

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2011
NAME OF PROVIDER OR SUPPLIER EVERGREEN LAKEPORT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1291 Craig Ave, Lakeport, CA 95453-5704 LAKE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- MEDICATION 11-2418-0008617-F Complaint(s): CA00278625</p> <p>Representing the Department of Public Health: Surveyor ID # 28936, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>F309 §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.</p> <p>F333 §483.25(m)(2) Provide Care/Services for Highest Well Being The facility must ensure that residents are free of any significant medication errors.</p> <p>The facility violated the regulation by failing to: 1) Follow physician's orders and administer the correct pain medication to the correct resident when the licensed nurse did not accurately identify Resident 1 prior to administering methadone (methadone is a controlled substance opioid pain medication) 30 milligrams(mg) by mouth that was not ordered by the physician; and 2) Transfer</p>	<p>F309</p> <p>F333</p>	<p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>F309/F333/5483.25</p> <p><u>What corrective action will be accomplished for the patient identified:</u></p> <p>The resident no longer resides at this center.</p> <p><u>How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken:</u></p> <p>All residents have the potential to be affected by this practice.</p>	<p>5/31/2013</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PK Miller

EXECUTIVE DIRECTOR

3/16/2013

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 5

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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	<p>Resident 1 to the acute care hospital for further evaluation and treatment after licensed nurses identified the medication error. Resident 1 remained at the facility for 8 hours and exhibited signs and symptoms of decreased oxygen saturations and increased sedation and was not treated with a reversal agent to prevent adverse effects of methadone. These failures resulted in delay in treatment of acute methadone toxicity and resulted in Resident 1's death.</p> <p>Resident 1 was admitted to the facility on [REDACTED] with the diagnoses including coronary artery bypass graft, pacemaker for sick sinus syndrome, and atrial fibrillation. A history and physical dated [REDACTED], indicated Resident 1 was alert, independent, spry, and lived with her daughter.</p> <p>Resident 1's record of medications ordered by the physician indicated no orders for Methadone.</p> <p>During an interview on 8/11/11 at 5:30 p.m., Licensed Nurse A stated she was in the hall passing medications on 8/8/11 at 1:30 a.m., when a CNA informed her that Resident 2 needed something for pain. Licensed Nurse A stated that she finished what she was doing and then prepared and gave the medication (Methadone 30 mg) for pain. Licensed Nurse A stated she used the picture with the medication administration records to identify the residents. She stated she looked at the picture for Resident 1 then went to the room and gave the medication to Resident 1. Licensed Nurse A stated that about fifteen minutes later a CNA again asked about the pain medication for</p>		<p><u>What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not reoccur:</u></p> <p>Licensed nurses to be in-serviced on identification of residents by name band and photo. 6.0 (General Dose Preparation and Medication Administration Policy).</p> <p>Licensed staff will be in-serviced on assessing residents for change in condition, appropriate interventions, notification of attending physician and /or designee, i.e. Nurse Practitioner, DNS and/or designee. Including the 6 rights of medication administration: right individual, right medication, right route, right time, right dosage, and right documentation. Documentation is to include detailed description of the change of condition, what interventions will be initiated, residents response to treatments and notification of responsible party.</p> <p>To be monitored by DNS/designee</p>	5/31/2013

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	<p>Resident 2, and that is when she realized that she had given Resident 1 the medication (Methadone 30 mg). She stated that at that time she called the Nurse Practitioner, and the Director of Nursing. The Nurse Practitioner gave orders to monitor Resident 1's vital signs and for signs of respiratory depression every hour.</p> <p>Nurse's Notes dated 8/8/11, written by Licensed Nurse A revealed that Resident 1 received the "wrong RX" (prescription) orally. Nurses notes dated 8/8/11 at 9:15 a.m., indicated that Resident 1's oxygen saturation levels did not increase from 86% (Normal range 92-100%) and Resident 1 was started on 3 liters of oxygen by mask. Resident 1 was sedated but would open his/her eyes to Resident 1's name. Approximately 8 hours later, Resident 1's blood pressure at 10:30 a.m., had decreased to 62/54 (normal range 120/80) with episode of apnea (no breathing). Licensed staff called 911 and Resident 1 required cardiopulmonary resuscitation. The physician pronounced Resident 1 at 10:45 a.m.</p> <p>During an interview on 8/9/11 at 9:00 a.m., the Nurse Practitioner stated that she decided to monitor Resident 1 every hour for vital signs, oxygen saturation, and mental status.</p> <p>During an interview on 8/10/11 at 8:20 a.m., the Director of Nurses stated that the facility does not have a specific policy for resident identification. The Director of Nurses stated the facility practice is that staff is to use the picture of the resident that is kept with the residents records or the identification</p>		<p><u>A description of the monitoring process and positions of persons responsible for monitoring how the facility plans to monitor its performance to ensure corrections are achieved and sustained:</u></p> <p>Medication pass will be randomly monitored weekly times four weeks and then quarterly thereafter by DNS and/or designee and pharmacy nurse consultant quarterly. Results of medication pass monitoring will be brought to CQI monthly for 3 months then quarterly for any further recommendations.</p> <p>Licensed nurses will be evaluated on assessment skills within 30 days and annually thereafter. Nurses scoring below 80% will receive additional training on the job until goal of 80% or greater is achieved.</p> <p>Any resident given a controlled substance opiate that leads to a change in Condition or signs and symptoms of Toxicity will be transferred to an acute hospital.</p> <p>Nurse Practitioner will be involved in in-servicing on assessment and follow up care for any resident showing signs and symptoms of toxicity or change of condition secondary to administration of controlled substances or opiates.</p>	5/31/2013

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	<p>bracelet.</p> <p>Lexicomp online indicated that concerns related to adverse effects of methadone are: 1) Central nervous system depression which may impair physical or mental abilities; 2) Hypotension; 3) Severe Respiratory depression. Geriatric considerations that the elderly may be particularly susceptible to central nervous system depression.</p> <p>A physician's orders for life sustaining treatment (POLST) dated 8/1/11, indicated that Resident 1 signed the document and the plan was "Full Treatment...Transfer to hospital if indicated. Includes intensive care."</p> <p>The County Coroner's report dated 8/10/11 indicated that the Nurse Practitioner gave a statement to the County Coroner as follows: "She [Nurse Practitioner] did not give Narcan (reversal agent) as we don't usually do that... I should have sent [resident named] to the hospital immediately but decided to watch and take her vitals to see how she would progress. I see so many advanced age residents here all year long that are sent to the hospital and sent right back by them as the patients are at our facility for comfort care." The County Coroner indicated "Based on autopsy and toxicological investigation, the cause of death is determined to be ACUTE METHADONE TOXICITY."</p> <p>Therefore, The facility violated the regulation by failing to: 1) Follow physician's orders and administer the correct pain medication to the correct resident when the licensed nurse did not</p>		<p>Licensed nurses will be in-serviced on Policy and procedure for event reports for medication errors, documentation and monitoring.</p> <p>Medication errors are reported and reviewed in daily stand up meeting and also brought to CQI quarterly for further recommendations.</p> <p>To be monitored by DNS/designee</p>	

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	<p>accurately identify Resident 1 prior to administering methadone (methadone is a controlled substance opioid pain medication) 30 milligrams(mg) by mouth that was not ordered by the physician; and 2) Transfer Resident 1 to the acute care hospital for further evaluation and treatment after licensed nurses identified the medication error. Resident 1 remained at the facility for 8 hours and exhibited signs and symptoms of decreased oxygen saturations and increased sedation and was not treated with a reversal agent to prevent adverse effects of methadone. These failures resulted in a delay in treatment of acute methadone toxicity resulted in Resident 1's death.</p> <p>These violations presented an imminent danger to the Resident and were a direct proximate cause of the death of the Resident.</p>			

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