

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

PRINTED: 02/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/18/2015
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	<p>An Abbreviated Survey was initiated and concluded on 02/18/15 to investigate KY 22842. The Division of Health Care substantiated the allegation with deficiencies cited.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of four (4) sampled residents received medication as ordered by the physician. (Resident #1) Licensed Practical Nurse (LPN) #1 administered an Intravenous (IV) medication to Resident #1 that was ordered for Resident #4. The Resident #1 did not experience any adverse reaction to the medication.</p> <p>The findings include:</p> <p>Review of the facility's Medication Administration Policy, revised 09/17/12, revealed medications are administered in accordance with written orders of the attending physician. Prior to administration, the medication and dosage schedule on the resident's Medication</p>	F 309	<p>The submission of this plan of correction does not indicate an admission by Glen Ridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents at Glen Ridge. The facility recognizes its obligations to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements for participation in title 18/19 programs. To this end, this plan of correction (POC) shall serve as the credible allegation of compliance with all state and federal requirements governing the management of the facility. It is thus submitted as a matter of statute only.</p>	

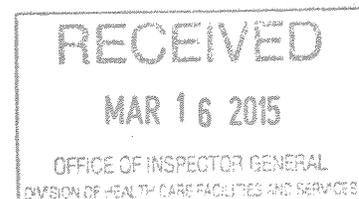
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X [Signature]* TITLE *X Executive Dir.* (X6) DATE *3/16/15*

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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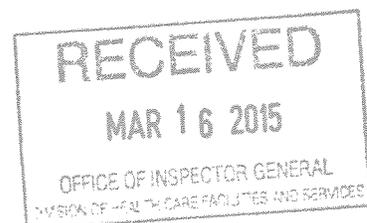
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F 309	<p>Continued From page 1</p> <p>Administration Record (MAR) are compared with the medication label. Review of the Choice Pharmacy Services IV Policy, revised 01/24/11, revealed prior to administration, the IV medication label is compared to the resident's MAR for accuracy.</p> <p>Review of the the facility's Medication Pass Clinical Competency form, no date, revealed the five rights: right patient, right drug, right dose, right time, right route were included on the competency form.</p> <p>Review of the facility's medication error report revealed Resident #1 received Resident #4's IV medication by error on 02/13/15 at 9:00 AM. Resident #1 was suppose to receive Vancomycin 1500 mg IV, but received Meropenem instead. No injury was noted.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 02/11/15 after hospitalization for removal of the left knee prosthesis. The clinical record revealed the prosthesis was infected with Methicillin Resistant Staphylococcal Aureus (MRSA) bacteria. The resident's physician had ordered Vancomycin (antibiotic) IV medication to be administered three times a day for six (6) weeks. Review of the resident's February MAR revealed the IV Vancomycin was scheduled to be administered at 8:00 AM, 2:00 PM, and 8:00 PM. Review of the lab work (trough levels) obtained since the medication error revealed the Vancomycin level were 16 and 17.4 (at the optimal therapeutic level between 10-20).</p> <p>Observation of Resident #1, on 02/18/15 at 9:25 AM, revealed the resident laying in bed with IV</p>	F 309	<p>F309 - Provide Care and Services for Highest Well Being</p> <p>1.) Resident #1 was not harmed. The physician was notified immediately and orders were received to monitor the resident for any adverse reactions. Family member was also informed at that time. The pharmacy was also contacted for review of the medication given and for any known allergic reactions. The patient was monitored for any adverse effects and none was noted. The nurse was educated on 2/13/15 on the Medication Pass Clinical Competency form, which included the five rights. On 2/18/15, all residents who were receiving an IV antibiotic were also audited to ensure that the residents were receiving the correct medications. Resident #4 did receive the correct dose of antibiotic at the right</p>	3-26-15	



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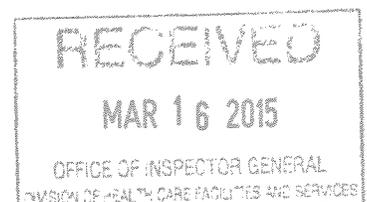
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F 309	<p>Continued From page 2</p> <p>tubing connected to a Peripheral Inserted Central Catheter (PICC) in the resident's right upper arm. A small IV bag of Vancomycin mixed in 250 ml of Normal Saline (with the resident's name on the bag) was observed running at 250 ml/hour via pump. The IV medication had infused and the nurse was observed to disconnect the IV tubing from the resident's PICC line.</p> <p>On 02/18/15 at 9:35 AM, interview with the resident and a family member, who was in the room at the time of observation, revealed the resident received the wrong IV medication on 02/13/15. The family member stated the Corporate Compliance Officer was in the room when the medication error was discovered. The Officer told the family member the facility would investigate the medication error and would get back with the resident. The family member stated the facility had not informed the resident the reason for the medication error.</p> <p>Interview with Resident #1's primary physician, on 02/18/15 at 2:40 PM, revealed the physician was notified of the medication error. He said he informed the nurse to monitor the resident for any adverse reactions and to call him if they observed any. He revealed the facility had not requested his assistance in development of any corrective action plans.</p> <p>Interview with the Corporate Director of Clinical Compliance, on 02/18/15 at 2:49 PM, revealed he was in Resident #1's room when the medication error was discovered. He revealed he was speaking with the family regarding some food concerns. The resident had only been at the facility for two days. A family member was talking to him and was at the resident's bedside where</p>	F 309	<p>time indicated per MD order.</p> <p>2.) Any resident receiving an IV antibiotic will be audited, using the Daily Audit Sheets, by the Director of Health Services, the Assistant Director of Health Services, or the Staff Development Coordinator, to ensure that any resident that receives an IV antibiotic is receiving the correct medication. These audits will be completed on or before March 25th, 2015.</p> <p>3.) Nursing staff will be in-serviced by the Director of Health Services, the Assistant Director of Health Services, or Staff Development Coordinator on the Medication Administration Policy on or before March 25th, 2015.</p> <p>4.) Director of Health Services, Assistant Director of Health Services, or Staff Development Coordinator will utilize the Daily</p>		



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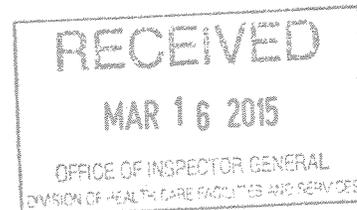
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F 309	<p>Continued From page 3</p> <p>the IV pole was located. The family member looked at the IV medication bag and said, "whose name is this?" He said he looked at the IV bag and it had another resident's name on it. The IV antibiotic medication had already infused into the resident's PICC line and was empty. The Compliance Officer stated he immediately called the pharmacy to see what class of antibiotic was given to the resident and if the resident had any allergies to the medication. The pharmacy told him the antibiotic given to the resident was the same drug class as the antibiotic medication the resident was supposed to have received (Vancomycin) and the resident had no allergies to the medication. The pharmacy told him to monitor the resident for any side effects. He revealed he completed a medication error report and with the Assistant Director of Nursing (ADON) interviewed the nurse who had hung the wrong medication. They went into the medication room where both IV medications were stored. He said the Vancomycin was in the refrigerator in a 250 ml bag with Resident #1's name on the bag. The medication (Meropenem) intended for Resident #4 was stored in a large Ziploc bag with the resident's name on it, in a tote in the medication room. This medication had to be mixed while the Vancomycin was already pre-mixed by the pharmacy.</p> <p>Continued interview with the Compliance Officer revealed when he interviewed the nurse, she told him she had failed to conduct the three checks, MAR, Medications, and Resident. She told him she was not familiar with the residents on that unit and was rushed that morning. He indicated after the discovery of the medication error, the resident was monitored for seventy-two (72) hours.</p>	F 309	<p>Audit Tool weekly for 4 weeks, then monthly for 6 months, then quarterly thereafter. These audits will be reviewed during the facility Quality Assurance Meeting. If non-compliance is found, then the action plan will be revised at the direction of the Quality Assurance Committee. The action plan will remain in place until substantial compliance is maintained.</p>		



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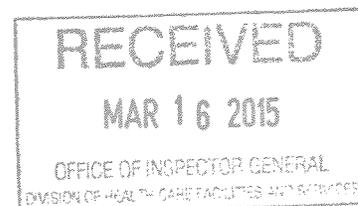
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F 309	Continued From page 4 Interview with the Executive Director (ED), Director of Nursing (DON), and the ADON, on 02/18/15 at 3:24 PM revealed the DON was not at the facility the day of the medication error, but the ADON was part of the investigation. Interview with the ADON revealed LPN #1 had recently transferred from night shift to the day shift and was having difficulty adjusting to the transition. She said LPN #1 told her she was busy and didn't do the triple checks that she would have conducted before giving a medication to a resident. She said the nurse failed to check the MAR and didn't look at the medication or IV solution bag. She said when they looked for the medications in the medication room, the Vancomycin was stored in the refrigerator and the Meropenem was in a Ziploc bag, inside a tote from the pharmacy. She said the medications are not alike because the Vancomycin was pre-mixed from pharmacy (in a 250 ml bag of Normal Saline) and the Meropenem comes in powder form and you have to mix with Normal Saline. She stated both medications were clearly marked with the residents' name. Interview with the DON and ED, on 02/18/15 at 3:24 PM, revealed the following actions were implemented after the medication error: education was provided to LPN #1 on the facility's medication policy with the Patient's Five Rights; the DON stated they had identified the need for a nurse who transition from another shift to follow a nurse on the new shift for a few days to adjust to the changes; and, a mandatory nursing meeting was scheduled for next week to review the medication error and provide training. The ED stated she was working on corrective actions for the deficiencies cited during the standard survey	F 309			



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F 309	<p>Continued From page 5</p> <p>ending on 02/12/15. She revealed there had been no Quality Assurance Meeting since the medication error and no other nurses had been re-trained. In addition, no audits had been performed as indicated by the Compliance Officer to determine if any other resident had received the wrong medication. The facility had not observed any medication pass to ensure residents were receiving medications as prescribed by their physician.</p> <p>A telephone interview with LPN #1, on 02/18/15 at 4:34 PM, revealed she was the nurse who hung the wrong IV medication for Resident #1 on Friday, 02/13/15. She stated it was human error because she was very busy that day. She revealed she had just started working the day shift and it was so different from night shift. She stated this was her first day working the health (long term) side of the building and she did not know the residents or the routine of that unit. She said she was in charge of thirty (30) plus residents because she was the only nurse scheduled for that unit that morning. She revealed a Certified Medication Tech (CMT) was scheduled to administer the oral medications. She indicated it was overwhelming for her. She recalled there was a delay in administering the IV medication for Resident #1 because she was waiting for a Register Nurse to obtain blood from the resident's PICC line for a trough level. She said the physician had ordered the trough level to be obtained prior to administering the IV Vancomycin. After the trough level was obtained, she went to hang the IV medication. She said she went into the medication room and saw a tote with IV supplies with Resident #1's name on it. She assumed the IV supplies and medication in the tote belonged to Resident #1. She stated she</p>	F 309			



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F 309	Continued From page 6 forgot Vancomycin must be stored in the refrigerator. However, she picked up the Meropenem medication without looking at the label and mixed the medication and gave it to Resident #1. She stated it was 100% her error because the resident's name was on the vial of medication and on the 50 ml IV bag. She said she should have checked the medication against the MAR and physician orders because she did not know the resident.	F 309			

