| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 000000 | A. BUILDING _____ B. WING _____ | C 07/12/2019 |

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| **STONEVALLEY** | **123 MAIN STREET ANYWHERE, US 66000** |

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| F 760 SS=G | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This Requirement is not met as evidenced by:<br>The facility had a census of 84 residents, with 8 residents selected for sample. Based on observation, interview and record review, the facility failed to ensure 2 of 8 sampled residents were free of significant medication errors. Staff administered 8 times the ordered dose of the blood pressure medication Clonidine to resident #2 after failing to clarify the order with the practitioner. The resident developed a rapid pulse rate following administration of the medication and required transfer and admission to the hospital with a diagnosis of "Clonidine toxicity." Additionally, staff administered another resident's insulin to resident #5 who did not have a diagnosis of diabetes (when the body cannot use glucose, not enough insulin is made or the body | F 760 | | |

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| F 760 | Continued From page 1<br>cannot respond to the insulin) and who did not have a physician's order for insulin.<br><br>Findings included:<br><br>- Resident #2's clinical record included a comprehensive diagnosis list which identified the resident with multiple medical diagnoses, including chronic obstructive pulmonary disease (a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to insulin) and chronic respiratory failure (inability of the respiratory system to oxygenate the blood and remove carbon dioxide from the lungs).<br><br>Progress Notes written on 1/5/19 at 11:31 p.m. noted resident #2's blood elevated blood pressure of 168/121 (normal blood pressure is a systolic/top number below 120 and a diastolic/bottom number below 80). According to the note, Licensed Nurse I phoned Mid-Level Practitioner H about the elevated blood pressure and the practitioner "ordered Claudadine [sic] 8 tablet of .1 mg [milligram] one time..."<br><br>Licensed Nurse I entered the medication order in the computer system as "Clonidine - give 0.8 mg by mouth one time only for hypertension." According to the MAR (medication administration record), Licensed Nurse I administered 0.8 mg of Clonidine to resident #2.<br><br>A progress note dated 1/5/19 at 11:50 p.m. described resident #2's physical symptoms of a rapid, unsteady pulse rate which "jumped" from 88 bpm (beats per minute) to 110 bpm. According | F 760 | | |

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| F 760 | Continued From page 2 | F 760 | | |

to the note, the resident complained of pain to the neck and left arm at that time. The licensed nurse then called EMS (emergency medical services) and arranged for transport to the hospital. The note described the resident with "A-fib" (atrial fibrillation, a rapid and irregular heart beat) and a pain rating of "10" on a 1-10 scale with 10 being excruciating pain.

Documentation from the hospital to which the resident transported identified the resident with hypotension (low blood pressure) and bradycardia (low pulse rate) upon arrival. The hospital contacted the Poison Control Center and followed their recommendations for an overdose of Clonidine. According to the note, the resident admitted to the hospital after treatment in the emergency room.

A hospital Discharge Summary dated 1/17/19 listed the resident's discharge diagnosis as "Clonidine toxicity and bradycardia due to Clonidine toxicity." The diagnosis list also referred to acute encephalopathy (sudden onset of brain malfunction) due to Clonidine toxicity and high levels of white blood cells and lactic acid also due to Clonidine toxicity.

The facility's investigation into the previously described medication error referred to a conversation with Licensed Nurse I about his/her administration of 8 Clonidine tablets (total of 0.8 mg) to resident #2 on 1/15/19. Nurse I reported he/she questioned the dose and discussed the dose with two other licensed nurses and "they decided the dose was correct." Nurse I reported he/she did not call the practitioner back to clarify the order.

A notarized statement written by Licensed Nurse I

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| F 760 | Continued From page 3<br>described resident #2's elevated blood pressure and pulse rate which necessitated the phone call to Mid-Level Practitioner H. According to the statement, the practitioner ordered "Clonidine 8 X .1 mg." Nurse I reported he/she "questioned" the order and asked another nurse if the order seemed right. The other nurse "questioned" the order as well, so they took it to a third nurse who allegedly said "yes, it sounds right." Nurse I then administered the medication to the resident. In the statement, Licensed Nurse I explained he/she "didn't feel comfortable" questioning Practitioner H because he/she called the practitioner prior to the night of 1/15/19 and the practitioner became upset when called at night.<br><br>In a 1/18/19 written statement, Mid-Level Practitioner H reported he/she ordered 0.1 mg of Clonidine as a one time dose for resident #2 due to an elevated blood pressure. The nurse then repeated the order back to the practitioner correctly and the practitioner confirmed it. According to the practitioner's statement, "It's a mystery to me where the 8 tablets came from. If that is what [Licensed Nurse I] heard, [he/she] should have asked for further clarification."<br><br>During an interview on 6/25/19 at 11:50 a.m., Administrative Staff B confirmed Licensed Nurse I administered 0.8 mg of Clonidine to resident #2 on 1/15/19 when Mid-Level Practitioner H intended for the resident to receive 0.1 mg of Clonidine. According to Nurse B, Licensed Nurse I no longer worked at the facility.<br><br>During a telephone interview on 6/26/19 at 1:30 p.m., Mid-Level Practitioner H acknowledged his/her written statement dated 1/18/19 and confirmed the statement included relevant concerns about the incident. Practitioner H had | F 760 | | |

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| F 760 | Continued From page 4 | F 760 | | |

no further information to add to his/her statement.

The facility's undated "General Dose Preparation and Medication Administration, Assistance or Observation" policy lacked guidance related to the 5 "rights" of medication administration to ensure safe administration of medications.

The facility failed to ensure resident #2 was free of significant medication errors when staff administered 8 times the ordered dose of Clonidine to the resident after failing to clarify the order with the practitioner. The resident required transfer and admission to the hospital with a diagnosis of Clonidine toxicity.

- Review of a progress note dated 6/3/19 for resident #5 revealed the resident had diagnoses of: dementia with behavioral disturbance (a decline in mental ability severe enough to interfere with daily life), anxiety disorder (chronic, exaggerated worry and tension that is unfounded or much more severe than the normal anxiety most people experience), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning), muscle weakness and difficulty in walking.

Review of the resident's admission minimum data set (MDS) dated 4/15/19 revealed the resident had a brief interview for mental status score (BIMS) of 00 indicating the resident could not complete the interview.

Review of the resident's cognitive care area assessment (CAA) dated 4/19/19 revealed the resident had severe cognitive impairment.

Review of resident #5's physician orders on

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| F 760 | Continued From page 5<br>5/9/19 lacked any evidence the resident had an order for insulin (a hormone which regulates the amount of glucose in the blood).<br><br>Review of a facility reported incident investigation report revealed a medication error occurred on 5/9/19 at approximately 9:00 PM involving resident #5. Administrative nursing staff B administered medications on the secured dementia unit during this time and prepared Lantus (insulin) 25 units to be given to a resident. Staff B utilized a shadow box (box located on the outside of resident rooms which contain a picture and the name of the resident residing in the room) to identify the resident before administering the Lantus. The shadow box only had a picture and did not have a resident name included in the box. Staff B addressed resident #5 with a name that was not his/hers and the resident nodded his/her head. Staff B believed resident #5 acknowledged he/she was the correct resident. Staff B then administered the insulin to resident #5. Later during shift change report, staff B realized he/she had administered the insulin to the wrong resident. Resident #5's blood sugar was taken and found to be low with a reading of 59 milligrams per deciliter (mg/dL) (normal range is approximately 80 to 120 mg/dl). The facility updated resident #5's shadow box to include his/her name and staff B was provided education on the 5 right of medication administration and 2 ways of identifying a resident.<br><br>During an interview on 6/26/19 at 12:11 PM, administrative nursing staff B revealed he/she failed to correctly identify the resident prior to giving insulin and gave another resident's insulin to resident #5 instead. Staff B revealed his/her expectation of the facility staff was to follow the five rights of medication administration to reduce | F 760 | | |

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| F 760 | Continued From page 6<br>the right for future medication errors.<br><br>The facility failed to provide an insulin administration policy as requested on 7/1/19.<br><br>The facility failed to ensure nursing staff correctly identified a resident prior to administering insulin resulting in the wrong resident receiving insulin. | F 760 | | |