### F 580

Notify of Changes (Injury/Decline/Room, etc.)

CFR(s): 483.10(g)(14)(i)-(iv)(15)

§483.10(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:

Based on record review, staff interviews and family interview the facility failed to notify the family that the resident received 20 times the amount of morphine (a narcotic pain medication) as prescribed by the physician. This was evident in 1 (Resident #7) of 3 residents reviewed for notification of change.

Findings Included:

Resident #7 was admitted to the facility on 4/17/15 and diagnoses included dementia, diabetes, atrial fibrillation and dysphagia.

A review of the annual minimum data set (MDS) dated 9/11/17 for Resident #7 identified the resident’s cognition as severely impaired and the resident had received routine pain medication during the 7-day look back period.

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 must be submitted and implemented within 30 days. The above isolated deficiencies pose no actual harm to the residents.
A care plan with an initiation date of 9/19/17 for Resident #7 identified she was at risk for alteration in comfort related to osteoarthritis. Interventions included to administer tender loving care (i.e. repositioning, back rub), encourage resident to report any pain, administer pain medications as ordered, observe for effectiveness of pain medication for the control of pain, handle gently and try to eliminate any environmental stimuli, encourage to express fears and concerns, observe for non-verbal signs of pain (i.e. grimacing, guarding, moaning, restlessness, diaphoresis), notify physician as needed and conduct pain assessment routinely.

Review of the medical record for Resident #7 identified she began Hospice services on 10/24/17. A physician telephone order dated 10/25/17 at 4:40 pm specified Resident #7 was to receive morphine 20 milligrams (mg) per milliliter (ml), 5mg by mouth every 4 hours scheduled, and every 2 hours as needed for pain / shortness of breath.

A review of the medication administration record (MAR) on 10/25/17 for Resident #7 revealed an order for morphine 20mg/ml - oral syringe. "Give 5mg sublingual every 2 hours as needed for shortness of breath/pain." There was a checkmark and nurses initials on 10/25/17 that the medication was administered at 8:14 pm.

Review of the controlled drug receipt record disposition form identified that 5ml of morphine was given to Resident #7 and 24.5ml of morphine was left in the bottle at 8:00 pm on 10/25/17. This reflected that the resident received 20 times more morphine than prescribed by the physician.

Review of the medical record face sheet for Resident #7 identified the primary responsible party was blank. There was a second and a third contact identified with names and phone numbers.

An interview with the Business Office Manager (BOM) on 12/21/17 at 11:27 am revealed that Resident #7’ s daughter was her primary responsible party when she was admitted on 4/16/15. The BOM stated when the resident was re-admitted to the facility on 10/28/15 Resident #7 was her own responsible party.

Review of a nursing note for Resident #7 dated 10/26/17 at 4:10 pm stated the resident had passed away at 9:10 am. Hospice was with the patient as she passed. Resident’ s second contact was not available so third contact was notified of Resident #7’ s death and came to the facility.

A phone interview on 12/20/17 at 4:37 pm with the third contact for Resident #7 revealed neither she nor the resident ’s second contact had been notified by the facility of the morphine overdose.

An interview with the Administrator on 12/21/17 at 9:45 am revealed Resident #7’ s family was not notified of the morphine overdose because the resident had passed away before they discovered the med error. She stated the resident passed away in the morning on 10/26/17 and the investigation confirming the morphine overdose wasn ’t completed until the afternoon of 10/26/17. The Administrator added the facility was not obligated to notify the family at that time since the resident had passed away and was no longer a resident of...
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