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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 7/19/18 - 7/20/18.<br><br>Past non compliance was identified at:<br><br>CFR 483.45 at tag F760 at a scope and severity (J)<br><br>Tag F760 constituted a Substandard Quality of Care<br><br>A partial extended survey was conducted. | F 000 | | |
| F 760 SS=J | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff and Physician interview, the facility failed to prevent a significant medication error by administering a wrong dose of Morphine Sulfate (a narcotic pain medication) to 1 of 3 sampled residents reviewed for pain (Resident #1). Resident #1 was administered 50 milligrams (mgs) of Morphine Sulfate instead of 5 mgs as ordered. Resident #1 had a significant change in condition with respiratory rate between 4-6 breaths per minute after receiving 3 doses of 50 mgs Morphine Sulfate.<br><br>Findings included:<br><br>Resident #1 was originally admitted to the facility on 12/18/17 and was readmitted from the hospital | F 760 | Past noncompliance: no plan of correction required. | 8/6/18 |

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

Electronically Signed | 08/06/2018

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on 7/6/18 with multiple diagnoses including Congestive Heart Failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 6/9/18 indicated that Resident #1's cognition was intact.

Resident #1's admitting orders dated 7/6/18 were reviewed. The orders included Morphine Sulfate 20 mgs/milliliter (ml) - give 0.25 ml by mouth every 4 hours as needed (PRN) for pain. The 0.25 ml of Morphine Sulfate (20 mg/ml) was equivalent to 5 mgs.

The July 2018 Medication Administration Record (MAR) was reviewed. The MAR revealed that Resident #1 had received 0.25 ml of Morphine Sulfate 20 mg/ml on 7/8/18 at 2:23 PM, 7/9/18 at 2:03 AM, 7/10/18 at 3:35 AM and on 7/11/18 at 12:38 AM.

On 7/11/18, Resident #1 had a new order for Morphine Sulfate 10 mgs/5 ml - give 2.5 ml every 4 hours by mouth for shortness of breath/pain. The 2.5 ml of Morphine Sulfate (10mg/5 ml) was equivalent to 5 mgs.

The July 2018 MAR and the Controlled Substance Count Sheet were reviewed and revealed that Resident #1 had received 2.5 ml of Morphine Sulfate 20 mg/ml on 7/12/18 at 12:00 midnight, 4:00 AM and 8:00 AM. The MAR indicated that on 7/12/18, the 12:00 noon and 4:00 PM doses were withheld. The 2.5 ml of Morphine Sulfate 20 mg/ml was equivalent to 50 mgs.

On 7/19/18 at 9:05 AM, the medication cart on the 400 hall, where Resident #1 used to reside, was observed. There was a full 100 ml bottle of

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Morphine Sulfate 10 mg/5 ml noted in the cart. The Controlled Substance Count Sheet for the Morphine Sulfate 10 mg/5 ml revealed that the bottle was never used. There was no Morphine Sulfate 20 mg/ml bottle noted in the cart.

Resident #1's nurse's notes were reviewed. The notes dated 7/12/18 at 12:55 PM revealed that the resident was declining and her blood pressure was 91/64, respiratory rate of 6 breaths per minute and oxygen saturation of 85% on room air. At 3:00 PM (hospice notes), the notes revealed that the resident had declined, she was unresponsive and her respiratory rate was 4 breaths per minute.

The notes dated 7/13/18 at 3:53 PM revealed that Resident #1's blood pressure was 89/54 and the respiratory rate was 5 breaths per minute. At 7:51 PM, the resident's blood pressure was 69/49 and her respiratory rate was 6.

The notes dated 7/14/18 at 9:12 AM, the notes indicated that the resident's respiratory rate was 8 per minute and the blood pressure was unable to obtain.

The notes dated 7/15/18 at 3:00 AM revealed that at 2:45 AM Resident #1 had passed.

On 7/19/18 at 10:35 AM, Nurse #1, assigned to Resident #1 on 7/12/18 (7-3 shift), was interviewed. Nurse #1 verified that she had documented on the MAR and on the Controlled Substance Count Sheet that she had administered 2.5 ml of Morphine Sulfate 20 mg/ml to Resident #1 on 7/12/18 at 8:00 AM but she thought she only administered 0.5 ml. She also stated that she did not administer the 12:00

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noon dose of Morphine Sulfate because the resident was too sleepy. Nurse #1 acknowledged that she did not read the label of the Morphine Sulfate on the bottle and the order on the MAR.

On 7/19/18 at 10:40 AM, Nurse #2, the unit manager, assigned to Resident #1, was interviewed. She stated that she was the nurse who verified the admitting orders for Resident #1 on 7/6/18. She had received an order from the physician on 7/6/18 for Morphine Sulfate 20 mg/ml - to give 0.25 ml by mouth every 4 hours (scheduled) for pain. Nurse #2 admitted that she electronically transcribed the order to give Morphine Sulfate every 4 hours as needed (PRN) instead of every 4 hours scheduled. She stated that on 7/11/18, she had caught her error and made a clarification order to give Morphine Sulfate 10 mg/5 ml - give 2.5 ml every 4 hours scheduled for shortness of breath/pain. Nurse #2 further indicated that she had changed the order of the Morphine Sulfate from 20 mg/ml to 10 mgs/5 ml because the pharmacy had dispensed the Morphine Sulfate on 10 mgs/5 ml concentration.

On 7/19/18 at 2:32 PM, the Hospice Nurse was interviewed. She stated that she visited Resident #1 on 7/12/18 after lunch. She stated that the resident was unresponsive and her respiration was 4 per minute. The Hospice Nurse indicated that she didn't know the resident's baseline condition because that was her first visit with the resident. She further indicated that she had asked the staff and she was told that the resident was declining, she was drowsy and she didn't eat lunch. The Hospice Nurse stated that she was not aware during her visit that the resident had an overdose of Morphine.

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On 7/19/18 at 3:25 PM, Nurse #3, assigned to Resident #1 on 7/11/18 (11-7 shift), was interviewed. She admitted that she had administered 2.5 ml of Morphine Sulfate 20 mgs/ml to Resident #1 on 7/12/18 at 12:00 midnight and 4:00 AM. Nurse # 3 verified that she did not read the label of the Morphine Sulfate on the bottle and she did not read the order on the MAR. She further stated that the resident was alert and responsive during her shift and her breathing was normal.

On 7/19/18 at 12:13 PM, the Physician of Resident #1 was interviewed. He stated that he was informed of the medication error on Resident #1. He indicated that he was told that Resident #1 had an overdose of Morphine Sulfate and the last dose administered was at 8:00 AM. He indicated that the resident was receiving hospice care so he didn't order to send the resident to the hospital. The Physician further stated that he didn't think that the cause of the resident's death was the Morphine overdose.

On 7/19/18 at 10:51 AM, the Director of Nursing (DON) was interviewed. The DON stated that the pharmacy was scheduled to deliver medications at night. Resident #1 was admitted on 7/6/18 during the day and had an order for Morphine Sulfate. The nursing staff had pulled the Morphine Sulfate 20 mg/ml bottle from the pyxis (an automated medication dispensing system). On 7/6/18 (night), the pharmacy had delivered the Morphine Sulfate 10 mgs/5 ml bottle and it was stored on the 400 hall medication cart. The nurses failed to remove the Morphine Sulfate 20 mgs/ml bottle from the 400 hall medication cart and they continued to use it. The DON revealed

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that the resident had a significant change in condition on 7/12/18 and she thought that the resident was actively dying.

On 7/19/18 at 12:30 PM, the DON was again interviewed. She stated that she was informed of the medication error around 5:00 PM on 7/12/18. The Physician was informed on 7/12/18 at 5:30 PM and he ordered to monitor the resident. The DON revealed that she monitored Resident #1 the entire night of 7/12/18 including her vital signs and her blood pressure and respiratory rate fluctuated. Her blood pressure readings were between 75/55 - 105/60 and her respiratory rate was between 8-14 breaths per minute. The DON further revealed that she expected the nurses to read the medication label on the bottle and to read the entire order on the MAR before administering medications to the resident. The DON further indicated that she also expected the nurses to remove discontinued medications and medications of discharged residents immediately from the medication carts.

The corrective action for past non-compliance dated 7/14/18 was as follows:

The Process that lead to the cited deficiency:

Facility has self-identified an issue with the dosage of a medication given to Resident #1. At the time of the discovery, the medication was discontinued by the physician.

On 7/6/18, Resident #1 was admitted to the facility from the hospital. The admitting order for the Morphine Sulfate (a narcotic pain medication) was clarified with the physician and an order was given for Morphine Sulfate 20 milligram

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(mgs)/milliliter (ml) - give 0.25 ml every 4 hours by mouth scheduled for shortness of breath (SOB)/pain. The unit Manager transcribed the Morphine Sulfate order to the electronic Medication Administration Record (MAR) to give 0.25 ml of 20 mg per ml solution, every 4 hours as needed (PRN) instead of scheduled every 4 hours as ordered. The facility staff pulled the Morphine Sulfate 20 mgs/ml bottle (30 ml) from the facility Pyxis (automated dispensing system supporting decentralized medication management). The pharmacy dispensed the Morphine Sulfate 10 mgs/5 ml bottle (100 ml) to the facility the night of 7/6/18. The morphine from the pharmacy with the concentration of 10 mg per 5 ml was never accessed by the nurses, as they kept using the 20 mg per ml concentration that was obtained from the Pyxis. The resident received 2.5 ml's each time administered for three doses. The residents name was on the bottle of 20 mg per ml concentration, written on tape. The resident did receive one dose on July 6th, from the 20 mg per ml bottle. From July 6th to July 11th, the resident received 0.25 ml of 20 mg per ml solution. She received this medication solution prn verses scheduled.

On 7/11/18, the Unit Manager entered a clarification order for Morphine Sulfate 10 mgs/5 ml - give 2.5 ml every 4 hours scheduled and transcribed it to the electronic MAR. After the clarification order, the Morphine Sulfate 20 mgs/ml bottle was left in the medication cart by the charge nurse that was assigned to that cart. The 10mg/5 ml bottle that came from the pharmacy, with the resident's name on it, was placed in the cart upon delivery.
On 7/12/18, Resident #1 was administered Morphine Sulfate 2.5 ml of the 20 mg/ml

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concentration by two different nurses, instead of 10 mgs/5 ml concentration at 12:00 midnight, 4:00 AM and 8:00 AM.

On 7/12/18 at 5:00 PM, the medication error was identified and the Morphine Sulfate was discontinued. The physician and the Responsible Party (RP) were informed of the medication error. Resident #1 was monitored for over sedation by monitoring vital signs. No signs of distress or pain were noted and patient returned to baseline and patient continued to respond when her name was called.

Root cause analysis was completed by the Quality Assurance Team and was determined that both nurses failed to follow the 6 rights of medication administration. Neither nurse validated that they were giving the correct concentration of morphine by matching the order to the morphine bottle. In addition, the discontinued medication had not been pulled from the cart when the order was changed.

The procedure for implementing the acceptable plan of correction for the cited deficiency:

All guests that receive controlled substances have the potential to be affected by this alleged deficient practice. All controlled substances that were ordered and available to be given to patients, were reviewed by the Director of Nurses (DON) and pharmacist on 7-13-18. A printout of all controlled substances that was currently being given was obtained from the electronic medical record by the DON. The orders for the narcotics were compared to the medication administration records and to the actual narcotics on the medication cart. The orders were compared to

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the medication in the narcotic box on the medication cart by the DON and pharmacist, to ensure that the correct strength and concentration matched the order. No other medication was found on the cart that did not have the correct concentration and matched the order.

All licensed staff on duty on July 12th were immediately reeducated on the 6 rights of medication administration, by the DON and ADON and pharmacist. All other nurses before being able to return to work, were reeducated as well by the DON and ADON and pharmacist, to include the six rights of medication administration. All in services were completed by July 14th. All new nurses will be educated upon hire on the 6 rights of medication administration. All guests that receive morphine sulfate orally, prior to administration, will be validated by two licensed nurses and the declining inventory narcotic sheet will be co-signed by the two licensed nurses, prior to administration. Guests who are discharged from the facility, or controlled substances that have been discontinued, will be removed from the medication cart by the charge nurse assigned to that cart or the unit manager for that unit, and stored in a lock box in medication room until it can be picked up by the pharmacy for return. All new orders for liquid morphine will be checked at the daily clinical meeting to verify the accuracy of orders and the orders are to be checked against the MAR and the bottle to make sure they are accurate. The Quality Assurance committee, with the Medical Director has recommended that only one concentration of oral morphine be available to be given. That recommendation has been implemented by the Administrator. The pharmacy

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has been instructed by the DON to supply only one concentration of oral morphine in the Pyxis and when filling orders at the pharmacy.

The monitoring procedure to ensure that the plan of correction is effective and that the cited deficiency remains corrected and/or in compliance with regulatory requirements:

The DON, ADON, Unit Managers and Pharmacist, will perform medication administration audits reviewing the charge nurse providing medication to the resident utilizing the 6 rights of medication administration, randomly on all shifts, to include administration of liquid medications and controlled substances, weekly for 4 weeks, then monthly for 6 months, and then quarterly for 2 quarters., to ensure proper administration of medications. Medication carts will be checked by the DON and/or ADON weekly times 4 weeks and then monthly for 6 months then quarterly for 2 quarters, for medications that have been discontinued or the resident has discharged from the facility, to ensure medications have been removed immediately. Orders reviewed in the clinical management meeting will be audited for accuracy, comparing the concentration of the medication to the transcribed order on an ongoing basis and the medication administration record. Results of these audits will be reviewed at the monthly facility Quality Assurance committee meeting. Any additional recommendations from that meeting will be the responsibility of the facility Administrator to carry out.

Date of compliance 7-14-2018 fo

On 7/20/18, as part of the validation process, the

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| F 760 | Continued From page 10<br>plan of correction was reviewed and verified through review of the audit sheets and the in-service records, observation of the medication carts and staff interview. Interview with the nursing staff revealed that they had received an in-service on the 6 rights of medication administration including 2 nurses witnessing the administration of Morphine Sulfate and returning of discontinued medications and medications of discharged residents to the pharmacy. A review of the audit sheets of resident's on narcotics and the in-service records including the sign in sheets was conducted. Observation of the medication carts was conducted comparing the order on the MAR and the label on the medication bottle. The validation process verified the facility's date of compliance as 7/14/18. | F 760 | | |