CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	06/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-PANA	4545 Shelley Ct, Stockton, CA 95207-7232 SAN JOAQUIN COUNTY

POC ACCEPTED 7/9/13 CH

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS B CITATION – MEDICATION 03-2615-0009986-S Complaint(s): CA00233171 Representing the Department of Public Health: Surveyor ID # 31879, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 72301 (f) - Required Service - (f) The facility shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated. 72313 (a) (2) - Nursing Service-Administration of Medication - (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed. An unannounced visit was made on 6/23/2010 to initiate the investigation of complaint #CA00233171. As a result of the investigation the Department determined that the facility failed to: 1. Ensure Patient A was protected from a significant medication error by giving Patient A the wrong medication. 2. Follow the physician's order to hold all sedative		Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This Plan of Correction constitutes my written credible allegation of compliance for the deficiency noted. 72301 (f) Required Services - (f) The facility shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated. 72313 (a) (2) - Nursing Services-Administration of Medications. (a) Medications and treatments shall be administered as follows: (2) Medications and treatments shall be administered as prescribed.	

7/3/13 7/9/13 To begin immediately & be corrected by 7/9/13 & appeal rights given to

Event ID:R65811 7/1/2013 12:36:33PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jay Evans TITLE Administrator (X6) DATE 7/9/13

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 8

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. Except for nursing homes, the findings 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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	medications. The combined effect of these errors resulted in increased sedation and confusion that necessitated administration of medication to counteract the sedative effect. Patient A experienced a dangerous elevation in blood pressure after the administration of this medication and required an unplanned transfer to the acute care hospital for evaluation and treatment. Review of Patient A's clinical record was conducted on 6/23/2010. Patient A was an 81 year old admitted on 12/18/2008, with diagnosis of hypertensive heart disease with heart failure and dementia with behavioral disturbances. Resident A's Admission Minimum Data Set (MDS, a standardized assessment tool), dated 11/28/2009 documented Resident A as having short-term memory loss, difficulty in new situations with daily decision making skills, clear speech, able to make herself understood and able to understand others. Patient A needed no assistance with walking, limited assistance with dressing, and extensive assistance with personal hygiene and toileting. Patient A was documented as not being in pain while on her current pain medicine regimen. Patient A's medication regimen included: Norco (acetaminophen-Hydrocodone, a narcotic pain medication), 325-10 milligrams tablet, was given by mouth, every four hours, around the clock. Remeron (Mirtazapine) 15 milligram tablet was given daily at bedtime for depression.		a. **Correction for Resident Affected** Patient A, the resident affected is no longer in the facility. b. **Identification of Residents with Potential to be Affected** All residents have the potential to be affected by medication and or treatment errors as alleged in the Statement of Deficiency. c. **Measures taken to Prevent Recurrence** The nursing staff have been inserviced by the DNS and DCE including the following: 1. Reviewed the Statement of Deficiency to provide context for the review of medication pass, carrying out physician orders and documenting medication errors. 2. Medication pass rules, the 5 Rs of a proper med pass.	7/8/13

HFEN 7/9/13

Jay Evans Administrator 7/9/13

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	Ambien (Zolpidem Tartrate) 5 milligrams tablet was given at bedtime every day for insomnia. Cardiac medications included: Imdur (Isosorbide Mononitrate), 30 milligrams, one daily was given for hypertensive heart disease with heart failure and Metoprolol Tartrate, 25 milligrams, 1 tablet every eight hours was given for congestive heart failure. Patient A's clinical record progress note dated 6/20/2010 at 13:25 (1:25 pm), documented RN 1 gave the wrong medication to Patient A. RN 1 was standing by the medication cart preparing medication for Patient B when she noticed Patient A was rolling by the cart in her wheel chair to go to lunch. RN 1 asked Patient A if she wanted her afternoon medication and "she stated that she did. I prepared her medication, set the cup [medication cup] down on the medication cart, turned to get her a glass of juice, [turned back] and picked up the wrong cup and gave it to her at 13:25.(1:25 pm)." The cup given to Patient A contained the afternoon medication for Patient B. The medication given in error to Patient A was Avinza (Morphine Sulfate Beads) a 90 milligram capsule Extended Release. It is intended to have effect for 24 hours. The following information (in part) was taken from: "Drugs.Com, Official FDA drug information." "Avinza is Morphine, a pure opioid (pain medication)...In addition to analgesia, the widely diverse effects of morphine include drowsiness, changes in mood, respiratory depression, decreased gastrointestinal motility, nausea, vomiting, and alterations of the endocrine and		4. The process of reporting a medication error utilizing the Data for Quality Improvement (DQI) Tracking system and accessing the Medication Error Reporting form through DQI and S (Share) drive. 3. MD Notification - The MD should be notified immediately or the Medical Director but the nurse must reach a physician when the med error occurs. 5. Reviewed the procedure for processing physician orders with special emphasis on the stes for a stop order. 6. Summarized the incident and the importance of compliance in processing physician orders, medication pass.	

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	autonomic nervous system." Review of the Progress Notes dated 6/21/2010 at 14:29 (2:29 pm) documented the following: "Verbally responsive, brief periods...morning medications given...Afternoon medications held due to some sedation." * The physician was not notified that the noon medications were held due to sedation noted by the nurse. On 6/22/2010, the physician telephone order stated, "Hold all sedative medications until sedative effects of Morphine wear off. No Ambien, No Norco for 3 days..." The order was not timed. A progress note dated 6/22/2010 at 15:59 (3:59 pm) documented, "At 1330 (1:30 pm) called MD to get additional orders; IV (intravenous) orders of [Dextrose in 5 1/2 normal saline at 75 milliliters per hour for three days] and medication orders endorsed all to next shift." Review of the MARs (Medication Administration Record) sheets for June 2010 revealed Patient A was taking Norco (Acetaminophen-Hydrocodone 325-10 milligrams, by mouth, every four hours, around the clock for her pain. She continued to get the Norco after getting the 90 milligrams of Morphine Sulfate extended release was given in error. Patient A received eleven doses of the Norco during the period of 6/20/2010 at 16:00 (4 pm) through 6/23/2010 at 4 am. Ambien was also given for sleep on 6/20/2010 and 6/21/2010 The order to hold all sedative medications was written on 6/22/2010. Four doses of Norco 325-10		d. **Monitoring Corrective Action** Clinical IDT review new orders within last 24 hours and listing of high risk medications daily during Clinical Start-up meeting. DNS, ADNS or designees follow through on issues identified in the review. Documentation is completed in Nursing Progress Notes. Clinical IDT review medication errors daily during Clinical Start-up. DNS reports and discusses a summary of medication errors for the prior month at the monthly Quality Assessment and Assurance Committee with participation by the Medical Director. Enclosures: Summary Report of Meeting which outlines the subjects covered in the inservices.	Ongoing Ongoing

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	milligrams were given by the night shift nurse, LVN 2, after the order was written. During an interview with LVN 2 on 2/27/2012 at 6:30 am, she stated, "That is my initials on the medication sheet. We routinely give Norco 325-10 mg every four hours around the clock. I gave the medication at 0000 [midnight] and at 4 am on 6/22/2010 and on 6/23/2010. I don't know how I missed the order to hold the Norco. I should have notified the Doctor. I should not have given the medication." During an interview on 6/23/2010 at 12:15 pm with the Acting DON (Director of Nursing), she was asked, "Based on what you have seen in the MARS, what do you think should have been done?" She stated, "I probably should have had an order to hold the sedative medications on Sunday [6/20/2010]...We should have questioned it and got a hold order from the physician." Review of a Progress Note dated 6/22/2010 at 15:59 (3:59 pm) revealed the following, "Resident continues on charting for medication error. Resident is alert and confused. This A.M. checked on resident, resident sleeping in bed...Offered resident breakfast, resident refused. Came in to medicate resident at 0830, unable to arouse resident for medications. Continue to monitor resident until 11:00 when called MD [Medical Doctor] as resident still had not gotten up. MD ordered one dose of Narcan given at 11:25. Monitored resident VS (vital signs) prior to administration of Narcan..." Narcan is a drug with a specific use to reverse		Entering Events into DQI Tracking - A brief description of DQI Tracking and the type of events entered into the system, investigated and follow-up on. Verification of Investigation form which is printed out, signed and filed as part of DQI Tracking. Medication Error Reporting form which is a sample with name, medical record number and birth date redacted.	

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	known or suspected opiod induced effects such as decreased responsiveness, drop in blood pressure or respiratory depression. Side effects may include nausea, vomiting, sweating, increased heart rate, increased blood pressure and seizures. The 6/22/2010 at 22:36 (10:36 pm) Progress Note documentation noted "Resident is alert to verbal stimuli. Continues to have slow speech and complains of being tired. IV assist place peripheral IV in right arm...started on Dextrose 5 1/2 Normal Saline at 75 ml. (milliliters) per hour. The 6/23/2010 at 6:49 am Progress Note from the night shift contained the following documentation, "VS - Temperature 99.5, Pulse 66, Respirations 18, and Blood Pressure of 147/63." Two doses of Norco 325-10 were given to Patient A during the night shift, at 0000 (midnight) and 4 am, even after the 6/22/2010 physician order to hold all sedative medications. The 6/23/2010 at 17:39 (5:39 pm) Progress Note from the day shift contained the following documentation, "VS [vital signs] Temperature 99.5, Pulse 66, Respirations 18, and Blood Pressure of 182/71. Resident is alert with periods on confusion. Upon arrival was given report that resident was still feeling effects of medication error given on Saturday. With grogginess and sedation still prevalent. Checked Resident. Easy to arouse when spoken to. Held all A.M. medications at 0900 due to sedation of resident unable to arouse easily and high risk for aspiration...MD ordered a second dose of Narcan to be given and to call him			

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	back after administration. At 1430 (2:30 pm) shift change, orders reviewed. Narcan given at 1520 (3:20 pm), first set of vitals at 1530 (3:30 pm) indicate BP is increasing due to dose given. Resident awake and alert but extremely confused. At 1545 (3:45 pm) BP was 201/109...call was placed to MD. MD requested to wait 30 more minutes and see what happens. MD called resident's son to inform of current situation. At 1612 (4:12 pm) called MD with last set of vitals and MD ordered resident to ER (Emergency Room)... Transported at 1700 (5:00 pm) to the [Hospital Name]..." Patient A was admitted to the hospital for evaluation and was returned to the facility on 06/24/2010. The Department determined the facility failed to: 1. Ensure Patient A was protected from a significant medication error when she was given the wrong medication. Ninety milligrams of Avinza (Morphine Sulfate Beads, extended release for 24 hours), meant for another patient, was administered to her in error. 2. Follow the physician's order written on 6/22/2010 at 11 am to "hold all sedative medications...No Norco for 3 days" after Patient A had received a strong, long acting narcotic analgesic in error. The combined effect of these errors resulted in increased sedation and confusion that necessitated administration of medication to counteract the sedative effect. Patient A experienced a dangerous			

Jan Evans HFEN 7/9/13

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	elevation in blood pressure after the administration of this medication which required an unplanned transfer to the acute care hospital for evaluation and treatment. These violations had a direct or immediate relationship to health, safety, or security, of long-term care facility patients.			

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