; however, the facility failed to investigate and determine how the staff obtained the medication for administration. Resident #3 received thirty-three (33) doses of Lisinopril 20 mg, in error, without a physician's

F 490 **F 490 483.75 EFFECTIVE
ADMINISTRATION/RESIDENT WELL-BEING:**

It is the practice of Princeton Health and Rehab Center, Inc. to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Corrective Measures for Resident Identified in the deficiency:

Under the leadership of the Administrator, Resident # 2 & Resident #3 were assessed by a R.N. on July 30, 2014. Physicians were notified with no new orders or medication changes for either resident. Resident #2 & Resident #3's clinical records were audited by the Director of Nursing (DON) and their individual care plans were reviewed. The physician for Resident # 5 was notified of the error. He/She was assessed by the nurse, with her findings noted on the clinical record. The assessment was repeated by the unit nurse on each shift for the next 24 hours then daily for the next two days. No adverse effects were identified. During the time he/she received the Lisinopril from June 1 through Sept 3, his /her blood pressure was taken daily, with the exception of one omission on 7/27/14. All blood pressure readings remained within the physician's established parameters for administration.

How Other Residents Were Identified Who May Have Been Impacted by the Practice:

The Administrator directed that 100 % of all residents' Medication Administration Records (MAR) be audited. They were audited by DON, Staff Development Coordinator (SDC), Clinical Care Coordinator (CCC), MDS coordinator & MDS nurse, and Unit Managers (UM) on July 29, 2014 to ensure accurate reflection of current Physicians' Orders for the July and August MARs. A second 100% audit

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F 490	<p>Continued From page 60 order from 05/01/14 to 05/17/14. (Refer to F333).</p> <p>On 05/02/14, the facility received a Physician's Order to discontinue Resident #5's Lisinopril 10 mg every day order. The medication was discontinued on the May 2014 MAR, however, the facility failed to ensure the medication was discontinued on the June, July, August and September 2014 MAR. Resident #5 received ninety-five (95) doses of Lisinopril 10 mg, in error, without a physician's order from 06/01/14 through 09/03/14.</p> <p>The facility's failure to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/30/14, and was determined to exist on 05/01/14.</p> <p>The facility was notified of the Immediate Jeopardy on 07/30/14. An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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. The facility conducted 100% resident MAR to physician orders audits on 07/29/14 and 08/04/14 to ensure accurate reflection of the current physician's orders per the facility's AoC; however, the facility failed to identify that Resident #5 was receiving hypertension medication that had been</p>	F 490	<p><u>F 490- cont'd:</u></p> <p>was conducted on August 4, 2014 by the DON and the Regional Quality Management Nurse (RQMN) for the August MARs. One medication error was identified with a telephone order and corrected. Based on the identification of an additional medication error, the Administrator directed that an additional in depth audit be completed. Between 9/5/14 and 9/8/14 all orders, MARs and TARs from April 2014 to the date of review, for current residents, were reviewed for accurate transcription of medication orders onto the POS and MARs. For additional validation, the audit was completed primarily utilizing the services of qualified outside RN's and LPN's w known performance credentials. The errors identified in this audit originated in April & May before new processes were implemented.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>On 7/31/14 the Regional Director of Operations educated the Administrator on utilizing the Abbreviated Quality Assurance processes, a review of the previous day's events, with focus on unusual events or deviation from normal. The process included audits of documents and departmental reports of activities and findings that may prompt the need for additional review, identify any weaknesses in processes as they relate to medication or other facility operations. Upon identification of a medication error or other failure, she will utilize available resources to conduct a root cause analysis/investigation and implement interventions to correct identified cause and avoid re-occurrence.</p> <p>The Regional Quality Management Nurse provided education to the Administrator on 7/30/14 regarding:</p>

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F 490 Continued From page 61
discontinued in May 2014. Therefore, it was determined the Immediate Jeopardy was not removed on 08/06/14, as alleged. The facility conducted additional audits and training related to ensuring the residents' MARs were an accurate reflection of the current physician's orders. After validation of the facility's actions, the State Survey Agency determined the Immediate Jeopardy was removed on 09/09/14.

The findings include:

Review of the Facility Administrator's Job Description, undated, revealed the job summary included the oversight of patient/resident care, managing overall operation, employee management, fiscal management, and ensuring compliance with State and Federal regulations. Job responsibilities included to review, monitor, and follow-up on incident reports, adverse incidents, resident grievances, and deficiencies cited by the agency. Develop plans of action to correct and respond to identified quality and risk issues.

1. Interview and record review revealed during the May 2014 MAR review staff transcribed Resident #2's Lisinopril 20 mg order onto Resident #3's MAR. Resident #3 received thirty-three (33) doses of Lisinopril 20 mg without a physician's order from 05/01/14 to 05/17/14; however, the facility failed to investigate and determine how the staff obtained the medication for administration.

2. Interview and record review revealed the facility received an order to discontinue Resident #5's Lisinopril 10 mg every day order on 05/02/14. The facility failed to ensure the order was

F 490 F 490 cont'd:
proper medication administration techniques; accuracy of transcribing medications; correct process for month end transcriptions & validation of physician orders & MARs; obtaining blood pressure prior to administration of anti hypertensive medication, accurate & consistent documentation of blood pressure reading prior to administration of anti-hypertensive medication, administration of medication, transcription of orders & assessment findings; and to ensure that staff administering medications are aware of care plan interventions for hypertension.

On 7/30/14 the Regional Risk Manager in serviced the Quality Assurance Committee members on Root Cause Analysis. The members of the committee included the Administrator, the DON, the LSW, the Admissions Coordinator, the Activities Director, the Medical Records Director, the Plant Manager, the CDM, SDC and Administrative Nurses (JM, MDS). The Administrator will utilize and lead her department leaders to utilize this process both formally and informally to identify root cause of areas in need of improvement or change.

Utilizing the Root Cause Analysis findings, the administrator led the facility in development and implementation of a revised process for managing orders for discontinued medications. A new process for validating that medication orders received were transmitted to pharmacy was modified to include attaching fax transmission results to the orders transmitted to the pharmacy. This process was implemented on 9/4/14. Licensed nurses were educated on the process on 9/4/14 by the SDC.

The process for managing and implementing discontinued medication orders was modified on 9/4/14 to include the following actions by the nurse: Write the telephone order for the discontinued medication, Note the

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discontinued on the June, July, August and September MARs which resulted in Resident #5 receiving ninety-five (95) doses between 06/01/14 through 09/03/14. The facility conducted audits on 07/29/14 and 08/04/14 to ensure accurate reflection of the current physician's orders as part of the facility's AoC but failed to identify the significant medication error.

Interview with the Administrator, on 07/30/14 at 2:00 PM, revealed the medication error involving Resident #2 and Resident #3 was discussed in the Quality Assurance meeting, on 05/20/14, where it was determined LPN #2 had written an order on the wrong MAR. She revealed it was discussed to have licensed staff "double check" the MAR for the right resident name when reviewing at the end of the month. She revealed there was no need for follow-up after the meeting on 05/20/14, as there was no change in either resident's condition. She stated it was not discussed how Resident #3 received the Lisinopril, as "borrowing" medication had not happened in years.

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

1. On 07/31/14, the Regional Director of Operations educated the Administrator on utilizing the Abbreviated Quality Assurance processes, a review of the previous day's events, with focus on unusual events or deviation from normal. The process included audits of documents and departmental reports of activities and findings that may prompt the need for additional review, identify any weaknesses in processes as they relate to medication or other facility operations and systems.

F 490: F 490 cont'd:

discontinuation on the current MAR., Remove the discontinued medication cards from the medication cart, Fax the physician's telephone order to the pharmacy and staple the confirmation to the order, Scan the bar code on the medication card for return to pharmacy, Place a "discontinue" sticker on all discontinued medication cards, Place the discontinued medication cards in the pharmacy tote for "return to pharmacy" or if a controlled substance secure for destruction. Licensed nurses were provided education by the SDC, regarding this new process on 9/4/14 for nurses present and with oncoming shifts.

Monitoring Measures to Maintain On-going Compliance:

The Administrator will continue to review the audit results of medication errors and/or other facility operations that are unusual events or a deviation from normal through the AQA meetings and the Quality Assurance Committee meetings for twelve months. Review of Audit findings will be recorded on a monitoring checklist following the scheduled time frames for each monitoring task through next 12 months.

The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director, MDS Coordinator, Plant Management, Medical Records, Social Services Director, Admission Coordinator, Dietary Manager, Unit Managers, Staff Development Coordinator and Clinical Care Coordinator.

The Regional Director of Operations will review the quality assurance records for indications of system failure or of medication errors monthly for three months. Based on findings, frequency of reviews may be increased or decreased.

10/13/14

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F 490	Continued From page 63 2. The Administrator reviewed survey findings, identified medication error, findings of root cause analysis, and corrective measures to be implemented to remove immediate jeopardy and sustain compliance. A meeting with the Medical Director occurred 07/31/14. 3. The Regional Director of Operations would review the quality assurance records of medication errors monthly for three months. 4. Resident #5's physician was notified and an order was obtained to discontinue the medication. The resident was assessed by the nurse, with her findings noted in the clinical record. The assessment was repeated each shift for the next twenty-four (24) hours then daily for the next two (2) days. No adverse effects were identified. All the resident's blood pressure obtained during the time the resident was receiving the medication were within the physician's parameters for administration. 5. The facility revised the process for the handling of medication discontinue orders to include the placement of a "Discontinue" sticker on the medication cards containing the remainder of the medication and remove that medication from the medication cart at that time. The facility conducted an additional one-hundred percent (100%) resident record review audit on 09/05/14 through 09/07/14; which included Physician Telephone Orders and MAR/TAR from 04/01/14 through 09/07/14 which revealed no errors related to transcription, communication with the pharmacy or removal of discontinued medications and no further medication order to MAR discrepancies. A re-audit was conducted by the	F 490		

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F 490	<p>Continued From page 64</p> <p>Director of Nursing (DON), Clinical Care Coordinator (CCC), Staff Development Coordinator (SDC), Unit Managers (UM), Regional Quality Control Specialist (RQMS), and Minimum Data Set (MDS) Coordinator, utilizing the services of outside Registered Nurses (RNs) with known performance credentials, on 09/05/14 through 09/07/14 of all the residents' records which included; the Physician Orders, the Medication Administration Records (MAR) and Treatment Administration Records (TAR) and Telephone Physician Orders dating from 04/01/14 to 09/07/14 to identify problems associated with order transcription and/or communication with the Pharmacy.</p> <p>6. The facility conducted re-education and in-servicing on 09/04/14 with all licensed staff related to the discontinuation of medications. The education included; write the order for the discontinued medication, make the correction on the MAR, pull medication from medication cart, scan the barcode for return, place "discontinued" stickers on each of the discontinued medication cards, and place the medication in the tote to be returned to the Pharmacy or if the medication was a controlled substance secure for destruction.</p> <p>7. The Regional Resource Team Nurse and the DON educated and in-serviced the licensed nurses and CMAs on 09/05/14 related to the facility's policy for the removal and disposal of narcotic patches by two (2) licensed nurses and that the CMAs should not dispose of the narcotic patches</p> <p>8. The facility reviewed and revised the medication administration schedule on the MAR for all residents; a revised administration time</p>	F 490		

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schedule was noted for daily routine medications and the special administration times (before breakfast, before meals, after meals, or with food) were noted and located on the MAR in a specific group for each type, the as needed (PRN) medications will be kept separated from the routine and special schedule medications. Nurses were monitored during medication administration on 09/07/14 and is ongoing; the DON, SDC, UM and CCC ensured the observations will continue to include; observations of appropriate technique, including securing medications when the cart is unattended, proper storage of supplies, administering medications as ordered and scheduled in the appropriate time frame, and is an ongoing Quality Control process.

** The State Survey Agency validated the corrective action taken by the facility as follows:

1. Interview with the Administrator, on 08/06/14 at 7:45 PM, revealed she was in-serviced by the Risk Manager on the root cause analysis process of investigation, different quality issues, how to ensure the well-being of residents, training on medications, the "rights" of medications, monitoring through the QAA, and discussing medication errors in the daily QA meeting. Interview with the Regional Director of Operations, on 08/06/14 at 7:50 PM, revealed she in-serviced the Administrator about how to utilize internal systems on how to monitor system errors, problems that were identified- to use the root cause analysis, how to utilize the audits integrated into our QA process, red flags that might need follow up, putting systems in place and monitoring.

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Review of the QA Committee Minutes, dated 07/31/14 revealed the Medical Director was present for the QA committee meeting and the IJ was explained and the process to remove IJ was discussed.

2. Interview with the Administrator, on 08/06/14 at 7:45 PM, revealed the MAR/TARs were to be audited every month times three months until 100% compliance was achieved. Vital sign audits will be conducted by the DON and CCC daily for four (4) weeks, then less often per schedule. If any problems are identified it will be addressed in QA. He stated medication errors will be reviewed in daily QA meetings and they will look at what caused it, who was involved, then ask the "why" questions.

3. Interview with the Regional Director of Operations, on 08/06/14 at 7:50 PM, revealed she will monitor medication error reports for three (3) months and tools we use to gather information (to look for potential things that may have been missed).

4. Review on 09/12/14 of Resident #5's September MAR and Physician's Orders revealed the Lisinopril order was discontinued. Review of a Nursing Assessments revealed the resident was assessed each shift for twenty-four hours then daily for two days.

5. Observation of the medication room, on 09/12/14 at 8:15 AM, revealed a medication box designated for medications to be sent back to the pharmacy containing a medication card with a "Discontinued" sticker attached below the resident's identifying information, a roll of stickers

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F 490	<p>Continued From page 67</p> <p>imprinted "Discontinued", and a copy of the Staff Development Attendance Record dated 09/04/14 for education on writing medication orders, affixing the sticker to discontinued medications, removal of discontinued medications from the medication carts, and the designated location to place the medications for return to the pharmacy. Review of facility audit reports, dated 09/05-07/14, revealed audits were conducted to ensure the MARs only contained current physician orders and discontinued medications were removed from the cart.</p> <p>6. Observation of a medication pass conducted on 09/12/14 beginning at 8:25 AM, on halls one-hundred (100), two-hundred (200) and three-hundred (300) respectively revealed no medication errors. Review of the in-service records, dated 09/04/14 and signed by all licensed staff and CMAs, education was provided related to discontinuation of medications. Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM, revealed they were in-serviced related to the actions to take when a medication was discontinued.</p> <p>7. Review of inservice records dated 09/05/14, revealed the RQMS and the DON provided all licensed staff and CMAs education on "Destroying Narcotics including Fentanyl Patches". Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM revealed the CMAs no longer removed or disposed of the pain patches only the licensed nurses do that now, that they were provided education related to the policy of two (2) licensed nurses witnessing the removal and disposal of the pain patches.</p>	F 490		

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F 490	<p>Continued From page 68</p> <p>Review of the MARs of Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10 revealed two (2) licensed nurses initials as witnesses to the removal and disposal of the pain patches.</p> <p>Interview with the DON and Administrator, on 09/12/14 at 9:00 AM revealed both were provided education by the Regional Resource Team Nurse on 09/05/14 and they in turn provided re-education and testing for all licensed nurses and CMA's starting on 09/06/14 related to the confirmation that two (2) licensed nurses removed patches and signed as witnesses of disposal.</p> <p>8. Observation of a medication pass on all three halls, on 09/12/14 at 7:12 AM, which included the administration of oral, inhaled, topical eye drops, and insulin injection which no medication errors identified.</p>	F 490	
F 514 SS=K	<p>483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>	F 514	<p><u>F 514: 483.75(1)(1) RESIDENTS' RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</u></p> <p>It is the practice of Princeton Health and Rehab Center, Inc. to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p>

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F 514 Continued From page 69

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure clinical records were maintained on each resident in accordance with accepted professional standards and practices that were accurately documented for three (2) of five (5) sampled residents (Resident #2, Resident #3 and Resident #5). The facility failed to have an effective system in place to ensure medications were transcribed correctly onto the Medication Administration Records (MARs).

On 03/16/14, Resident #2 received an order for Lisinopril 40 mg (milligrams) daily for Hypertension. On 03/21/14, Licensed Practical Nurse (LPN) #2 transcribed a telephone order for Resident #2 for Lisinopril 20 mg twice daily, the order did not include to discontinue the Lisinopril 40 mg daily. However, LPN #2 indicated on the March 2014 MAR that the resident's Lisinopril 40 mg daily had been changed, with the initiation of the Lisinopril 20 mg twice daily. The same changes were made on the resident's April 2014 MAR. When the residents' MARs for May 2014 were verified for accuracy, Resident #2's Lisinopril 20 mg twice daily was transcribed onto the MAR for Resident #3 in error. Resident #3 received thirty-three (33) doses of Lisinopril 20 mg twice daily without a physician's order from 05/01/14 to 05/17/14. Resident #2 received Lisinopril 40 mg daily from 05/01/14 through 05/17/14, since LPN #1 had placed the 20 mg Lisinopril order on Resident #3's MAR. When LPN #1 identified the medication error on

F 514 F 514 cont'd:

The records for Resident # 2, Resident #3 were reviewed on July 30 & 31, 2014 and for Resident #5 on 9/3/14, by the Director of Nursing, to verify that current records accurately reflect orders.

How Other Residents Were Identified Who May Have Been Impacted by the Practice:

100 % of all residents' Medication Administration Records (MAR) were audited by DON, Staff Development Coordinator (SDC), Clinical Care Coordinator (CCC), MDS coordinator & MDS nurse, and Unit Managers (UM) on July 29, 2014 to ensure accurate reflection of current Physicians' Orders for the July and August MARs. A second 100% audit was conducted on August 4, 2014 by the DON and the Regional Quality Management Nurse (RQMN) for the August MARs. One medication error was identified and corrected. Between 9/5/14 and 9/8/14 all orders, MARs and TARs from April 2014 to the date of review, for current residents, were reviewed for accurate transcription of medication orders onto the POS and MARs. For additional validation, the audit was completed primarily utilizing the services of qualified outside RN's and LPN's with known performance credentials. The errors identified in this audit originated in April & May before new processes were implemented.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

On July 31, 2014 the SDC re-educated CMTs and Licensed Nurses on: when administering medications always follow your five rights, if a medication is unavailable, it cannot be borrowed from another resident, check the EDK and if the medication is not available in the EDK, have the nurse call the pharmacy for the medication to be sent from back up, and always report to your supervisor when a medication is not available to

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F 514	<p>Continued From page 70</p> <p>05/17/14 she failed to clarify the order for Resident #2's Lisinopril, leaving both of the orders (Lisinopril 40 mg daily and Lisinopril 20 mg twice daily) on the resident's MAR which resulted in the resident receiving 80 mg of Lisinopril from 05/18/14 through 05/30/14. (Refer to F281, F309, F333)</p> <p>On 05/02/14, Resident #5 received an order to discontinue his/her Lisinopril 10 mg. every day order. The facility discontinued the order on the May 2014 MAR; however, failed to discontinue the order on the June, July, August and September 2014 MARs. Resident #5 received ninety-five doses of the Lisinopril without a physician's order from 06/01/14 through 09/03/14. (Refer to F281, F333)</p> <p>The facility's failure to ensure that clinical records were maintained on each resident in accordance with accepted professional standards and practices that were accurately documented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/30/14, and was determined to exist on 05/01/14. The facility was notified of the Immediate Jeopardy on 07/30/14.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 08/06/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 08/06/14, as alleged. The Scope and Severity was lowered to a "E" 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. Even though 100% resident MAR to physician orders audits were conducted on 07/29/14 and 08/04/14 to ensure accurate</p>	F 514	<p><u>F 514 cont'd:</u></p> <p>be given.</p> <p>On July 31, 2014, SDC re-educated Licensed Nurses regarding: accurate transcription of telephone orders to the MAR, read back order to prescribing physician, verify documents belonging to the correct resident when transcribing order onto the MAR/TAR, and to clearly discontinue existing orders that are stopped or modified by a new order.</p> <p>Telephone orders from the previous day are reviewed by the CCC to verify accuracy. On weekends, the night shift nurse will review new orders to verify that they have been accurately transcribed on August 1, 2014.</p> <p>The end of month procedure for reviewing MARs was modified to designate one specific nurse to be removed from additional duties other than MAR change over at the end of the month. The nurse was designated as the Order Validation Nurse (OVN). The OVN was trained by the SDC on 7/31/14 on the process which included comparing the previous month's orders and subsequent telephone orders to ensure new orders contained all changes that occurred since the previous month began. The new orders would be utilized to verify that the MARs accurately reflected those orders. On the last day of the month, prior to utilization, the night nurse will compare the new MAR which had been checked against the new orders to the MAR currently being utilized.</p> <p>The OVN has been designated to complete 100% of month end change over MARs/TARs/POS checks. When the OVN has completed her checks, the DON, CCC, UM, MDS, or SDC will complete a second 100% check of the MARs/TARs/POS. Then a third MAR to MAR will be completed by a Licensed Nurse on change over night.</p>

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F 514	<p>Continued From page 71</p> <p>reflection of the current physician's orders as part of the facility's AoC; another example (Resident #5) was found. Therefore, it was determined the Immediate Jeopardy was not removed on 08/06/14, as alleged. The facility conducted additional audits and training related to ensuring the residents' MARs were an accurate reflection of the current physician's orders. After validation of the facility's actions, the State Survey Agency determined the Immediate Jeopardy was removed on 09/09/14.</p> <p>The findings include:</p> <p>Review of the facility's "Documentation Standards" policy/procedure, last revised 01/02/14, revealed prior to documenting, always check the identifying information to verify and authenticate it as the correct medical record for charting.</p> <p>Review of the facility's "Physician's Orders" policy/procedure, last revised 06/28/11, revealed physician's orders would be transcribed, noted, and implemented in a timely manner.</p> <p>1. Record review revealed the facility admitted Resident #2 on 07/02/13 with diagnoses which included Hypertension and Congestive Heart Failure (CHF).</p> <p>Review of the Physician's Orders, dated 03/16/14, revealed an order for Lisinopril 40 mg daily for Hypertension. Further review revealed a Physician's Order, dated 03/21/14, for Lisinopril 20 mg twice daily for Hypertension. Review of the MAR, dated March 2014, revealed the order for Lisinopril 40 mg daily was marked on the MAR as "changed", with the last dose initialed as</p>	F 514	<p><u>F 514 cont'd:</u></p> <p>The process for reviewing new orders was revised to include the CCC validating accurate transcription of new orders on the correct MAR on weekdays. The night shift nurse validates the accurate transcription on weekends and holidays. The DON reassigns responsibility or completes the reviews in the absence of the CCC. The process included implementation of a task list to utilize when reviewing orders to guide the reviewer through the process on August 1, 2014.</p> <p>Orientation program for newly hired Medication Techs and Licensed Nurses has been revised to reflect the changes with post testing to confirm understanding on August 5, 2014.</p> <p>The Order Validation Nurse (OVN) was trained by the SDC on 7/31/14. The OVN was re educated a second time by the DON on 8/15/14. The OVN has been designated to complete 100% of month end change over MARs/TARs/POS checks. When the Order Validation Nurse has completed her checks, the DON, CCC, UM, MDS, or SDC will complete a second 100% check of the MARs/TARs/POS. Then a third MAR to MAR will be completed by a Licensed Nurse on change over night.</p> <p>A new process for validating that medication orders received were transmitted to pharmacy was modified to include attaching fax transmission results to the orders transmitted to the pharmacy. This process was implemented on 8/05/14. Licensed nurses were educated on the process on 8/04/14 by SDC.</p> <p>The process for managing and implementing discontinued medication orders was modified on 9/4/14 to include the following actions by the nurse: Write the telephone order for the discontinued medication, Note the discontinuation on the current MAR., Remove the discontinued medication cards from the medication cart, Fax the physician's telephone</p>

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F 514	<p>Continued From page 72</p> <p>administered on 03/21/14 at 8:00 AM. Lisinopril 20 mg twice daily was transcribed on the MAR with the first dose initialed as administered on 03/21/14 at 8 00 PM. Review of the MAR, dated April 2014, revealed an order for Lisinopril 20 mg twice daily with Lisinopril 40 mg daily indicated as "changed" on the MAR. However, review of the MAR, dated May 2014, revealed the Lisinopril 40 mg once daily was initialed as administered from 05/01/14 through 05/31/14 with Lisinopril 20 mg twice daily initialed as administered, starting 05/18/14 through 05/30/14.</p> <p>Phone interview with LPN #2, on 07/28/14 at 3:10 PM; and, on 07/29/14 at 10:40 AM, revealed she received the order from Physician #1 for Lisinopril 20 mg twice daily on 03/21/14. She revealed if the previous order was replaced, it should have been discontinued.</p> <p>Interview with Physician #1, on 07/28/14 at 3:45 PM and on 07/29/14 at 10:15 AM, revealed if he gave an order for Lisinopril 20 mg twice daily, he would not have intended for the resident to remain on Lisinopril 40 mg daily.</p> <p>Interview with LPN #1, on 07/28/14 at 3:30 PM, revealed she identified the medication error involving Resident #2, on 05/17/14. She stated the resident's Lisinopril 20 mg twice daily order was transcribed on the wrong MAR (Resident #3's). After the error was found, Lisinopril 20 mg twice daily was transcribed onto Resident #2's MAR; however, there had been no discontinue order for the Lisinopril 40 mg daily. She "assumed" the resident was supposed to have both orders (Lisinopril 40 mg and Lisinopril 20 mg twice daily).</p>	F 514	<p><u>F 514 cont'd:</u></p> <p>order to the pharmacy and staple the confirmation to the order, Scan the bar code on the medication card for return to pharmacy, Place a "discontinue" sticker on all discontinued medication cards, Place the discontinued medication cards in the pharmacy tote for "return to pharmacy" or or if a controlled substance secure for destruction. Licensed nurses were provided education regarding this new process beginning on 9/4/14 and continuing with nurses prior to their next oncoming shift duties.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>100% of all medication errors will be brought through the morning Abbreviated Quality Assessment committee for review of the completion of the RCA and the assessment of the resident for a minimum of 24 hours after the medication error is identified. The Quality Assurance Committee meeting will review 100% of medication errors, the documentation of assessments and root cause analysis. Quality Assurance Committee will review results for the next twelve months.</p> <p>The members of the Quality Assurance and Assessment Committee Meeting are our: Medical Director, Administrator, Director of Nursing, Human Resources, Activities Director, MDS Coordinator, Plant Management, Medical Records, Social Services Director, Admissions Coordinator, Dietary Manager, Admission Coordinator, Staff Development Coordinator, Unit Managers and Clinical Care Coordinator.</p> <p>When the Order Validation Nurse has completed her checks, the DON, CCC, UM, MDS, or SDC will complete a second 100% check of the MARs/TARs/POS. This 100% audit will continue monthly for the first three months. If the results reported by the CCC in the Quality</p>

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2. Record review revealed Resident #3 was admitted to the facility on 11/28/05 with diagnoses which included Hypertension. Review of the MAR, dated May 2014, revealed an entry for Lisinopril 20 mg twice daily. The Lisinopril was initialed as administered thirty-three (33) times from 05/01/14 through 05/17/14; however, review of the Physician's Orders, dated May 2014, revealed no order for Lisinopril.

Interview with the Director of Nursing (DON), on 07/29/14 at 10:55 AM, 12:00 PM, and 2:30 PM; and, on 07/30/14 at 10:30 AM, revealed it was expected for licensed staff to discontinue the previous order if an order change was received. She stated staff should have received clarification for the two (2) Lisinopril orders for Resident #2, as common practice. The process for verifying accuracy of a resident's MAR each month included comparison from the resident's current Physician's Orders with the resident's new MAR. The DON stated the MARs were reviewed by one licensed staff, but not double checked by another licensed staff member. The DON verified LPN #2 was most likely the nurse reviewing the May 2014 MAR for Resident #3. Further interview with the DON revealed the investigation of the medication error involving both Resident #2 and Resident #3 concluded the order for Lisinopril 20 mg twice daily was written on the wrong resident's MAR, it was "human error."

3. Record review revealed the facility admitted Resident #5 on 02/05/13 with diagnoses which included Hypertension and Cerebral Artery Occlusion with Infarct. Review of a Physician's Order, dated 05/02/14 at 5:35 PM, revealed an order to discontinue the Lisinopril. Review of the May 2014 MAR revealed the order was

F 514 F 514 cont'd:

Assurance Committee meeting demonstrate no errors in physician orders, the second audit will consist of 50% of resident population's MARs/POS for the next three months. If no further problems are identified, the Quality Assurance Committee will determine the sample size for further audits.

The SDC will continue to provide in-servicing related to: accurate transcription of telephone orders to the MAR, read back order to prescribing physician, verify documents belonging to the correct resident when transcribing order onto the MAR/TAR, and to clearly discontinue existing orders that are stopped or modified by a new order. The SDC will report the results of the post- testis through the Quality Assurance Committee meeting.

Blood pressure audits to be conducted to ensure that blood pressures are being taken before anti-hypertensive medications are given. The MARs will be audited to verify vital signs that are indicated prior to medication administration have been recorded. The audit will be conducted seven times a week for four weeks, three times a week for four weeks, one time a week for four weeks, every other week for four weeks, then monthly for 3 months. The results of the audit will be reported during the Quality Assurance Committee meeting .

Monitoring to assure that all telephone orders for medication are being transmitted will be accomplished by review through validation by the CCC on weekdays and by weekend night nurse on weekends, that the transmission document accompanied the telephone orders. The CCC will also validate that the weekend nurse reviewed the weekend transmissions. The findings of the CCC's review will be reported in Abbreviated Quality Assurance meeting held on routine workdays.

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F 514	<p>Continued From page 74</p> <p>discontinued. However, review of the June, July, August, and September 2014 MARs revealed the Lisinopril 10 mg order remained on the MARs and had not been discontinued. Resident #5 received ninety-five (95) doses of Lisinopril without a physician's order from 06/01/14 and 09/03/14.</p> <p>Interview with the Clinical Care Coordinator, on 09/12/14 at 8:25 AM, revealed an audit was conducted on all resident MARs on 07/29/14 and a second audit was conducted on 08/04/14 as part of the facility's AoC to ensure accurate reflection of the physician's orders on the MAR; however, staff failed to identify Resident #5's Lisinopril 10 mg daily order remained on the MARs with no physician's order. She stated Resident #5 received Lisinopril 10 mg daily from 06/01/14 through 09/03/14 in error.</p> <p>Interview on 09/02/14 at 1:55 PM with the Medical Director, who was also Resident #5's Primary Care Provider, revealed she stopped the Lisinopril 10 mg daily on 05/02/14 probably due to his/her B/P being low and renal insufficiency. Further interview revealed she would have expected the resident's B/P to remain low when the medication was continued, and due to the resident's renal insufficiency she would not have restarted the medication at all as that could cause further renal compromise.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>1. On 07/29/14, all resident Medication Administration Records (MARs) were audited by the Director of Nursing (DON) Clinical Care Coordinator (CCC), Staff Development</p>	F 514	<p><u>F 514 cont'd:</u></p> <p>Any concerns identified through the audit or monitoring process will be promptly addressed as indicated by the issue noted, based on the recommendation by the Quality Assurance & Assessment Committee, Administrator or DON.</p>	10/13/14

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F 514	<p>Continued From page 75</p> <p>Coordinator (SDC), Regional Quality Management Nurse, Unit Managers and Minimum Data Set (MDS) Coordinators to ensure accurate reflection of the current physician's orders. A second audit was conducted, on 08/04/14, by the DON and the Regional Quality Management Nurse. After the audit, the facility implemented a revised process for faxing telephone orders to the pharmacy. Education was provided to licensed staff beginning on 08/04/14 by the SDC of the new process, which included the attachment of the fax verification to the telephone order. The Clinical Care Coordinator (CCC) or the weekend monitor would verify the fax confirmation was present for all new orders.</p> <p>2. The end of the month procedure for reviewing MARs was modified to designate one specific nurse to be removed from additional duties other than MAR revision at the end of the month. The nurse was designated as the "Order Validation Nurse." That nurse was trained by the SDC, on 07/31/14, on the process of comparing the previous month's orders and subsequent telephone orders to ensure new orders contained all changes that occurred since the previous month began. The new orders would be utilized to verify that the MARs accurately reflected those orders. On the last day of the month, prior to utilization, the night nurse would compare the new MAR which had been checked against the new orders to the MAR currently being utilized.</p> <p>3. The process for reviewing new orders was revised to include the CCC validating accurate transcription of new orders on the correct MAR on weekdays. The night shift nurse would validate on the weekends and holidays. The DON would assign responsibility or complete the reviews in</p>	F 514		

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F 514	<p>Continued From page 76</p> <p>the absence of the CCC. The process included implementation of a task list to utilize when reviewing orders to guide the reviewer through the process.</p> <p>4. On 07/31/14, the August MARs were audited by the DON, CCC and Unit Managers to verify that residents who have medications for which vital signs should be obtained, have parameters listed and that the appropriate vital signs were being obtained. The August MARs were revised to clearly connect vital signs with medication administration.</p> <p>5. Education was provided, on 07/30/14 to the Administrator, DON, CCC, SDC, Unit Managers, and MDS Nurses by the Regional Resource Team Nurse regarding proper administration techniques utilizing the "rights" of medication administration to prevent errors, accuracy of transcribing medications, correct process for month end transcription and validation of physician's orders and MARs, need for obtaining blood pressure prior to administration of anti-hypertensive medication, need for assessment following identification of a medication error, need for accurate and consistent documentation of blood pressure reading prior to administration of anti-hypertensive medication, administration of medication, transcription of orders and assessment findings.</p> <p>6. Licensed nurses and Certified Medication Aides (CMAs) were educated on 07/30/14 by the SDC regarding obtaining a blood pressure before an anti-hypertensive medication was administered. If the blood pressure was outside the established parameters on the MAR, the CMA</p>	F 514
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F 514	<p>Continued From page 77</p> <p>would notify the nurse, who would notify the physician. On 07/31/14, education was provided to the Licensed Nurses and CMTs by the SDC that the interventions for residents receiving anti-hypertension medications would be located in the MAR and were to be followed. Training would be provided to all staff currently working and would continue with oncoming staff, prior to beginning duty, until completed by the SDC.</p> <p>7. On 07/31/14, education was provided by the SDC to licensed staff and CMAs regarding accurate medication administration, obtaining vital signs as indicated by medication and as directed on the MAR, and the prohibition of borrowing medication from another resident. If a medication was not available, the pharmacy should be contacted regarding the medication. The physician should be notified for clarification if there were any discrepancies. Education was provided to licensed nurses by the SDC on 07/31/14 regarding accurate transcription of telephone orders onto the MAR. The education included to read back the order to the prescriber to ensure the initial order reflects his/her verbal order correctly, transcribe the order onto the correct MAR, clearly discontinue existing orders that may be stopped or modified due to the new order. Training would be provided to all staff currently working and would continue with oncoming staff, prior to beginning duty, until completed by the SDC.</p> <p>8. Audits would be initiated to verify accuracy of transcription to new month's orders and MARs. One-hundred percent (100%) would be reviewed for three months. Findings would be reviewed by the Quality Assurance and Assessment Committee (QAA). If no significant transcription</p>	F 514		

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F 514	<p>Continued From page 78</p> <p>error was identified, the committee may reduce the sample size to fifty percent (50%) for the next three months.</p> <p>9. The MARs would be audited by the Unit Charge Nurse, CCC, MDS Coordinator or the DON to verify vital signs that were indicated prior to medication administration have been recorded. The audits would be completed daily for four weeks, then three times per week for four weeks, then one week for four weeks, then every other week for four weeks, then monthly for three months. When a medication error was identified, the record would be reviewed to validate that the root cause of the error was identified and an assessment of the condition impacted by the involved error was conducted. The monitoring would continue for three months. If no concerns, medication errors would be reviewed by the DON or CCC and reported to the QAA monthly.</p> <p>10. Resident #5's physician was notified and an order was obtained to discontinue the medication. The resident was assessed by the nurse, with her findings noted in the clinical record. The assessment was repeated each shift for the next twenty-four (24) hours then daily for the next two (2) days. No adverse effects were identified. All the resident's blood pressure obtained during the time the resident was receiving the medication were within the physician's parameters for administration.</p> <p>11. The facility revised the process for the handling of medication discontinue orders to include the placement of a "Discontinue" sticker on the medication cards containing the remainder of the medication and remove that medication from the medication cart at that time. The facility</p>	F 514		

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F 514	<p>Continued From page 79</p> <p>conducted an additional one-hundred percent (100%) resident record review audit on 09/05/14 through 09/07/14; which included Physician Telephone Orders and MAR/TAR from 04/01/14 through 09/07/14 which revealed no errors related to transcription, communication with the pharmacy or removal of discontinued medications and no further medication order to MAR discrepancies. A re-audit was conducted by the Director of Nursing (DON), Clinical Care Coordinator (CCC), Staff Development Coordinator (SDC), Unit Managers (UM), Regional Quality Control Specialist (RQMS), and Minimum Data Set (MDS) Coordinator, utilizing the services of outside Registered Nurses (RNs) with known performance credentials, on 09/05/14 through 09/07/14 of all the residents' records which included; the Physician Orders, the Medication Administration Records (MAR) and Treatment Administration Records (TAR) and Telephone Physician Orders dating from 04/01/14 to 09/07/14 to identify problems associated with order transcription and/or communication with the Pharmacy.</p> <p>12. The facility conducted re-education and in-servicing on 09/04/14 with all licensed staff related to the discontinuation of medications. The education included; write the order for the discontinued medication, make the correction on the MAR, pull medication from medication cart, scan the barcode for return, place "discontinued" stickers on each of the discontinued medication cards, and place the medication in the tote to be returned to the Pharmacy or if the medication was a controlled substance secure for destruction.</p> <p>13. The Regional Resource Team Nurse and the DON educated and in-serviced the licensed</p>	F 514		

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F 514	<p>Continued From page 80</p> <p>nurses and CMAs on 09/05/14 related to the facility's policy for the removal and disposal of narcotic patches by two (2) licensed nurses and that the CMAs should not dispose of the narcotic patches.</p> <p>14. The facility reviewed and revised the medication administration schedule on the MAR for all residents; a revised administration time schedule was noted for daily routine medications and the special administration times (before breakfast, before meals, after meals, or with food) were noted and located on the MAR in a specific group for each type, the as needed (PRN) medications will be kept separated from the routine and special schedule medications. Nurses were monitored during medication administration on 09/07/14 and is ongoing; the DON, SDC, UM and CCC ensured the observations will continue to include; observations of appropriate technique, including securing medications when the cart is unattended, proper storage of supplies, administering medications as ordered and scheduled in the appropriate time frame, and is an ongoing Quality Control process.</p> <p>** The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>1. Review of facility documentation revealed each resident's August MAR was reviewed for accuracy, reflecting the resident's current orders 07/31/14, with all blood pressure parameters listed on the MARs. Review of an inservice record, dated 08/04/14, revealed licensed staff was inserviced on the new process related to attaching a copy of fax confirmation to the</p>	F 514	

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F 514	<p>Continued From page 81</p> <p>physician's order.</p> <p>2. Interview with the Order Validation Nurse, on 08/06/14 at 4:55 PM, revealed she was the "order validation nurse". She stated she checked the MARs the last month and the SDC in-serviced her on checking the new physician orders against the old ones, any telephone orders brought forward (ensure on the new orders), check the new orders against the new MAR/TAR, then compare them to the old MAR/TAR. She revealed if she identifies a discrepancy, she checked the chart to see how the order was written. If there is a med error, she assessed the resident, and called the Physician and the DON. She stated she conducts a full head to toe assessment, fills out the error report, documents on the twenty-four (24) hour report to follow up assessment with vitals a minimum every twenty-four (24) hours (document assessments in the chart). She stated if she has a question about a medication she clarifies it with the physician.</p> <p>3. Interview with the CCC, on 08/06/14 at 6:45 PM, revealed she receives the written orders Monday-Friday, then sorts them out by Wings. She stated she ensures all orders are written on the MAR correctly. She revealed she has a form to type out each resident's name with the new order and there was a check list to ensure all criteria was met and the orders were transcribed accurately. She stated the new order checklist had been in effect, but now she initials the orders after she has checked them. She stated the night nurse on the weekends checks to ensure accurate transcription on the weekends, then on Monday, she checks behind them to make sure nothing was missed.</p>	F 514		

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F 514	<p>Continued From page 82</p> <p>4. Interviews conducted on 08/06/14 with Unit Manager (UM) #1 at 2:40 PM, UM #2 at 5:20 PM and the DON at 7:27 PM revealed they conducted audits of MARs to physician orders on 07/31/14. They stated they compared the newest physician orders to the old ones (July/August). In addition, they compared the new physician orders with the new MAR, then July MAR to August MAR. They stated they made sure the blood pressure and pulse parameters were in place.</p> <p>5. Review of the in-service form, dated 07/30/14, revealed administrative staff was in-serviced on the rights of medication, receiving new orders/transcription, end of the month MAR review, medication administration, anti-hypertensive medications, and medication errors. Review of the in-service form, dated 07/31/14, revealed the administrative team was educated on root cause analysis.</p> <p>6. Review of the in-service forms dated 07/30/14 and 07/31/14, revealed licensed nurses and CMAs were in-serviced on the "rights" of medication administration, unavailable medications, borrowing medication, medication errors/assessment of the resident, blood pressures obtained prior to administration of anti-hypertensive medications, what to do if the blood pressure was outside the written parameters, and care plans. Licensed Nurses were also educated on the accurate transcription of telephone orders on the MAR.</p> <p>7. Review of the In-service forms dated 07/30/14 and 07/31/14, revealed licensed nurses and CMAs were in-serviced on the "rights" of medication administration, unavailable medications, borrowing medication, medication</p>	F 514		

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F 514	<p>Continued From page 83</p> <p>errors/assessment of the resident, blood pressures obtained prior to administration of anti-hypertensive medications, what to do if the blood pressure was outside the written parameters, and care plans. Licensed Nurses were also educated on the accurate transcription of telephone orders on the MAR.</p> <p>Interviews with RN #1, LPN #2, LPN #3, and LPN #4, on 08/06/14 at 3:40 PM, 5:05 PM, 4:55 PM, and 5:30 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, receiving new orders/transcription of new orders, end of the month MAR review, obtaining blood pressures before administering anti-hypertensive medications, identification of medication errors and assessment of the resident afterwards, and care plans.</p> <p>Interviews with CMA #10, CMA #4, and CMA #3 on 08/06/14 at 4:25 PM, 5:15 PM, and 5:45 PM, respectively, revealed they were in-serviced related to the "rights" of medication administration, not borrowing medication for a resident, obtaining blood pressures before administering anti-hypertensive medications, and care plans.</p> <p>Verified with the SDC all medication observations and in-servicing of staff were completed with the exception of 2-3 weekend staff who would receive their training/testing prior to starting their shift.</p> <p>8/9. Interview with the DON, on 08/06/14 at 7:27 PM, revealed daily audits were being conducted to ensure vital signs were obtained and documented correctly. She stated the audits will be conducted daily times four (4) weeks, then three (3) a week times four (4) weeks, then one</p>	F 514	

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F 514	<p>Continued From page 84</p> <p>(1) time a week times four (4) weeks, then every other week times four (4) weeks, then monthly times three (3). She revealed when a medication error was identified staff would conduct a root cause analysis. We have audit tool to use to ensure all aspects are covered (MD notification, assessment of resident, immediate corrective action, systemic problems, etc.) She revealed it would be taken through the next QA meeting and talked about as a group.</p> <p>10. Review on 09/12/14 of Resident #5's September MAR and Physician's Orders revealed the Lisinopril order was discontinued. Review of a Nursing Assessments revealed the resident was assessed each shift for twenty-four hours then daily for two days.</p> <p>11. Observation of the medication room, on 09/12/14 at 8:15 AM, revealed a medication box designated for medications to be sent back to the pharmacy containing a medication card with a "Discontinued" sticker attached below the resident's identifying information, a roll of stickers imprinted "Discontinued", and a copy of the Staff Development Attendance Record dated 09/04/14 for education on writing medication orders, affixing the sticker to discontinued medications, removal of discontinued medications from the medication carts, and the designated location to place the medications for return to the pharmacy. Review of facility audit reports, dated 09/05-07/14, revealed audits were conducted to ensure the MARs only contained current physician orders and discontinued medications were removed from the cart.</p> <p>12. Observation of a medication pass conducted on 09/12/14 beginning at 8:25 AM, on halls</p>	F 514	

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F 514	<p>Continued From page 85</p> <p>one-hundred (100), two-hundred (200) and three-hundred (300) respectively revealed no medication errors. Review of the in-service records, dated 09/04/14 and signed by all licensed staff and CMAs, education was provided related to discontinuation of medications. Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM, revealed they were in-serviced related to the actions to take when a medication was discontinued.</p> <p>13. Review of inservice records dated 09/05/14, revealed the Regional Quality Supervisor (QMS) and the DON provided all licensed staff and CMAs education on "Destroying Narcotics including Fentanyl Patches". Interviews on 09/12/14 with RN #1 at 9:35 AM, RN #2 at 1:00 PM, LPN #1 at 2:30 PM, LPN #2 2:45 PM, and UM #1 at 3:00 PM revealed the CMAs no longer removed or disposed of the pain patches only the licensed nurses do that now, that they were provided education related to the policy of two (2) licensed nurses witnessing the removal and disposal of the pain patches. Review of the MARs of Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10 revealed two (2) licensed nurses initials as witnesses to the removal and disposal of the pain patches.</p> <p>Interview with the DON and Administrator, on 09/12/14 at 9:00 AM revealed both were provided education by the Regional Resource Team Nurse on 09/05/14 and they in turn provided re-education and testing for all licensed nurses and CMA's starting on 09/06/14 related to the confirmation that two (2) licensed nurses removed patches and signed as witnesses of disposal.</p>	F 514	

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F 514	Continued From page 86 14. Observation of a medication pass on all three halls, on 09/12/14 at 7:12 AM, which included the administration of oral, inhaled, topical eye drops, and insulin injection which no medication errors identified.	F 514		