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

POC Accepted 5/20/05 CR

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	295034		C 04/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHOE PROGRESSIVE CARE CENTER	1835 ODDIE BLVD. SPARKS, NV 89431

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 3/24/05 with continuing investigation until 4/6/05. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00007356 alleged that the facility administered an unusually large dose of morphine sulfate to Resident #1 on 2/23/05, in the morning, which caused the resident to become unresponsive later in the day. The investigation determined that the incident occurred and deficiencies are cited on Tag 281 related to professional standards.	F 000	RECEIVED MAY 20 2005 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an	F 157	Identification: A. Nursing managers to complete a random audit of shift-to-shift reports between nursing shifts to assess resident status information being communicated to the nurse assuming shift responsibility. Confirm if appropriate items are being reported to physician. met B. Review facility's 24-hour Nursing report book for any changes in condition or other symptoms that are to be communicated to the attending physician. Subsequent audit of applicable residents' records to verify that this communication has occurred. met	6/24/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ellen Kelly
TITLE: Administrator
(X6) DATE: 5/19/05

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 157	Continued From page 1 existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was that the facility failed to promptly notify the physician of the administration of an higher than normal dose of Morphine Sulfate to Resident #1. Findings include: Resident #1: Refer to Tag F 281. A review of the clinical record revealed that the nurse wrote an order for MS (Morphine Sulfate) Contin 30 mg IM STAT. Shortly after obtaining the physician's order, according to the nurse's written statement, the nurse retrieved three vials of Morphine Sulfate (1 milliliter each) from an emergency kit, faxed the order and requisition for replacement of the Morphine to the pharmacy and proceeded to administer the Morphine. According to the Nursing Drug Handbook 2004, the normal dose of	F 157	Corrective Action: Retrospective review of case completed. Review of resident record and statements reflect Nurse #2, who assumed coverage for the hall around 2 p.m., was working under the transitional information provided by Nurse #1 that resident had received MS Contin. At 5:30 p.m., she noted blood pressure, respiration rate and oxygen saturation. She appropriately reported to the attending physicians APN, who is the physician's call procedure. Order to administer Narcan was received by PM shift unit nurse at about 21:30 from nurse practitioner and administered. Systemic Action: Conduct sessions with licensed nursing staff on reportable symptoms/conditions to the attending physician. In addition, review with licensed staff facility's existing policy on emergency transfers to the Emergency Room as a supportive procedure in the event the on-call physician is unable to or unwilling to assess the case at the facility. Quality Monitoring: Director of Nursing and Medical Director will select a random sample of skilled and long-term cases. Cases will be reviewed for compliance with facility and regulatory standards for prompt physician notification. The first sample period to review shall involve cases from 5/21 – 7/21/05. Quarterly results will be shared with the facility's Quality Committee.	6/24/05 6/24/05 met met 6/24/05 and Ongoing met

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F 157	Continued From page 2 Morphine Sulfate for an adult is 5 mg - 20 mg intramuscularly for pain. An interview conducted with the pharmacist on 4/7/05 at 3 PM, revealed that the pharmacy had contacted the nursing staff at the facility to discuss the order that they had received on 2/23/05 in the morning. The pharmacist explained that the pharmacy informed the nursing staff at the facility that MS Contin could not be given IM, and that Morphine Sulfate 30 mg IM was too high of a dose to give a resident. The pharmacy was informed that the nurse had already administered the medication. A review of the clinical record revealed that there was no nursing documentation regarding assessments or notification of the physician or his delegate until 7:00 PM on 2/23/05.	F 157		
F 281 SS=G	483.20(k)(3)(i) RESIDENT ASSESSMENT 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, it was determined that the facility failed to ensure that nursing staff followed standards of care regarding the administration of Morphine Sulfate to Resident #1. Findings include: Resident #1: The resident was admitted to the facility on 6/18/98 with the diagnoses including cerebral vascular accident, aphasia, diabetes mellitus, hypertension, and psychosis. According to the MDS (Minimum Data Set) dated 2/8/05, the resident had moderate cognitive impairments,	F 281	Identification: 1. Audit removal of narcotics from Emergency Kit in accordance with facility procedure and regulations. Initial audit by Pharmacy as of 3/18/05. Follow-up audit by Director of Nursing completed. 2. Audit existing facility narcotic orders in comparison to Nursing 2005 Drug Handbook: Combination Drugs for Pain Management for acceptable dosing. (See Attachment 1.) 3. Random audit of facility PRN pain medication orders. Assess for resident's capability to receive via route in order, usage of PRN and documentation of outcome post administration. Corrective Action: Corrective action completed with Nurse #1 by Director of Nursing relative to pouring and sign-off of medications. Facility self-referred the incident to the Bureau of Licensure/Certification and Ombudman's office.	4/26/05 6/24/05 6/24/05 3/14/05 met 3/11/05

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F 281	Continued From page 3 had difficulty communicating verbally, was totally dependent for feeding and dressing, was incontinent, had no weight loss issues and no skin ulcers. The resident was assisted at each meal by a restorative aide, due to her difficulties swallowing. Resident #1 was up in her wheelchair in the restorative dining area for meals previous to 2/23/05, according to the clinical record. The record revealed that on 2/20/05 at 6:00 PM, the nurse sent a fax to the physician indicating that Resident #1 had complained to her family of severe pain in her left leg for the past two days. Staff had noted on 2/20/05 that the resident was grimacing and "guarding" her left leg. The physician ordered Ibuprofen liquid 4 ounces to be given routinely, three times a day with food. For the next three days, the routine order of Ibuprofen was circled on the MAR (Medication Administration Record) by the nurses, indicating that it was omitted. There was no documentation on the back of the MAR indicating why the medication had been omitted; there were no notations in the Nurse's Notes from 2/20/05 to 2/23/05, regarding the resident's pain and whether measures were being taken to relieve the resident's pain. It was not clear why the facility failed to provide the resident the routine pain medication. There was no evidence that the facility notified the physician and there was no documentation as to the status of the resident's pain from 2/20/05 to 2/23/05. On 2/23/05 at approximately 9:40 AM, Nurse #1 talked with Resident #1's physician at the nursing station and received an order for Morphine Sulfate 30 mg, intramuscular STAT (with no delay), then Morphine sulfate 5 mg every four	F 281	Facility actions as part of self-referral included: - Case review with Washoe Health System's Risk Management. - Audit of Emergency Kit medication removal. - Sample narcotic order compliance across facility by nursing management. - Policy revisions completed by Director of Nursing, i.e.: Policy on read back of verbal orders: • Delegation and chain of command. • Role of witnessing nursing in Emergency Kit removal process. • Elimination of accepting verbal orders from attending physicians or nurse practitioners when onsite. Inservice education with licensed nursing staff on above outlined policy revisions: On processing for clarification of medication on order sheet and on medication administration record. Post-narcotic administration monitoring. Pain assessment and documentation intervals. Revision of facility's orientation and competency process. Licensed staff inhouse to be rotated gradually through revised competency program. All new hire licensed staff to complete competencies as part of initial orientation going forward. Pain assessment and documentation intervals.	3/10/05 3/18/05 3/21/05 3/18/05 met met 3/21/05 met met met 3/30/05 met met met

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F 281	Continued From page 4 hours. This information came from Nurse #1's written statement regarding the day's events. The resident had been complaining of severe pain since 7:10 AM, according to the statement. A review of the clinical record revealed that the nurse wrote an order for MS (Morphine Sulfate) Contin 30 mg IM STAT. Shortly after obtaining the physician's order, according to the nurse's written statement, the nurse retrieved three vials of Morphine Sulfate (1 milliliter each) from an emergency kit, faxed the order and requisition for replacement of the Morphine to the pharmacy and proceeded to administer the Morphine at approximately 9:45 AM. Nurse #1 left the facility at 2:20 PM and Nurse #2 assumed the care of the resident. Review of the record revealed a nursing note on 2/21/05 at 3:00 PM. The next entry in the nursing notes was untimed and dated 2/23/05 and indicated that the resident was unable to participate in the restorative dining program. The record failed to have documentation of an assessment of the resident's pain complaints or response to the pain medication until a nurse's note at 7:00 PM on 2/23/05 revealed that the resident was unresponsive. According to the Nursing Drug Handbook 2004, the normal dose of Morphine Sulfate for an adult is 5 mg - 20 mg intramuscularly for pain. The peak of Morphine, given IM, is approximately five hours. The symptoms of Morphine overdose are drowsiness, depressed respirations and low blood pressure. On 2/23/05 at 5:30 PM, according to a written statement by Nurse #2, (who took over for Nurse #1 at 2:20 PM), the resident's oxygen saturation was 63 (normal 90+), with a blood pressure of	F 281	Revision of facility's orientation and competency process. Licensed staff inhouse to be rotated gradually through revised competency program. All new hire licensed staff to complete competencies as part of initial orientation going forward. Systemic Action: Nurse witnessing Emergency Kit removal by another licensed nurse will verify order, dose and route. All licensed staff to be proficient on procedure. Facility is adopting Nursing 2005 Drug Handbook: Combination Drugs for Pain Management as its definition of acceptable ranges. (See Attachment 1.) Licensed nursing staff to be proficient on reference table usage and accessing pharmacy provider for dosages outside these parameters prior to any administration. In the event any licensed staff member must take over a unit from another nurse, the facility is adopting the following mandatory procedural steps to ensure continuity in resident care, i.e., Nurse taking over unit will review with a licensed nurse from another unit: Medication Administration Record and medications for residents on medication cart. Review Emergency Kit status for any withdrawals for the unit assuming responsibility for and the associated documentation for medication on the administration record. Review any orders or other communications faxed to pharmacy provider for that date. Review treatment administration record. Report any concerns to designated Charge Nurse before proceeding.	4/11/05 6/24/05 met met met met met met

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F 281	Continued From page 5 63/40 (normal 120/80). The nurse reported the findings to the APN (Advanced Nurse Practitioner) around that time, according to the nurse's statement. A review of the clinical record failed to reveal nursing documentation regarding assessments of the resident or notification of the physician or his delegate until 7:00 PM on 2/23/05. According to the written statement by Nurse #3 (the night nurse), Resident #1 was found unresponsive at 7:00 PM on 2/23/05, with respirations of 6 per minute (normal 20), and an oxygen saturation of 78 (normal 90+). The resident was on 4 liters of oxygen by nasal cannula. The residents's APN (nurse practitioner) assessed the resident at approximately 7:00 PM and told the family that the resident was having a "reaction" to the Morphine Sulfate. At about 9:30 PM, the APN called the nurse and gave orders for the administration of Narcan (an opiate antagonist), according to Nurse #3's written statement The physician was interviewed by a State Agency Ombudsman from the Division of Aging Services. In the Ombudsman's written statement she wrote that the physician denied giving an order for 30 mg of Morphine Sulfate IM; he indicated that his usual order would be Morphine Sulfate 5 mg IM. Nurse #1, who was also interviewed by the Ombudsman, revealed that she thought the dose was high when she received it, however she did not call the pharmacy or ask another nurse about the order. An interview conducted with the pharmacist on 4/7/05 at 3:00 PM, revealed that the pharmacy had contacted the nursing staff at the facility to	F 281	Adhere to facility's chain of command policy to take additional steps, if necessary, in nurse's judgment. Implement nursing staff to retain pink copy of all orders processed on their shift with medication cart so any relieving or oncoming shift can expediently access and review new orders. After 24 hours, orders sheet copies are routed to Health Information Management for confidential processing. Above processes will be addressed with licensed nursing staff via an education session and incorporate in new hire orientation procedures. Implement process with pharmacy provider to also inform the Nurse Manager or designated Charge Nurse of any concerns with order's route of administration or dosage in addition to the unit nurse. Quality Monitoring: Nurse from clinical pharmacy consultant provider will conduct unannounced audits on licensed staff medication administration and documentation. Results will be forwarded to the Director of Nursing in consultant's report. Director of Nursing will conduct unannounced scenario inquiries with licensed staff on a 1:1 basis to assess continued standards of compliance. Results will be communicated to the facility's Quality Committee on a quarterly basis.	met met met 4 observations licensed & monthly 6/24/05 and Ongoing met 5/17/05 B met July 1 Q

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F 281	Continued From page 6	F 281		

discuss the order that was received on the morning of 2/23/05. The pharmacist explained that the pharmacy had informed the nursing staff at the facility that MS Contin cannot be given IM, and that Morphine Sulfate 30 mg IM was too high of a dose to give a resident. The pharmacy was informed that the nurse had already administered the medication. On 4/7/05 at 3:10 PM, the surveyor asked the pharmacist what time the pharmacy had called the facility to inform them of the error in the order; the pharmacist looked up the information in the computer. The pharmacy had documented an order entry time of 11:43 AM in the computer; which meant, explained the pharmacist, that the facility had spoken to a nurse about the order within the 30 minutes of the order entry time of 11:43 AM. The pharmacist did not disclose the nurse's name that the pharmacy spoke to.

An interview conducted with the ADON (Assistant Director of Nursing) on 3/24/05 at 11:00 AM, revealed that she thought that there were several problems with the way the incident was handled by the nursing staff. She stated that the nursing staff did not use the proper chain of command to inform someone that a medication error had occurred when contacted by the pharmacy. She indicated that nursing management did not know of the medication error until the morning of 2/24/05. The ADON indicated that the facility's management staff were at a meeting on 2/23/05, but that the MDS coordinator was available all day for consultation. The ADON had identified that the other problem area concerned verbal orders taken by the nursing staff.

According to the written statement of Nurse #2, Nurse #1 had already "poured" controlled

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F 281	Continued From page 7 substances into medicine cups on 2/23/05 for medications due at 4:30 PM; Nurse #1 then left work at 2:20 PM. Nurse #1 had signed for them in the narcotic sheet as being administered at a later time. Nurse #2 did not administer the medications that Nurse #1 signed-out. The facility failed to ensure that nursing staff followed standard practices regarding the control of controlled substances. According to an interview conducted by the Ombudsman with Nurse #1 on 3/30/05, Nurse #1 indicated that she had written the verbal order on a scrap of paper. She indicated that writing MS Contin instead of Morphine Sulfate was a transcription error. Nurse #1 also told the Ombudsman that she drew up three vials of Morphine Sulfate (10 mg per 1 ml), using a 10 ml syringe and injected Resident #1 with three different injections. The nurse failed to consult with another nurse, pharmacist or the physician when she decided that the medication should be divided into three separate injections. It is not standard practice to give three separate injections to a patient at one time. The standard practice when writing a verbal order is to write it on the physician's verbal order sheet and read the order back to the physician. The facility's policy regarding verbal orders could not be located on 3/24/05. On 2/23/05, (no time) the APN documented in the progress notes that Resident #1 was seen by her for increased lethargy. The APN's notes indicated that Resident #1 was obtunded, with diminished breath sounds and respirations of 10. The APN indicated on the progress note that the resident could be sent to the hospital for	F 281		

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F 281	Continued From page 8 evaluation of possible narcotic overdose, reaction or illness, but the family did not want her transferred. On 2/25/05, the physician noted that Resident #1 still had low blood pressure (80/56) and had developed a urinary tract infection that showed group B beta streptococcus; the resident was started on antibiotics. On 2/28/05, the physician noted that the resident had acute renal failure. According to the clinical record and staff accounts, Resident #1 did not get up for meals or get out of bed again after 2/23/05. The resident died on 3/5/05. In summary, the facility failed to promptly notify the physician after it was discovered by the facility that Resident #1 had received a higher than normal dose of Morphine Sulfate on 2/23/05 at 9:40 AM. The resident did not receive narcotic antagonists until 9:30 PM, 12 hours after the overdose of medication. In addition to the failure to notify the physician promptly and initiate treatment, the facility failed to ensure that nursing staff followed standard procedures for taking verbal orders, for signing-out controlled substances, and for obtaining guidance when faced with an unusual medication order. Cross reference Tag F 157.	F 281		

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