STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____ AUG 05 2011	C 07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE ST JACKSONVILLE, NC 28546

(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 329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, facility staff interviews, and physician interview the facility failed to ensure that 1 of 4 residents (Resident #1) was free from unnecessary medication by giving an excessive dose of Roxanol(50 mg) rather than the ordered dose of Roxanol(5mg).	F 329	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Ross — TITLE: Administrator — (X6) DATE: 8/3/2011

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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The findings include:
Resident #1 was admitted to the facility on 4/30/11 and re-admitted on 06/28/11 with cumulative diagnoses of large bilateral pleural effusions with respiratory failure, hypoxemia, hypertension, peripheral vascular disease, diabetes mellitus type 2, and chronic pain. Resident #1 expired in the facility on 7/3/11 at 12:10 AM.

Resident #1 ' s most recent Quarterly Minimum Data Set (MDS) dated 6/23/11 revealed that the Resident was moderately cognitively impaired. The Resident was identified as requiring extensive assistance from facility staff for Activities of Daily Living.

The physician admission assessment note dated 6/29/11 revealed that the resident had chronic respiratory failure secondary to bilateral large pleural effusions and was re-admitted on 6/28/11 to the facility on comfort care only under Hospice care.

Resident #1 ' s physician orders dated 6/29/11 stated, " Oral Roxanol (Morphine) 20 milligram (mg) per milliliter(ml) concentration in every 0.25ml PO (by mouth) or SL (sublingual) every 2 hours PRN (as needed) for pain or air hunger. " The ordered dose of 0.25ml contained 5 mg of Roxanol.

The MAR (medication administration record) for Resident #1 revealed an order was transcribed to give Oral Roxanol (Morphine) 20 milligram (mg) per milliliter(ml) concentration in every 0.25ml PO (by mouth) or SL (sublingual) every 2 hours PRN (as needed) for pain or air hunger Nurse

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#1 ' s initials were written on the MAR in the space for 7/1/11 (nurses put their initials in those spaces to indicate they have administered the medication).

Resident #1 ' s Controlled substance receipt/count sheet for Roxanol/Morphine 20mg/ml was signed by Nurse #1 on July 1, 2011 at 4:15 PM with the dose given documented as 2.5ml and not the ordered dose of 0.25ml.

Resident #1 ' s nurse ' s notes dated 7/2/11 at 2:17 AM revealed that Nurse #1 gave the resident Morphine at 4:15 PM (on 7/1/11) and that the Morphine count was incorrect. She noted that she had given 2.5ml of Morphine which is equal to 50mg. The nurse ' s note also indicated that Nurse # 1 notified the doctor and the DON was notified by the supervisor.

Nurse #1 was not available to be interviewed.

On 7/18/11 at 2:50 PM, the Director of Nursing (DON) stated that she was made aware on 7/1/11 around 11:30 PM by the nurse supervisor that Nurse #1 gave Resident #1 an incorrect dose of Roxanol. She stated that the supervisor reported no changes in the resident ' s condition.

On 7/18/11 at 4:28 PM, Nurse #2 stated that he worked as the 3PM-11PM shift supervisor when he was informed that there was an error with the narcotic count. Nurse #2 stated that Nurse #1 showed him a 30ml medication cup and pointed to the line that showed 2.5ml. Nurse #2 stated

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that he told Nurse #1 that she had given Resident #1 the wrong dose and too much Roxanol and that the ordered dose should be 0.25ml. He stated that he and Nurse #3 went to assess the resident and the resident was lethargic but able to be aroused and his vital signs were stable. He stated that Nurse # 1 notified the MD of the resident ' s status. Nurse #1 received orders to monitor the resident. Nurse #2 immediately gave Nurse # 1 a consultation on giving the wrong dose of Roxanol.

On 7/18/11 at 4:40PM, the MD stated that he was contacted on 7/2/11 around 1:00AM and was made aware by Nurse #1 that Resident #1 was given 2.5ml of Roxanol which was more than the ordered dose of 0.25ml of Roxanol. He ordered Resident #1 to be monitored and to call him if anything changed. He also stated that he instructed the nurse to call the family and complete an incident report.

On 7/19/11 at 1:30 PM, Nurse #10 stated she worked as the 7AM-3PM nurse supervisor on 7/2/11 and that Resident #1 was extremely lethargic. She called the MD at 10:30AM and made him aware of the resident ' s status and received an order for Narcan 0.4mg/ml-0.5ml. She stated the Narcan was ordered to reverse any lingering effects of the morphine and after giving the resident Narcan at 10:45AM, he did not respond that much. She stated that the MD only ordered half of a normal dose so the resident would not be in pain. She stated that the call to the MD was made as an update due the morphine overdose incident on 7/1/11.

Resident #1 ' s nurses note dated 7/2/11 at 12:05

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PM revealed that the resident ' s respiratory rate was 12 (within the normal limit) after he was administered the ordered dose of Narcan at 10:45 AM on 7/2/11, he aroused to touch and responded to questions appropriately.

On 07/19/11 at 11:39 AM, Interview with the Pharmacist contracted by the facility revealed that in almost all cases, the pharmacy dispensed Roxanol in the manufacturer ' s packing which was a cardboard box with the bottle on one side of the divider and the syringe on the other side. The package insert was left in the cardboard box when it was dispensed. The box was packaged in a plastic bag with a 2x2 adhesive STOP sticker on it that refers to a ' warning sheet ' . The warning sheet described the way to convert from mg to ml.

On 7/19/11 at 12:38PM, the MD stated that he did not order Narcan on 7/2/11 when he was first notified of the incident because he was told that the resident was not doing anything different, he was still in pain and his condition had not changed. He stated that he ordered the Narcan to reverse the effects of the morphine on 7/2/11 around 10:30AM because he was called and was told that the patient was still sleeping and would not awake. The MD indicated the resident ' s cause of death as bilateral pleural effusions with respiratory failure. (He stated it was unrelated to the dose of Roxanol).

The facility determined that all residents had the potential to be affected by the incident that occurred on 7/1/11 and initiated a quality improvement plan on 7/2/11. During the investigation, the facility provided documentation

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F 329	Continued From page 5 of interventions put into place as a result of the incident on 7/1/11. The facility submitted the following corrective action plan on 7/19/11 at 6:24pm. Corrective Action Plan Roxanol Overdose on 7/2/11 1) Resident #1 received 2.5mL of roxanol 20mg/mL solution, received narcan 0.5mg subcutaneous, on 7/2/11 at 1045 ordered by physician. He was receiving hospice care and expired on 7/3/11 at 0010. *An immediate disciplinary action on 7/2/11 and direct re-training was initiated on 7/3/11, under the supervision of Nurse #10, weekend supervisor, for employee involved in incident. Involved employee suspended after direct re-training as of 7/3/11 for further investigation, termed on 7/7/11 2) A detailed review on 200 Hall was completed by the Director of Nursing on 7/4/11, as was a review of all narcotic medications in the facility. Two residents had an order and supply of roxanol solution last dose received in Feb 2011 on one and May 2011 for the other. No other residents within facility received roxanol solution, all morphine medication including tablet and liquid forms provided as ordered. 3) 7/5/11 - 100% In-servicing for all licensed nurses 1:1 regarding proper medication administration given by Director of Nursing. In-service covered 6 Rights of medication, right resident, right medication, right route, right method, right time. Triple check all medications, prior to administration. Proper documentation signing, documenting assessment, effectiveness, and dose, route, time and date.	F 329		

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F 329	Continued From page 6 *Completed 7/15/11, Director of Nursing and supervisors 7/11/11- 100% In-servicing for all licensed nurses 1:1 regarding morphine medication administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Re-training regarding general medication administration, right medication, patient, frequency, route, order, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Director of Nursing and supervisors one on one. *Completed 7/15/11, by Director of Nursing and supervisors 7/15/11- Nursing in-service, addressing medication administration and dosing, this in-service was a general monthly in-service covering a review of the medication administration in-service, using the six rights of medication, having a second a second nurse verify all morphine medications, and informing staff of random audits that may take place. 4) Monitor - Random audits will be done weekly for four weeks by the Director of Nursing or appointed personnel, then monthly for 3 months to ensure compliance *Audit on 200 Hall completed on 200 Hall completed 7/4/11, by Director of Nursing, noted one resident on liquid morphine sulfate 10mg/5mL. *Audit on 300 Hall completed 7/13/11, by Director of Nursing, noted roxanol in cart and ordered for resident, has not received roxanol/morphine sulfate 20mg/mL since May of 2011 *Audit on 100, 200, 300, 700, 800A/B Hall completed 7/19/11, by 7-3 Supervisors Audit - The executive QI committee will meet	F 329		

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F 329	Continued From page 7 weekly to discuss issue and/or trends regarding audit and the need for future interventions *QI meeting held on 7/4/11, 7/11/11, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 ' s employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. The record indicated Nurse #1 was terminated on 7/7/11 due to her poor work performance and inability to adapt to work role. Nurse #1 was also reported to North Carolina Board of Nursing by the facility on 7/18/11. On 7/4/11 a record review revealed that the facility ' s initial audits were completed on 100, 200, 300, 700, and 800A/B Halls. The DON completed the audits that consisted of a review of all narcotic logs and current medication administration records of residents on morphine. There were two residents in the facility on morphine. Review of the audits revealed that all forms of morphine administration were correct and documented correctly. Record review revealed that 1:1 in-servicing began on 7/5/11 for licensed nurses and	F 329		

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F 329	Continued From page 8 medication aides on proper medication administration and documentation with 100% compliance of all licensed staff and medication aides. This was completed on 7/15/11. In-service records showed that additional 1:1 in-servicing took place on 7/11/11 for licensed nurses regarding morphine administration. The in-service topics included a mandatory new practice introduced to staff requiring every nurse to have a second nurse to verify dose including double signature on narcotic count sheet with all morphine products- facility policy to be revised. Re-training on general medication administration was also covered. In-services were completed by the DON and nurse supervisors. The in-service record indicated 100% attendance of all licensed staff by 7/15/11. Record review revealed that on 7/15/11, a nursing in- service/ general monthly in service was held and addressed the topics of medication administration, administration of morphine with a second nurse to verify dose and the staff was informed of continuing random audits. The Quality Improvement Committee meeting minutes revealed meeting were held on 7/4/11, 7/11/11, and 7/18/11 to review results of the audits and areas of concerns to determine the need for the frequency of continued monitoring. Record review revealed that on 7/13/11 an audit was completed to review narcotic log and current medication administration record of residents on morphine in which there was one resident on 300 Hall.	F 329		

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F 329	Continued From page 9 On 7/18/11 at 9:05 AM, Nurse #7 stated that she was in-serviced on medication administration. The nurse explained the steps of medication administration and how to document on the front and back of the medication administration record. She stated there had to be two nurses to verify and witness dosage to prevent errors. She stated that Morphine came with a special syringe. Med errors should be reported to supervisor, family and MD as soon as it happens. On 7/18/11 at 9:13 AM, Med Aide #1 stated that she did not administer morphine and had to ask the nurse to administer it if a resident needed it. She stated that she was aware that nurses needed a second nurse to witness liquid morphine and that she was in-serviced on medication administration. On 7/18/11 at 1:57 PM, Observation of medication administration of a PRN controlled medication was made without error, documentation was completed and the narcotic count was correct. This observation was made on the hall with the only resident that had a PRN order for Roxanol. On 7/18/11 at 2:02 PM, Nurse #4 stated that she used a syringe to administer Morphine if it was not the concentrated form and only used the calibrated syringe that came packaged with the Roxanol from the pharmacy to administer Roxanol. The nurse showed the syringe that was used and how it was documented. She stated that she had one resident that had a PRN order for Roxanol but that resident had not used it in around a month, therefore the Roxanol was not on the medication cart.	F 329		

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F 329	Continued From page 10 On 7/18/11 at 2:08 PM, Nurse #5 stated there had to be a second nurse present to check the dosage to give morphine and that a calibrated syringe should be used. On 7/18/11 at 8:56 AM, Nurse #6 stated that morphine usually came with a calibrated syringe. She stated that she was in-serviced on medication administration and that each and every time there had to be a second nurse to witness the dosage to assure it was correct. The nurse stated that she did not have anyone on her hall that was ordered Morphine liquid. She stated that if there was medication error she would notify the supervisor and complete the paperwork/incident report. The nurse that made the med error would have to call the MD and that resident ' s family. On 7/19/11 at 5:05 PM, the DON revealed that the QI committee will audit results weekly for 4 weeks and then monthly for 3 months and will follow up as need is determined. DON also stated that all new licensed employees will receive current in-service on medication administration and morphine administration with a second nurse by the Staff Development Coordinator prior to working on the floor. On 7/19/11 at 5:39PM, Nurse #9 stated that morphine had to be drawn up with a second nurse to verify dose. She stated that she had attended inservices on medication administration. The nurse explained the process of giving PRN medications and how to document. She stated that in the event a med error was made, it should be reported to the supervisor right away, notify	F 329		

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F 329	Continued From page 11 family and MD and complete the paperwork.	F 329		
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 record review, facility staff interviews, pharmacist interview and physician interview the facility failed to ensure 1 of 4 residents (Resident #1) was free from a significant medication error by administering a dose of Roxanol (50mg) rather than the ordered dose of Roxanol (5mg). The findings include: Resident #1 was admitted to the facility on 4/30/11 and re-admitted on 06/28/11 with cumulative diagnoses of large bilateral pleural effusions with respiratory failure, hypoxemia, hypertension, peripheral vascular disease, diabetes mellitus type 2, and chronic pain. Resident #1 expired in the facility on 7/3/11 at 12:10 AM. Resident #1 ' s most recent Quarterly Minimum Data Set (MDS) dated 6/23/11 revealed that the Resident was moderately cognitively impaired. The Resident was identified as requiring extensive assistance from facility staff for Activities of Daily Living. The physician admission assessment note dated 6/29/11 revealed that the resident had chronic respiratory failure secondary to bilateral large pleural effusions and was re-admitted on 6/28/11	F 333	Past noncompliance: no plan of correction required.	

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F 333	Continued From page 12 to the facility on comfort care only under Hospice care. Resident #1 ' s physician orders dated 6/29/11 stated, " Oral Roxanol (Morphine) 20 milligram (mg) per milliliter(ml) concentration in every 0.25ml PO (by mouth) or SL (sublingual) every 2 hours PRN (as needed) for pain or air hunger. " The ordered dose of 0.25ml contained 5 mg of Roxanol. The MAR (medication administration record) for Resident #1 revealed an order was transcribed to give Oral Roxanol (Morphine) 20 milligram (mg) per milliliter(ml) concentration in every 0.25ml PO (by mouth) or SL (sublingual) every 2 hours PRN (as needed) for pain or air hunger Nurse #1 ' s initials were written on the MAR in the space for 7/1/11. Resident #1 ' s Controlled substance receipt/count sheet for Roxanol/Morphine 20mg/ml was signed by Nurse #1 on July 1, 2011 at 4:15 PM with the dose given documented as 2.5ml and not the ordered dose of 0.25ml. Resident #1 ' s nurse ' s notes dated 7/2/11 at 2:17 AM revealed that Nurse #1 gave the resident Morphine at 4:15 PM (on 7/1/11) and that the Morphine count was incorrect. She noted that she had given 2.5ml of Morphine which is equal to 50mg. The nurse ' s note also indicated that Nurse # 1 notified the doctor and the DON was notified by the supervisor. A hand written telephone order dated 7/1/11 was signed by Nurse #1 at 1:15 AM stated, " Keep	F 333		

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PREMIER NURSING AND REHABILITATION CENTER	225 WHITE ST JACKSONVILLE, NC 28546

(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 13 watch on resident during night for decreased respirations and pulse " . Nurse #1 was not available to be interviewed. On 7/18/11 at 2:50 PM, the Director of Nursing (DON) stated that she was made aware on 7/1/11 around 11:30 PM by the nurse supervisor that Nurse #1 gave Resident #1 an incorrect dose of Roxanol. She stated that the supervisor reported no changes in the resident ' s condition. She stated that Nurse #2 did determine how Nurse #1 administered the dose incorrectly and Nurse #1 was immediately counseled, given a drug screen test and told to leave at the end of the shift and was to be notified when to return to work pending an investigation. The DON stated she started her investigation and quality improvement plan on 7/2/11. On 7/18/11 at 4:28 PM, Nurse #2 stated that he worked as the 3PM-11PM shift supervisor when he was informed that there was an error with the narcotic count. He stated that on 7/1/11 around 11:00 PM Nurse #3 made him aware that the count for Resident #1 ' s Roxanol was incorrect and Nurse #3 refused to take the cart until it was fixed. Nurse #2 stated that he questioned Nurse #1 and asked her how she administered the Roxanol. Nurse #2 stated that Nurse #1 showed him a 30ml medication cup and pointed to the line that showed 2.5ml. Nurse #2 stated that he told Nurse #1 that she had given Resident #1 the wrong dose and too much Roxanol and that the ordered dose should be 0.25ml. He stated that he and Nurse #3 went to assess the resident and the resident was lethargic but able to be aroused and his vital signs were stable. He stated that Nurse #	F 333		

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1 notified the MD of the resident ' s status. Nurse #1 received orders to monitor the resident. Nurse #2 immediately gave Nurse # 1 a consultation on giving the wrong dose of Roxanol. Nurse #2 helped Nurse # 1 adjust the count to the correct amount of Roxanol that was in the bottle. The DON was also called more than once during this incident.

On 7/18/11 at 4:40PM, the MD stated that he was contacted on 7/2/11 around 1:00AM and was made aware by Nurse #1 that Resident #1 was given 2.5ml of Roxanol which was more than the ordered dose of 0.25ml of Roxanol. He ordered Resident #1 to be monitored and to call him if anything changed. He also stated that he instructed the nurse to call the family and complete an incident report. The MD stated that he also spoke to Nurse #2, the supervisor, and told him to take Nurse #1 off the floor immediately due the medication error.

On 7/18/11 at 5:28 PM, Nurse #3 revealed that on 7/1/11 around 10:45 PM she was the oncoming 11PM-7AM nurse and counted the narcotics on 200 Hall medication cart with Nurse #1. She stated that she noticed there was a lot of the Roxanol missing from the bottle. She stated that it was a brand new 45ml bottle of Roxanol and it was documented that only 2 doses at 0.25ml per dose were administered. She noticed there was less than 40ml of Roxanol noted during the count. She stated that she asked Nurse #1 if she used the right syringe and she (Nurse #1) stated " no. " Nurse #3 stated she refused to take the medication cart until the count was corrected and she notified the shift supervisor.

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F 333	Continued From page 15 On 7/19/11 at 11:30 AM, Nurse #8 stated that on 7/2/11 at 9:17 AM, Resident #1 was assessed and " he had apnea and rales really bad. " She stated that she was not able to compare him to before and that was her first time taking care of him. She stated she was aware of the overdose of morphine on 7/1/11. She made her supervisor aware and the same MD who was called on 7/1/11 was called again 7/2/11 at 10:15 AM. She stated that the MD ordered to monitor the resident closely and if there was no change in his current condition to call him back by 1:00PM and he would then take other steps. She notified her supervisor, the hospice nurse and the family. On 7/19/11 at 1:30 PM, Nurse #10 stated she worked as the 7AM-3PM nurse supervisor on 7/2/11 and that Resident #1 was extremely lethargic. She called the MD at 10:30AM and made him aware of the resident ' s status and received an order for Narcan 0.4mg/ml-0.5ml. She stated the Narcan was ordered to reverse any lingering effects of the morphine and after giving the resident Narcan at 10:45AM, he did not respond that much. She stated that the MD only ordered half of a normal dose so the resident would not be in pain. She stated that the call to the MD was made as an update due the morphine overdose incident on 7/1/11. On 07/19/11 at 11:39 AM, Interview with the Pharmacist contracted by the facility revealed that in almost all cases, the pharmacy dispensed Roxanol in the manufacturer ' s packing which was a cardboard box with the bottle on one side of the divider and the syringe on the other side. The package insert was left in the cardboard box when it was dispensed. The box was packaged	F 333		

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in a plastic bag with a 2x2 adhesive STOP sticker on it that refers to a ' warning sheet ' . The warning sheet described the way to convert from mg to ml. The Pharmacist stated, " Last year and into the early part of this year (2011), there was a shortage of the small bottles of Roxanol. At that time the pharmacy pre-poured from stock bottles but always included a syringe and all of the above warnings and sticker. However, the small bottles are now available and we use the manufacture ' s packaging to dispense. "

On 7/19/11 at 12:38PM, the MD stated that he did not order Narcan on 7/2/11 when he was first notified of the incident because he was told that the resident was not doing anything different, he was still in pain and his condition had not changed. He stated that he ordered the Narcan to reverse the effects of the morphine on 7/2/11 around 10:30AM because he was called and was told that the patient was still sleeping and would not awake. The MD stated that he did not discontinue the Roxanol because the resident could have needed it again due to his pain. The MD stated that he spoke with the DON on 7/4/11 regarding the incident and to do staff education on how to give Morphine. The MD indicated the resident ' s cause of death as bilateral pleural effusions with respiratory failure. (He stated it was unrelated to the dose of Roxanol).

The facility determined that all residents had the potential to be affected by the incident that occurred on 7/1/11 and initiated a quality improvement plan on 7/2/11. During the investigation, the facility provided documentation of interventions put into place as a result of the incident on 7/1/11.

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The facility submitted the following corrective action plan on 7/19/11 at 6:24pm.

Corrective Action Plan
Roxanol Overdose on 7/2/11
1) Resident #1 received 2.5mL of roxanol 20mg/mL solution, received narcan 0.5mg subcutaneous, on 7/2/11 at 1045 ordered by physician. He was receiving hospice care and expired on 7/3/11 at 0010.
*An immediate disciplinary action on 7/2/11 and direct re-training was initiated on 7/3/11, under the supervision Nurse #10, weekend supervisor, for employee involved in incident. Involved employee suspended after direct re-training as of 7/3/11 for further investigation, termed on 7/7/11
2) A detailed review on 200 Hall was completed by the Director of Nursing on 7/4/11, as was a review of all narcotic medications in the facility. Two residents had an order and supply of roxanol solution last dose received in Feb 2011 on one and May 2011 for the other. No other residents within facility received roxanol solution, all morphine medication including tablet and liquid forms provided as ordered.
3) 7/5/11 - 100% In-servicing for all licensed nurses 1:1 regarding proper medication administration given by Director of Nursing. In-service covered 6 Rights of medication, right resident, right medication, right route, right method, right time. Triple check all medications, prior to administration. Proper documentation signing, documenting assessment, effectiveness, and dose, route, time and date.
*Completed 7/15/11, Director of Nursing and

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F 333	Continued From page 18 supervisors 7/11/11- 100% In-servicing for all licensed nurses 1:1 regarding morphine medication administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Re-training regarding general medication administration, right medication, patient, frequency, route, order, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Director of Nursing and supervisors one on one. *Completed 7/15/11, by Director of Nursing and supervisors 7/15/11- Nursing in-service, addressing medication administration and dosing, this in-service was a general monthly in-service covering a review of the medication administration in-service, using the six rights of medication, having a second a second nurse verify all morphine medications, and informing staff of random audits that may take place. 4) Monitor - Random audits will be done weekly for four weeks by the Director of Nursing or appointed personnel, then monthly for 3 months to ensure compliance *Audit on 200 Hall completed on 200 Hall completed 7/4/11, by Director of Nursing, noted one resident on liquid morphine sulfate 10mg/5mL. *Audit on 300 Hall completed 7/13/11, by Director of Nursing, noted roxanol in cart and ordered for resident, has not received roxanol/morphine sulfate 20mg/mL since May of 2011 *Audit on 100, 200, 300, 700, 800A/B Hall completed 7/19/11, by 7-3 Supervisors Audit - The executive QI committee will meet weekly to discuss issue and/or trends regarding	F 333		

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F 333	Continued From page 19 audit and the need for future interventions *QI meeting held on 7/4/11, 7/11/11, and 7/18/11 Staff development training, has been scheduled with pharmacy consultant, regarding medication administration, focusing on morphine dosing, will be completed prior to staff taking floor The corrective action plan was validated during the survey. Nurse #1 ' s employee record revealed that Nurse #1 received an immediate disciplinary action and a drug screen on 7/2/11 and direct re-training per medication pass audit under the supervision of a nurse supervisor on 7/3/11. The record indicated Nurse #1 was terminated on 7/7/11 due to her poor work performance and inability to adapt to work role. Nurse #1 was also reported to North Carolina Board of Nursing by the facility on 7/18/11. On 7/4/11 a record review revealed that the facility ' s initial audits were completed on 100, 200, 300, 700, and 800A/B Halls. The DON completed the audits that consisted of a review of all narcotic logs and current medication administration records of residents on morphine. There were two residents in the facility on morphine. Review of the audits revealed that all forms of morphine administration were correct and documented correctly. Record review revealed that 1:1 in-servicing began on 7/5/11 for licensed nurses and medication aides on proper medication	F 333		

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administration and documentation with 100% compliance of all licensed staff and medication aides. This was completed on 7/15/11.

In-service records showed that additional 1:1 in-servicing took place on 7/11/11 for licensed nurses regarding morphine administration. The in-service topics included a mandatory new practice introduced to staff requiring every nurse to have a second nurse to verify dose including double signature on narcotic count sheet with all morphine products- facility policy to be revised. Re-training on general medication administration was also covered. In-services were completed by the DON and nurse supervisors. The in-service record indicated 100% attendance of all licensed staff by 7/15/11.

Record review revealed that on 7/15/11, a nursing in- service/ general monthly in service was held and addressed the topics of medication administration, administration of morphine with a second nurse to verify dose and the staff was informed of continuing random audits.

The Quality Improvement Committee meeting minutes revealed meeting were held on 7/4/11, 7/11/11, and 7/18/11 to review results of the audits and areas of concerns to determine the need for the frequency of continued monitoring.

Record review revealed that on 7/13/11 an audit was completed to review narcotic log and current medication administration record of residents on morphine in which there was one resident on 300 Hall.

On 7/18/11 at 9:05 AM, Nurse #7 stated that she

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F 333	Continued From page 21 was in-serviced on medication administration. The nurse explained the steps of medication administration and how to document on the front and back of the medication administration record. She stated there had to be two nurses to verify and witness dosage to prevent errors. She stated that Morphine came with a special syringe. Med errors should be reported to supervisor, family and MD as soon as it happens. On 7/18/11 at 9:13 AM, Med Aide #1 stated that she did not administer morphine and had to ask the nurse to administer it if a resident needed it. She stated that she was aware that nurses needed a second nurse to witness liquid morphine and that she was in-serviced on medication administration. On 7/18/11 at 1:57 PM, Observation of medication administration of a PRN controlled medication was made without error, documentation was completed and the narcotic count was correct. This observation was made on the hall with the only resident that had a PRN order for Roxanol. On 7/18/11 at 2:02 PM, Nurse #4 stated that she used a syringe to administer Morphine if it was not the concentrated form and only used the calibrated syringe that came packaged with the Roxanol from the pharmacy to administer Roxanol. The nurse showed the syringe that was used and how it was documented. She stated that she had one resident that had a PRN order for Roxanol but that resident had not used it in around a month, therefore the Roxanol was not on the medication cart.	F 333		

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On 7/18/11 at 2:08 PM, Nurse #5 stated there had to be a second nurse present to check the dosage to give morphine and that a calibrated syringe should be used.

On 7/18/11 at 8:56 AM, Nurse #6 stated that morphine usually came with a calibrated syringe. She stated that she was in-serviced on medication administration and that each and every time there had to be a second nurse to witness the dosage to assure it was correct. The nurse stated that she did not have anyone on her hall that was ordered Morphine liquid. She stated that if there was medication error she would notify the supervisor and complete the paperwork/incident report. The nurse that made the med error would have to call the MD and that resident ' s family.

On 7/19/11 at 5:05 PM, the DON revealed that the QI committee will audit results weekly for 4 weeks and then monthly for 3 months and will follow up as need is determined. DON also stated that all new licensed employees will receive current in-service on medication administration and morphine administration with a second nurse by the Staff Development Coordinator prior to working on the floor.

On 7/19/11 at 5:39PM, Nurse #9 stated that morphine had to be drawn up with a second nurse to verify dose. She stated that she had attended inservices on medication administration. The nurse explained the process of giving PRN medications and how to document. She stated that in the event a med error was made, it should be reported to the supervisor right away, notify family and MD and complete the paperwork.

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Premier Nursing and Rehabilitation Center

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Corrective Action Plan

Roxanol Overdose on 7/2/11

1) Resident in room 218B received 2.5mL of roxanol 20mg/mL solution, received narcan 0.5mg subcantenous, on 7/2/11 at 1045 ordered by physician. He was receiving hospice care and expired on 7/3/11 at 0010.

   *An immediate disciplinary action on 7/2/11 and direct re-training was initiated on 7/3/11, under the supervision on Ann Kottal, RN, weekend supervisor, for employee involved in incident. Involved employee suspended after direct re-training as of 7/3/11 for further investigation, terminated on 7/7/11

2) A detailed review on 200 Hall was completed by the Director of Nursing on 7/4/11, as was a review of all narcotic medication in the facility to including 100, 300, 700, 800A/B halls. Two residents had an order and supply of roxanol solution last dose received in Feb 2011 on one and May 2011 for the other. No other residents within facility received roxanol solution, all morphine medication including tablet and liquid forms provided as ordered.

3) 7/5/11 - 100% In-servicing for all licensed nurses 1:1 regarding proper medication administration given by Director of Nursing and supervisors. In-service covered 6 Rights of medication, right resident, right medication, right route, right frequency, right documentation, and right dose. Triple check all medications, prior to administration. Proper documentation signing, documenting assessment, effectiveness, and dose, route, time and date.

   *Completed 7/15/11, Director of Nursing and supervisors

   7/11/11- 100% In-servicing for all licensed nurses 1:1 regarding morphine medication administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Re-training regarding general medication administration, right medication, patient, frequency, route, dose, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Director of Nursing and supervisors one on one.

   *Completed 7/15/11, by Director of Nursing and supervisors

   7/15/11- Nursing in-service, addressing medication administration and dosing, this in-service was a general monthly in-service covering a review of the medication administration in-service, using the six rights of medication, having a second a second nurse verify all morphine medications, and informing staff of random audits that may take place.

   Monitor - Random audits, controlled substance documentation inspection form, with focus on monitoring double signatures of morphine administration, declining count sheets, wasting

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narcotics, correct form, as needed medication adminstration noting reason, route, timing, and effectiveness. Random audit using medication pass audit form, including transcribing orders, resident rights, documentation, observing direct administration method, and calculation of medication error. This will be done weekly for four weeks by the Director of Nursing or appointed personnel, then monthly for 3 months to ensure compliance.

*Audit on 200 Hall completed on 200 Hall completed 7/4/11, by Director of Nursing, noted one resident on liquid morphine sulfate 10mg/5mL.

*Audit on 100, 300, 700, 800A/B, completed on 7/4/11, Director of Nursing reviewed narcotic log, and current morphine medication administration, reviewing last dose received for use as needed medication. Two residents has supply and order for roxanol 20mg/mL, last dose received for one on Feb 2011, and the other received dose on May 2011. All forms of morphine medication administration were correct and documented in narcotic log.

*Audit on 300 Hall completed 7/13/11, by Director of Nursing, noted roxanol in cart and ordered for resident, has not received roxanol/morphine sulfate 20mg/mL since May of 2011

4) Executive QI Committee will review results of audits weekly X's 4 weeks and then monthly X's 3 months for any identified trends and/or area of concerns and will follow up as indicated to determine the need for and the frequency of continuing monitoring.

*QI meeting held on 7/4/11, 7/11/11, and 7/18/11

Staff development – new licensed employees will receive current in-service of medication administration regarding morphine administration, all licensed individuals are to have second nurse verify dose, double signatures on narcotic count with all morphine products. Inform new licensed nurses regarding general medication administration and that random audits will be conducted. Right medication, patient, frequency, route, dose, and documentation for all morphine products, to ensure medication is given correctly. Provided by the Staff Development Coordinator prior to being assigned to medication administration.

Staff development training has been scheduled with pharmacy consultant regarding medication administration, focusing on morphine dosing. Will be completed prior to staff taking floor

Nancy K. Rlegos NHA
8/3/2011