STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055079	A. BUILDING _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION VIEW HEALTH CENTER	1425 WOODSIDE DR SAN LUIS OBISPO, CA 93401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health - Licensing and Certification during an abbreviated survey conducted for Complaints: CA00354892 - substantiated at F281 and F309 CA00351626 - unsubstantiated Representing the Department: 28928, HFEN Facility census: 129 Sample: 3 The inspection was limited to the investigation of the reported incident and does not reflect the findings of a full inspection of the facility.	F 000	This Plan of Correction shall constitute this facility's written credible allegation of compliance for the deficiencies noted	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure services provided met professional standards of care for one of three sampled residents (Resident 3): 1. The facility failed to follow the physician's order to limit the amount of APAP (Tylenol, medication used for pain) medication in a 24 hour period for Resident 3. This failure may have placed the resident at risk for potential liver damage.	F 281	F 281 483.20 (k)(3)(i) PROFESSIONAL STANDARDS The services provided by the facility must meet professional standards of quality. 1. A. For the Resident identified, The Resident discharged from the facility on [redacted]	

Accepted 7/15/13 by Suzanne Chenoweth, RN, HFEN

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

ADMINISTRATOR — 7-9-13

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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2. The facility failed to ensure an incomplete pain medication order was clarified with the physician for Resident 3. Resident 3's pain medication order did not contain a dose of the medication. This omission resulted in an error in the transcription of the order to the Medication Administration Record (MAR). The dose transcribed to the MAR changed from one day to the next, reflecting different doses of the medication, even though there was no dose ordered. This failure placed the resident at risk for medication errors and inadequate pain relief.

Findings:

During review of the clinical record for Resident 3 on 6/17/13, the comprehensive assessment dated 3/4/13 indicated the resident had diagnoses which included septicemia (infection in the blood) and osteomyelitis (infection in a bone) of the shoulder. Resident 3 was assessed as having pain frequently.

1. Review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicated, "Nurses are obligated to follow physician order unless they believe they orders are in error or would harm clients."

During a review of the clinical record for Resident 3 on 6/17/13, the physician's order dated 2/26/13 indicated, "Tylenol (APAP) 325 milligrams (mg) tabs 2 PO (by mouth) Q4 hrs (every 4 hours) PRN (when necessary) mild pain (pain scale 1-4)" and "Do not exceed 3,000 mg of APAP in 24 hour period." Review of the physician's order dated

B. For all Residents potentially affected by this deficient practice. Evaluate all Residents receiving Tylenol to ensure that each Resident is receiving 3000mg or less of Tylenol within a twenty four hour period unless specified by a Physician.

C. The Director of Nurses and/or designee will in-service all licensed nurses with regard to monitoring Tylenol dosage over a twenty four hour period to ensure that 3000mg of Tylenol or less are administered unless a physician has directed otherwise.

D. The Director of Nurses and or designee will conduct an audit of Tylenol dosage within a twenty four hour period on a monthly basis and discuss any discrepancies in the Quality Assurance committee for recommendations of re-in servicing or changes to the current policy and procedure

7-31-13

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F 281	Continued From page 2	F 281	2.	

2/27/13 indicated "Percocet (pain medication which contains 325 mg of APAP) 1 - 2 tabs PO Q4 hours PRN moderate-severe pain."

During a review of Resident 3's MAR dated 2/28/13 indicated Resident 3 had the following medications administered:
* Two Percocet tablets administered five times for a total of 3,250 mg of APAP
* One Percocet tablet administered one time for a total of 325 mg of APAP
The total of APAP administered on 2/28/13 was 3,575 mg, which was greater than the maximum daily dose of 3,000 mg.

During a review of Resident 3's MAR dated 3/5/13 indicated Resident 3 had the following medications administered:
* One Percocet tabled administered two times for a total of 650 mg of APAP
* Two Percocet tablets administered two times for a total of 1300 mg of APAP
* Two Tylenol tablets administered two times for a total of 1300 mg of APAP
The total of APAP administered on 3/5/13 was 3,250 mg, which was greater than the maximum daily dose of 3,000 mg.

During an interview on 6/17/13 at 3:04 p.m., the director of nurses (DON) explained the nurses are responsible for keeping track of how much Tylenol (APAP) is given in a 24 hour period

2. Review of Potter and Perry, seventh Edition, Mosby's Fundamentals of Nursing, page 847 in the section titled Medication Administration indicated, "A medication order is incomplete unless it has the following parts: ...Date that the

A. For the Resident identified, The Resident discharged from the facility on [redacted]

B. For all Residents potentially affected by this deficient practice. All Resident's physician orders for pain medication were evaluated to ensure that all physician orders were complete and included all parts of a medication order.

C. The Director of Nurses and/or designee will in-service all licensed nurses with regard to accurate completion of medication orders.

D. The Director of Nurses and or designee will conduct an audit of physician orders pertaining to medication orders on a monthly basis and discuss any discrepancies in the Quality Assurance committee for recommendations of re-in servicing or changes to the current policy and procedure

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order is written...Medication name...Dose: The amount or strength of the medication is included...Route of administration ...Time and frequency of administration. "
Page 846 of the same section indicated, "If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

During review of Resident 3's initial pain medication order dated 2/26/13 indicated Percocet 10/325 mg 1 tablet every 6 hours for moderate pain and Percocet 10/325 mg 2 tablets every 6 hours for severe pain.

During review of a physician's order dated 2/27/13 at 8:30 a.m., indicated "Percocet i - ii tabs (tablets) PO Q4 hours PRN mod (moderate) -severe pain." This medication order does not include the dose of the Percocet. There is no evidence in Resident 3's clinical record that this order was clarified with the physician.

Review of the MAR dated 2/27/13 indicated the 2/27/13 physician's order for pain medication was transcribed as Percocet 5/325 mg 1 PO Q4 hours for moderate pain and Percocet 5/325 mg 2 PO Q4 hours for severe pain. This transcription included a dose, however the order on 2/27/13 did not.

Review of the MAR for March 2013 indicated the Percocet order written on 2/27/13 was transcribed as Percocet 10/325 mg. The dose of Percocet was transcribed as 5/325 mg in February 2013 and 10/325 mg in March 2013, both of these transcriptions reflected the same physician's order written on 2/27/13 which did not include a

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F 281	Continued From page 4 dose of Percocet. Review of the February 2012 MAR indicated 5/325 mg of Percocet was administered seven times. Review of Resident 3's "Controlled Drug Record, Individual Patient's Narcotic Record" sign out log dated 2/27 - 2/28/13 indicated the doses of Percocet signed out for those dates was 10/325 mg, not the 5/325 mg as indicated as administered in the MAR. During an interview on 6/17/13 at 3:04 p.m., the DON confirmed Resident 3's medication order did not include the dose of the medication to be administered.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide necessary care and services for one of three sampled residents (Resident 3). The facility failed to ensure Resident 3's pain medication was obtained timely from the pharmacy and available to meet the resident's pain relief requirements on 3/5/2013. This failure resulted in inadequate pain relief for Resident 3.	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each Resident must receive and the facility must provide the necessary care and services. A. For the Resident identified, The Resident discharged from the facility on [redacted].	

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F 309	Continued From page 5	F 309		

Findings:

During review of the clinical record for Resident 3 on 6/17/13, the comprehensive assessment dated 3/4/13 indicated the resident had diagnoses which included septicemia (infection in the blood) and osteomyelitis (infection in a bone) of the shoulder. Resident 3 was assessed as having pain frequently. Resident 3 was assessed as having no hearing, vision, or cognition problems.

During review of Resident 3's pain medication order dated 2/26/13 indicated Percocet (narcotic pain medication) 10/325 milligrams (mg) 1 tablet every 6 hours for moderate pain and Percocet 10/325 mg 2 tablets every 6 hours for severe pain. The 2/26/13 physician's order also included an order for Tylenol 325 mg two tablets every four hours for mild pain (pain scale 1-4). The Percocet order was changed on 2/27/13 to increase the frequency of Percocet to every four hours.

Review of Resident 3's MAR dated 3/5/13 indicated a pain level of 5 (on a scale of 1-10) at 9 a.m. and again at 1 p.m. Tylenol was administered, however Percocet was written and crossed out in error. Tylenol was ordered to be administered when the resident's pain was mild "pain scale 1-4."

During an interview on 6/12/13 at 1:25 p.m., Resident 3 explained the facility ran out of her Percocet on 3/5/13. They told her they only had one left. Resident 3 explained that she had severe pain in her hip due to arthritis and an infection. Resident 3 said she had undergone hip surgery to clean out the infection. Resident 3 said

B. For all Residents potentially affected by this deficient practice. All Resident's physician orders for pain medication were evaluated to ensure that all pain medications were re-ordered as per the facility policy to ensure medication availability.

C. The Director of Nurses and/or designee will in-service all licensed nurses with regard to the policy and procedure for ordering and receiving controlled medications.

D. The Director of Nurses and or designee will conduct an audit of controlled medication re-orders on a monthly basis and discuss any discrepancies in the Quality Assurance committee for recommendations of re-in servicing or changes to the current policy and procedure

7-31-13

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she received Percocet at 4 a.m. on 3/5/13 and then had to wait until the afternoon for another dose. Resident 3 said she suffered with pain at a level of 7-8 on the 1-10 pain scale during the day when the facility ran out of the Percocet. Resident 3 said the facility staff did not do anything for her pain, "not offered ice pack or anything." Resident 3 explained when the Dr. came into the facility, he was very upset that she suffered in pain.

During an interview with the assistant director of nurses (ADON 2) on 6/25/13 at 11:30 a.m., ADON 2 explained the facility system to re-order medication from the pharmacy. The ADON said there is a sticker on the package of medication that the licensed nurses removes when the medication is about to run out. The nurse puts the sticker on a re-order form and it is faxed to the pharmacy for replacement.

The facility policy and procedure titled " Ordering and Receiving Controlled medications" dated 9/10 reviewed on 7/1/13 indicated refills should be "requested from the pharmacy a minimum of 3 days in advance of need to assure an adequate supply is on hand."

Review on 6/25/13 of the facility's "EZ Refill Form" indicted a sticker for Resident 3 to re-order the Percocet was faxed to the pharmacy on 3/4/13 at 9:38 a.m. Review of the pharmacy delivery notice dated 3/5/13 indicated a delivery of Resident 3's Percocet at 8:40 p.m., 35 hours after it was ordered. Review of the Controlled Drug Record dated 3/5/13 indicated there were seven Percocet tablets left when the medication was faxed to the pharmacy for re-order, not a three day supply as indicated in the policy.

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F 309	Continued From page 7 During an interview and consecutive record review with LN 2 on 6/17/13 at 2:15 p.m. who was Resident 3's nurse on 3/5/13, said she had intended to give Percocet when the resident complained of pain, but gave Tylenol instead. LN 2 confirmed that she wrote Percocet on the Medication Notes in the MAR at 9 a.m. and 1 p.m. on 3/5/13, then crossed out the word Percocet and wrote Tylenol.	F 309		