STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345393	A. BUILDING _____ B. WING _____	C 06/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

(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 000	INITIAL COMMENTS 483.25 (F333) at J Immediate jeopardy began on 06/09/14 when Resident #1 received an incorrect dose of concentrated Oxycodone liquid resulting in a significant medication error. Immediate jeopardy was removed on 06/21/14 at 3:05 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		7/14/14

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

Electronically Signed | 07/14/2014

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to notify an interested family member of a new medication for pain ordered by the physician for 1 of 3 sampled residents reviewed for notification of change (Resident #1). The findings included: Resident #1 was originally admitted to the facility on 03/22/07 and re-admitted on 08/11/09 with diagnoses which included senile delusions, diabetes mellitus, hypertension, cardiac dysrhythmia and dementia with behavioral disturbance. A review of a quarterly Minimum Data Set (MDS) dated 04/21/14 indicated Resident #1 had short term and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Review of Resident #1's medical record revealed a physician's order dated 06/09/14 for Oxycodone 20 milligrams (mg) per milliliter (ml) - give 2.5 mg by mouth or tube every 12 hours scheduled and	F 157	Resident #1 was discharged to the hospital on 6/12/2014 and will not return to the facility. A new policy was created on 7/10/14 stating that the Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) will notify the resident/ responsible party of any needs to alter treatment significantly. In this policy it is outlined that once the nurse has notified the resident/responsible party, they will then make a nurses note as well as stamp the physician order RP Notified. All resident/responsible parties sign a form on admission signifying that they give permission for the Pisgah Manor staff, Physician, Physician Assistant, or Family Nurse Practitioner to call on the emergency numbers given at the time of admission. This signifies that they can leave a message if no one answers and that they can leave a message with whoever answers the phone. A new policy was created on 7/10/14	

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F 157	Continued From page 2 every 4 hours as needed (PRN) pain. A physician's order dated 06/11/14 included: all medication changes to be discussed with son, Power of Attorney (POA). Review of the nurse's notes from 06/09/14 through 06/11/14 revealed no documentation that Resident #1's POA was notified when the physician ordered the Oxycodone on 06/09/14. An interview on 06/19/14 at 1:46 PM with Resident #1's POA revealed he was not notified that Resident #1 was started on Oxycodone for pain until 06/10/14 at 11:00 PM after Resident #1 had experienced an adverse reaction to the medication. An interview on 06/20/14 at 11:03 AM with Resident #1's physician revealed she gave the order for a low dose of Oxycodone because staff thought the resident's agitation might be due to pain which she was unable to express. The physician stated she didn't notify Resident #1's POA of the new order for pain medication. An interview on 06/20/14 at 4:15 PM with the Staff Development Coordinator (SDC) about the facility's policy for notifying interested family members about changes in a resident's medication revealed the facility didn't routinely notify family members of every medication change. The SDC stated most residents' family members didn't want to be notified of every change. She further stated the family members who did request to be notified of every medication change had a note placed in the resident's chart and were notified of every change. The SDC stated she didn't notify Resident #1's POA about the new order for Oxycodone.	F 157	stating that the Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) will notify the resident/responsible party of any needs to alter treatment significantly. In this policy it is outlined that once the nurse has notified the resident/responsible party, they will then make a nurses note as well as stamp the physician order RP Notified. Administrator drafted and sent a letter to all residents/ responsible parties notifying them of this new policy on 7/14/14. A task added to the 11-7 Nurse Checklist on 7/11/14 requiring the 11-7 Nurses to check that all physician orders are stamped RP Notified. If an order is found without this stamp, the nurse will notify the next nurse at change of shift to call. The 11-7 nurse will call if change warrants an immediate notification. Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Staff Development Coordinator (SDC) will check the physician orders daily to ensure that each order has been stamped RP Notified. This daily check with be an ongoing practice. If problematic areas occur, they will be addressed at the time of the findings and brought to the attention of the Quality Assurance Performance Improvement (QAPI) committee. All data will be reported to the QAPI committee quarterly. The next meeting is scheduled for October 2014.	

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F 157	Continued From page 3 An interview on 06/21/14 at 3:25 PM with the Administrator about the facility's protocol for notifying interested family members about changes in a resident's medication revealed the facility protocol was to notify the family members who had expressed a desire to be notified of all medication changes but they didn't routinely notify the resident's responsible party of every medication change.	F 157		
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 staff interview and medical record review, the facility failed to administer a correct dose of medication, resulting in a significant medication error for 1 of 3 sampled residents (Resident #1). Immediate jeopardy began on 06/09/14 when Resident #1 received an incorrect dose of concentrated Oxycodone liquid resulting in a significant medication error. Immediate jeopardy was removed on 06/21/14 at 3:05 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.	F 333	Resident #1 was discharged to the hospital on 6/12/2014 and will not return to the facility. On 6/20/14, The Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) reviewed the declining count sheets for every resident with concentrated liquid opioids in the medication carts. There were no residents identified with medication errors. The Director of Nursing (DON) and the ADON counseled the two Licensed Practical Nurses (LPNs) involved in alleged Oxycodone administration error for Resident #1 on 6/11/14. Counseling discussion included the need to use a calibrated oral dosing syringe when	7/17/14

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F 333	Continued From page 4 The findings included: Resident #1 was originally admitted to the facility on 03/22/07 and re-admitted on 08/11/09 with diagnoses which included senile delusions, diabetes mellitus, hypertension, cardiac dysrhythmia and dementia with behavioral disturbance. A review of a quarterly Minimum Data Set (MDS) dated 04/21/14 indicated Resident #1 had short term and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Review of the June 2014 recapitulation of physician's orders revealed orders that included: Cardizem 30 milligrams (mg) by gastrostomy tube (G-tube) four times a day. Resident #1's resuscitation status was listed as Do Not Resuscitate. A physician's order dated 06/09/14 read: Oxycodone 20 milligrams per milliliter (mg/ml), give 2.5 mg by mouth or tube every 12 hours scheduled and every 4 hours as needed (PRN) pain. Review of the June 2014 Medication Administration Record (MAR) revealed an entry dated 06/09/14 for Oxycodone 100 mg/5 ml (equivalent to 20 mg/ml) - give 2.5 mg dose by mouth or per tube every 12 hours. A second entry dated 06/09/14 read Oxycodone 100 mg/ 5 ml - give 2.5 mg dose by mouth or per tube every 4 hours PRN pain. The June 2014 MAR indicated medications were given as follows: 06/09/14 9:00 PM Oxycodone 100 mg/5 ml 2.5 mg, Cardizem 30 mg	F 333	measuring/administering concentrated oral liquid opioids. Both nurses were also counseled that if they had any questions in regards to calibrations, they are to contact the pharmacy or their supervisor. Both nurses were suspended for three days and further investigation continued. The ADON contacted the North Carolina Board of Nursing (NCBON) on 6/13/14 and spoke with a NCBON Consultant. The ADON was referred to complete a Complaint Evaluation Tool on each nurse involved in the incident. This was done in collaboration with the NCBON Consultant. A new policy was approved by the Administrator on 6/20/14 concerning the administration of all concentrated liquid opioids. All Registered Nurses (RN), LPNs, and Medication Aides (MA) were informed of this new policy on 6/20/14 requiring a nurse cosign with the administering nurse for all concentrated liquid opioids. The Facility Administrator, ADON, SDC, and Consultant Pharmacist developed the Liquid Narcotic Calculation Review with Return Demonstration In-Service form on 6/20/14. RNs, LPNs, and MAs received this in-service by the ADON, SDC, or Consultant Pharmacist. RNs, LPNs, and MAs were not allowed to continue work until they had completed the Liquid Narcotic Calculation Review with Return Demonstration In-Service and successfully demonstrated the appropriate procedure to measure and administer a concentrated liquid oral opioid. All RNs, LPNs, and MAs were in-serviced by 6/27/14. In-servicing will be	

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F 333	Continued From page 5 06/10/14 8:00 AM Oxycodone 100 mg/5 ml 2.5 mg, Cardizem 30 mg 06/10/14 1:00 PM Cardizem 30 mg Review of a Nurse's Note dated 06/10/14 at 3:25 PM by Nurse #1 revealed Nurse Aide (NA) notified the Nurse at 12:50 PM that Resident #1 had a change in condition. Nurse #1 assessed the Resident and observed that her eyes were open with no focus and her respirations were audible while using accessory muscles with periods of apnea (not breathing). Her skin tone was gray/blue with no mottling noted. Nurse #1 notified Resident #1's Power of Attorney (POA) that Resident had taken a sharp decline. Nurse #1 reassessed Resident #1 at 1:00 PM and notified the POA that it appeared that Resident was actively dying. The note also indicated the nurse notified the Physician's Assistant (PA), who was in the facility at the time, of the Resident's condition. Review of a Nurse's Note dated 06/10/14 at 6:45 PM by Nurse #2 revealed the Nurse attempted to administer a PRN dose of liquid Oxycodone 2.5 mg to Resident #1 per the request of family for dyspnea (labored breathing) but the Resident spit the medication out. A physician's telephone order dated 06/10/14 read: hold all meds until further notice, discontinue all Oxycodone orders, Narcan (a medication used to reverse the action of narcotic analgesics) 0.4 mg intramuscularly (IM) now; if respirations fall below 8 to 10 per minute, give Narcan 0.4 mg IM and call on call physician. Review of the June 2014 MAR revealed the following medications were documented as given: 06/10/14 9:00 PM Narcan 0.4 mg IM	F 333	provided for all new licensed staff and medication aides at the time of orientation and every six months. Skills validation of dosage calculations will be identified by return demonstration by ADON, SDC, or Consulting Pharmacist. On 6/20/14, Morphine Concentrate calculation sheet was added to each med cart□s narcotic notebook under reference and is dispensed with each oral concentrated opioid. A Controlled Declining Inventory Checklist was created for monitoring purposes on 7/4/14. This checklist will be used by the supervisors to ensure accuracy of documentation, medication count, and that the RNs, LPNs, and MAs are following the instructions given for the physicians order. On 7/4/14, The Medical Director and other physicians agreed to order tablet narcotics versus liquids when able. All nurses were instructed to request a tablet versus liquid form of narcotic when receiving new orders. Also RNs and LPNs were in-serviced that two nurses must sign the Declining Count Sheets for all liquid narcotics signifying that the appropriate dose was being given and that documentation was accurate. On 7/10/14, all residents that were receiving a liquid narcotic medication were able to be changed to a tablet form. An in-service will be held on 7/17/14 by the Consulting Pharmacist regarding Common Mistakes to Avoid on Med Pass. This in-service will be reoccurring every six months.	

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F 333	Continued From page 6 The following medications were documented as held and not administered: 06/10/14 5:00 PM Cardizem 30 mg 06/10/14 9:00 PM Cardizem 30 mg 06/11/14 8:00 AM Cardizem 30 mg Review of a Physician's progress note dated 06/11/14 revealed Resident #1 had a marked change in status with decreased level of consciousness on 06/10/14. The note further revealed the Resident had declined markedly in the last 4 to 6 months and it was difficult to control her behaviors which included striking out at staff when they were trying to care for her. The behavior management team at the facility recommended pain medication as staff thought she might be having discomfort at times and wasn't verbal to tell them. So on 06/09/14 Resident #1 was started on Oxycodone 2.5 mg orally twice a day scheduled. Resident #1 received the first dose on the evening of 06/09/14. According to the note, Resident #1 was sleepy all day on 06/10/14 and by late afternoon she was not responsive. The nurses called Resident #1's family because they were concerned she was actively dying. Narcan was given once the Family Nurse Practitioner (FNP) was alerted of the situation and the possibility of reaction to Oxycodone as it was the last new medication started. Resident #1 became slightly more alert and was no longer apneic per nursing report. Her blood pressure (BP) was very low and Cardizem was held the morning of 06/10/14. An interview with Resident #1's physician on 06/20/14 at 11:03 AM revealed she was unsure if the Resident was given too much Oxycodone or if it was an adverse reaction but she did have a marked change for the worse after it was given.	F 333	A Quality Assurance (QA) check was added to the Supervisor QA Checklist for Declining Inventory Sheets on 7/11/14. The DON, ADON, and SDC will check the Controlled Declining Inventory Sheets two times a week for one month, one times week for one month, bi-weekly times one month, and monthly for three months. 3-11 Supervisor will check Declining Inventory Sheets weekly. This will be ongoing. All audit sheets and data will be reported to the Quality Assurance Performance Improvement (QAPI) committee quarterly. The next meeting is scheduled for October 2014. If problematic areas occur, they will be addressed at the time of the findings and brought to the attention of the QAPI committee.	

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The physician stated Resident #1 responded positively to the Narcan and showed some improvement after it was given. She stated she ordered the Oxycodone on a trial basis at a very small dose in an attempt to control possible pain that was causing her agitation. The physician stated her main concern was that Resident #1 either had an adverse allergic reaction to the Oxycodone or was possibly given too much due to a medication error.

An interview on 06/20/14 at 12:35 PM with the Staff Development Coordinator (SDC) and visual inspection of the medication bottle labeled for Resident #1 revealed it was labeled with the resident's name, Oxycodone 20 mg/ml (15 ml was listed as quantity dispensed) - administer 0.125 ml = 2.5 mg every 12 hours. The SDC stated she measured the amount remaining in the bottle and there was 7.5 ml of medication in the bottle. The SDC showed surveyor calibrated dose syringes that were available for measuring liquid narcotic medication.

A review of the narcotic count sheet with the SDC on 06/20/14 at 12:35 PM revealed a dosage was documented as given on 06/09/14 at 9:30 PM by Nurse #4 and the quantity given was listed as 2.5 ml with 12.5 ml remaining. The next dosage documented as given was on 06/10/14 at 6:45 PM by Nurse #2 and the quantity given was listed as 0.125 ml with 7.5 ml remaining. When asked about the discrepancy between the narcotic count sheet and Resident #1's MAR, she stated Nurse # 5 had documented on the June 2014 MAR that she administered a dose on 06/11/14 at 8:00 AM but hadn't signed it out on the narcotic count sheet.

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An interview with Resident #1's physician on 06/20/14 at 2:34 PM revealed Resident #1's baseline condition was a non-verbal, frail woman. She stated when she assessed the Resident on 06/11/14 her level of consciousness was close to her baseline given her cognition was quite poor but her extremities were quite weak. The physician stated it was probably due to the Oxycodone dosage, which was a suspected medication error based on the Resident's response to the Narcan. The physician explained that Resident #1's Cardizem was held because her BP was too low on 06/10/14 and she went into rapid atrial fibrillation, an abnormal heart rhythm, on 06/12/14. The physician stated the low heart rate was due to the Oxycodone. The physician stated there was a direct correlation to the 2 events. The physician further stated that missing a dose of Cardizem might not effect some people but it did Resident #1 because she was so frail.

An interview with Nurse #1 on 06/20/14 at 12:10 PM revealed she regularly works the 7:00 AM to 3:00 PM shift as the Resource Nurse on the Unit where Resident #1 lived. Nurse #1 explained that she was responsible for handling emergencies and acute situations with residents. When asked about Resident #1's condition on 06/10/14, Nurse #1 stated the Resident was awake and alert at the beginning of the shift and throughout the morning. She stated the NA who gave Resident #1 her shower commented that she was having a good day.

An interview with the PA on 06/20/14 at 3:10 PM revealed she was at the facility on 06/10/14 and she recalled being notified about Resident #1's condition by staff and that they thought the

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resident's death was imminent. The PA stated she asked staff if the resident needed anything and staff reported the Resident appeared to be comfortable. The PA stated she didn't think the decline was unexpected so she didn't see the Resident or do an assessment.

An interview with Nurse #2 on 06/20/14 at 3:37 PM revealed she was the Resource Nurse on 06/10/14 on the 3:00 PM to 11:00 PM shift for the hall on which Resident #1 lived. She stated she checked on Resident #1 every hour and she started having worse dyspnea about 6:30 PM. Nurse #2 stated Resident #1's family asked if she could give the Resident anything to help because she seemed to be in distress and struggling to breathe. Nurse #2 stated she (Nurse #2) asked the Medication Nurse to get a dose of Oxycodone for the Resident. Nurse #2 stated she (Nurse #2) attempted to put the liquid medication in the Resident's mouth with a syringe and the Resident spit it out. Nurse #2 stated when the pulled the narcotic count sheet to document the dosage she attempted to give, she realized the dosage that was given on 06/09/14 at 9:30 PM was the wrong dosage. She stated based on the amount that was remaining in the bottle it appeared the wrong dosage was also given on 06/10/14 at 8:00 AM. She stated she immediately notified her supervisor and they both started trying to get in contact with the nurses (Nurse #4 and #5) who had administered the medication on 06/09/14 at 9:30 PM and on 06/10/14 at 8:00 AM. Nurse #2 stated after they spoke with the nurses and confirmed the incorrect dosage was administered, she notified the FNP who was on call and received orders to administer Narcan, which she did.

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Review of the facility's investigation revealed a written statement by Nurse #4 acknowledging she made a medication error and realized the seriousness of the error. A written statement by Nurse #5 revealed she didn't remember administering Oxycodone to Resident #1.

An interview with Nurse #5 on 06/21/14 at 10:41 AM revealed she was regularly assigned as the Medication Nurse for Resident #1 and worked on the 7:00 AM to 3:00 PM or the 3:00 PM to 11:00 PM shift. When asked if she could recall the amount of medication that was in the bottle of Oxycodone liquid for Resident #1 on 06/10/14 at 7:00 AM, she stated she couldn't remember how much was in the bottle. When asked if she recalled giving a dose of Oxycodone to Resident #1 on 06/10/14 at 8:00 AM, Nurse #5 stated she didn't give the Resident a dose of Oxycodone because she seemed sleepier than usual. When asked about signing on the MAR that she gave the medication, she stated that was an error on her part and she should have corrected it. She stated she didn't sign that she gave it on the narcotic count sheet. Nurse #5 stated when she counted narcotics at 3:00 PM with the nurse who was coming on duty, they realized there had been a medication error and Resident #1 had been given too much Oxycodone. When asked if she or the other nurse reported the medication error to a supervisor, she stated she didn't think so. She further stated it was really busy that day and they had a meeting to attend.

An interview with Nurse #4 on 06/21/14 at 2:53 PM revealed she was the Medication Nurse for Resident #1 on 06/09/14 for the 3:00 PM to 11:00 PM shift. When asked if she recalled giving Oxycodone liquid to Resident #1 on 06/09/14 at

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9:30 PM, she stated she put a small amount in a medication cup which was about halfway between the bottom of the medication cup and the 5 ml mark on the cup to approximate 2.5 ml. She stated she thought the dosage was 2.5 ml. She stated she didn't use a syringe to measure the medication and did not realize she had given the wrong dosage until contacted by the nursing supervisor. Nurse #4 stated Resident #1 was sitting in a geri chair when she gave the medication and went to sleep in the geri chair. Nurse #4 stated she and 2 other staff members assisted Resident #1 to bed and she was fighting, pinching and hitting the staff who were trying to transfer her into bed. Nurse #4 stated when she checked on Resident #1 before the end of her shift she was sleeping and was breathing normally.

A physician's telephone order dated 06/10/14 read: restart Cardizem if Heart Rate (HR) greater than 110 and systolic blood pressure greater than 100. Vital signs every 3 hours starting at 11:00 PM until 7:00 AM.

Review of a Nurse's Note dated 06/10/14 at 11:01 PM by Nurse#2 revealed Resident #1's condition had improved with time and after Narcan dose. The note further revealed Resident #1 had a possible adverse reaction to meds and suspected overdose. Nurse #2 notified the Resident's physician and the clinician on call, a FNP. Her heart rate (HR) was 80 and her blood pressure (BP) was 102/68.

Review of a Nurse's Note dated 06/11/14 at 12:24 AM by Nurse #2 revealed Resident #1 had roused for short intervals the past 2 hours, opened her eyes and followed movement with

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hand grips strong and attempted to talk.

Review of a Nurse's Note dated 06/11/14 at 2:56 AM by Nurse #3 revealed Resident #1 was much more alert, opened her eyes when spoken to, had good grips in bilateral hands and was moving her extremities normally. Her HR was 88 and her BP was 118/69.

Review of a Nurse's Note dated 06/11/14 at 6:29 AM by Nurse #3 revealed Resident #1 opened her eyes when spoken to and sat up in bed. Her HR was 84 and her BP was 124/80.

Review of a Nurse's Note dated 06/11/14 at 10:13 AM revealed Resident #1 was more alert, opening her eyes and smiling at staff and family that were by the bedside. Her HR was 106 and her BP was 150/88.

A physician's order dated 06/11/14 read: Hydrocodone/Acetaminophen 5 mg/325 mg 1/2 tablet by mouth every 8 hours PRN pain or discomfort, restart Cardizem per prior orders now.

Review of the June 2014 MAR revealed medications were documented as given as follows:
06/11/14 1:00 PM Cardizem 30 mg
06/11/14 5:00 PM Cardizem 30 mg
06/11/14 9:00 PM Cardizem 30 mg
06/12/14 2:42 AM Phenergan 25 mg suppository
06/12/14 8:00 AM Cardizem 30 mg
06/12/14 1:00 PM Cardizem 60 mg per tube and Cardizem 30 mg by mouth

Review of a Nurse's Note dated 06/12/14 at 1:04 AM revealed Resident #1 vomited a large amount

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of green liquid and her tube feeding was held. Her HR was 115 and her BP was 147/97.

Review of a Nurse's Note dated 06/12/14 at 2:07 AM revealed Resident #1 vomited again and Resident #1 was given a Phenergan 25 mg suppository by Nurse #3, per the physician's standing orders.

An attempt was made to contact Nurse #3 but she did not return surveyor's phone call.

A physician's order dated 06/12/14 read: give extra dose of Cardizem 30 mg this morning.

A physician's order dated 06/12/14 at 11:32 AM read: Cardizem 60 mg per tube now; send to Emergency Room (ER) for tachycardia, atrial fibrillation not responding to Cardizem per tube, nausea and vomiting and right sided weakness.

Review of a Nurse's Note dated 06/12/14 at 1:28 PM by Nurse #1 revealed Resident #1 had a HR of 136 and a BP of 207/123 at 7:15 AM - she was given the Cardizem scheduled for 8:00 AM at that time. Resident #1 was reassessed at 9:00 AM - her HR was 132 and her BP was 168/110. Resident #1 had vomited a small amount. Resident #1's physician was at the facility and notified of her condition. Resident #1 was reassessed at 10:00 AM - her HR was 141 and her BP was 168/104. Resident #1's physician was notified and gave orders to administer a second dose of Cardizem 30 mg per tube which was administered at that time. Resident #1 was reassessed at 11:30 AM - her HR was 142 and her BP was 162/110. Resident #1's physician was notified and gave orders to administer Cardizem 60 mg per tube which was administered at that

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time. Further assessment after administration of the Cardizem revealed Resident #1 had a HR of 137 and BP of 154/108. Resident #1's physician was notified and gave orders to send resident to ER via ambulance and 911 was notified at 1:40 PM of need to transport.

Review of an addendum Nurse's Note dated 06/12/14 at 1:48 PM by Nurse #1 revealed Resident #1 had right arm weakness and did not follow command to squeeze the nurse's or POA's hand. After administration of Cardizem 60 mg dose her symptoms improved and she moved her right arm and hand and was able to hold onto nurse's and POA's hand.

During an interview with Nurse #1 on 06/20/14 at 12:10 PM she was asked to verify the amount of Cardizem that was given on 06/12/14 and the time it was administered - Nurse #1 reviewed Resident #1's medical record and stated Resident #1 was given Cardizem 30 mg at 7:15 AM, Cardizem 30 mg at 10:00 AM and Cardizem 60 mg at 11:30 AM. Nurse #1 stated she called the physician and notified her that Resident #1's BP and HR were still elevated and the physician called the Resident's POA to ask if he wanted her sent to the hospital. Nurse #1 stated the physician then called and gave orders to send Resident #1 to the ER.

Review of a Nurse's Note dated 06/12/14 at 2:55 PM by Nurse #1 revealed Resident #1 left the facility via ambulance at 2:10 PM.

An interview was conducted with the Administrator on 06/21/14 at 3:25 PM about the discrepancy in the amount of Oxycodone liquid remaining in the bottle labeled for Resident #1 as

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compared to the narcotic count sheet. The Administrator stated they suspected the amount that was given on 06/10/14 at 8:00 AM may have been more than 2.5 ml. She stated the Pharmacist thought there could have also been some variation in the amount given on 06/09/14 at 9:30 PM that was more than 2.5 ml because the nurse didn't use a syringe. The Administrator stated Nurse #5 had completed training with the DON and the ADON prior to being allowed to return to work. The Pharmacist had provided additional remedial education to Nurse #5 on 06/20/14 and Nurse #5 had difficulty doing the skills validation. The Pharmacist was uncomfortable with Nurse #5 continuing to administer medications so she was terminated on 06/20/14. The Administrator stated Nurse #4 had completed training with the DON and the ADON prior to being allowed to return to work and had also completed additional remedial education with the Pharmacist on 06/20/14. Nurse #4 successfully completed the skills validation with the Pharmacist.

The facility's Chief Executive Officer and Administrator were notified of Immediate Jeopardy on 06/20/14 at 5:00 PM for Resident #1. The facility provided a credible allegation of compliance on 06/21/14 at 3:05 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

CREDIBLE ALLEGATION OF COMPLIANCE FOR FREE OF SIGNIFICANT MEDICATION ERRORS

Identified Incident of Immediate Jeopardy
F333 - Significant Medication Error

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F 333	Continued From page 16 Resident(s) Identified Resident #1 was discharged to the hospital and will not return to the facility. Other Residents with Potential to be affected by the Immediate Jeopardy Incident Current residents have potential to be affected by the alleged deficient practice. On 06/2014, the Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) reviewed the declining count sheets for every resident with concentrated liquid opioid in the medication carts. There were no residents identified with medication errors. Notification of the Allegation of Immediate Jeopardy and actions taken: On 06/11/14, the Director of Nursing (DON) and the ADON counseled two Licensed Practical Nurses (LPNs) involved in alleged Oxycodone administration error for Resident #1. Counseling discussion included the need to use a calibrated oral dosing syringe when measuring/administering concentrated oral liquid opioids. Both nurses were also counseled that if they had any questions in regards to calibrations, they are to contact the pharmacy or their supervisor. Both nurses were suspended for three days and further investigation continued. On 06/13/14 the ADON contacted the North Carolina Board of Nursing (NCBON) and spoke with a NCBON consultant. The ADON was referred to complete a Complaint Evaluation Tool on each nurse involved in the incident. This was done in collaboration with the NCBON Consultant.	F 333		

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F 333	Continued From page 17 Immediate Changes to Facility Systems: On 06/20/14, a new policy was approved by the Administrator concerning administration of all concentrated liquid opioids. All medication administration staff members were informed of this new policy on 06/20/14 requiring a nurse cosign with the administering nurse for all concentrated liquid opioids. On 06/20/14 the Facility Administrator, ADON, SDC, and Consultant Pharmacist developed the "Liquid Narcotic and Calculation Review with Return Demonstration In-Service" form. Medication Administration staff received this in-service by the ADON, SDC, or Consultant Pharmacist. Medication Administration staff will not be allowed to continue work until they have completed the "Liquid Narcotic and Calculation Review with Return Demonstration In-Service" and have successfully demonstrated the appropriate procedure to measure and administer a concentrated liquid oral opioid. In-servicing will be provided for all new licensed staff and medications aides at the time of orientation. Skills validation of dosage calculations will be identified by return demonstration by ADON, SDC, or Consulting Pharmacist. Morphine Concentrate calculation sheet will be added to each med carts narcotic notebook under reference and will be dispensed with each oral concentrated opioid. Immediate jeopardy was removed on 06/21/14 at 3:45 PM. Observations of each medication cart in the facility revealed a reference guide for each type of liquid narcotics in use by the facility with the dosages listed in milligrams and milliliters. Interviews with nursing staff revealed they had received in-service training on 06/20/14 and	F 333		

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F 333	Continued From page 18 06/21/14 regarding the administration of liquid narcotic medications. They explained each medication cart now had a reference guide for dosages and a guide was also included with each container of liquid narcotic medications. They further stated the dosage of the medication required verification of the amount by 2 nurses prior to administration of the medication. They explained that both nurses were required to sign the electronic MAR every time a liquid narcotic medication was administered.	F 333		