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F 490	Continued From page 53 examined all residents currently receiving narcotics to insure there were no errors in the resident's medial regiment. 3. October 3, 2006 - The administrator will meet the the Director of Nursing to clarify that she understands her responsibilities and is up to the job. Specifically, she must know: a. She must vigorously pursue medical intervention when it is called for. b. Every significant accident and incident must be immediately investigated by her and reported to the appropriate agency on a timely basis and records of State correspondences must be organized and accessible. c. Policies and procedures on every aspect of nursing department operation must be existent, available, and updated. 4. Over the last couple weeks, it was increasingly clear that the Director of Nursing was not keeping up with the Minimum Data Set/Care Plan (MDS/CP) responsibilities. Realizing this, the Administrator sought out additional personnel to assist. Our software vendor in fact is scheduled to train the Assistant Administrator, one of our floor nurses, and a new hire on the MDS/ system on Tuesday, October 3, 2006. Once the new personnel have been adequately trained, the job will no longer be the responsibility of the DON. It will be given to the newly trained nurse. The Administrator will clarify to the nurse that the MDS's and Care Plans must be done timely, they must be updated, and they must be accessible. The Administrator must check on a weekly basis to insure that these expectations are met. If he sees that delays persist, re-education will take place and	F 490		

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F 490	Continued From page 54 disciplinary actions will be taken if necessary.	F 490		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: 300.1010h) 300.1220b)8) 300.1620a) 300.1630e) 300.1650d)1) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques	F9999		

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F9999	Continued From page 55 through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. Section 300.1650 Control of Medications d) Inventory Controls 1) For all Schedule II controlled substances,	F9999		

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F9999	Continued From page 56 a controlled substances record shall be maintained that lists on separate sheets, for each type and strength of Schedule II controlled substance, the following information: date, time administered, name of resident, dose, licensed prescriber's name, signature of person administering dose, and number of doses remaining. These REGULATIONS are not met as evidenced by: Based on observation, record review, and interview, the facility failed to prevent a significant medication error for 2 of 2 residents (R13, R16). Facility staff gave R16 ten times the ordered dose of Morphine Sulfate, a Scheduled II Controlled Substance, failed to recognize the medication error during the following narcotic counts, failed to notify the resident's physician that the medication error had occurred while continuing to administer further doses of controlled substances without physician involvement, and failed to inform and educate the nurse responsible for the medication error before the nurse worked another shift at the facility. R16 died on 9-26-06. The facility failed to give R13 the correct dose and kind of insulin. The facility failed to follow-up with required documentation and review, failing to even know upon questioning what the exact medication error was. Findings include: 1. R16's physician order sheet for September 2006 shows R16 had diagnoses including congestive heart failure, hypertension, diabetes	F9999		

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mellitus, and chronic kidney disease. R16's weight record for the month of September shows R16 weighed 93 pounds and was 59 inches tall.

R16's nursing notes dated 9-25-06 at 7:00 p.m. state, "this nurse notes patient received wrong dose of Morphine Sulfate for initial dose on 9-24-06, unable to reach (Z6-R16's physician), patient is alert to name and no distress noted. Pharmacy label is incorrect, dose ordered is 10mg (milligrams) BID (twice a day) and label states to take 5ml (millimeters) BID, medication is 20mg/ml, pharmacy notified and request new label for drug to read give 0.5ml to equal 10mg dose." R16 was given 100mg of Morphine Sulfate instead of the ordered 10mg.

Prentice Hall's Nurse's Drug Guide 2005 list Roxanol as another name for Morphine Sulfate, a Scheduled II Controlled Substance classified as a central nervous system agent; analgesic, narcotic (opiate) agonist. Route and dosage for adult pain relief states: PO (by mouth) 10-30mg every 4 hours PRN (as needed) or 15-30mg sustained release every 8-12- hours, increase dose PRN for pain relief. Under Administration of drug is states "use lower dosage for older adult or debilitated patients that for adults, and ...a calibrated dropper comes with the bottle. Read labels carefully when using liquid preparation; available solutions: 20mg/ml; 100mg/ml." Absorption rate: Peak; 60 minute PO (by mouth) with a duration up to 7 hours. Nursing implications listed include: Assess vital signs at regular intervals. Morphine-induced respiratory depression may occur even with small doses, and it increases progressively with higher doses."

R16's current physician order sheet for

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F9999	Continued From page 58 September 2006 shows a telephone order dated 9-23-06 stating "Roxanol (Morphine Sulfate) oral solution 10mg/5ml (10mg equals 5ml), give 5ml (equaling 10mg) BID for pain, monitor times one week then increase if needed." The box the Roxanol came in read "Morphine Sulfate, Immediate release, concentrated oral solution, 20mg/1ml, CAUTION! HIGHLY CONCENTRATED." The pharmacy label placed on the box states "take 5ml twice daily for pain. Monitor for 1 week and increase as needed." At the bottom of the label it states "Morphine Sul 100mg/5ml (20mg/ml)." The actual bottle of Roxanol had a label stating "20mg/1ml." R16 was given 5ml per the incorrect pharmacy label which equaled 100mg instead of being given 0.5ml to equal the 10mg which was ordered. Even though the pharmacy label was incorrect, the box was clearly marked with the the correct strength and language indicating to use caution since the medication was highly concentrated. The facility's policy titled Medication Errors and Drug Reactions, revised September 2003, states: "1. All medication errors and drug reactions must be promptly reported to the director of nursing services, attending physician and the pharmacist. 2. A detailed account of the incident must be recorded in the resident's medical record. Such documentation must include, but is not limited to: The time and date of the incident; the name, strength, and dosage of medication administered; the resident's reaction to the medication, the condition of the resident, any treatment administered; and the date and time the physician was notified and his/her instructions. 3. Residents receiving incorrect medication or having a drug reaction must be closely	F9999		

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monitored. Any change in the resident's condition must be immediately reported to the director of nursing services and attending physician.
4. The nurse supervisor will be responsible for completing an incident report and submitting a copy to the director of nursing services and a copy to the administrator."

On 9-27-06 at 2:25 p.m., E4, Director of Nursing (DON), stated she was on duty or received a call on the way home when E12, Registered Nurse, found the medication error. E4 stated she did not notify R16's physician or family as that was the nurse-on-duty's responsibility. E4 stated she did not fill out a medication error report form at the time the medication error was found, nor did she contact the agency nurse or her company that the agency nurse worked for that Z7 had made a medication error. E4 stated she was not responsible for anything related to agency personnel; it would be up to the agency to inform the nurse and discipline her. On 10-2-06 at 12:45 p.m., E4 stated she did not inform Z7's agency of the medication error until 9-27-06, after Z7 had worked in the facility again the evening of 9-26-06.

On 9-27-06, E4 presented a Medication Error Report form for R16's medication error of 9-24-06. E4 verified she had not completed this form until 9-27-06. The form states "Could the error have endangered the life or welfare of the resident?" E4 responded "Resident could have experienced severe respiratory depression/insufficiency or severe central nervous depression."

The Controlled Drugs-Count Record form states

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F9999	Continued From page 60 "signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drugs-Count Record." R16's narcotic record for 9-24-06 includes a sign off sheet for the Roxanol labeled with R16's name, and "Roxynl (Roxanol) 10mg/5cc, give 0.5cc BID." Z7, Agency Registered Nurse (RN), signed at 8:00 p.m. on 9-24-06 that she gave 5cc or ml which totaled 100mg of the Roxanol. Z7 and E16, LPN, each signed the sheet stating they completed a narcotic count at shift change the night of 9-24-06. E16 and E12, both nurses, signed that they completed a narcotic count the morning of 9-25-06. None of the nurses involved in these counts found the medication error. There were five times when this narcotic count sheet was not signed off as being completed in September 2006. During interview on 9-27-06 at 12:25 p.m. and 9-28-06 at 11:00 a.m., E12, RN, provided the following information: E12 stated she gave the 8:00 a.m. dose of Roxanol on 9-25-06, the day after the overdose, giving the correct dose of 10mg which was 0.5ml. She read the order as 10mg BID and since she had 20mg/ml she gave 0.5ml of the medication. E12 did not sign off the medication on the narcotic sheet that morning saying she was called away from the facility about 10:00 to 11:00 a.m. on a family emergency. E12 returned about 4:00 p.m. that afternoon and remembered when she was giving R16's another medication that she had forgotten to sign off the narcotic Roxanol she had given R16 that morning. When E12 went to sign off the Roxanol for the morning dose, she discovered the medication error from the night before. When	F9999		

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F9999	Continued From page 61 asked if she had completed a narcotic count at the beginning of her morning shift with the nurse going off duty, E12 stated yes but "we must have missed that sheet." When asked about R16's condition on 9-25-06 E12, states that R16 was alert but very quiet and sleeping a lot. R16 oxygen saturation level had dropped requiring oxygen to be applied. E12 called R16's physician to notify him of the medication error but could not reach him. When asked if she considered calling the Medical Director when she did could not reach R16's primary physician, E12 stated no she did not, stating R16's physician was also considered the Medical Director of the facility. On 9-28-06 at 9:50 a.m., E4, DON, stated Z6, R16's attending physician, was not the facility's Medical Director. E4 also stated Z6 was hard to reach at times since he had no answering machine, fax machine, or cell phone. Staff have to call around to his office, home, or hospital to find Z6. Z7, Agency RN, was interviewed on 9-29-06 at 2:20 p.m. and provided the following information: Z7 worked at the facility for the first time the evening of 9-24-06. She was told in report that R16 was "comfort measure only" and that they were waiting for the medication Roxanol to be delivered by the pharmacy and to give it when it came in. Z7 stated when the medication came in she gave 5ml, the dose that was written on the MAR (medication administration record), on order sheet and on the "tag" on the box. Z7 did a narcotic count with E13, Licensed Practical Nurse, who relieved her that night.	F9999		

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Z7 gave the Roxanol about 6:45 p.m when it came from the pharmacy. R16 continued to yell out in pain until about one hour after the medication was given at which time she calmed and rested through the rest of her shift. R16's respirations were 14-18 per minute with no distress noted. R16's oxygen saturation level was within normal limits. Z7 stated when she met the Director of Nursing while working the evening shift on 9-26-06, the Director of Nursing did not discuss the details of the medication error with her, only that someone had made one.

The facility's policy titled Administrating Oral Medication revised September 2003 states "1. Always verify the "5 Rights" before administering medication-the right medication; the right dose; the right resident; the right route; and the right time.
3. Double check the Medication Administration Record (MAR) against physician orders before administering medications.

During interview on 9-28-06 at 10:50 a.m., Z6, R16's primary physician, stated he was notified of the medication error involving the Roxanol but was unable to say when he was notified. Z6 could not say if he was notified 9-25-06 when the medication error was discovered. When asked if the dosage of 100 mg could have caused harm to R16, Z6 stated that when he talked with the facility, they stated R16 was "OK" but that it "put her to sleep." When asked if the facility should have given more doses after the overdose, Z6 stated "it would have depended on the results of the first dose and it just put her to sleep."

On 9-28-06 at 3:00 p.m., Z8, Medical Director, stated she would expect to be notified of a

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F9999	Continued From page 63 significant medication error such as R16's if the resident's primary physician could not be reached. Z8 stated she was not notified in this case. Z8 stated one side effect of receiving a large dose of Morphine Sulfate could be decreased respirations. R16's MAR (Medication Administration Record) shows R16 was given Roxanol the evening of 9-24-06, morning and evening of 9-25-06, and the morning of 9-26-06. Demerol 50gm IM (another Scheduled II narcotic which acts in the same way as Morphine Sulfate) was documented in the nursing notes as being given 9-25-06 at 2:00 a.m., about seven hours after being given 100mg of Morphine Sulfate instead of the ordered 10mg. During interview on 9-29-06 at 9:15 a.m., E14, LPN, stated she worked the evening of 9-25-06 and was told by E12 that R16 had been given the wrong dose of Morphine Sulfate the evening before. E14 stated she was not instructed that more Morphine Sulfate should not be given so she gave R16 her evening dose of 10mg. E14 described R16 as restless, yelling out in pain, oxygen saturation level 93% stating she did calm later in the shift. E14 believed R16 be "comfort measure only" and felt "OK" with R16's condition and continued to monitor her. During interview on 9-28-06 at 3:35 p.m., E15, LPN, stated she worked the day shift on 9-26-06 and gave R16 her morning dose of Morphine Sulfate 10mg as ordered. E15 stated no one had informed her of R16 receiving 10 times the ordered dose of Morphine Sulfate on 9-24-06. E15 stated if she knew of the error she would have questioned giving her another dose of the medication. E15 was told in report that R16 was "terminal" so she monitored R16 but felt no need	F9999		

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F9999	Continued From page 64 to notify R16's physician about her condition. There is no documentation in the nursing notes from 9-24-06 to 9-26-06 when R16 passed away that Z6, R16's physician, or the Medical Director of the facility was notified of R16 being given ten (10) times the ordered dose of Morphine Sulfate, or that nurses consulted R16's about her lower oxygen level and being given more doses of narcotics after the medication error was discovered. R16's physician order sheet for September 2006 shows an oxygen order reading "oxygen at 2L per nasal cannula to keep SATS (saturation level) greater that 90%." Nursing notes for 9-25-06 a.m. state oxygen level 85%, given 4L (liters) of oxygen and at 8:00 a.m. level was up to 89% on 4L. There is no other documentation of R16's oxygen status or condition until 9-26-06 at 2:00 a.m. At 10:30 a.m. on 9-26-06, R16's oxygen level documented in the nursing notes was only 85% on 4L with no evidence of physician notification to increase oxygen even for "comfort measure." 2) R13's current face sheet indicates that R13 is 77 years of age with diagnoses including: Diabetes Type II, Hypertension and Depression. The 6/05/06 MDS (Minimum Data Set) indicates that R13 has modified independence in cognition for daily decision making. During review of R13's nursing notes, a medication error was noted to have occurred on 8/30/06. The nurse documented on 8/30/06 at 7:00 a.m., "This nurse gave this resident (R13) another resident's insulin - different type and different dose. Resident given doughnut and	F9999		

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F9999	Continued From page 65 orange juice with sugar." E4, DON, was interviewed on 9/28/06 at 12:30 p.m. regarding an incident report and an investigation of this incident. E4 stated, "I don't have any. That nurse (E11) doesn't work for us anymore. She's very hard to get a hold of." Two different phone numbers were called on 3 different occasions with no success in reaching the ex-staff member. E12, RN (Registered Nurse), was interviewed on 9/29/06 at 8:45 a.m. as to her having any knowledge of what Insulin was given in error to R13. E12 stated, "I know it happened, but I don't have any idea of whose Insulin she did get." E13 stated on 9-29-06 at 8:50 a.m., "Yes I did get the wrong Insulin one morning. I felt sick and really weak until I ate lunch. Then I began to feel better." The MAR (medication administration record) for R13 shows R13 was to receive 60 units of Lantus (Insulin) at 6:30 am. There is no information as to what medication R13 was given. R13's blood glucose check at 12:00 p.m. was documented on the MAR to be 98. During the month of August R13's blood sugars normal range was from 341 down to 117. (A)	F9999		