POC ACCEPTABLE ... 5/22/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	BUILDING _____ WING _____	C 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN NURSING & REHABILITATION CARE CENTER	2030 EVERGREEN AVENUE MODESTO, CA 95350

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health-Licensing and Certification during an abbreviated survey for Entity Reported Incident: CA00331163. Representing the California Department of Public Health-Licensing and Certification: 31258, RN, HFEN. The abbreviated survey was limited to the specific Entity Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for Entity Reported Incident number: CA00331163.	F 000	Revised 5/21/13 Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq. This plan of correction constitutes my written credible allegation of compliance for the deficiencies noted.	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record and administrative document review, the facility failed to ensure Resident 1 was free from a significant medication error when Morphine Sulfate (MS) (a medication to control pain) was not administered as prescribed and policies and procedures were not in place to protect resident safety when 1 of 1 Residents (Resident 1) was administered 100 mg of MS, an overdose 20 times the ordered dose, in error by the facility's licensed vocational nurse (LVN 1). This failure had a direct proximate cause of Resident 1's death.	F 333	483.25(m)(2) Residents Free of Significant Med Error. It is the policy of Evergreen Nursing & Rehabilitation Care Center that residents are free of significant medication errors Licensed nurse 1 was immediately terminated. All resident's have the potential to be effected by this regulation, therefore 1 on 1 in-servicing was provided to the licensed staff by the DSD on 10/28/12 10/29/12, 10/30/12 which included medication safety and new policy for co-signing liquid narcotics.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel J. Capponeri	Administrator	5/21/13

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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F 333	Continued From page 1 Findings: The facility violated the regulation by failing to ensure Resident 1 was free from a significant medication error when Morphine Sulfate (MS) (a medication to control pain) was not administered as prescribed and policies and procedures were not in place to protect resident safety. Resident 1 had been prescribed 5 milligrams (mg) of MS for pain control. Resident 1 had been given 100 mg of MS, an overdose 20 times the ordered dose, in error by the facility's licensed vocational nurse (LVN 1). Resident 1 developed respiratory distress and became unresponsive as a result of the overdose of medication. Resident 1 died as a direct result of MS toxicity. Review of Resident 1's clinical records on 11/6/12 indicated Resident 1 had been admitted to the facility on 12/3/10. He had diagnoses that included Chronic Obstructive Pulmonary Disease (a disease that decreases the ability of the lungs to breathe effectively) and colon cancer with metastasis [extended to] the liver and the lung. Resident 1 had received hospice services beginning 8/7/12 at the facility for comfort and pain control. The hospice staff on 10/22/12 described Resident 1 as alert and oriented, minimally responsive verbally and required total assistance for basic care and nutrition needs. Resident 1 was described by hospice staff as "unable to take medication(s) unless administered by someone else." Resident 1's physician orders dated 10/16/12 indicated, "Morphine Sulfate (Concentrate) 20 mg/ml (milliliter) Solution by mouth. Dose	F 333	Another in-service was provided to the licensed staff on 1/9/13 by the DSD which included policies on medication administration, verifying the "5 rights", right patient, right medication, right dose, right time, right route Newly hired licensed nurses will receive training on medication administration during orientation, including administration of liquid controlled substances to ensure proper dosing and review of Evergreen's medication administration policy which includes liquid controlled substances. The Medication Administration Policy was revised on 5/20/13 to include; the licensed nurse will sign out the narcotic on the count sheet prior to administering the medication. Licensed staff received in-service training by the D.O.N on 3/28/13, 3/29/13, 4/7/13, 4/8/13, 4/13 which included medication administration and liquid controlled substance policy. 4 per diem nurses have not received in-service training as of yet. Those 4 nurses will receive one on one in-service training regarding medication administration and updated policies for liquid controlled substances prior to their next shift or no later than June 14, 2013 or they will be ineligible for work.	

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F 333	Continued From page 2 Ordered: 0.25 ml/5 mg PO [by mouth] q [every] 6 h [hours] ATC [around the clock] 6 am 12 pm 6 pm 12 MN for Pain." On 1/9/13 at 10:50 a.m., during a telephone interview, LVN 1 stated on 10/26/12 at 12 noon she went into Resident 1's room. Resident 1 was awake and alert and able to respond appropriately to her questions with "yes" or "no." LVN 1 stated on 10/26/12 at 12 noon she had poured the liquid morphine into a plastic cup to measure the dose. LVN 1 stated she administered 100 mg (5.0 ml) of morphine instead of 5 mg (0.25 ml) to Resident 1. LVN 1 stated she realized her error when she documented the MS administration on the "Drug Accountability Record" (a document that tracks the time and amount of each dose of morphine given to every resident) after giving Resident 1 the medication. LVN 1 stated she then notified the Director of Nursing (DON), the hospice nurse and the resident's family of the error at 1 p.m. Review of professional reference, "Davis's Drug Guide for Nurses, Eleventh Edition," identified MS as a "High Alert" medication. The guide indicated, "Some medications, because of a narrow therapeutic [effective] range or inherent toxic nature, have a high risk of causing devastating injury or death if improperly ordered, prepared, stocked, dispensed, administered or monitored....they require special attention due to the potential for serious, possibly fatal consequences. These have been termed high-alert medications to communicate the need for extra care and safeguards." Davis's guide for MS "Nursing Implications" indicated: "High Alert...clarify doses that greatly exceed normal	F 333	Licensed staff will receive one on one in-service training on 5/20, 5/21, 5/22 by the D.O.N. or designee which will include the revised medication administration policy. 90% of nursing staff will be in-serviced by 5/24/13, the other 10% will be in-serviced prior to their next working shift. The Licensed staff will receive in-service training twice a year on medication administration and will include administration of liquid controlled substances The D.O.N. or designee will observe 1 nurse per week effective immediately pour / sign out a liquid controlled substance to ensure proper dosing and the count sheet is being signed prior to administration of medication. The D.O.N. or designee will do weekly audits of the narcotic sheets effective immediately for all liquid controlled substances to ensure that 2 nurses are signing that the dose administered was correct. Any discrepancies will be immediately addressed with the licensed staff member. A copy of this audit will be given to CQI monthly for review of compliance and any additional training needed. The plan of correction will be completed by June 13, 2013.	

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F 333	Continued From page 3 range. Have second practitioner independently check original order and dose calculations... administer oral solution with properly calibrated measuring device...older adults are more sensitive to the effects of opioid analgesics and may experience side effects and respiratory complications more frequently." Davis's Guide indicated: "Morphine...usual starting dose for moderate to severe pain...30 mg q 3 to 4 hours... Review of professional reference, "Institute for Safe Medication Practices" website www.ismp.org dated 2012 included liquid concentrate narcotics on their list of "High Alert" medications. The website indicated, "High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. ...the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors." On 11/6/12 at 12:45 p.m., during an interview, the DON stated, Resident 1 had been given 100 mg of MS on 10/26/12 in error by a facility licensed nurse. The DON stated Resident 1 should have received 5 mg of morphine (0.25 ml), not 100 mg (5.0 ml). On 2/21/13 at 3:34 p.m., during an interview, the DON stated there was no policy or procedure for signing the drug accountability record before or after giving a narcotic medication such as MS. The DON stated the facility had no policy for licensed nurses to have a high alert medication double checked by another nurse prior to administration.	F 333		

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F 333	Continued From page 4 On 2/21/13 at 4:20 p.m., during an interview, the Director of Staff Development (DSD) stated newly hired licensed nurses are provided orientation to medication administration, but not specifically to high risk narcotic administration. The DSD stated there had not been a system in place in October 2012 for double checking high alert medications. Review of facility document "Lesson Plan - Inservice, Title: Medication Administration" dated 9/11/12 did not indicate inclusion of safe guards for "High Alert" medications. Resident 1's nurse's notes dated 10/26/12 at 1:10 p.m. indicated Resident 1 was alert, blood pressure (B/P) was 121/67, heart rate (HR) was 117 and respiratory rate (RR) was 24. Resident 1's hospice notes dated 10/26/12 at 1:30 p.m. indicated Hospice Nurse (HN) 1 had arrived and assessed Resident 1. The hospice note indicated Resident 1 was not able to speak but was "able to track with eyes" in response to verbal stimulation. The document indicated Resident 1's blood pressure (B/P) had been 107/56, and heart rate (HR) 113 [high] and respirations (RR) were 20 per minute (within normal limits.) On 12/3/12 at 9:50 a.m. during a telephone interview, LN 2 stated she went into Resident 1's room on 10/26/12 at 2:15 p.m. LN 2 stated Resident 1 was not responding to her verbal questions or directions at that time. LN 2 stated the unresponsiveness was unusual for Resident 1 as normally he would respond with one or two word answers to her questions. LN 2 stated	F 333		

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F 333	Continued From page 5 Resident 1 tried to open his eyes when she had then rubbed his legs. Resident 1's hospice note dated 10/26/12 at 3 p.m. indicated Resident 1 had responded "slower to verbal stimuli." The nursing note indicated Resident 1 no longer opened his eyes to verbal stimuli. On 11/27/12 at 7:05 a.m., during a telephone interview, HN 1 stated he had placed a needle into Resident 1's vein (IV) on 10/26/12 at 3 p.m. in order to administer Narcan [a narcotic antagonist] (a medication to reverse the effects of morphine) 0.2 mg I.V. HN 1 stated Narcan had been ordered by the hospice physician due to the change in Resident 1's ability to respond to stimulation after the administration of MS at noon on 10/26/12. HN 1 stated after Resident 1 had received the dose of Narcan he then began to speak in response to questions asked. Resident 1 then had followed activity with his eyes and nodded his head in response to questions as well as responded with one word answers. HN 1 stated when he had left the facility at 5 p.m. Resident 1 had been sleeping, was easily awakened by verbal stimuli and opened his eyes but did not verbalize. At this time the hospice notes indicated Resident 1's B/P was 109/77, HR was 96 (per minute), and RR had been 20 (per minute). HN 1 stated prior to leaving the facility he instructed LN 2 to monitor Resident 1's condition closely and HN 1 had notified Resident 1's daughter of his condition. On 12/3/12 at 9:50 a.m., during a telephone interview, LN 2 stated she went into Resident 1's room on 10/26/12 at 6 p.m. LN 2 stated Resident	F 333		

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F 333	Continued From page 6	F 333		

1 had loud, wet sounding breathing that she could "hear across the room without a stethoscope [instrument for amplification to listen to breath sounds]." LN 2 stated Resident 1 had not responded to her voice. Resident 1's vital signs had changed to a B/P of 86/47 [low] HR had increased from 96 to 142/minute and had a RR of 21/minute. LN 2 stated Resident 1 did not have the use of supplemental oxygen at that time. LN 2 stated she then measured Resident 1's oxygen saturation level (a test that shows how much oxygen is transported by the blood to the tissues in the body) and it was "very low" at 37%. LN 2 stated she then called for a second nurse who placed an oxygen mask on Resident 1. LN 2 stated she then phoned and asked a hospice nurse to return to the facility due to the decrease in Resident 1's level of consciousness and significant decrease in the oxygen saturation level which now had required the administration of supplemental oxygen.

Review of professional reference, "Mosby's Diagnostic and Laboratory Test Reference, Ninth Edition" indicated, "oxygen saturation... normal findings 95% or greater...critical values 75% or less...causes of low oxygen saturation levels...severe hypoventilation (e.g. oversedation)."

On 11/27/12 at 7:07 a.m., during a telephone interview, HN 2 stated she had been called to the facility to check on Resident 1 on 10/26/12 and had arrived shortly after 6 p.m. HN 2 stated Resident 1 at that time had not responded to her questions and would not follow her verbal directions. Resident 1's breathing rate had increased to 30 to 40 times per minute, and

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F 333	Continued From page 7	F 333		

Resident 1 had foam around his mouth and was diaphoretic (sweaty). HN 2 stated this had been a definite change in Resident 1's condition compared with earlier visits. HN 2 stated she had then notified Physician 1 of Resident 1's change in condition. HN 2 stated Resident 1 was then transferred to the acute care hospital at 7:25 p.m. by ambulance.

Review of the acute hospital emergency room notes dated 10/26/12, indicated Resident 1 arrived to the hospital emergency room on 10/26/12 at 7:29 p.m. and had been described as "unresponsive to verbal/tactile stimuli."

The emergency room physician's documentation for Resident 1 dated 10/26/12 at 7:45 p.m. indicated Resident 1's status was "not responsive." The physician notes indicated Resident 1's breath sounds were loud, and wet sounding with wheezes though out his lungs. The physician note indicated Resident 1 had been evaluated by the emergency room physician and had received supplemental oxygen by mask, and treatments to ease his breathing.

Resident 1's emergency room nurse's notes dated 10/26/12 at 11:12 p.m. indicated the facility had been notified of the hospital's plan to transfer him back to the facility and of Resident 1's condition. Resident 1's condition was described in the nursing notes as "still having difficulty breathing, congested, unresponsive to verbal and tactile stimuli." The notes indicated the emergency room physician and Resident 1's family had agreed to the transfer of Resident 1 back to the facility.

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F 333	Continued From page 8 On 12/3/12 at 9 a.m., during a telephone interview, Licensed Nurse (LN) 3 stated she had been on duty in the facility on 10/27/12 at 12:20 a.m. when Resident 1 returned from the emergency room. LN 3 stated Resident 1 had returned wearing an oxygen mask and described his breathing as fast and labored. Resident 1 did not respond to any verbal questions or follow verbal directions. Resident 1 did not make any purposeful movement when moved from the transport stretcher to the bed. LN 3 stated the resident's oxygen saturation was "very low" at 50%. LN 3 stated she left Resident 1's room to obtain an oxygen tank which would deliver a high percentage of oxygen. LN 3 stated when she returned to the room minutes later, Resident 1 had not been breathing and no pulse could be found. LN 3 stated she then called the house supervisor to assess the resident. LN 3 stated the house supervisor pronounced Resident 1 dead at 12:55 a.m. LN 3 stated she then notified the hospice staff and Resident 1's family of his death. On 3/7/13 at 12 noon. during a telephone interview, the Facility Consultant Pharmacist (FCP) confirmed 5 ml of Roxanol 20 mg/1 ml would have been 100 mg, not 5 mg. The FCP stated he had not seen a dose that large (100 mg) routinely given. The toxicology report dated 10/30/12 indicated Resident 1's morphine level was recorded as 0.40 mg/L (Effective Level: 0.01-0.12 mg/L [Liter] and potentially Toxic 0.15-0.5 mg/L). The Coroner's report dated 11/27/12 indicated, " CAUSE OF DEATH: Morphine Intoxication."	F 333		