

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating complaints #KY22170 and KY22171 was conducted on 09/16/14 through 09/19/14 to determine the facility's compliance with Federal requirements. Complaint #KY22170 was unsubstantiated with no deficiencies cited. Complaint #KY22171 was substantiated with Past non-compliance identified at a Scope and Severity of a "D". After Supervisory review the Abbreviated Survey was reopened on 10/09/14 through 10/10/14 and it was determined the past non-compliance was a Past Immediate Jeopardy.</p> <p>On 07/17/14 at approximately 9:15 AM, RN #3 failed to administer medication according to professional standards of quality when she administered another resident's (Resident #11's) medications to Resident #10 which resulted in a significant medication error. The significant medication error resulted in Resident #10's blood pressure dropping to 82/57 and the need to encourage fluids.</p> <p>Immediate Jeopardy (IJ) was identified in the areas of CFR 483.20 Resident Assessment at F281 and CFR 483.25 Quality of Care at F333 at a Scope and Severity of a "J". Substandard Quality of Care was identified at CFR 483.25 at F333. Immediate Jeopardy was identified on 10/09/14 and was determined to exist on 07/17/14. The facility was notified of the Immediate Jeopardy on 10/09/14.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 10/10/14, which alleged removal of the Immediate Jeopardy on 07/26/14, prior to the initiation of the Abbreviated Survey. The</p>	F 000			

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

TITLE

(X6) DATE

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

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F 000	Continued From page 1 State Survey Agency determined the deficient practice was corrected related to significant medication error on 07/26/14 as alleged in the AoC; therefore, it was determined to be Past Immediate Jeopardy.	F 000			
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, and review of the facility's Medication Administration Policy, it was determined the facility failed to provide services to meet professional standards of quality for one (1) of three (3) sampled residents (Resident #10) when the nurse failed to ensure medications were given to the right resident per the facility's policy and procedure. On 07/17/14, Registered Nurse (RN) #3 failed to ensure medication was administered to the right resident by looking at the picture of the resident or asking the resident his/her name. Resident #10 was given Resident #11's medications in error, resulting in Resident #10's blood pressure dropping to (82/57). Resident #10 required additional fluids. The findings include: Review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement fourteen, (AOS #14),	F 281	Past noncompliance: no plan of correction required.		

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F 281	<p>Continued From page 2</p> <p>last revised 10/2010, revealed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were required to administer medications and treatments prescribed by the physician, physician assistant, dentist and advanced practice registered nurse. Components of medication administration included preparing and giving medication in the prescribed dosage, route, and frequency.</p> <p>Review of the facility's policy and procedure titled, "Medication Administration", dated 12/31/12, revealed in Preparation of Medication Administration the medication should be prepared using the five (5) rights of medication administration with the first right as "right resident".</p> <p>Record review revealed the facility admitted Resident #10 on 12/28/13 with diagnoses which included Post Surgery Seizure Disorder, Depression, Anxiety, History of Lung Cancer, and Resection of Benign Brain Tumors with Craniotomy. Review of Resident #10's Quarterly Minimum Data Set (MDS) assessment, dated 06/03/14, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of Resident #10's Nursing Progress Note, dated 07/17/14 at 9:15 AM, revealed the resident had received (Resident #11's medications) Tecfidera 240 milligrams (mg) (medication for Multiple Sclerosis), Neurontin 800 mg, (anticonvulsant and analgesic for nerve pain) Baclofen 10 mg (muscle relaxer and antispastic agent) Cymbalta 30 mg (anti-depressant and anti-anxiety drug) Klonopin 1 mg (medication for</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>anxiety and to control seizures in epilepsy), Oxycontin 30 mg (narcotic pain medication), Omeprazole 40 mg (medication for gastric reflux), and Senna-docusate (stool softener). At 9:30 AM the resident's blood pressure was noted to be 124/98 (normal: 120/70); and, at 10:45 AM, the resident's blood pressure had dropped to 82/57. The physician was notified with orders received to encourage fluids.</p> <p>Review of the Medication Variance Report Worksheet, dated 07/17/14, revealed Registered Nurse (RN) #3 made a medication error by administering the wrong medications (Resident #11's) to Resident #10. RN #3 realized her error immediately and started the medication error reporting process, she filled out the Medication Variance Report at 9:15 AM and notifications were made to the Physician, Family, Administrator, Director of Nursing Services (DNS), and the resident involved (Resident #10). Further review of this Worksheet revealed the facility did not check this error as a significant medication error, nor was the resident transferred to the hospital. The Worksheet noted that per facility policy this error required the alert monitoring of the resident to confirm that the error did not result in harm to the resident and/or require intervention to preclude harm.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/17/14 at 11:50 AM, revealed she was the preceptor for the RN #3 who had given Resident #10 the medications prescribed for Resident #11. She revealed she had observed RN #3 administering medications to several residents on the morning of 07/17/14, and she was with RN #3 every step of the process. LPN #1 stated RN #3 pulled the medications for Resident #11; but she</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>did not go into the resident's room with RN #3 to watch her administer the medications to the resident. She stated that Resident #10 had been moved into Resident #11's room during the night, since maintenance was preparing to paint Resident #10's room. LPN #1 stated when RN #3 entered the resident's room, she failed to identify the resident properly and handed the medications to Resident #10 and the resident took them. Further interview revealed when she got back to the medication cart RN #3 and LPN #1 realized at the same time that RN #3 had administered those medications to the wrong resident. LPN #1 stated the medication error process was started immediately, the doctor, the resident, and the family members were all informed of the error, as well as the Director of Nursing Services (DNS). LPN #1 stated the RN obtained Resident #10's vital signs and new orders were received from the doctor to monitor Resident #10's for vital signs and do neurological checks every 15 minutes for one (1) hour; every hour for two (2) hours, every four (4) hours for eight (8) hours, then every eight (8) hours for a total of seventy-two (72) hours of alert charting of vital signs and neurological checks. LPN #1 revealed the resident's blood pressure dropped to 82/57 and the physician was notified with an order received to encourage fluids due to the resident not having any neurological changes except a little drowsiness.</p> <p>An attempt to interview RN #3, on 09/17/14 at 11:45 AM, revealed the employee no longer worked at the facility and the phone number the facility had was no longer a working number.</p> <p>Interview with the Director of Nursing (DON) and the Administrator, on 09/18/14 at 10:30 AM, revealed they would have expected any prudent</p>	F 281		

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F 281	Continued From page 5 nurse administering medications to ensure they were giving the right medications to the right resident according to the five (5) rights of medication administration which "we all learned in Nursing 101." The licensed nurses should compare the resident's photograph to the resident and/or ask the resident's name before handing them any medications. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #10 was placed on alert charting on 07/17/14 with documentation of vital signs and neurological checks to determine level of consciousness and or presence of nausea or vomiting or excessive drowsiness. 2. On 07/17/14, the DON counseled the nurses involved. 3. The facility conducted an interview audit of thirty-one (31) interviewable residents, which revealed those residents had no problems with the administration of their medication by the licensed nurses. Additionally, a Medication Administration Record (MAR) to medication cart audit was conducted for all the residents in the facility which included forty-seven (47) non-interviewable residents; with no medication variances identified. 4. Education was conducted on 07/18/14 through 07/23/14, by the Staff Development Coordinator (SDC) with the licensed nurses. No licensed nurse was allowed to perform medication pass until the education was completed, the last licensed staff member received education	F 281			

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F 281	Continued From page 6 07/23/14. 5. The Medical Records Clerk updated all current residents' photographs and placed the photographs on the residents' MAR cover sheet. Medication Administration Record (MAR) audit was conducted on 07/17/14, on all current residents to confirm all residents' photo identifier was present in the MAR books. 6. Monitoring of medication pass was conducted randomly by the SDC, three (3) times a week which began 07/25/14, which revealed no noted concerns or medication errors or variances; the audits were reduced to weekly on 08/25/14 and are ongoing. ***The State Agency validated the corrective action taken by the facility as follows: 1. Review of the Resident #10's Nurse's Notes, dated 07/17/14 at 9:15 AM, revealed RN #3 documented she administered medications to Resident #10 of Tecfidera, Neurontin, Baclofen, Omeprazole, Senna-Docusate, Cymbalta, Klonopin, and Oxycontin. Consecutive documentation of vital signs, presence or absence of nausea or vomiting, level of consciousness and mentation were recorded every fifteen (15) minutes for one (1) hour, every one hour for two (2) hours, every two (2) hours for four (4) hours, and every shift for seventy-two (72) hours. The documentation revealed there were no adverse effects of the medications received in error, no nausea or vomiting occurred, there was no change in level of consciousness, and vital signs remained stable.	F 281			

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F 281	<p>Continued From page 7</p> <p>2. Review of education related to the medication error that was provided to the licensed nurses involved in the medication error as well as a Written Warning, dated 07/17/14, revealed RN #3 and LPN #1 were counseled for the medication error and failure to properly identify the resident using the 5 (rights) of medication administration according to the facility's policy and procedure.</p> <p>Interview with the Staff Development Coordinator (SDC), on 09/19/14 at 9:30 AM, revealed she was aware of the medication error but the Interim DNS at that time took care of the discipline and re-education for the nursing staff involved in the error. LPN #1 and RN #3 both received Written Counseling and Corrective Action for their Job Performance on 07/18/14 as a written warning. Further interview revealed LPN #1 no longer acts as preceptor, she received education on Medication Administration and the five (5) rights and the education and monitoring is ongoing. RN #3 was monitored for ten (10) medication passes which started on 07/18/14 conducted by RN #1, a Charge Nurse. On 07/21/14, the SDC reviewed with RN #3 medication administration which revealed no problems, and again on 07/25/14 the SDC observed RN #3 passing medications which revealed no problems observed.</p> <p>3. Review of the resident roster dated 07/17/14 revealed the facility's census of seventy-eight (78) residents. Thirty-one (31) interviewable residents were interviewed which revealed interviews were conducted by the SCD questioned whether the interviewable residents thought they had been subjected to any medication errors; thirty-one (31) interviewable residents were not aware of any medication administration problems concerning their medications. The remaining forth-seven (47)</p>	F 281			

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F 281	Continued From page 8 non-interviewable residents were included in the facility wide Medication Administration Record to medication cart audit, dated 07/17/14, which revealed Medication Administration Record (MAR) to Medication Cart audit revealed no issues noted per the Staff Development Coordinator (SDC). 4. Review of In-service Attendance Rosters entitled Licensed Nurse (LN) Meeting, dated 07/22/14 and 07/23/14 revealed signatures of all Licensed Nurses who administer medications were present on the attendance rosters for the in-service. Interview with LPN #2, on 09/18/14 at 1:20 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights. Interview with LPN #1, on 09/18/14 at 1:25 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights. Interview with RN #2, on 09/18/14 at 1:30 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights.	F 281			

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F 281	<p>Continued From page 9</p> <p>Interview with LPN #4, on 10/10/14 at 2:30 PM, revealed she had started work in the facility in May 2014 and worked the 7:00 AM to 7:00 PM shift. She revealed she received an education refresher from the SDC just a few weeks ago on the five (5) rights of medication administration which she had been educated on during her orientation. She stated the SDC covered the five (5) rights of medication administration of right patient, right medication, dose, route and time. Further interview revealed she said there was a picture of each resident in the MAR for identification.</p> <p>Interview with LPN #5, on 10/10/14 at 2:40 PM, revealed she worked in Medical Records and did administer medications from time to time. She revealed she did get education from the SDC about medication errors and the five (5) rights; right resident, route, time, dose, and medication. Additionally she had reviewed medication errors in the last few weeks and had the SDC audit her medication pass on one occasion.</p> <p>Interview with RN #4, on 10/10/14 at 2:35 PM, revealed she had received some instruction recently related to the five (5) rights of medication administration and recalled right patient, right medication, right route, right dose, and right time. Further revealed the Licensed Nurses verify the right resident by a picture that was in the MAR and we also ask the resident for their name. Additionally the SDC talked about change in the residents' condition and documenting on the Situation Background Action Recommendation (SBAR) form and she had also watched her perform medication passes to verify use of the five (5) rights. The observations were done pretty frequently.</p>	F 281			

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F 281	Continued From page 10 Interview with RN #5, on 10/10/14 at 2:50 PM, revealed she had worked in the facility for twelve (12) years and worked from 8:30 AM to 4:30 PM. She revealed the SDC did education about medication errors, passing medications and the five (5) rights; named the five (5) rights of right patient, right medication, right time, right dose, and right route. Further interview revealed that the SDC went over verification of the residents even though they were well known to her, she did not pass medications very often so she was very careful when she did; and there was a picture in the MAR of every resident as a cover sheet for their MAR pages. Interview with Unit Manager (RN #1), on 10/10/14 at 2:20 PM, revealed she received an inservice on the five (5) rights of medication administration; she recalled stating right patient, right medication, right time, right route, and right dose. The education was provided by the SDC and she participated in the Performance Improvement Committee (PIC) meetings. Medication Administration and Medication Error reporting had been discussed weekly and was ongoing, additionally the facility was conducting audits and observations of medication passes. Interview with the Minimum Data Set (MDS) Coordinator, on 10/10/14 at 3:30 PM, revealed the SDC conducted an inservice for all the Licensed Nurses that provided education on the five (5) rights of medication administration; right patient or resident, right medication, right dose, right time, and right route. Additionally the SDC talked about medication errors. Further interview revealed the MAR's also have an updated picture of each resident as their MAR page cover sheet	F 281			

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F 281	<p>Continued From page 11</p> <p>and had seen audits being conducted on the medication passes. She revealed she participated in the PIC and the committee discussed this subject and the process was ongoing.</p> <p>Interview with the Administrator and the DNS, on 09/18/14 at 1:00 PM, revealed that only Licensed Nurses were utilized in the facility to administer medications. Further interview revealed they had phased out using Medication Aides. Further interview revealed the Licensed Nurses were in-serviced and re-educated on the Medication Administration policy included the five (5) rights of medication administration.</p> <p>5. Record review of a form dated, 07/17/14, indicated a MAR audit was initiated by the Medical Records Clerk which revealed she audited the MARs and updated every resident's photograph for identification. A Medication Pass conducted on 10/10/14 revealed a photograph identifier was located on the cover page of each resident's MAR and the Licensed Nurse was observed making identification of the residents before medication administration.</p> <p>6. Review of a form, dated 07/24/14 and 07/25/14, entitled two (2) medication pass spot check completed with no errors performed by the SDC for three (3) times a week for two (2) months. Medication pass observation were conducted on 07/28/14, 07/31/14 and 08/01/14, 08/04/14, 08/06/14, 08/08/14, 08/11/14, 08/13/14, 08/15/14, 08/18/14, 08/20/14 then weekly medication pass audits began on 08/27/14, and continued 09/03/14, 09/10/14, 09/17/14, 09/24/14, 10/01/14, and 10/08/14. The audits were ongoing.</p>	F 281			

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2014
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F 281	Continued From page 12 Interview with the SDC, on 10/10/14 at 2:25 PM, revealed she performed all the medication pass audits the past three (3) weeks and did spot check observations on medication passes every Wednesday. During the audits she watched for the Licensed Nurses to identify the five (5) rights; right patient, right route, right dose, right time, and right medication documentation.	F 281			
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #10) was free of significant medication errors; when eight (8) medications were administered to Resident #10 that were not prescribed for him/her. On 07/17/14 at approximately 9:15 AM, RN #3 administered another resident's (Resident #11's) medications to Resident #10 which resulted in a significant medication error. The significant medication error resulted in Resident #10's blood pressure dropping to 82/57 and the need to encourage fluids. The findings include: Review of the facility's policy entitled Medication	F 333	Past noncompliance: no plan of correction required.		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

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F 333	<p>Continued From page 13</p> <p>Administration dated 12/31/12 revealed the nursing staff uses the medication cart to systematically distribute physician ordered medications to patients, page two (2); Procedure of Medication Administration point number seven (7) revealed the Licensed Nurse shall prepare the medication using the five (5) rights of medication administration; (a. through g.) with the first right as (a.) Right patient.</p> <p>Record review revealed the facility admitted Resident #10 on 12/28/13 with diagnoses which included Post Surgery Seizure Disorder, Depression and Anxiety, History of Lung Cancer, Resection of Benign Brain Tumors with Craniotomy. Review of Resident #10's Quarterly Minimum Data Set (MDS) dated 06/03/14, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Review of the Medication Variance Report Worksheet, dated 07/17/14, revealed RN #3 noted her medication error and filled out a Medication Variance Report at 9:15 AM which revealed notifications were made to the Physician, Family, Administrator, and Director of Nursing Services; additionally, there was no indication that this was noted as a significant medication error, nor was the resident transferred to the hospital. However, the error did require monitoring the resident to confirm that it did not result in harm.</p> <p>Review of the Nurse's Notes, dated 07/17/14 at 9:15 AM, revealed "Resident awake, alert, and pleasant, sitting up in bed eating breakfast. PO meds given Tecfidera 240 mg (medication for</p>	F 333			

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

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OMB NO. 0938-0391

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F 333	<p>Continued From page 14</p> <p>Multiple Sclerosis), Neurontin 800 mg (medication for restless legs and multiple sclerosis), Baclofen 10 mg (medication for muscle spasms), Omeprazole 40 mg (medication for gastric reflux), Senna-Docusate (for constipation), Cymbalta 30 mg (an anti-depressant), Klonopin 1 mg (medication for anxiety disorder), and Oxycontin 30 mg (narcotic pain medication). These were the medications given in error.</p> <p>Review of Nurse's Notes, dated 07/17/14 at 9:30 AM, revealed RN #3 obtained the resident's vital signs which included blood pressure measurement, heart rate, respiratory rate, and temperature; and notified the doctor who ordered close monitoring of the resident. At 9:30 AM, the resident's blood pressure was 124/98 (normal 120/70); and, at 10:45 AM the resident's blood pressure had dropped to 82/57. The physician was notified with orders received to encourage fluids.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/17/14 at 11:50 AM, revealed she was the preceptor for Registered Nurse (RN) #3 who had given Resident #10 the medications prescribed for Resident #11. She revealed she had observed and was with RN #3 administering medications to several residents on the morning of 07/17/14. LPN #1 stated when RN #3 pulled the medications for Resident #11; she turned her back and did not go into the resident's room with RN #3 to watch her hand the medications to Resident #11. LPN #1 revealed Resident #10 had been moved into Resident #11's room during the night; since maintenance was preparing to paint Resident #10's room. LPN #1 stated RN #3 failed to identify Resident #11 according to the five (5) rights of medication administration (right resident,</p>	F 333			

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

PRINTED: 10/17/2014
FORM APPROVED
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F 333	<p>Continued From page 15</p> <p>right time, right medication, right dosage, right route) and handed the medications to Resident #10 and he/she took them. LPN #1 stated when RN #3 got back to the medication cart both RN #3 and LPN #1 realized at the same time she had handed the medications to the wrong resident; so she started the medication error process immediately and called the doctor, informed the resident, called the family member, and notified the Director of Nursing Services (DNS). LPN #1 revealed RN #3 obtained Resident #10's vital signs and called the doctor. She received orders to monitor Resident #10 every fifteen (15) minutes for one (1) hour, every one (1) hour for two (2) hours, every two (2) hours for four (4) and every eight (8) hours for a total of seventy-two (72) hours of alert charting of vital signs and neurological checks monitoring. LPN #1 stated after one of the hourly checks the doctor was notified that Resident #10's blood pressure (B/P) had dropped to 82/57 and the resident presented with some drowsiness; the doctor was contacted and an order to encourage fluids was obtained at that point.</p> <p>An attempt to interview RN #3, on 09/17/14 at 11:45 AM, revealed the employee no longer worked at the facility and the phone number the facility had was no longer a working number.</p> <p>Interview with the Director of Nursing and the Administrator, on 09/18/14 at 10:30 AM, revealed the two would have expected any prudent nurse administering medications to ensure they were giving the right medications to the right resident according to the five (5) rights of medication administration which "we all learned in Nursing 101." The licensed nurses should compare the resident's photograph to the resident and/or ask</p>	F 333			

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

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FORM APPROVED
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F 333	Continued From page 16 the resident's name before handing them any medications. Further interview with the DON revealed she thought that RN #3 made a human error. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #10 was placed on alert charting on 07/17/14 with documentation of vital signs and neurological checks to determine level of consciousness and or presence of nausea or vomiting or excessive drowsiness. 2. On 07/17/14, the DON counseled the nurses involved. 3. The facility conducted an interview audit of thirty-one (31) interviewable residents, which revealed those residents had no problems with the administration of their medication by the licensed nurses. Additionally, a Medication Administration Record (MAR) to medication cart audit was conducted for all the residents in the facility which included forty-seven (47) non-interviewable residents; with no medication variances identified. 4. Education was conducted on 07/18/14 through 07/23/14, by the Staff Development Coordinator (SDC) with the licensed nurses. No licensed nurse was allowed to perform medication pass until the education was completed, the last licensed staff member received education 07/23/14. 5. The Medical Records Clerk updated all current residents' photographs and placed the	F 333			

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

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F 333	<p>Continued From page 17</p> <p>photographs on the residents' MAR cover sheet. Medication Administration Record (MAR) audit was conducted on 07/17/14, on all current residents to confirm all residents' photo identifier was present in the MAR books.</p> <p>6. Monitoring of medication pass was conducted randomly by the SDC, three (3) times a week which began 07/25/14, which revealed no noted concerns or medication errors or variances; the audits were reduced to weekly on 08/25/14 and are ongoing.</p> <p>***The State Agency validated the corrective action taken by the facility as follows:</p> <p>1. Review of the Resident #10's Nurse's Notes, dated 07/17/14 at 9:15 AM, revealed RN #3 documented she administered medications to Resident #10 of Tecfidera, Neurontin, Baclofen, Omeprazole, Senna-Docusate, Cymbalta, Klonopin, and Oxycontin. Consecutive documentation of vital signs, presence or absence of nausea or vomiting, level of consciousness and mentation were recorded every fifteen (15) minutes for one (1) hour, every one hour for two (2) hours, every two (2) hours for four (4) hours, and every shift for seventy-two (72) hours. The documentation revealed there were no adverse effects of the medications received in error, no nausea or vomiting occurred, there was no change in level of consciousness, and vital signs remained stable.</p> <p>2. Review of education related to the medication error that was provided to the licensed nurses involved in the medication error as well as a Written Warning, dated 07/17/14, revealed RN #3</p>	F 333			

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

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F 333	<p>Continued From page 18</p> <p>and LPN #1 were counseled for the medication error and failure to properly identify the resident using the 5 (rights) of medication administration according to the facility's policy and procedure.</p> <p>Interview with the Staff Development Coordinator (SDC), on 09/19/14 at 9:30 AM, revealed she was aware of the medication error but the Interim DNS at that time took care of the discipline and re-education for the nursing staff involved in the error. LPN #1 and RN #3 both received Written Counseling and Corrective Action for their Job Performance on 07/18/14 as a written warning. Further interview revealed LPN #1 no longer acts as preceptor, she received education on Medication Administration and the five (5) rights and the education and monitoring is ongoing. RN #3 was monitored for ten (10) medication passes which started on 07/18/14 conducted by RN #1, a Charge Nurse. On 07/21/14, the SDC reviewed with RN #3 medication administration which revealed no problems, and again on 07/25/14 the SDC observed RN #3 passing medications which revealed no problems observed.</p> <p>3. Review of the resident roster dated 07/17/14 revealed the facility's census of seventy-eight (78) residents. Thirty-one (31) interviewable residents were interviewed which revealed interviews were conducted by the SCD questioned whether the interviewable residents thought they had been subjected to any medication errors; thirty-one (31) interviewable residents were not aware of any medication administration problems concerning their medications. The remaining forth-seven (47) non-interviewable residents were included in the facility wide Medication Administration Record to medication cart audit, dated 07/17/14, which revealed Medication Administration Record</p>	F 333			

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

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F 333	<p>Continued From page 19 (MAR) to Medication Cart audit revealed no issues noted per the Staff Development Coordinator (SDC).</p> <p>4. Review of In-service Attendance Rosters entitled Licensed Nurse (LN) Meeting, dated 07/22/14 and 07/23/14 revealed signatures of all Licensed Nurses who administer medications were present on the attendance rosters for the in-service.</p> <p>Interview with LPN #2, on 09/18/14 at 1:20 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights.</p> <p>Interview with LPN #1, on 09/18/14 at 1:25 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights.</p> <p>Interview with RN #2, on 09/18/14 at 1:30 PM, revealed she had received an in-service related to the facility's medication administration policy and re-educated on the importance of following the five (5) rights of medication administration every time, even if they know the resident they still need to confirm the five (5) rights.</p> <p>Interview with LPN #4, on 10/10/14 at 2:30 PM, revealed she had started work in the facility in May 2014 and worked the 7:00 AM to 7:00 PM shift. She revealed she received an education</p>	F 333			

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

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FORM APPROVED
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F 333	<p>Continued From page 20</p> <p>refresher from the SDC just a few weeks ago on the five (5) rights of medication administration which she had been educated on during her orientation. She stated the SDC covered the five (5) rights of medication administration of right patient, right medication, dose, route and time. Further interview revealed she said there was a picture of each resident in the MAR for identification.</p> <p>Interview with LPN #5, on 10/10/14 at 2:40 PM, revealed she worked in Medical Records and did administer medications from time to time. She revealed she did get education from the SDC about medication errors and the five (5) rights; right resident, route, time, dose, and medication. Additionally she had reviewed medication errors in the last few weeks and had the SDC audit her medication pass on one occasion.</p> <p>Interview with RN #4, on 10/10/14 at 2:35 PM, revealed she had received some instruction recently related to the five (5) rights of medication administration and recalled right patient, right medication, right route, right dose, and right time. Further revealed the Licensed Nurses verify the right resident by a picture that was in the MAR and we also ask the resident for their name. Additionally the SDC talked about change in the residents' condition and documenting on the Situation Background Action Recommendation (SBAR) form and she had also watched her perform medication passes to verify use of the five (5) rights. The observations were done pretty frequently.</p> <p>Interview with RN #5, on 10/10/14 at 2:50 PM, revealed she had worked in the facility for twelve (12) years and worked from 8:30 AM to 4:30 PM.</p>	F 333			

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

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F 333	<p>Continued From page 21</p> <p>She revealed the SDC did education about medication errors, passing medications and the five (5) rights; named the five (5) rights of right patient, right medication, right time, right dose, and right route. Further interview revealed that the SDC went over verification of the residents even though they were well known to her, she did not pass medications very often so she was very careful when she did; and there was a picture in the MAR of every resident as a cover sheet for their MAR pages.</p> <p>Interview with Unit Manager (RN #1), on 10/10/14 at 2:20 PM, revealed she received an inservice on the five (5) rights of medication administration; she recalled stating right patient, right medication, right time, right route, and right dose. The education was provided by the SDC and she participated in the Performance Improvement Committee (PIC) meetings. Medication Administration and Medication Error reporting had been discussed weekly and was ongoing, additionally the facility was conducting audits and observations of medication passes.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 10/10/14 at 3:30 PM, revealed the SDC conducted an inservice for all the Licensed Nurses that provided education on the five (5) rights of medication administration; right patient or resident, right medication, right dose, right time, and right route. Additionally the SDC talked about medication errors. Further interview revealed the MAR's also have an updated picture of each resident as their MAR page cover sheet and had seen audits being conducted on the medication passes. She revealed she participated in the PIC and the committee discussed this subject and the process was ongoing.</p>	F 333			

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

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F 333	Continued From page 22 Interview with the Administrator and the DNS, on 09/18/14 at 1:00 PM, revealed that only Licensed Nurses were utilized in the facility to administer medications. Further interview revealed they had phased out using Medication Aides. Further interview revealed the Licensed Nurses were in-serviced and re-educated on the Medication Administration policy included the five (5) rights of medication administration. 5. Record review of a form dated, 07/17/14, indicated a MAR audit was initiated by the Medical Records Clerk which revealed she audited the MARs and updated every resident's photograph for identification. A Medication Pass conducted on 10/10/14 revealed a photograph identifier was located on the cover page of each resident's MAR and the Licensed Nurse was observed making identification of the residents before medication administration. 6. Review of a form, dated 07/24/14 and 07/25/14, entitled two (2) medication pass spot check completed with no errors performed by the SDC for three (3) times a week for two (2) months. Medication pass observation were conducted on 07/28/14, 07/31/14 and 08/01/14, 08/04/14, 08/06/14, 08/08/14, 08/11/14, 08/13/14, 08/15/14, 08/18/14, 08/20/14 then weekly medication pass audits began on 08/27/14, and continued 09/03/14, 09/10/14, 09/17/14, 09/24/14, 10/01/14, and 10/08/14. The audits were ongoing. Interview with the SDC, on 10/10/14 at 2:25 PM, revealed she performed all the medication pass audits the past three (3) weeks and did spot check observations on medication passes every	F 333			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 23 Wednesday. During the audits she watched for the Licensed Nurses to identify the five (5) rights; right patient, right route, right dose, right time, and right medication documentation.	F 333		