| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345131 | A. BUILDING _____ B. WING _____ | C 09/02/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CLEMMONS NURSING & REHAB CENTER** | **3905 CLEMMONS ROAD CLEMMONS, NC 27012** |

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| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews with staff, interview with the pharmacy consultant, interview with the physician and record review, the facility administered to Resident #1 twice the dose of Morphine concentrate prescribed. This was evident in 1 of 3 residents in the sample for medication review.<br>Findings included:<br>Resident #1 recent readmission to the facility was on 6/20/14 with cumulative diagnoses which included idiopathic end stage pulmonary fibrosis and a fractured odontoid (common cervical spine fracture).<br>Record review revealed the resident was receiving palliative /comfort care 6/23/14.<br>Review of the 6/27/14 Minimum Data Set revealed in part Resident #1was alert and oriented and required extensive assistance from staff for care.<br>Review of the June 20, 2014 physician orders revealed in part;<br>· Morphine concentrate 100 milligrams (mg) per 5 milliliters (ml). Administer 5 mg (0.25 ml) by mouth three times a day. The scheduled times were 6 AM, 2 PM and 10 PM. Morphine is a strong opioid used to treat severe, chronic pain or acute respiratory problems.<br>Review of the computerized skilled nursing observation form dated 6/28/14 at 4:46 pm and 4:50 pm revealed at approximately 10:45 am the nurse was informed that the resident was sleeping a lot. On assessment the resident was | F 333 | Resident # 1 was assessed by nurse # 2, and found to be tired and lethargic. Resident□s O2 saturation was fluctuating between 89% and 94%. A review of the controlled drug record revealed Nurse # 1 had administered more than prescribed amount of Morphine.<br>Resident # 1 was sent to the local hospital for evaluation and treatment. All residents receiving morphine have and will be Monitored and interviewed for effectiveness and side effects. If residents receiving morphine exhibited adverse reactions, physician notified and resident will receive Narcan, if it was determined that the resident received a dosage of morphine greater than the prescribed order, and/or sent to Hospital for evaluation and treatment, per physician orders. Resident #2 and #3 were not affected by the practice.<br><br>All nurses will use the manufacturers syringe to administer morphine. Two (2) nurses will be required to review and sign off on the dosage of liquid morphine that is being ordered and administered to a resident. This corrective action will continue with each Administration of liquid morphine times three (3) Months. The Director of Nursing will be Responsible for | 9/30/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/24/2014

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| F 333 | Continued From page 1<br>responsive but seemed tire and lethargic. The resident vital signs were measured as blood pressure 119/62, heart rate 107 beats per minute, and respirations 22 with a pulse oximetry of 97% on nasal oxygen. At approximately 12 noon the resident ' s pulse oximetry level fluctuated between 89% and 94%. The oxygen liter rate was increased. Subsequently, the resident was transferred to the hospital. There were no other notes regarding the resident ' s mental status.<br>Review of the controlled drug record revealed Nurse #1 documented Morphine concentrate 0.5 ml was administered to Resident #1 on 6/28/14 at 6:30 am.<br>Review of the medication error report (undated) revealed on 6/28/14 at 6:30 am Resident #1 was administered Morphine 10 mg instead of the 5 mg which was ordered.<br>Interview on 9/2/14 at 5:45 pm via the phone with Nurse #1(who administered the 10 mg) revealed the Resident #1 looked tired. By 7 am the resident positioned herself up in the bed, held a conversation then laid down to sleep. Nurse #1 indicated she was mentally preoccupied on 6/28/14 and was not sure if she gave .25 ml (5 mg) or .5 ml (10 mg) of Morphine to Resident #1.<br>Interview on 9/2/14 at 6 pm via the phone with Nurse #2 revealed she reported to the manager on duty that Resident #1 may have gotten too much Morphine because the resident seemed sedated when the Emergency medical technician ' s arrived. Nurse #2 indicated that staff were in serviced on the proper method to administer Liquid Morphine after Resident #1 went to the hospital.<br>An interview was held on 9/2/14 at 1:08 pm with the administrator, current director of nurses (DON) and staff development coordinator (SDC). The administrator indicated she was contacted on | F 333 | compliance.<br><br>A Morphine audit was completed for all residents receiving morphine in the facility on Sept. 4th, 11th, and 18th and again on the 25th. Morphine audits will continue weekly for an additional 1 month.<br>By-weekly audits will continue for an additional two months, continue monthly for an additional two months. Nurses will be in-serviced on Medication Administration and conversion chart, followed by a test for proficiency in administration and Calculation. The Director of Nursing will be responsible for compliance.<br><br>New hires will be in-serviced upon hire. Current Employees will be in-serviced quarterly on Morphine administration and calculation. Nurses will be in-serviced upon hire and thereafter quarterly to ensure nurses are proficient in administering morphine and documenting appropriately. Each month four different nurses will have a Medication Pass Review by the Pharmacy Consultant or RN Nurse Managers. This will continue for six months. The Director of Nursing will be responsible for compliance.<br><br>The Corrective Action will be monitored monthly for six months for compliance. If the defective practice is repeated, all Corrective Actions will continue until a three month compliance has been achieved. The Quality Assurance Committee is Responsible for the ongoing monitoring Of the Corrective Action Plan. | |

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| F 333 | Continued From page 2<br>6/28/14 by the manager on duty that an allegation of too much Morphine was administered to Resident #1. Further interview with the administrator indicated that an investigation and medication error report was completed. The administrator provided the medication error report but was unable to locate files/supporting evidence that a thorough investigation and corrective actions had been taken by the facility. The administrator indicated that the resident was admitted to the hospital with a urinary tract infection and not associated with the additional dose of Morphine that was given. The SDC indicated she could not locate the investigative files but had previously witnessed written statements from staff and in services/ training attendance sheets that had been provided by the previous director of nurses. The SDC indicated the Corrective actions included training about milligrams versus milliliters, using the manufacturer ' s syringe, and 2 (two) nurses to verify the amount of Morphine in the liquid container. Continued interview on 9/2/14 at 7 pm with the administrator, current DON, SDC and unit manager revealed no ongoing assessment audits were performed on residents with orders to receive Morphine or any other controlled substances. Record review during the interview revealed the facility held a quality assurance committee meeting on July 17, 2014 but did not discuss the Morphine error.<br>The manager on duty on 6/28/14 was not available for interview at the time of the survey. Interview on 9/2/14 pm at 1:50 pm via the phone with the pharmacy consultant revealed the facility staff called her about the effect/impact of symptoms related to the increased dose of Morphine given on 6/28/14. The consultant pharmacist indicated Morphine immediate | F 333 | | |

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| F 333 | Continued From page 3<br>release has an onset of 30 minutes and 4 hours duration of action. The consultant indicated that was not involved in corrective actions implemented by the facility.<br>Interview on 9/2/214 at 3 pm via the phone with the attending physician and medical director revealed the facility discussed the timely dispensed of opioids and the management in the use of Fentanyl patches. Further interview with the attending physician/medical director indicated that the resident ' s transfer and admission to the hospital could not be directly related to the additional dose of Morphine.<br>Interview on 9/2/14 at 3:48 pm with Nurse #3 revealed in-services were provided by the previous DON regarding the Morphine error, using the manufacture ' s dropper and to be alert for ml versus mg.<br>Interview on 9/2/14 at 4:10 pm via the phone with the previous DON was conducted. The previous DON indicated that the SDC did training for the staff. Further interview revealed no audits of other residents who would have been affected by the administration of Morphine was done. | F 333 | | |