For Training Purposes Only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0000	A. BUILDING 00 B. WING	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
Stone Valley	123 MAIN ST ANYWHERE, US 66000

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review and interview, the facility failed to ensure medication was administered to the right resident for 1 of 1 resident reviewed for significant medication error in a sample of 3 residents. (Resident B) Findings include: On 3/7/2019 at 12:30 p.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to: chronic kidney disease, bi-polar disorder, schizoaffective disorder, and diabetes. Resident B's quarterly Minimum Data Set Assessment (MDS), dated 12/5/18, indicated Resident B was cognitively intact. Nurses notes, dated 2/20/2019 (no time documented), indicated Resident B was accidentally given the wrong medication by RN 1. Resident B had been monitored very closely after the medication was administered. Vital signs were being taken and stayed within normal limits. Resident B was alert and oriented and occasionally drowsy, however this symptom was chronic. Medications that were documented as incorrectly administered indicated: Baclofen (muscle relaxant) 20mg Gabapentin (nerve pain/ anticonvulsant) 600mg Cymbalta (nerve pain/antidepressant) 60mg Diclofenac Sodium (non-steroidal anti-inflammatory) 75mg Drisdol (vitamin d) 50,000 units Vitamin D3 Lasix (water pill) 40mg Morphine ER (opioid) 60mg Potassium 20mEq	F 0760	**F760 Residents are Free of Significant Med Errors** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B is receiving all medications per physician's orders. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents that are administered medications have the potential to be affected by the alleged deficient practice. · Licensed nursing staff were in-serviced on medication administration regarding the 5 rights, including 'right resident'. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service has been completed by DNS /designee with all licensed nursing staff regarding the 5 rights of medication administration including administering to the "right resident". · Observational rounds were completed by the DNS/designee with all staff that administer medications to ensure medications are being	04/01/2019

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	Thera M vitamin tablet On 2/21/19 at 7:00 a.m., order received to begin 1000ml sodium chloride 0.9% parental solution at 80ml/hr sub-Q (beneath the skin). Nurses notes, dated 2/21/2019 at 10:58 a.m., indicated due to a decline in health status to administer NARCAN (treatment for opioid/narcotic overdose), 12mg intranasal (in the nose) at 4 mg every 3 minutes with NP (Nurse Practioner) at bedside. Resident B's respirations increased, but no change in neurological status. Nurses notes, dated 2/21/2019 at 10:26 p.m., indicated at approximately 7:30 p.m., Resident B's respirations dropped to less than 12 breathes per minute. The clinical nurse returned to Resident B's room to re-assess before administration of more NARCAN and Resident B was noted to be unresponsive, cool to the touch, pale, with slight response to pain from strong external rub, and pupils non-reactive to light and 3mm in size. Respirations were noted to now be at 10 breathes per minute. Nurses notes, dated 2/21/2019 at 10:26 p.m., indicated NARCAN 4mg nasal was ordered and administered at 8:55 p.m. and there was no change. NP was called and was advised the family wanted Resident B to be taken to the hospital for evaluation. Nursing facility hospital transfer form, dated 2/21/2019 at 10:52 p.m., indicated Resident B was transferred to a local acute care hospital due to unresponsiveness for greater than 12 hours with decreased respirations following a medication administration error than was not responding to NARCAN.		administered per policy. · Medication administration observations will be completed by DNS/designee weekly until continued compliance is maintained **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS/designee will be responsible for the completion of the Medication Error Quality Assurance Tool and medication administration observations weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 4/1/2019	

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	Nurses notes, dated 2/26/2019 at 4:33 p.m. (5 days later), indicated Resident B returned to facility. Hospital noted Resident B had been placed on C-Pap (non-invasive breathing support) in hospital due to no intubation advance directive order and received dialysis one time for a new diagnoses of congestive heart failure. On 3/8/2019 at 12:00 p.m., interview with RN 1, indicated she was the nurse who had given Resident B the wrong medication. RN 1 had pulled up a different resident's medications, placed them in a cup with the different resident's name, and applied a small amount of applesauce on top. She then set up Resident B's medications, placing them in another cup, and also applied a small amount of applesauce on top of those pills. Resident B came to her room's door. RN 1 picked up one of the medication cups topped with applesauce and proceeded to give it to Resident B, who took the medication without problem. RN 1 then noted the name on the other cup was in fact Resident B's. RN 1 indicated she then immediately went to the DNS (Director of Nursing Services) to advise her of the medication error, called Resident B's physician and began monitoring the resident and the resident's vital signs. On 3/8/2019 at 11:02 a.m., the DNS provided the facility's current Medication Pass Procedure, review date of 12/2016, which included the 5 rights of medication administration. One of the 5 rights indicated to ensure medication was administered to the, "right resident." This Federal tag relates to Complaint IN00287877. 3.1-48(c)(2)			

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