

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BLUMENTHAL NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3724 WIRELESS DRIVE</b> <b>GREENSBORO, NC 27455</b>
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint investigation survey was conducted from 10/29/17 through 10/31/17. Immediate Jeopardy was identified at:</p> <p>CFR 483.10 at tag F157 at a scope and severity (J) CFR 483.45 at tag F329 at a scope and severity (J) CFR 483.45 at tag F333 at a scope and severity (J)</p> <p>The tags F329J and F333J constituted Substandard Quality of Care.</p> <p>Immediate Jeopardy began on 10/25/17 and was removed on 10/30/17. A Partial extended survey was conducted.</p>	F 000		
F 157 SS=J	<p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)</p> <p>(g)(14) Notification of Changes.</p> <p>(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-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(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);</p>	F 157		11/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  11/15/2017
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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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F 157	Continued From page 1  (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). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the medical director and the director of clinical pharmacy services, the facility staff failed to notify the physician immediately after discovering that a resident received 20 times the amount of morphine (a narcotic pain medication) prescribed by the physician. The resident did receive two	F 157	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to		

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F 157	<p>Continued From page 2</p> <p>additional scheduled doses of morphine after the excessive dose. This was evident in 1 (Resident #1) of 3 sampled residents receiving narcotic medications.</p> <p>Immediate jeopardy began on 10/26/17 when Resident #1's physician was not notified of the excessive dose immediately after discovery. Resident #1 received 20 times the prescribed dose of morphine. The immediate jeopardy was removed on 10/30/17 when the facility provided an acceptable credible allegation of removal. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 4/17/15. The resident's diagnoses included atrial fibrillation, implantable cardiac fibrillator, repeated falls, diabetes and ataxic gait, dementia without behaviors, and essential hypertension.</p> <p>Review of the resident's annual Minimum Data Set (MDS) of 9/11/17 revealed the Brief Interview for Mental Status score was 7 which indicated the resident was severely cognitively impaired. The MDS indicated the resident received a scheduled pain medication regimen in the last 5 days during the look behind period. Pain did not trigger on the MDS.</p> <p>A Care plan was initiated on 9/19/17 to address the resident's risk for alteration in comfort related to osteoarthritis. The goal was the resident will verbalize or show non-verbal (no grimacing, no</p>	F 157	<p>continue to provide a quality of life for our residents.</p> <p>The processes that lead to the deficiency:</p> <p>On 10/29/2017 at approximately 4:30pm, the Licensed Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She stated, she noticed 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated resident #6677 did not show any signs or change in condition to warrant contacting the physician. Licensed Nurse #2 will not be allowed to work until re-educated on physician notification requirements. Unit Coordinator #1 attempted to contact licensed nurse #2 with no response on 10/26/2017 at 9:30AM. Director of Health Services attempted to contact nurse #2 on 10/30/2017 at 5:52PM, and no responses. Licensed Nurse #2 will not be allowed to work until re-educated on physician notification requirements.</p> <p>On 10/25/2017, Licensed Nurse #1 administered 5ml of Morphine Sulfate</p>		

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F 157	<p>Continued From page 3</p> <p>moaning etc.) relief of pain 45 minutes to an hour after administering of medications through the next review. The interventions included to administer tender loving care (i.e. change in position, back rub etc.) as needed, encourage resident to report any pain (noting location, duration, intensity and severity), give medication as ordered, observe for effectiveness of pain medications 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 Medical Doctor as needed, and conduct pain assessment routinely.</p> <p>Review of the resident's Departmental Notes revealed that on 10/23/17, the resident started hospice services.</p> <p>Review of the Physician's Telephone Order revealed a physician order dated 10/25/17 at 4:40 PM to start "morphine 20 mg (milligram) /ml (milliliter). Give 5 mg PO (by mouth)/SL (sublingual) Q (every) 4 h (hour) scheduled and Q 2 hr (hour) prn (as needed) (for) pain/SOB (shortness of breath)."</p> <p>Review of Resident #1's "eMAR (electronic medication administration record) -Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page, "Morphine 20mg/ml-oral syringe, Give 5 mg sublingual every 2 hours as needed for shortness of breath/pain." On the same row as the order, on the right side of the page, and under the column of 10/25/17, there was a check mark and the initials of Nurse #1 indicating Nurse #1 administered morphine at 8:14 PM on 10/25/17.</p>	F 157	<p>(100mg) instead of 0.25mL (5mg) as ordered by physician to resident #6677. No adverse effects were noted in relation to this medication error. Resident #6677 had a terminal diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less. On 10/26/2017, resident #6677 was moaning with pain at 1am and 5am; Licensed Nurse #2 administered Morphine 0.25mL per Physician order without contacting the Physician. Licensed Nurse #2 recognized the previous shift documented Morphine 5mL instead of 0.25mL. Licensed nurse #2 did not have the ability to contact Licensed nurse #1 to verify whether Morphine 5mL documented on the Controlled Drug receipt form was administered to resident #6677 or not. Per licensed nurse #2 no signs or symptoms of distress was noted during the night. The attending Physician was notified about this medication error on 10/26/2017 at 3:30Pm, this was done within 24 hours. At 11pm on 10/25/2017 controlled drugs receipt for resident #6677 indicated the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in resident #6677 dispensed medication bottle.</p> <p>On 10/26/2017 at approximately 9:00 am, during controlled drug reconciliation for resident #6677, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The control sheet indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician.</p>		

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F 157	<p>Continued From page 4</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 5 ml of morphine were given to the resident and 24.50 ml of morphine were left in the bottle at 8 PM on 10/25/17. The resident received 100 mg (5 ml) of morphine instead of 5 mg (0.25 ml) at 8 PM on 10/25/17. This resident received 20 times more morphine than prescribed by the physician.</p> <p>Review of Resident #1's "eMAR-Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page that read as "Morphine 20mg/ml oral syringe, Give every 4 hours sublingual for pain." There was no dosage specified on this order. On the same row of the order, on the right side of the page, and under the column of 10/26/17, there were check marks indicating Nurse #2 administered morphine at 1:00 AM and 5:00 AM on 10/26/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 0.25 ml of morphine were given to the resident and 24.25 ml of morphine were left in the bottle at 1:00 AM on 10/26/17. There was also documentation that 0.25 ml of morphine were given to the resident and 24.00 ml of morphine were left in the bottle at 5:00 AM on 10/26/17.</p> <p>Review of the resident's Departmental Notes dated 10/26/17 revealed the Resident died at 9:10 AM.</p> <p>An interview with Nurse #1 was conducted on 10/29/17 at 5:30 PM. She worked with the resident on 10/25/17 on the 3-11 shift. The nurse gave the resident a morphine dose around 8:00</p>	F 157	<p>On 10/26/2017 at approximately 3:00pm, the Licensed Nurse #1, who administered the stated medication to resident #6677 was interviewed by the Administrator. She revealed that during the medication administration on the previous day, she noted medication order change for resident #6677. She verified the written order in resident's record and read it as 5ml instead of 5mg.</p> <p>On 10/29/2017 at approximately 4:30pm, the Licensed Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She started, she noticed 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated resident #6677 did not show any signs or change in condition to warrant contacting the physician. Licensed Nurse #2 will not be allowed to work until re-educated on physician notification requirements.</p> <p>Procedure for implementing the acceptable plan of correction for the specific deficiency cited:</p>		

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F 157	<p>Continued From page 5</p> <p>PM on 10/25/17. At around 10:45 PM, the resident "was sleeping" and her breathing was slow. The nurse listened to her heart and checked her pulse and repositioned her. The nurse gave report at 11:00 -11:15 PM. Nurse #1 told the incoming nurse (Nurse #4) about the resident's slow breathing and the nurse said that was normal for the resident when she got morphine. Nurse #1 left the facility for the day. The next day, Nurse #1 came to the facility at 3:00 PM and was told that the resident passed away. The administrator told Nurse #1 that she gave Resident #1 5 ml of morphine instead of 5 mg. When asked what contributed to the error, Nurse # 1 said she read the physician order wrong.</p> <p>An interview was conducted with Nurse #2 on 10/29/17 at 6:15 PM. Nurse #2 provided care to Resident #1 on the 11 PM - 7 AM shift that started on 10/25/17. The nurse said she administered 0.25 ml of morphine at 1:00 AM as prescribed by the physician. Then, she went to the Controlled Drug Receipt Record to record the administration of the morphine to the resident and noticed documentation that the resident received 5 ml instead of 5 mg at 8:00 PM. Nurse #2 said the amount of morphine in the bottle matched the documented amount of morphine left on the Controlled Drug Receipt Record. Nurse #2 thought there was no way the resident received the 5 ml of morphine since the resident was still moaning when Nurse #2 went to look at the resident. Nurse #2 said she gave the resident the scheduled doses of 5 mg of morphine at 1:00 AM and again at 5:00 AM. Nurse #2 said she left the facility at 7:15 AM.</p> <p>Nurse #2 was interviewed again via telephone on</p>	F 157	<p>100% audit of all active resident controlled medication was completed on 10/27/2017 by Director of Health Services to identify any other resident with an order for controlled medication (Schedule II <input type="checkbox"/> V) that was not transcribed correctly and/or administered per physician order. All written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. There were no other discrepancies in any other written Controlled medication orders. 100% audit of all current residents <input type="checkbox"/> clinical documentation within the last 7 days completed by the Director of Nursing, Quality assurance nurse, Nurse Supervisor, MDS nurse #1 and/or MDS nurse #2 and to determine any identified need for notification of changes was completed in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 10/30/17. Findings of this audit are documented on clinical records audit tool located in the facility compliance binder.</p> <p>On 10/30/2017, 100% audit was completed by the Director of Nursing, Quality assurance nurse, Nurse Supervisor, MDS nurse #1 and/or MDS nurse #2 of all incidents reports completed within the last 30 days to ensure notifications were done in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and</p>		

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F 157	<p>Continued From page 6</p> <p>10/30/17 at 6:35 AM. The nurse said she did not call the doctor because the resident was still moaning, so she doubted that the resident got 5 ml of morphine. Nurse #2 said she did not assess the resident.</p> <p>On 10/30/17 at 2:58 PM, an interview was conducted with Nurse #3. Nurse #3 said she never worked with Resident #1. Nurse #3 said on 10/25/17 around 11:05 PM to 11:10 PM, she did a drug count with Nurse #1 and the count on the Controlled Drug Receipt Record matched the amount in the medication bottle for Resident #1. Nurse #3 said she did not look at the Controlled Drug Receipt Records during the drug count because she was not supposed to. Nurse #3 said that around 1:00 AM, Nurse #2 came to her and told her that documentation on the Controlled Drug Receipt Form indicated Resident #1 got 5 ml instead of 5 mg of morphine at 8 PM. Nurse #3 said she did not give Nurse #2 any direction on what she should do. Nurse #2 said she would let Unit Coordinator #1 know in the morning. Nurse #3 said if this happened to her and she gave a resident an incorrect dose, Nurse #3 would let her supervisor know immediately. If there was no supervisor in the facility she would call the doctor.</p> <p>An interview was conducted with the Unit Coordinator #1 on 10/30/17 at 9:29 AM. She usually worked the 7 AM -3 PM shift. She said Nurse #2 came to her about 8:00 or 8:30 AM on 10/26/17 and said she (Nurse #2) did not know if Resident #1 morphine dose was given correctly. Unit Coordinator #1 looked at the Controlled Drug Receipt Record and the morphine bottle. The amount in the morphine bottle matched what was</p>	F 157	<p>responsible party. This audit was completed on 10/30/17. Findings of this audit are documented on incident reports audit tool located in the facility compliance binder.</p> <p>Effective 10/27/2017, and moving forward, all liquid medication orders will be written with the specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include give 0.25ml as part of order instruction instead of giving 5Mg. This will mitigate errors in medication administration.</p> <p>Effective 10/30/2017, the facilities nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical</p>		

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F 157	<p>Continued From page 7</p> <p>documented as left on the Controlled Drug Receipt Record, then she told the administrator. Unit Coordinator #1 observed the resident and the resident was moving some and she was not moaning. The Unit Coordinator #1 stated, when she realized a resident got more than the prescribed dose of morphine, then she would assess the resident and notify the doctor immediately and get an order for Narcan. Narcan is a medication used to treat an opioid overdose.</p> <p>An interview was conducted with the physician on 10/30/17 at 10:32 AM via telephone. He said he was familiar with Resident #1 situation. He was notified of the medication error on the morning of 10/26/17 after the facility's administrator became aware of the error. He said that adverse effect of a morphine overdose would appear during the first 60 minutes to two hours after administration of the overdose. His expectation was the physician would be notified immediately when a medication error occurred. He expected the nursing staff to monitor vital signs, may be every 15 minutes, monitor breathing, and check clinical status. However, since the first nurse (Nurse #1) did not become aware of the error before the end of her shift at 11:00 PM, he stated "we missed the window of opportunity for monitoring and preventing harm (if it was to happen) since the harm would have appeared during the first two hours after the overdose." If he was notified when Nurse #2 discovered the error around 1:00 AM, the physician would not have given the resident Narcan right away, unless she was having breathing problems. At that time, the nurse would check the resident's level of consciousness and sedation. The physician stated that he did not see any problem with the nurse (Nurse #2) giving the resident the</p>	F 157	<p>meeting binder.</p> <p>Effective 10/30/2017, week end Registered Nurse supervisor and/or designated licensed nurse will review clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday &amp; Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in daily clinical rounds. Any negative findings will be documented on the daily checklist form and maintained in the daily clinical meeting binder.</p> <p>Monitoring procedure and education to ensure plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory compliance:</p> <p>Effective 10/30/2017, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party by conducting clinical meeting daily (M-F), review the daily clinical meeting checklist to ensure completion and proper follow through to include notification to Physician</p>		



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F 157	<p>Continued From page 8</p> <p>scheduled morphine doses at 1:00 AM and 5:00 AM, even after Nurse #2 became aware that the resident received 20 times more morphine than prescribed. The physician thought the resident did not absorb the morphine and that was why she did not have the typical overdose symptoms. The physician did not think the morphine overdose hastened the resident's death.</p> <p>The administrator was interviewed on 10/31/17 at 10:30 AM. The administrator stated that Nurse #1 told her she had to use five 1-ml syringe full of morphine to administer 5 ml of morphine to Resident #1.</p> <p>The administrator was notified of immediate jeopardy on 10/30/17 at 1 PM. The facility provided the following acceptable allegation of removal of the immediate jeopardy on 10/31/17 at 1:26 PM:</p> <p>On 10/29/17 at approximately 4:30pm, Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/17 (1am and 5am) to Resident #1 was interviewed by the Administrator. She revealed that during her shift on 10/26/17, Resident #1 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She stated, she noticed 5ml was documented on the Controlled Drug Receipt form for Resident #1 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because Resident #1 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated Resident #1 did not show any signs of change in condition to warrant contacting the physician.</p>	F 157	<p>and responsible party, will review any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting to include any medication error happened from the previous clinical meeting. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in a clinical meeting binder in the Director of Health Services office.</p> <p>Director of Nursing will review the completion of daily clinical report, and daily clinical checklist forms daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained.</p> <p>Effective 10/31/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include</p>		

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F 157	<p>Continued From page 9</p> <p>Nurse #2 will not be allowed to work until re-educated on physician notification requirements. Unit Coordinator #1 attempted to contact Nurse #2 with no response on 10/26/17 at 9:30AM. Director of Health Services attempted to contact Nurse #2 on 10/30/17 at 5:52PM, and no response. Nurse #2 will not be allowed to work until re-educated on physician notification requirements.</p> <p>On 10/25/17, Nurse #1 administered 5ml of Morphine Sulfate (100mg) instead of 0.25mL (5mg) as ordered by physician to Resident #1. No adverse effects were noted in relation to this medication error. Resident #1 had a terminal diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less.</p> <p>On 10/26/17, Resident #1 was moaning with pain at 1am and 5am; Nurse #2 administered Morphine 0.25mL per Physician order without contacting the Physician. Nurse #2 recognized the previous shift documented Morphine 5ml instead of 0.25mL. Per Nurse #2, no signs or symptoms of distress were noted during the night. Although Resident #1 died on 10/26/17 it is our assertion that the resident's death was a result of their terminal illness and not from the medication error approximately thirteen hours prior. Our assertion is based on the following facts; Morphine Sulfate Pharmacokinetics indicate:</p> <ul style="list-style-type: none"> <li>" 30% of orally administered medication is typically absorbed</li> <li>" Has a half-life of 2-4 hours</li> <li>" Peak time of 60 minutes</li> <li>" Duration of 4-6 hours</li> </ul> <p>The attending Physician was notified about this medication error on 10/26/17 at 3:30PM, this was done within 24 hours. At 11pm on 10/25/17 controlled drugs receipt for Resident #1 indicated</p>	F 157	<p>full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, resident <input type="checkbox"/> change of condition, change of treatment/intervention an injury of unknown source and/or Medication error if any, and if there is any evidence or concern of a medication error MD will be notified immediately and patient assessed accordingly. This education completed by 10/30/2017. Any Licensed Nurse or Medication Aide not educated by 10/31/2017 not allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 10/30/2017.</p> <p>Title of person responsible for implementing the acceptable plan of correction: Effective 10/31/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance.</p> <p>Compliance date: 11/1/2017</p>	

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F 157	<p>Continued From page 10</p> <p>the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in Resident #1 dispensed medication bottle.</p> <p>On 10/26/17 at approximately 9:00 am, during a controlled drug reconciliation for Resident #1, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The Controlled Drug Receipt form indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician. On 10/26/17 at approximately 3:00pm, Nurse #1, who administered the stated medication to Resident #1 was interviewed by the Administrator. She revealed that during the medication administration on the previous day, she noted medication order change for Resident #1. She verified the written order in the resident's record and read it as 5ml instead of 5mg.</p> <p>On 10/29/17 at approximately 4:30pm, Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/17 (1am and 5am) to Resident #1 was interviewed by the Administrator. She revealed that during her shift on 10/26/17, Resident #1 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She stated, she noticed 5ml was documented on the Controlled Drug Receipt form for Resident #1 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because Resident #1 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated Resident #1 did not show any signs of change in condition to warrant contacting the physician. Nurse #2 will not be allowed to work until re-educated on physician notification</p>	F 157			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	<p>Continued From page 11 requirements.</p> <p>100% audit of all active resident controlled medication was completed on 10/27/17 by Director of Health Services to identify any other resident with an order for controlled medication (Schedule II - V) that was not transcribed correctly and/or administered per physician order. All written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. There were no other discrepancies in any other written Controlled medication orders. 100% audit of all current residents' clinical documentation within the last 7 days were completed by the Director of Nursing, Quality assurance nurse, Nurse Supervisor, MDS nurse #1 and/or MDS nurse #2 and to determine any identified need for notification of changes was completed in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 10/30/17. Findings of this audit are documented on "clinical records audit tool" located in the facility compliance binder.</p> <p>On 10/30/17, 100% audit was completed by the Director of Nursing, Quality assurance nurse, Nurse Supervisor, MDS nurse #1 and/or MDS nurse #2 of all incidents reports completed within the last 30 days to ensure notifications were done in a timely manner. The audit revealed no other incident of missing/delayed notification of changes to both physician and responsible party. This audit was completed on 10/30/17. Findings of this audit were documented on "incident reports audit tool" located in the facility compliance binder.</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>Effective 10/27/17, and moving forward, all liquid medication orders will be written with the specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of giving 5Mg. This will mitigate errors in medication administration.</p> <p>Effective 10/30/17, the center nursing administrative team, which includes DON, ADON, and/or SDC, initiated a process for reviewing clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in a daily clinical rounds. Any negative findings will be documented on the "daily checklist form" and maintained in the daily clinical meeting binder.</p> <p>Effective 10/30/17, week end Registered Nurse supervisor and/or designated Nurse will review clinical documentation for the last 24 hours, 24 hour report sheets, incident reports for the last 24 hours and Physician orders written in the last 24 hours to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place every Saturday and</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>Sunday. Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor. This process will be incorporated in daily clinical rounds. Any negative findings will be documented on the "daily checklist form" and maintained in the daily clinical meeting binder.</p> <p>Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff Development Coordinator (SDC) will complete 100% education for all Nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education was on the importance of notifying Physician and the responsible party in a timely manner for any incident/accidents, resident's change of condition, change of treatment/intervention, an injury of unknown source and/or Medication error if any. This education will be completed by 10/30/17. Any Nurse or Medication Aide not educated by 10/30/17 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Nurses and Medication Aides effective 10/30/17. Effective 10/31/17, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with notification of changes to Physician and/or responsible party by conducting clinical meeting daily (M-F), review the daily clinical meeting checklist to ensure completion and proper follow through to include notification to Physician and responsible party, will review any admission/discharges occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting to include any medication error happened from the previous</p>	F 157			

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F 157	<p>Continued From page 14</p> <p>clinical meeting. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in a clinical meeting binder in the Director of Health Services office.</p> <p>Director of Nursing will review the completion of daily clinical report, and daily clinical checklist forms daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained.</p> <p>Effective 10/31/17, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>Effective 10/30/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.</p> <p>Validation of the credible allegation was done on 10/31/17 at 11:47 AM.</p> <p>The facility provided documentation that the physician was notified of the medication error shortly after the facility became aware of the error. Review of the clinical record audit tools revealed all records were audited for physician notification on 10/30/17. Review of audit for incident and skin was also checked. the inservice</p>	F 157			

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F 157	Continued From page 15 was conducted on 10/30/17 regarding physician notification. Interview with Nurse #1 validated that she did receive education and counselling from the administrator. A written statement was reviewed indicating that the administrator interviewed Nurse #2 on 10/29/17 at 4:30 pm. The statement indicated that the resident was showing signs and symptoms of pain and was not showing signs of distress. That was why Nurse #2 did not think that the 5 ml of morphine on the Controlled Drug Receipts was accurate. The facility has filled out a medication discrepancy report.  The facility provided evidence of audits of medication orders and inservices provided to staff about medication error and physician notification.  Staff were interviewed to validate that they received education on medication error and notifying the physician.  Residents who received morphine were reviewed for medication errors.	F 157			
F 329 SS=J	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2)  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or  (2) For excessive duration; or	F 329		11/1/17	



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F 329	<p>Continued From page 16</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic 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 and interviews with staff, the medical director and the director of clinical pharmacy services, the facility failed to administer the correct dose of morphine (a narcotic pain medication) resulting in Resident #1 receiving 20 times more morphine than what was prescribed by the physician. The facility staff failed to immediately assess the resident for adverse effects after facility staff discovered documentation that the resident received 20</p>	F 329	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for our residents.</p>		

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F 329	<p>Continued From page 17</p> <p>times more morphine than prescribed. The resident did receive two additional scheduled doses of morphine after the excessive dose. This was evident in 1 (Resident #1) of 3 sampled residents receiving narcotic medications.</p> <p>Immediate jeopardy began on 10/25/17 when Resident #1 received 20 times the prescribed dose of morphine, was not assessed for adverse effects after facility staff discovered documentation that the resident received 20 times more morphine than prescribed. The immediate jeopardy was removed on 10/30/17 when the facility provided an acceptable credible allegation of removal. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time.</p> <p>Findings included: Resident #1 was admitted to the facility on 4/17/15. The resident's diagnoses included atrial fibrillation, implantable cardiac fibrillator, repeated falls, diabetes and ataxic gait, dementia without behaviors, and essential hypertension.</p> <p>Review of the resident's annual Minimum Data Set (MDS) of 9/11/17 revealed the Brief Interview for Mental Status score was 7 which indicated the resident was severely cognitively impaired. The MDS indicated the resident received a scheduled pain medication regimen in the last 5 days during the look behind period. Pain did not trigger on the MDS.</p> <p>A Care plan was initiated on 9/19/17 to address the resident's risk for alteration in comfort related</p>	F 329	<p>The processes that lead to the deficiency:</p> <p>On 10/25/2017, Licensed Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to resident #6677. No adverse effects were noted in relation to this medication error. Resident #6677 had a terminal diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less. On 10/29/2017 at approximately 4:30pm, the Licensed Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She started, she noticed 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated resident #6677 did not show any signs or change in condition to warrant contacting the physician. Unit Coordinator #1 attempted to contact licensed nurse #2 with no response on 10/26/2017 at 9:30AM. Director of Health Services attempted to contact nurse #2 on 10/30/2017 at 5:52PM, and no responses. Licensed Nurse #2 will not be allowed to</p>		

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F 329	<p>Continued From page 18</p> <p>to osteoarthritis. The goal was the resident will verbalize or show non-verbal (no grimacing, no moaning etc.) relief of pain 45 minutes to an hour after administering of medications through the next review. The interventions included to administer tender loving care (i.e. change in position, back rub etc.) as needed, encourage resident to report any pain (noting location, duration, intensity and severity), give medication as ordered, observe for effectiveness of pain medications 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 Medical Doctor as needed, and conduct pain assessment routinely.</p> <p>Review of the resident's Departmental Notes revealed the following about the resident's condition:</p> <p>On 10/23/17, the resident started hospice services.</p> <p>On 10/23/17 and 10/24/17, the resident refused some of her medications.</p> <p>On 10/24/17, the Resident was lying in bed sleeping most of the day. She mumbled, refused all morning medications by spitting it back out after taking them.</p> <p>Review of the Physician's Telephone Orders revealed a physician order dated 10/24/17 to "stop all PO (by mouth) meds (medications) and supplements, morphine 20 mg (milligram)/ml (milliliter). Give 5 mg Q (every) 8 hrs (hours) SL (sublingual) routinely for pain/SOB (shortness of</p>	F 329	<p>work until re-educated on physician notification requirements.</p> <p>On 10/26/2017, resident #6677 was moaning with pain at 1am and 5am; Licensed Nurse #2 administered Morphine 0.25mL per Physician order. Nurse #2 recognized the previous shift documented Morphine 5mL instead of 0.25mL. Licensed nurse #2 did not have the ability to contact Licensed nurse #1 to verify whether Morphine 5mL documented on the Controlled Drug receipt form was administered to resident #6677 or not. Per Licensed nurse #2, no signs or symptoms of distress noted during the night for resident #6677.</p> <p>The attending Physician was notified about this medication error on 10/26/2017 at 3:30Pm, this was done within 24 hours. At 11pm on 10/25/2017 controlled drugs receipt for resident #6677 indicated the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in resident #6677 dispensed medication bottle.</p> <p>On 10/26/2017 at approximately 9:00 am, during controlled drug reconciliation for resident #6677, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The control sheet indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician.</p> <p>On 10/26/2017 at approximately 3:00pm, the Licensed Nurse #1, who administered the stated medication to resident #6677 was interviewed by the Administrator. She revealed that during the medication</p>		

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F 329	<p>Continued From page 19 breath). Give 5 mg SL Q 2hrs prn (as needed) SOB/pain."</p> <p>Review of Resident #1's "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 30 ml of Morphine 100mg/5ml solution were received at the facility on 10/24/17. The order written on the "Controlled Drug Receipt/Record/Disposition Form" was to give the resident 0.25 ml (5 mg) every 8 hours as needed.</p> <p>Review of Resident #1's "eMAR (electronic medication administration record)-Medication Record" for the month of October, 2017 revealed a typed "Description" of the order on the left side of the page that read as "Morphine 20mg/ml oral syringe, Give 5 mg every 8 hours sublingual for pain." On the same row of the order, on the right side of the page, and under the column of 10/25/17, there were a check mark and the initials of the medication aide indicating the resident was administered morphine at 6:00 AM and, again, 2 PM on 10/25/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 0.25 ml (5 mg) of morphine were given to the resident and 29.75 ml of morphine were left in the bottle at 6 AM on 10/25/17. Another 0.25 ml of morphine were documented as given to the resident and 29.50 ml of morphine were left in the bottle at 2 PM on 10/25/17.</p> <p>Review of the resident's Departmental Notes written by Nurse #4 on 10/25/17 at 4:15 PM revealed documentation that the Resident was lying in bed moaning, and was given morphine as ordered 0.25 (ml). The resident refused breakfast</p>	F 329	<p>administration on the previous day, she noted medication order change for resident #6677. She verified the written order in resident's record and read it as 5ml instead of 5mg.</p> <p>The Administrator explained and demonstrated to Licensed Nurse #1 what was supposed to be administered compared to what she signed for on the Controlled Drug Receipt form. Licensed Nurse #1 acknowledged that an incorrect amount of Morphine Sulfate had been administered. Based on the interview conducted by the Administrator and the record review of all controlled medications administered by Licensed Nurse #1, it was concluded that this error resulted from an honest oversight. Licensed nurse#1 misread the order, and misinterpreted of Morphine 5mg as Morphine 5mL. Licensed Nurse #1 was re-educated and counseled by the Director of Health Services and the Administrator on 10/27/2017. Medication administration competency and morphine dosage calculation education was provided to Licensed Nurse #1 by the Director of Health Services on 10/27/2017.</p> <p>Procedure for implementing the acceptable plan of correction for the specific deficiency cited:</p> <p>100% audit of all active residents controlled medications was completed on 10/27/2017 by Director of Health Services to identify any other resident with an order for a controlled medication (Schedule II □ V) that was transcribed incorrectly and/or</p>		

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F 329	<p>Continued From page 20</p> <p>and lunch. The resident declined water, when offered, by biting on the straw. The staff will continue to monitor the resident and provide comfort, and keep call bell in place.</p> <p>Review of the Physician's Telephone Order revealed a physician order dated 10/25/17 at 4:40 PM to discontinue current morphine order and to start "morphine 20 mg/ml. Give 5 mg PO/SL Q 4 h (hour) scheduled and Q 2 hr (hour) prn (for) pain/SOB."</p> <p>Review of Resident #1's "eMAR-Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page read as "Morphine 20mg/ml-oral syringe, Give 5 mg sublingual every 2 hours as needed for shortness of breath/pain." On the same row as the order, on the right side of the page, and under the column of 10/25/17, there were a check mark and the initials of Nurse #1 indicating Nurse #1 administered morphine at 8:14 PM on 10/25/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 5 ml of morphine were given to the resident and 24.50 ml of morphine were left in the bottle at 8:00 PM on 10/25/17. The resident received 100 mg (5 ml) of morphine instead of 5 mg (0.25 ml) at 8:00 PM on 10/25/17. This resident received 20 times more morphine than prescribed by the physician.</p> <p>Review of Resident #1's "eMAR-Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page that read as "Morphine 20mg/ml oral syringe, Give every 4 hours sublingual for pain." There was no dosage specified on this order. On the same row</p>	F 329	<p>not administered per physician order. All written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. No other written Controlled medication order noted with any discrepancy.</p> <p>Effective 10/27/2017, and moving forward, all liquid medication orders will be written with the specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include give 0.25ml as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were educated of this new process on 10/26/2017 and 10/27/2017 by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).</p> <p>Effective 10/27/2017 any Liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.</p> <p>Effective 10/27/2017, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will review all new medication and treatment orders from</p>		

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F 329	<p>Continued From page 21</p> <p>of the order, on the right side of the page, and under the column of 10/26/17, there were a check mark and the initials of Nurse #2 indicating Nurse #2 administered morphine at 1:00 AM and 5:00 AM on 10/26/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 0.25 ml of morphine were given to the resident and 24.25 ml of morphine were left in the bottle at 1 AM on 10/26/17. There was also documentation that 0.25 ml of morphine were given to the resident and 24.00 ml of morphine were left in the bottle at 5 AM on 10/26/17.</p> <p>Review of the resident's Departmental Notes dated 10/26/17 revealed the Resident died at 9:10 AM.</p> <p>An interview with Nurse #1 was conducted on 10/29/17 at 5:30 PM. She worked with the resident on 10/25/17 at the 3-11 shift. The resident would not eat or drink and would yell help and mumble. The resident was not verbal but this nurse would assess the resident's pain by looking for grimacing and moaning. The resident would sleep when her pain was relieved. The nurse gave the resident a morphine dose around 8:00 PM on 10/25/17. At around 10:45 PM, the resident "was sleeping" and her breathing was slow. The nurse listened to her heart and checked her pulse and repositioned her. The nurse gave report at 11-11:15 PM. Nurse #1 told the incoming nurse (Nurse #4) about the resident's slow breathing and the nurse said that was normal for the resident when she got morphine. Nurse #1 left the facility for the day. The next day, Nurse #1 came to the facility at 3 PM and was told that the resident passed away.</p>	F 329	<p>prior day (M-F), by comparing new written telephone orders and written orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds. Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Daily Clinical round binder located in the Director of Health Services office.</p> <p>Effective 10/27/2017, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator, initiated a process for reviewing all new admission/re-admissions Monday through Friday to ensure all ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly.</p> <p>Effective 10/27/2017, the center , week end RN supervisor and/or designated licensed nurse will review all new admission/re-admissions by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy every Saturday &amp; Sunday to ensure all new ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly, and reported to the Director of Health Services.</p>		

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F 329	<p>Continued From page 22</p> <p>The administrator told Nurse #1 that she gave Resident #1 5 ml (100 mg) of morphine instead of 5 mg. When asked what contributed to the error, Nurse # 1 said she read the physician order wrong. Nurse #1 said the administrator educated her about medication error and gave her print out on how to avoid medication error on 10/27/17.</p> <p>An interview was conducted with Nurse #2 on 10/29/17 at 6:15 PM. Nurse #2 provided care to Resident #1 on the 11 PM - 7 AM shift that started on 10/25/17. The resident had pain in her legs because they were contracted and she yelled constantly. Nurse #2 acknowledged that the physician order for the scheduled morphine on 10/25/17 did not have a dose on the electronic MAR. It only indicated 20 mg/ml of morphine but no dose. Nurse #2 said she looked at the hand written physician order to find out about the dosage. The nurse said she administered 0.25 ml of morphine at 1 AM as prescribed by the physician. Then, she went to the Controlled Drug Receipt Record to record the administration of the morphine to the resident and noticed documentation that the resident received 5 ml (100 mg) instead of 5 mg at 8:00 PM. Nurse #2 said the amount of morphine in the bottle matched the documented amount of morphine left on the Controlled Drug Receipt Record. Nurse #2 thought there was no way the resident received the 5 ml of morphine since the resident was still moaning when Nurse #2 went to look at the resident. Nurse #2 said she gave the resident the scheduled doses of 5 mg of morphine at 1 AM and again at 5 AM. Nurse #2 said she left the facility at 7:15 AM.</p> <p>Nurse #2 was interviewed again via telephone on 10/30/17 at 6:35 AM. The nurse said she did not</p>	F 329	<p>Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and medication aides, to include full time, part time and as needed staff, regarding medication administration per physician orders and medication error reporting. The emphasis of this education was on the liquid medication specifically Morphine sulfate. This education will be completed by 10/27/2017. Any licensed nurse and/or Medication aide not educated by 10/27/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/2017, and will be provided annually.</p> <p>Monitoring procedure and education to ensure plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory compliance:</p> <p>Effective 10/27/2017, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will monitor compliance or medication order administration per physician orders, specifically, all morphine Controlled Drug Receipts will be reviewed in clinical meeting, 5 times per week times (Monday <input type="checkbox"/> Friday) for 2 weeks, then 3 time weekly for 2 more weeks, then weekly for 4 weeks then monthly x 3</p>		

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F 329	<p>Continued From page 23</p> <p>call the doctor because the resident was still moaning, so she doubted that the resident got 5 ml of morphine. Nurse #2 said she did not assess the resident.</p> <p>On 10/30/17 at 2:58 PM, an interview was conducted with Nurse #3. Nurse #3 said she never worked with Resident #1. Nurse #3 said on 10/25/17 around 11:05 PM to 11:10 PM, she did a drug count with Nurse #1 and the count on the Controlled Drug Receipt Record matched the amount in the medication bottle for Resident #1. Nurse #3 said she did not look at the Controlled Drug Receipt Records during the drug count because she was not supposed to. Nurse #3 said that around 1 AM, Nurse #2 came to her and told her that documentation on the Controlled Drug Receipt Form indicated Resident #1 got 5 ml instead of 5 mg of morphine at 8:00 PM. Nurse #3 stated to Nurse #2, "surely to God, she did not give her 5 ml". Nurse #3 said she did not give Nurse #2 any direction on what she should do. Nurse #2 said she would let Unit Coordinator #1 know in the morning. Nurse #3 said if this happened to her and she gave a resident an incorrect dose, Nurse #3 said she would let her supervisor know immediately. If there was no supervisor in the facility she would call the doctor.</p> <p>An interview was conducted with Unit Coordinator #1 on 10/30/17 at 9:29 AM. She usually worked the 7 AM -3 PM shift. She said Nurse #2 came to her about 8:00 or 8:30 AM on 10/26/17 and said she (Nurse #2) did not know if Resident #1 morphine dose was given correctly. Unit Coordinator #1 looked at the Controlled Drug Receipt Record and the morphine bottle. The amount in the morphine bottle matched what was documented as left on the Controlled Drug</p>	F 329	<p>months or until the pattern of compliance is maintained. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done.</p> <p>Executive Director will review the completion of daily clinical report, and daily clinical checklist forms daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.</p> <p>Effective 10/27/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remove the alleged immediate jeopardy.</p> <p>Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and medication aides, to include full time, part time and as needed staff, regarding medication administration per physician orders and medication error reporting, including if there is any evidence or concern of a medication error the MD will be notified immediately and patient assessed accordingly. The emphasis of this education was on the liquid medication specifically Morphine</p>		



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F 329	<p>Continued From page 24</p> <p>Receipt Record, then she told the administrator. Unit Coordinator #1 observed the resident and the resident was moving some and she was not moaning. The Unit Coordinator #1 stated, when she would realize a resident got more than the prescribed dose of morphine, then she would assess the resident and notify the doctor immediately and get an order for Narcan. Narcan is a medication used to treat an opioid overdose.</p> <p>An interview was conducted with the physician on 10/30/17 at 10:32 AM via telephone. He said he was familiar with Resident #1 situation. He was notified of the medication error on the morning of 10/26/17 after the facility's administrator became aware of the error. He said that adverse effect of a morphine overdose would appear during the first 60 minutes to two hours after administration of the overdose. His expectation was the physician would be notified immediately when a medication error occurred. He expected the nursing staff to monitor vital signs, may be every 15 minutes, monitor breathing, and check clinical status. However, since the first nurse (Nurse #1) did not become aware of the error before the end of her shift at 11 PM, he stated "we missed the window of opportunity for monitoring and preventing harm (if it was to happen) since the harm would have appeared during the first two hours after the overdose." If he was notified when Nurse #2 discovered the error around 1 AM, the physician said he would not have given the resident Narcan right away, unless the resident was having breathing problems. At that time, the nurse would check the resident's level of consciousness and sedation. The physician stated that he did not see any problem with the nurse (Nurse #2) giving the resident the</p>	F 329	<p>sulfate. This education completed 10/27/2017. Any licensed nurse and/or Medication aide not educated by 10/27/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/2017, and will be provided annually.</p> <p>Title of person responsible for implementing the acceptable plan of correction:</p> <p>Effective 10/31/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance. Compliance date: 11/1/2017</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 25</p> <p>scheduled morphine doses at 1 AM and 5 AM, even after Nurse #2 became aware that the resident received 20 times more morphine than prescribed. The physician thought the resident did not absorb the morphine and that was why she did not have the typical overdose symptoms. The physician did not think the morphine overdose hastened the resident's death.</p> <p>On 10/30/17 at 5:28 PM, an interview was conducted with the director of clinical pharmacy services. She explained that physician orders were written on the physician telephone order and were faxed to the pharmacy. The facility's nurses were responsible for entering the physician order into the eMAR-Medication Record. If the order on the eMAR was not complete, then the nurse should go back to the original order to verify and they can correct it on the eMAR without pharmacy intervention. The morphine order is delivered to the facility with a Controlled Drug Receipt Record form that would have the resident's name, physician name, the name of the drug, a concentration, administration route, a dose (with the number of ml that needed to be administered so nurses would not have to do the math) and frequency of administration. When a nurse needed to administer morphine, the order would come up on the computer and the nurse should compare the morphine dose on the computer with the dose on the Controlled Drug Receipt Record to make sure it matched. Nurses would measure the morphine with a 1 ml syringe and administer it and document on the Controlled Drug Receipt Record how much was given and how much was left in the morphine bottle. During the narcotic count at the end of the shift, the oncoming nurse would be looking only at the amount of morphine in the bottle and the outgoing nurse would be</p>	F 329			

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F 329	<p>Continued From page 26</p> <p>looking at the Controlled Drug Receipt Record and then they match them up. The oncoming nurse would not look at the Controlled Drug Receipt Record until they administer morphine or at the drug count at the end of their shift. The director stated the nurse (Nurse #1) would have to fill up the 1 ml syringe with morphine 5 times to administer 5 ml to Resident #1.</p> <p>On 10/30/17 at 6:44 PM, an interview was conducted with the corporate nurse consultant. He said Nurse #2 did not assess the resident when she found out that the resident received an incorrect dose of morphine on 10/25/17. The only source of information of the resident's condition after she received the incorrect dose of morphine was from interviews with Nurse #2 by the facility and the state agency. There was no documentation in the medical record by Nurse #2 that the resident was moaning during the 11 PM-7 AM shift on 10/25/17.</p> <p>The administrator was interviewed on 10/31/17 at 10:30 AM. The administrator stated that Nurse #1 told her she had to use five 1-ml syringe full of morphine to administer 5 ml of morphine to Resident #1.</p> <p>The administrator was notified of immediate jeopardy on 10/30/17 at 1 PM. The facility provided the following acceptable allegation of removal of the immediate jeopardy on 10/31/17 at 1:26 PM:</p> <p>On 10/25/17, Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to Resident #1. No adverse effects were noted in relation to this medication error. Resident #1 had a terminal</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
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F 329	<p>Continued From page 27</p> <p>diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less.</p> <p>On 10/29/17 at approximately 4:30pm, Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/17 (1am and 5am) to Resident #1 was interviewed by the Administrator. She revealed that during her shift on 10/26/17, Resident #1 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She stated, she noticed 5ml was documented on the Controlled Drug Receipt form for Resident #1 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because Resident #1 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated Resident # 1 did not show any signs or change in condition to warrant contacting the physician. Unit Coordinator #1 attempted to contact Nurse #2 with no response on 10/26/17 at 9:30AM. Director of Health Services attempted to contact Nurse #2 on 10/30/17 at 5:52PM, and no response. Nurse #2 will not be allowed to work until re-educated on physician notification requirements.</p> <p>On 10/26/17, Resident #1 was moaning with pain at 1am and 5am. Nurse #2 administered Morphine 0.25mL per Physician order. Nurse #2 recognized the previous shift documented Morphine 5mL instead of 0.25mL. Nurse #2 did not have the ability to contact Nurse #1 to verify whether Morphine 5mL documented on the Controlled Drug receipt form was administered to Resident #1 or not. Per Nurse #2, no signs or symptoms of distress noted during the night for Resident #1.</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>Although Resident #1 died on 10/26/17, it is our assertion that the resident's death was a result of their terminal illness and not from the medication error approximately thirteen hours prior. Our assertion is based on the following facts;</p> <p>Morphine Sulfate Pharmacokinetics indicate:</p> <ul style="list-style-type: none"> <li>" 30% of orally administered medication is typically absorbed</li> <li>" Has a half-life of 2-4 hours</li> <li>" Peak time of 60 minutes</li> <li>" Duration of 4-6 hours</li> </ul> <p>The attending Physician was notified about this medication error on 10/26/17 at 3:30PM, this was done within 24 hours. At 11pm on 10/25/17 controlled drugs receipt for Resident #1 indicated the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in Resident #1's dispensed medication bottle.</p> <p>On 10/26/17 at approximately 9:00 am, during a controlled drug reconciliation for Resident #1, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The control sheet indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician.</p> <p>On 10/26/17 at approximately 3:00pm, Nurse #1, who administered the stated medication to Resident #1 was interviewed by the Administrator. She revealed that during the medication administration on the previous day, she noted medication order change for Resident #1. She verified the written order in resident's record and read it as 5ml instead of 5mg.</p> <p>The Administrator explained and demonstrated to Nurse #1 what was supposed to be administered compared to what she signed for on the Controlled Drug Receipt form. Nurse #1</p>	F 329			

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F 329	<p>Continued From page 29</p> <p>acknowledged that an incorrect amount of Morphine Sulfate had been administered. Based on the interview conducted by the Administrator and the record review of all controlled medications administered by Nurse #1, it was concluded that this error resulted from an honest oversight. Nurse #1 misread the order, and misinterpreted Morphine 5mg as Morphine 5mL. Nurse #1 was re-educated and counseled by the Director of Health Services and the Administrator on 10/27/17. Medication administration competency and morphine dosage calculation education was provided to Nurse #1 by the Director of Health Services on 10/27/17.</p> <p>100% audit of all active residents controlled medications was completed on 10/27/17 by Director of Health Services to identify any other resident with an order for a controlled medication (Schedule II - V) that was transcribed incorrectly and/or not administered per physician order. All written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. No other written Controlled medication order were noted with any discrepancy. Effective 10/27/17, and moving forward, all liquid medication orders will be written with the specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were notified of this new process on 10/26/17 and 10/27/17 by an education conducted by the Director of Health</p>	F 329			

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F 329	<p>Continued From page 30</p> <p>Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).</p> <p>Effective 10/27/17 any liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.</p> <p>Effective 10/27/17, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will review all new medication and treatment orders from prior day (M-F), by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds. Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Daily Clinical round binder located in the Director of Health Services office.</p> <p>Effective 10/27/17, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator, initiated a process for reviewing all new admission/re-admissions Monday through Friday to ensure all ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly.</p> <p>Effective 10/27/17, the center's week end RN supervisor and/or designated licensed nurse will review all new admission/re-admissions by comparing new written telephone orders to orders</p>	F 329			

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F 329	<p>Continued From page 31</p> <p>transcribed in electronic health record to ensure accuracy every Saturday and Sunday to ensure all new ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly, and reported to the Director of Health Services.</p> <p>Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and medication aides, to include full time, part time and as needed staff, regarding medication administration per physician orders and medication error reporting. The emphasis of this education was on the liquid medication specifically Morphine sulfate. This education will be completed by 10/27/17. Any licensed nurse and/or Medication aide not educated by 10/27/17 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/17, and will be provided annually.</p> <p>Effective 10/27/17, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will monitor compliance or medication order administration per physician orders, specifically, all morphine. Controlled Drug Receipts will be reviewed in clinical meeting, 5 times per week (Monday - Friday) for 2 weeks, then 3 time weekly for 2 more weeks, then weekly for 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups</p>	F 329			



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F 329	<p>Continued From page 32 are done.</p> <p>Executive Director will review the completion of daily clinical report, and daily clinical checklist forms daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.</p> <p>Effective 10/27/17, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility removal of the alleged immediate jeopardy.</p> <p>Effective 10/30/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.</p> <p>Validation of the credible allegation was done on 10/31/17 at 11:47 AM.</p> <p>The facility provided documentation that the administrator initiated an investigation as soon as she became aware of the medication error. The administrator interviewed Nurse #1 to determine how the error occurred and provided the nurse education on how to avoid future medication error. Interview with Nurse #1 validated that she did receive education and counselling from the administrator. A written statement was reviewed indicating that the administrator interviewed Nurse #2 on 10/29/17 at 4:30 pm. The statement indicated that the resident was showing signs and symptoms of pain and was not showing signs of</p>	F 329			

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F 329	Continued From page 33 distress. That was why Nurse #2 did not think that the 5 ml of morphine on the Controlled Drug Receipts was accurate. The facility has filled out a medication discrepancy report.  The facility provided evidence of audits of medication orders and inservices provided to staff about medication error and physician notification.  Staff were interviewed to validate that they received education on medication error and notifying the physician.  Resident who received morphine were reviewed for medication error.	F 329			
F 333 SS=J	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2)  483.45(f) Medication Errors.  The facility must ensure that its-  (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the medical director and the director of clinical pharmacy services, the facility failed to administer the correct dose of morphine (a narcotic pain medication) per physician order. Resident #1 received 100 mg of morphine instead of 5 mg which was 20 times more morphine than what was prescribed by the physician and a significant medication error. This was evident in 1 (Resident #1) of 3 residents receiving narcotic medications.	F 333	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for our residents.  The processes that lead to the deficiency:	11/1/17	

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F 333	<p>Continued From page 34</p> <p>Immediate jeopardy began on 10/25/17 when Resident #1 received 20 times the prescribed dose of morphine. The immediate jeopardy was removed on 10/30/17 when the facility provided an acceptable credible allegation of removal. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time.</p> <p>Findings included: Resident #1 was admitted to the facility on 4/17/15. The resident diagnoses included atrial fibrillation, implantable cardiac fibrillator, repeated falls, diabetes and ataxic gait, dementia without behaviors, and essential hypertension.</p> <p>Review of the resident's annual Minimum Data Set (MDS) of 9/11/17 revealed the Brief Interview for Mental Status score was 7 which indicated the resident was severely cognitively impaired. The MDS indicated the resident received a scheduled pain medication regimen in the last 5 days during the look behind period. Pain did not trigger on the MDS.</p> <p>A Care plan was initiated on 9/19/17 to address the resident's risk for alteration in comfort related to osteoarthritis. The goal was the resident will verbalize or show non-verbal (no grimacing, no moaning etc.) relief of pain 45 minutes to an hour after administering of medications through the next review. The interventions included to administer tender loving care (i.e. change in position, back rub etc.) as needed, encourage resident to report any pain (noting location, duration, intensity and severity), give medication as ordered, observe for effectiveness of pain</p>	F 333	<p>On 10/25/2017, Licensed Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to resident #6677. No adverse effects were noted in relation to this medication error. Resident #6677 had a terminal diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less.</p> <p>On 10/29/2017 at approximately 4:30pm, the Licensed Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/2017 (1am and 5am) to resident #6677 was interviewed by the Administrator. She revealed that during her shift on 10/26/2017, resident #6677 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She started, she noticed 5ml was documented on the Controlled Drug Receipt form for resident #6677 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because resident #6677 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated resident #6677 did not show any signs or change in condition to warrant contacting the physician. Unit Coordinator #1 attempted to contact licensed nurse #2 with no response on 10/26/2017 at 9:30AM. Director of Health Services attempted to contact nurse #2 on 10/30/2017 at 5:52PM, and no responses. Licensed Nurse #2 will not be allowed to work until re-educated on physician</p>		

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F 333	<p>Continued From page 35</p> <p>medications 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 Medical Doctor as needed, and conduct pain assessment routinely.</p> <p>Review of the resident's Departmental Notes revealed on 10/23/17, the resident started hospice services.</p> <p>Review of the Physician's Telephone Orders revealed a physician order dated 10/24/17 to "stop all PO (by mouth) meds (medications) and supplements, morphine 20 mg (milligram)/ml (milliliter). Give 5 mg Q (every) 8 hrs (hours) SL (sublingual) routinely for pain/SOB (shortness of breath). Give 5 mg SL Q 2hrs prn (as needed) SOB/pain."</p> <p>Review of Resident #1's "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 30 ml of Morphine 100mg/5ml solution were received at the facility on 10/24/17. The order written on the "Controlled Drug Receipt/Record/Disposition Form" was to give the resident 0.25 ml (5 mg) every 8 hours as needed.</p> <p>Review of Resident #1's "eMAR (electronic medication administration record) -Medication Record" for the month of October, 2017 revealed a typed "Description" of the order on the left side of the page that read as "Morphine 20mg/ml oral syringe, Give 5 mg every 8 hours sublingual for pain." On the same row of the order, on the right side of the page, and under the column of 10/25/17, there were a check mark and the initials of the medication aide indicating the</p>	F 333	<p>notification requirements.</p> <p>On 10/26/2017, resident #6677 was moaning with pain at 1am and 5am; Licensed Nurse #2 administered Morphine 0.25mL per Physician order. Nurse #2 recognized the previous shift documented Morphine 5mL instead of 0.25mL. Licensed nurse #2 did not have the ability to contact Licensed nurse #1 to verify whether Morphine 5mL documented on the Controlled Drug receipt form was administered to resident #6677 or not. Per Licensed nurse #2, no signs or symptoms of distress noted during the night for resident #6677.</p> <p>The attending Physician was notified about this medication error on 10/26/2017 at 3:30Pm, this was done within 24 hours. At 11pm on 10/25/2017 controlled drugs receipt for resident #6677 indicated the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in resident #6677 dispensed medication bottle.</p> <p>On 10/26/2017 at approximately 9:00 am, during controlled drug reconciliation for resident #6677, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The control sheet indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician. On 10/26/2017 at approximately 3:00pm, the Licensed Nurse #1, who administered the stated medication to resident #6677 was interviewed by the Administrator. She revealed that during the medication administration on the previous day, she</p>		

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F 333	<p>Continued From page 36</p> <p>resident was administered morphine at 6:00 AM and, again, 2 PM on 10/25/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 0.25 ml (5 mg) of morphine were given to the resident and 29.75 ml of morphine were left in the bottle at 6 AM on 10/25/17. Another 0.25 ml of morphine were documented as given to the resident and 29.50 ml of morphine were left in the bottle at 2 PM on 10/25/17.</p> <p>Review of the Physician's Telephone Order revealed a physician order dated 10/25/17 at 4:40 PM to discontinue current morphine order and to start "morphine 20 mg/ml. Give 5 mg PO/SL Q 4 h (hour) scheduled and Q 2 hr (hour) prn (for pain/SOB."</p> <p>Review of Resident #1's "eMAR-Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page read as "Morphine 20mg/ml-oral syringe, Give 5 mg sublingual every 2 hours as needed for shortness of breath/pain." On the same row as the order, on the right side of the page, and under the column of 10/25/17, there were a check mark and the initials of Nurse #1 indicating Nurse #1 administered morphine at 8:14 PM on 10/25/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 5 ml of morphine were given to the resident and 24.50 ml of morphine were left in the bottle at 8 PM on 10/25/17. The resident received 100 mg (5 ml) of morphine instead of 5 mg (0.25 ml) at 8 PM on 10/25/17. This resident received 20 times more morphine than prescribed</p>	F 333	<p>noted medication order change for resident #6677. She verified the written order in resident's record and read it as 5ml instead of 5mg.</p> <p>The Administrator explained and demonstrated to Licensed Nurse #1 what was supposed to be administered compared to what she signed for on the Controlled Drug Receipt form. Licensed Nurse #1 acknowledged that an incorrect amount of Morphine Sulfate had been administered. Based on the interview conducted by the Administrator and the record review of all controlled medications administered by Licensed Nurse #1, it was concluded that this error resulted from an honest oversight. Licensed nurse#1 misread the order, and misinterpreted of Morphine 5mg as Morphine 5mL. Licensed Nurse #1 was re-educated and counseled by the Director of Health Services and the Administrator on 10/27/2017. Medication administration competency and morphine dosage calculation education was provided to Licensed Nurse #1 by the Director of Health Services on 10/27/2017.</p> <p>Procedure for implementing the acceptable plan of correction for the specific deficiency cited:</p> <p>100% audit of all active residents controlled medications was completed on 10/27/2017 by Director of Health Services to identify any other resident with an order for a controlled medication (Schedule II <input type="checkbox"/> V) that was transcribed incorrectly and/or not administered per physician order. All</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>BLUMENTHAL NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3724 WIRELESS DRIVE</b> <b>GREENSBORO, NC 27455</b>		
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F 333	<p>Continued From page 37 by the physician.</p> <p>Review of Resident #1's "eMAR-Medication Record" for the month of October, 2017 revealed a typed order on the left side of the page that read as "Morphine 20mg/ml oral syringe, Give every 4 hours sublingual for pain." There was no dosage specified on this order. On the same row of the order, on the right side of the page, and under the column of 10/26/17, there were a check mark and the initials of Nurse #2 indicating Nurse #2 administered morphine at 1:00 AM and 5:00 AM on 10/26/17.</p> <p>Review of the "Controlled Drug Receipt/Record/Disposition Form" revealed documentation that 0.25 ml of morphine were given to the resident and 24.25 ml of morphine were left in the bottle at 1 AM on 10/26/17. There was also documentation that 0.25 ml of morphine were given to the resident and 24.00 ml of morphine were left in the bottle at 5 AM on 10/26/17.</p> <p>Review of the resident's Departmental Notes dated 10/26/17 revealed the Resident died at 9:10 AM.</p> <p>An interview with Nurse #1 was conducted on 10/29/17 at 5:30 PM. She worked with the resident on 10/25/17 at the 3-11 shift. The nurse gave the resident a morphine dose around 8 PM on 10/25/17. At around 10:45 PM, the resident "was sleeping" and her breathing was slow. The nurse listened to her heart and checked her pulse and repositioned her. The nurse gave report at 11-11:15 PM. Nurse #1 told the incoming nurse (Nurse #4) about the resident's slow breathing and the nurse said that was normal for the resident when she got morphine. Nurse #1 left</p>	F 333	<p>written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. No other written Controlled medication order noted with any discrepancy. Effective 10/27/2017, and moving forward, all liquid medication orders will be written with the specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include give 0.25ml as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were educated of this new process on 10/26/2017 and 10/27/2017 by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).</p> <p>Effective 10/27/2017 any Liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.</p> <p>Effective 10/27/2017, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will review all new medication and treatment orders from prior day (M-F), by comparing new written</p>		

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F 333	<p>Continued From page 38</p> <p>the facility for the day. The next day, Nurse #1 came to the facility at 3 PM and was told that the resident passed away. The administrator told Nurse #1 that she gave Resident #1 5 ml (100 mg) of morphine instead of 0.25 ml (5 mg). When asked what contributed to the error, Nurse # 1 said she read the physician order wrong. Nurse #1 said the administrator educated her about medication error and gave her print out on how to avoid medication error on 10/27/17.</p> <p>An interview was conducted with Nurse #2 on 10/29/17 at 6:15 PM. Nurse #2 provided care to Resident #1 on the 11 PM - 7 AM shift that started on 10/25/17. She said she gave the resident her scheduled dose of morphine of 5 mg around 1 AM on 10/26/17. Then she went to the Controlled Drug Receipt Record to record the morphine administration to the resident and noticed documentation that the resident received 5 ml (100 mg) instead of 0.25 ml (5 mg) at 8 PM. Nurse #2 said the amount of morphine in the bottle matched the documented amount of morphine left on the Controlled Drug Receipt Record. Nurse #2 thought there was no way the resident received the 5 ml of morphine since the resident was still moaning when Nurse #2 went to look at the resident. Nurse #2 said she gave the resident the scheduled doses of 5 mg of morphine at 1 AM and again at 5 AM. Nurse #2 said she left the facility at 7:15 AM.</p> <p>Nurse #2 was interviewed again via telephone on 10/30/17 at 6:35 AM. The nurse said she did not call the doctor because the resident was still moaning, so she doubted that the resident got 5 ml of morphine.</p>	F 333	<p>telephone orders and written orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds. Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Daily Clinical round binder located in the Director of Health Services office.</p> <p>Effective 10/27/2017, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator, initiated a process for reviewing all new admission/re-admissions Monday through Friday to ensure all ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly.</p> <p>Effective 10/27/2017, the center , week end RN supervisor and/or designated licensed nurse will review all new admission/re-admissions by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy every Saturday &amp; Sunday to ensure all new ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly, and reported to the Director of Health Services.</p>		

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F 333	<p>Continued From page 39</p> <p>On 10/30/17 at 2:58 PM, an interview was conducted with Nurse #3. Nurse #3 said she never worked with Resident #1. Nurse #3 said on 10/25/17 around 11:05 PM to 11:10 PM, she did a drug count with Nurse #1 and the count on the Controlled Drug Receipt Record matched the amount in the medication bottle for Resident #1. Nurse #3 said she did not look at the Controlled Drug Receipt Records during the drug count because she was not supposed to. Nurse #3 said that around 1 AM, Nurse #2 came to her and told her that documentation on the Controlled Drug Receipt Form indicated Resident #1 got 5 ml instead of 5 mg of morphine at 8 PM. Nurse #3 stated to Nurse #2, "surely to God, she did not give her 5 ml". Nurse #3 said she did not give Nurse #2 any direction on what she should do. Nurse #2 said she would let Unit Coordinator #1 know in the morning. Nurse #3 said if this happened to her and she gave a resident an incorrect dose, Nurse #3 would let her supervisor know immediately. If there was no supervisor in the facility she would call the doctor.</p> <p>An interview was conducted with the Unit Coordinator #1 on 10/30/17 at 9:29 AM. She usually worked the 7 AM -3 PM shift. She said Nurse #2 came to her about 8 or 8:30 AM on 10/26/17 and said she (Nurse #2) did not know if Resident #1 morphine dose was given correctly. Unit Coordinator #1 looked at the Controlled Drug Receipt Record and the morphine bottle. The amount in the morphine bottle matched what was documented as left on the Controlled Drug Receipt Record, then she told the administrator. Unit Coordinator #1 did look at the resident and the resident was moving some and she was not moaning. Unit Coordinator #1 stated, when she would realize a resident got more than the</p>	F 333	<p>Monitoring procedure and education to ensure plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory compliance:</p> <p>Effective 10/27/2017, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will monitor compliance or medication order administration per physician orders, specifically, all morphine Controlled Drug Receipts will be reviewed in clinical meeting, 5 times per week times (Monday <input type="checkbox"/> Friday) for 2 weeks, then 3 time weekly for 2 more weeks, then weekly for 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done.</p> <p>Executive Director will review the completion of daily clinical report, and daily clinical checklist forms daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.</p> <p>Effective 10/27/2017, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until the pattern of compliance is maintained. The QAPI committee can</p>		



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F 333	<p>Continued From page 40</p> <p>prescribed dose of morphine, then she would assess the resident and notify the doctor immediately and get an order for Narcan.</p> <p>An interview was conducted with the physician on 10/30/17 at 10:32 AM via telephone. He said he was familiar with Resident #1 situation. He said that adverse effect of a morphine overdose would appear during the first 60 minutes to two hours after administration of the overdose. His expectation was the physician would be notified immediately when a medication error occurred. He expected the nursing staff to monitor vital signs, may be every 15 minutes, monitor breathing, and check clinical status. However, since the first nurse (Nurse #1) did not become aware of the error before the end of her shift at 11 PM, he stated "we missed the window of opportunity for monitoring and preventing harm (if it was to happen) since the harm would have appeared during the first two hours after the overdose." If he was notified when Nurse #2 discovered the error around 1 AM, the physician would not have given the resident Narcan right away, unless she was having breathing problems. At that time, the nurse would check the resident's level of consciousness and sedation. The physician stated that he did not see any problem with the nurse (Nurse #2) giving the resident the scheduled morphine doses at 1 AM and 5 AM, even after Nurse #2 became aware that the resident received 20 times more morphine than prescribed. The physician thought the resident did not absorb the morphine that was why she did not have the typical overdose symptoms. The physician did not think the morphine overdose hastened the resident's death.</p> <p>On 10/30/17 at 5:28 PM, an interview was conducted with the director of clinical pharmacy</p>	F 333	<p>modify this plan to ensure the facility remove the alleged immediate jeopardy.</p> <p>Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and medication aides, to include full time, part time and as needed staff, regarding medication administration per physician orders and medication error reporting, including if there is any evidence or concern of a medication error, the MD will be notified immediately and patient assessed accordingly. The emphasis of this education was on the liquid medication specifically Morphine sulfate. This education completed 10/27/2017. Any licensed nurse and/or Medication aide not educated by 10/27/2017 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/2017, and will be provided annually.</p> <p>Title of person responsible for implementing the acceptable plan of correction:</p> <p>Effective 10/31/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of acceptable plan of correction to ensure regulatory compliance.</p> <p>Compliance date: 11/1/2017</p>		

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F 333	<p>Continued From page 41</p> <p>services. The director stated the morphine order is delivered to the facility with a Controlled Drug Receipt Record form that would have the resident's name, physician name, the name of the drug, a concentration, administration route, a dose (with the number of ml that needed to be administered so nurses would not have to do the math) and frequency of administration. When a nurse needed to administer morphine, the order would come up on the computer and the nurse should compare the morphine dose on the computer with the dose on the Controlled Drug Receipt Record to make sure it matched. Nurses would measure the morphine with a 1 ml syringe and administer it and document on the Controlled Drug Receipt Record how much was given and how much was left in the morphine bottle. The director stated the nurse (Nurse #1) would have to fill up the 1 ml syringe with morphine 5 times to administer 5 ml to Resident #1.</p> <p>On 10/30/17 at 6:44 PM, an interview was conducted with the corporate nurse consultant. He said Nurse #2 did not assess the resident when she found out that the resident received an incorrect dose of morphine on 10/25/17. The only source of information of the resident's condition after she received the incorrect dose of morphine was from interviews with Nurse #2 by the facility and the state agency. There was no documentation in the medical record by Nurse #2 that the resident was moaning during the 11 PM-7 AM shift on 10/25/17.</p> <p>The administrator was interviewed on 10/31/17 at 10:30 AM. The administrator stated that Nurse #1 told her she had to use five 1-ml syringe full of morphine to administer 5 ml of morphine to Resident #1.</p> <p>The administrator was notified of immediate</p>	F 333			

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F 333	<p>Continued From page 42</p> <p>jeopardy on 10/30/17 at 1 PM. The facility provided the following acceptable allegation of removal of the immediate jeopardy on 10/31/17 at 1:26 PM:</p> <p>On 10/25/17, Nurse #1 administered 5ml of Morphine Sulfate 100mg instead of 0.25mL (5mg) as ordered by physician to Resident #1. No adverse effects were noted in relation to this medication error. Resident #1 had a terminal diagnosis, and elected to receive Hospice services, with the life expectancy of six months or less.</p> <p>On 10/29/17 at approximately 4:30pm, Nurse #2 who administered two doses of Morphine Sulfate during the night on 10/26/17 (1am and 5am) to Resident #1 was interviewed by the Administrator. She revealed that during her shift on 10/26/17, Resident #1 showed signs and symptoms of pain and she administered 0.25mL of Morphine per physician order. She stated, she noticed 5ml was documented on the Controlled Drug Receipt form for Resident #1 at 1am when she was signing for the Morphine she administered. She did not think 5ml was administered because Resident #1 was still moaning with pain and showed no symptoms of medication overdose. She interpreted the entry as documentation error. She also indicated Resident # 1 did not show any signs or change in condition to warrant contacting the physician. Unit Coordinator #1 attempted to contact Nurse #2 with no response on 10/26/17 at 9:30AM. Director of Health Services attempted to contact Nurse #2 on 10/30/17 at 5:52PM, and no response. Nurse #2 will not be allowed to work until re-educated on physician notification requirements.</p> <p>On 10/26/17, Resident #1 was moaning with pain</p>	F 333			

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F 333	<p>Continued From page 43</p> <p>at 1am and 5am. Nurse #2 administered Morphine 0.25mL per Physician order. Nurse #2 recognized the previous shift documented Morphine 5mL instead of 0.25mL. Nurse #2 did not have the ability to contact Nurse #1 to verify whether Morphine 5mL documented on the Controlled Drug receipt form was administered to Resident #1 or not. Per Nurse #2, no signs or symptoms of distress noted during the night for Resident #1.</p> <p>Although Resident #1 died on 10/26/17, it is our assertion that the resident's death was a result of their terminal illness and not from the medication error approximately thirteen hours prior. Our assertion is based on the following facts; Morphine Sulfate Pharmacokinetics indicate: " 30% of orally administered medication is typically absorbed " Has a half-life of 2-4 hours " Peak time of 60 minutes " Duration of 4-6 hours</p> <p>The attending Physician was notified about this medication error on 10/26/17 at 3:30PM, this was done within 24 hours. At 11pm on 10/25/17 controlled drugs receipt for Resident #1 indicated the remaining quantity of Morphine Sulfate was 24.5mL. This amount matched the amount of Morphine sulfate remaining in Resident #1's dispensed medication bottle.</p> <p>On 10/26/17 at approximately 9:00 am, during a controlled drug reconciliation for Resident #1, a discrepancy was noted on the Controlled Drug Receipt form by the facility Administrator. The control sheet indicated resident received 5ml of Morphine sulfate instead of 0.25ml of Morphine as ordered by the Physician.</p> <p>On 10/26/17 at approximately 3:00pm, Nurse #1,</p>	F 333			

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F 333	<p>Continued From page 44</p> <p>who administered the stated medication to Resident #1 was interviewed by the Administrator. She revealed that during the medication administration on the previous day, she noted medication order change for Resident #1. She verified the written order in resident's record and read it as 5ml instead of 5mg.</p> <p>The Administrator explained and demonstrated to Nurse #1 what was supposed to be administered compared to what she signed for on the Controlled Drug Receipt form. Nurse #1 acknowledged that an incorrect amount of Morphine Sulfate had been administered. Based on the interview conducted by the Administrator and the record review of all controlled medications administered by Nurse #1, it was concluded that this error resulted from an honest oversight. Nurse #1 misread the order, and misinterpreted Morphine 5mg as Morphine 5mL. Nurse #1 was re-educated and counseled by the Director of Health Services and the Administrator on 10/27/17. Medication administration competency and morphine dosage calculation education was provided to Nurse #1 by the Director of Health Services on 10/27/17.</p> <p>100% audit of all active residents controlled medications was completed on 10/27/17 by Director of Health Services to identify any other resident with an order for a controlled medication (Schedule II - V) that was transcribed incorrectly and/or not administered per physician order. All written orders for controlled medications were verified for accuracy in electronic health records and on the electronic medication administration record. No other written Controlled medication order were noted with any discrepancy. Effective 10/27/17, and moving forward, all liquid medication orders will be written with the</p>	F 333			

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F 333	<p>Continued From page 45</p> <p>specificity of the amount of liquid to be administered based on concentration; for example an order for morphine 5mg, in a 20mg/ml solution, the direction on the order entered in electronic Medication administration record will include "give 0.25ml" as part of order instruction instead of give 5Mg. This will mitigate errors in medication administration. All Licensed nurses and Medication aides were notified of this new process on 10/26/17 and 10/27/17 by an education conducted by the Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC).</p> <p>Effective 10/27/17 any liquid medication ordered and written by the physician will be transcribed in resident Electronic Administration records to reflect the amount of liquid to be administered by licensed nurses on duty.</p> <p>Effective 10/27/17, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will review all new medication and treatment orders from prior day (M-F), by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy. This process will be incorporated in the facility daily Clinical rounds. Any medication not transcribed correctly will be corrected promptly and findings reported to the Director of Health Services. Findings from this process will be maintained in the Daily Clinical round binder located in the Director of Health Services office.</p> <p>Effective 10/27/17, the center clinical interdisciplinary team, which includes Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development</p>	F 333			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/31/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BLUMENTHAL NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3724 WIRELESS DRIVE</b> <b>GREENSBORO, NC 27455</b>		
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F 333	<p>Continued From page 46</p> <p>Coordinator, initiated a process for reviewing all new admission/re-admissions Monday through Friday to ensure all ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly.</p> <p>Effective 10/27/17, the center's week end RN supervisor and/or designated licensed nurse will review all new admission/re-admissions by comparing new written telephone orders to orders transcribed in electronic health record to ensure accuracy every Saturday and Sunday to ensure all new ordered medication were transcribed appropriately and administered per physician orders. Any negative finding will be addressed promptly, and reported to the Director of Health Services.</p> <p>Director of Health Services (DHS), Quality Assurance Nurse and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and medication aides, to include full time, part time and as needed staff, regarding medication administration per physician orders and medication error reporting. The emphasis of this education was on the liquid medication specifically Morphine sulfate. This education will be completed by 10/27/17. Any licensed nurse and/or Medication aide not educated by 10/27/17 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new Licensed nurses and Medication aides effective 10/27/17, and will be provided annually.</p> <p>Effective 10/27/17, Director of Health Services, Quality Assurance Nurse, Unit Coordinator and/or Staff Development Coordinator will monitor</p>	F 333			

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F 333	<p>Continued From page 47</p> <p>compliance or medication order administration per physician orders, specifically, all morphine. Controlled Drug Receipts will be reviewed in clinical meeting, 5 times per week (Monday - Friday) for 2 weeks, then 3 time weekly for 2 more weeks, then weekly for 4 weeks then monthly x 3 months or until the pattern of compliance is maintained. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done.</p> <p>Executive Director will review the completion of daily clinical report, and daily clinical checklist forms daily (M-F) for 2weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained.</p> <p>Effective 10/27/17, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility removal of the alleged immediate jeopardy.</p> <p>Effective 10/30/17, the center Executive Director and the Director of Health services will be ultimately responsible to ensure implementation of credible allegation to remove this alleged immediate jeopardy.</p> <p>Validation of the credible allegation was done on 10/31/17 at 11:47 AM.</p> <p>The facility provided documentation that the</p>	F 333			



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F 333	<p>Continued From page 48</p> <p>administrator initiated an investigation as soon as she became aware of the medication error. The administrator interviewed Nurse #1 to determine how the error occurred and provided the nurse education on how to avoid future medication error. Interview with Nurse #1 validated that she did receive education and counselling from the administrator. A written statement was reviewed indicating that the administrator interviewed Nurse #2 on 10/29/17 at 4:30 pm. The statement indicated that the resident was showing signs and symptoms of pain and was not showing signs of distress. That was why Nurse #2 did not think that the 5 ml of morphine on the Controlled Drug Receipts was accurate. The facility has filled out a medication discrepancy report.</p> <p>The facility provided evidence of audits of medication orders and inservices provided to staff about medication error and physician notification.</p> <p>Staff were interviewed to validate that they received education on medication error and notifying the physician.</p> <p>Resident on morphine were reviewed for medication error.</p>	F 333			