STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 000	INITIAL COMMENTS For the complaint survey started on February 11, 2014 and completed on February 12, 2014, the review included 3 current residents and 3 residents for closed records.	F 000	Fargo Plan of Correction for Complaint Survey on 2/11-12/14 The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 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 §483.12(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 §483.15(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.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S Ellering | Administrator | 3/10/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident's family member regarding a change in the resident's status and the need to alter treatment for 1 of 1 sampled resident (Resident #4) who experienced a change in condition. Failure to notify family members of condition changes and/or altered treatment limits their ability to participate in the resident's care and is an infringement of the resident's rights. Findings include: Review of Resident #4's medical record occurred on February 11-12, 2014. Diagnoses included history of stoke and hypertension. Medications included Tramadol (a pain medication), Elavil (an antidepressant), vitamin D3, multivitamin, Celexa (an antidepressant), calcium, Marinol (an appetite stimulant), Detrol (for overactive bladder), and Xalatan (glaucoma eye drops). Vital sign monitoring included the following blood pressures: *01/11/14 at 1:59 p.m.: 183/88 *01/11/14 at 4:17 p.m.: 165/82 *01/11/14 at 11:31 p.m.: 180/80 *01/12/14 at 4:00 a.m.: 178/86 *01/12/14 at 6:00 a.m.: 160/78 Nurses' notes identified the following: *01/12/14 at 3:14 a.m.: ". . . Pt [patient] noted to have increased b/p [blood pressure] this noc [night], re-check b/p at 3a [3:00 a.m.]: 204/86. At 3a, called on call for [physician name], and orders	F 157	F157: ManorCare Fargo strives to notify appropriate family members when a patient has a change in condition and/or a medication change. Patient # 4 has discharged from the facility. Residents residing in this facility have the potential to be affected by this practice. Licensed nursing staff members were re-educated on the appropriate communication of change in condition/medication to family members and/or appropriate parties. ADNS or designee will conduct random audits weekly to ensure that appropriate parties were notified in a timely manner per facility policy. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 3/25/14.	

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F 157	Continued From page 2 rec'd [received] for clonidine [an antihypertensive] 0.1 mg [milligram] PO [by mouth] every hour until b/p less than 160 systolic. . . ." *01/12/14 at 7:36 a.m.: ". . . Note b/p already decreased at 6a [6:00 a.m.]: 160/78 and gave most likely last clonodine [sic] needed. . . ." The record lacked evidence to indicate facility staff notified Resident #4's family regarding her increased blood pressure and the need to start a new medication (an antihypertensive). During an interview on 02/12/14 at 1:25 p.m., a supervisory nurse (#2) stated she would expect staff to update the family regarding elevated blood pressures and the initiation of a new medication.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

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F 225	Continued From page 3 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure that all alleged violations including misappropriation of resident property, mistreatment, neglect, or abuse, were reported immediately to the administrator of the facility and to other officials in accordance with State law for 1 of 1 sampled resident (Resident #4) who incorrectly received a narcotic topical medication. Failure to identify, report, and investigate allegations of misappropriation of property for all property, including a controlled medication (Fentanyl - an opiate pain reliever) resulted in Resident #4 receiving topical Fentanyl for a 10 hour period before identified by a family member. Findings include:	F 225	F225: ManorCare Fargo strives to ensure that cases of missing duragesic patches are reported to the administrator, investigated per ManorCare policy and reported to the DOH in accordance with state law. Patient # 5 is no longer in the facility. Residents residing in this facility and prescribed use of duragesic patches have the potential to be affected by this practice. Staff members were re-educated on reporting missing duragesic patches to the administrator immediately and begin investigation in a timely manner per facility policy. Staff members were re-educated on documenting placement of duragesic patches on patients and checking placement every shift.	

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F 225	Continued From page 4 Review of the facility policy for abuse prohibition identified the seven key components for an effective policy. The policy, dated 2011, stated, ". . . The center must follow the timeframes established in the regulations; that is, the center must ensure that any alleged violations are reported immediately . . . "immediately" to mean as soon as possible, but ought not exceed 24 hours after discovery of the incident . . ." - Review of Resident #4's and Resident #5's medical record occurred on February 11-12, 2014. Resident #5's medication regimen through the length of stay included Fentanyl 50 mcg (micrograms) per hour transdermal (to the skin surface) patch applied every 72 hours. Resident #4's medications included Tramadol (a pain medication), Elavil (an antidepressant), vitamin D3, multivitamin, Celexa (an antidepressant), calcium, Marinol (an appetite stimulant), Detrol (for overactive bladder), and Xalatan (glaucoma eye drops). During interview on 02/11/14 between 5:45 p.m. and 6 p.m., an administrative nurse (#1) stated that on January 11, 2014, a staff nurse incorrectly administered/applied a Fentanyl topical patch scheduled for Resident #5 at 8 a.m. to Resident #4, the roommate. On the afternoon of 02/11/14 and morning of 02/12/14, an administrative nurse (#1) stated no incident report was completed regarding the patch the nurse could not find on Resident #4 before re-applying a new patch, and the patch Resident #5 did not get. Resident #4's record identified a change in mental status and hospitalization in less than 24 hours after a family member discovered the patch on Resident #4's chest.	F 225	ADNS or designee will conduct random audits of duragesic patch placement on resident and documentation of placement on the medication administration record. Results will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 3/27/14.	

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F 225	Continued From page 5 On the morning of 02/12/14, an administrative nurse (#1) indicated awareness of the missing patch and stated the nurse looked for the patch "all over" Resident #4's body and couldn't find it and in the event of a missing Fentanyl patch Certified Nursing Assistants would be asked to assist in locating the patch. The nurse stated an incident report would include the investigation of the incident. A request for additional information, including the facility's investigation of the incident, the contributing and causative factors were requested and not provided. Failure to identify the importance of locating a narcotic pain patch prior to the application of a new patch to administrative staff, and complete a thorough investigation, resulted in Resident #4 receiving 10 hours of the incorrect medication. Refer to F333	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 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, review of professional reference, review of facility policies, and staff interview, the facility failed to meet professional standards of nursing practice for 1 of 3 closed record residents (Resident #4). Failure to ensure residents have orders for discharge to an emergency department (ED), follow physician orders regarding monitoring/administration of a new medication, and ensure the accuracy of the	F 281		

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F 281	Continued From page 6 medication administration record (MAR) may result in medication errors, worsening resident condition, and inadequate monitoring of the resident's health status. Findings include: Review of the facility policy titled "Medication Management Guidelines: Documentation" occurred on 02/13/13. This policy, dated 08/11/06, stated, ". . . Document signature or initials, as required, for medications and treatments administered on the MAR immediately following administration or per state specific standards. Circle initials for those that were not administered and document reason for the non-administration on the back of the MAR. . . . Review each MAR . . . prior to the end of the shift to ensure documentation is complete and supports services provided . . ." Review of the facility policy titled "Orders Management: Medication and Treatment Orders" occurred on 02/13/14. This policy, dated 08/29/11, stated, ". . . Written physician orders are used as the routine method of order communication when possible . . . Verbal and telephone orders are used as a method of order communication when physician is un unable to be on the premises . . . The licensed nurse reads back order(s) in entirety to ordering physician, including patient identification information, before acceptance of order is considered complete and the order can be transcribed and implemented . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc.,	F 281	F281: ManorCare Fargo strives to ensure services provided meet professional standards of quality. Resident # 4 has discharged from the facility. Residents residing in this facility have the potential to be affected by this practice. Licensed nursing staff members were re-educated regarding noting and transcribing orders and documenting appropriately in the patient's medical record. ADNS or designee will conduct random audits of patients' medical records to validate that orders are transcribed to the medication administration record/treatment administration record and being followed appropriately.	

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F 281	Continued From page 7 New Jersey, page 73-75, states, " . . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . . Question and record verbal orders to avoid miscommunications. . . ." Review of Resident #4's medical record occurred on February 11-12, 2014. Diagnoses included stroke and hypertension. Nurses' notes identified the following: *01/12/14 at 3:14 a.m.: ". . . Pt [patient] noted to have increased b/p [blood pressure] this noc [night], re-check b/p at 3a [3:00 a.m.]: 204/86. At 3a, called on call for [physician name], and orders rec'd [received] for clonidine [an antihypertensive] 0.1 mg [milligram] PO [by mouth] every hour until b/p less than 160 systolic. . . ." *01/12/14 at 7:36 a.m.: ". . . Note b/p already decreased at 6a [6:00 a.m.]: 160/78 and gave most likely last clonodine [sic] needed. . . ." Resident #4's January 2014 MAR identified the following: *01/12/14 at 4:00 a.m.: staff recorded a blood pressure of 178/86; however, did not initial the MAR to identify if Clonidine was given. *01/12/14 at 5:00 a.m.: staff initialed the MAR and circled the initials, a note of the back of the MAR stated, "med [not] given." The MAR failed to identify a reason staff withheld Clonidine, and also failed to identify a blood pressure reading to ensure Resident #4's blood pressure was below 160 systolic. *01/12/14 at 6:00 a.m.: staff recorded a blood pressure of 160/78; however, did not initial the MAR to identify if Clonidine was given. *The record showed no further blood pressure monitoring until 01/12/14 at 1:55 p.m.	F 281	Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 3/27/14.	

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F 281	Continued From page 8 A nurse's note, dated 01/12/14 at 1:40 p.m. stated, ". . . Was reported to pt [patient] nurse by family that pt has decreased LOC [level of consciousness]. Family and nurse agreed that pt should be seen in ED for decreased LOC. Oncall [physician name] notified and T.O. [telephone order] order [sic] for pt to be seen in ED for evaluation . . ." Resident #4's medical record lacked evidence of a physician's telephone order written by the nurse. During an interview on 02/12/14 at 9:20 a.m., a supervisory nurse (#2) stated staff should write a telephone order if a resident is transferred to the ED, sign off a medication on the MAR with their initials, and document the reason a medication was not given. Staff failed to complete the MAR accurately, failed to monitor Resident #4's blood pressure until it remained below 160 systolic, as per physician's orders, and failed to complete a verbal order for Resident #4's discharge to the ED. The incomplete MAR does not accurately reflect Resident #4's course of treatment, and failure to ensure appropriate follow-up to Resident #4's elevated blood pressure may result in a deterioration of her health status. Failure to record and verify verbal orders may result in medication/treatment errors.	F 281		
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.	F 333		

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F 333	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, information submitted by the complainant, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 2 of 3 closed records (Resident #4 and #5) reviewed. Failure to ensure the administration of a Fentanyl (an opiate pain reliever) patch to the correct resident resulted in Resident #4's decreased level of consciousness and admission to the emergency department (ED), and may result in avoidable pain for Resident #5. Findings include: Review of the "Nursing 2013 Drug Handbook" described the use and adverse effects of Fentanyl transdermal system, on page 576-579. The handbook described indications as "To manage persistent, moderate to severe chronic pain in opioid-tolerant patients who require around-the-clock opioid analgesics for an extended time. . . Adverse reactions . . . clouded sensorium, confusion . . . sedation . . . arrhythmias, chest pain, hypertension, hypotension . . ." Review of facility policies occurred on 02/12/14. These policies stated the following: *"Medication Administration: Transdermal Drugs" (dated March 2010): "PURPOSE: To administer medication for systemic or local effect by way of applying to skin . . . PROCEDURE: . . . 6. Examine patient's chest, back and shoulders for	F 333	F333: ManorCare Fargo strives to maintain the right of the residents to be free from significant medication errors. Resident # 4 has discharged from the facility. Residents residing in this facility have the potential to be affected by this practice. Licensed nursing staff were re-educated regarding identifying patients during medication pass by calling name, identifying photograph in medication administration record and by checking name bands. Licensed nursing staff were re-educated regarding the process for reporting a medication error and the steps to follow per ManorCare policy. Licensed nursing staff were re-educated regarding completing the acute care transfer form and discharge order when a resident has an acute discharge from the facility.	

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F 333	Continued From page 10 any residual medication patches. Remove previous patch and wipe away any remaining medication. . . ." * Review of the facility policy titled "Medication Management Guidelines: Errors" occurred on 02/12/13. This policy, dated 08/11/06, stated, ". . . An 'error' means any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. . . . Actions To Take Following A Medication Error . . . Complete the Incident Report and the Occurrence Investigation Report, as outlined in the Quality Assessment and Assurance manual; After the error is resolved, participate in a root cause analysis - asking why five (5) times . . . Type of error . . . wrong patient, wrong time or interval, wrong documentation . . . Performance Improvement . . . If harm to patient occurred, suspend employee pending investigation and follow appropriate disciplinary action including reporting incident to the licensure board if appropriate . . ." *"Medication Administration: Medication Pass" (dated March 2010): "PURPOSE: To safely and accurately prepare and administer medication according to physician order and patient needs . . . 9. Administer medication . . . identify patient by: calling name, checking identification band, referring to photo . . . document initials on MAR for each medication administered . . ." Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 73-75, stated, " . . . The Incident Report . . . The report should be	F 333	ADNS or designee will conduct random audits of medication passes with nurse supervisors. ADNS or designee will conduct random audits of patients with an acute discharge. ADNS of designee will conduct random audits on medication errors to determine if nursing followed incident and investigation policy. Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. ADNS or designee responsible for compliance by 3/27/14.	

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F 333	Continued From page 11	F 333		

completed as soon as possible and filed . . . " Page 262 stated, ". . . Nursing Discharge/Referral Summaries . . . If a client is transferred . . . from a long-term facility to a hospital, a report needs to accompany the client to ensure continuity of care in the new area. It should . . . describe the condition of the client before the transfer. . . . A thorough transfer summary will facilitate communication and promote continuity of care in these situations. . . ." Page 267 stated, ". . . Practice Guidelines: Documentation . . . DO . . . Be timely. A late entry is better than no entry; however, the longer the period of time between actual care and charting, the greater the suspicion. . . ." Page 862, stated, ". . . Process of Administering Medications . . . 1. Identify the client. . . . One of the Joint Commission's National Patient Safety Goals is to improve the accuracy of client identification. This goal requires a nurse to use at least two client identifiers whenever administering medications. . . . In the long-term care setting . . . the requirement for two identifiers is appropriate at the first encounter. Thereafter, one identifier can be facial recognition . . . Clinical Alert: Do not ask 'Are you John Jones?' because the client may answer 'yes' to the wrong name. . . ."

- Review of Resident #4's medical record occurred on February 11-12, 2014. Diagnoses included stroke and hypertension. Medications included Tramadol (a pain medication), Elavil (an antidepressant), vitamin D3, multivitamin, Celexa (an antidepressant), calcium, Marinol (an appetite stimulant), Detrol (for overactive bladder), and Xalatan (glaucoma eye drops).

Resident #4's nurses' notes stated the following: *01/11/14 at 11:00 p.m.: ". . . 1800 [6:00 p.m.] Pt's

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F 333	Continued From page 12 [patient's] son called this author into room to remove pocketed food from pt mouth, pt was asked to open mouth and noted to have delayed reaction to following commands which was unusual for her. Son concerned that 'not acting herself.' Pt less talkative as usual, eye contact poor until spoken to but will only look towards you for moment, responds to questions appropriately but delayed in response, eyes glassy, flat affect, noted to be continuous chewing on Rt [right] side even though nothing in mouth. VS [vital signs] 97.9 [temperature] - 88 [pulse] - 16 [respirations] - 101/60 [blood pressure], O2 [oxygen] sats [saturations] 95% RA [room air]. Neuro [neurological] check done and WNL [within normal limits], Lt [left] sided weakness which has been present since recent CVA [cerebrovascular accident]. During assessment, son questioned a patch that was on pt, upon inspection found Fentanyl Duragesic [a transdermal Fentanyl patch] 50 mcg [micrograms] dated 01/11/14 on pt Lt chest, pt does not have an order for this med [medication], Duragesic removed immediately . . . Duragesic applied in a.m. and was on for less than 10 hours. . . . Pt monitored through the shift, noted to need assistance with meal, pocketing food and meds, normal manneurisms [sic] and behaviors more evident later in the shift . . ." Although the record showed the "effective date" for this note was 01/11/14 at 11:00 p.m., further record review identified the "created date" for this note was 01/12/14 at 4:31 p.m. (nearly 24 hours after the discovery of the medication error). During an interview on the morning of 02/12/14, a supervisory nurse (#2) confirmed the "created date" is the date/time that staff actually made the entry.	F 333		

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An "Incident Report" provided by the facility also identified the medication error. Staff completed the report on 01/12/14 at 10:38 p.m. (over 24 hours after the discovery of the medication error).

During an interview on the morning of 02/12/14, an administrative nurse (#2) stated she would expect staff to complete an incident report at the time of the incident or shortly thereafter.

Resident #4's nurses' notes further stated:
*01/12/14 at 3:14 a.m.: ". . . Pt noted to have increased b/p [blood pressure] this noc [night], re-check b/p at 3a [3:00 a.m.]: 204/86. At 3a, called on call for [physician name], and orders rec'd [received] for clonidine [an antihypertensive] 0.1 mg [milligram] PO [by mouth] every hour until b/p less than 160 systolic. . . ."
*01/12/14 at 7:36 a.m.: ". . . Note b/p already decreased at 6a [6:00 a.m.]: 160/78 and gave most likely last clonodine [sic] needed. . . ."
*01/12/14 at 1:40 p.m.: ". . . Was reported to pt [patient] nurse by family that pt has decreased LOC [level of consciousness]. Family and nurse agreed that pt should be seen in ED for decreased LOC. Oncall [sic] [physician name] notified and T.O. [telephone order] order [sic] for pt to be seen in ED for evaluation. Incident report filled out from yesterday. . . ."

Resident #4's transfer form, completed by the facility and dated 01/12/14 at 12:53 p.m., identified the "Reason for Transfer" as "Decreased LOC." Staff provided no further health history regarding Resident #4's condition (such as the accidental application of the Fentanyl patch, the resident's elevated blood pressure, and the initiation of the Clonidine). Failure to include relevant and important

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information on the transfer form does not allow ED staff to receive an accurate presentation of Resident #4's health status, and does not allow for continuity of care.

The ED Provider Note, dated 01/12/14 at 2:34 p.m., stated the following:
". . . Chief Complaint . . . Lethargy . . . History is extremely limited because the patient is not talking and unable to follow commands appropriately or provide history. The history is provided by the patient's son. . . . The patient's chief complaint is of worsening lethargy, confusion, altered mental status, and weakness. . . . The patient reportedly had a right-sided CVA 6 days ago . . . Then she left the hospital to go to the nursing home several days ago, the patient was able to actually ambulate with assistance, and carry on a conversation. Her son states now she is unable to ambulate or lift her legs at all, speak with him, or follow commands. The was a period in time yesterday where the patient inadvertently had a fentanyl patch placed for approximately 8 hours, which was not intended for her and actually was her roommates medication. . . ."

A nurse's note from the ED, dated 01/12/14 at 6:53 p.m., stated, ". . . Patient given 0.2 mgs [milligrams] narcan [a medication used to counter the effects of opiate overdose, specifically the depression of the central nervous and respiratory systems] and she began to awaken and respond to us and questions. Patient understood she was being admitted to floor. . . ."

Resident #4's hospital record following her admission on 01/12/14 stated, ". . . Assessment/Plan . . . Active Hospital Problems . .

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F 333	Continued From page 15 . UTI (lower urinary tract infection). Culture pending. Continue Levaquin [an antibiotic] pending cultures. . . . Encephalopathy [disorder of the brain] acute. Multifactorial with accidental drug overdose and UTI. . . . Narcotic overdose. Duragesic patch removed. . . ." Information submitted by the complainant identified the nurse who identified the medication error (on the evening of 01/11/14) contacted the nurse who applied the Duragesic patch earlier that morning. The nurse who applied the patch stated she had asked Resident #4, "Are you [Resident #5]," to which Resident #4 replied "yes." Then nurse then applied the patch to Resident #4, instead of Resident #5. An interview with administrative nursing staff (#1 and #2) on the afternoon of 02/11/14 confirmed the above information. Facility staff incorrectly administered an opioid pain medication to Resident #4 medication. This resulted in decreased level of consciousness and lethargy for Resident #4, as well as an admission to the ED and the administration of emergency Narcan. - Review of Resident #5's record occurred on February 11-12, 2014. Resident #5's medication regimen through the length of stay included Fentanyl 50 mcg per hour transdermal patch applied every 72 hours. The medication administration record (MAR) included "Remove old patch before placing new." The MAR identified the patch scheduled for 8 a.m. on January 2, 5, 8, 11, 14, 17, 20, 23, 26 and 29. The MAR identified the location of the patch placement with each administration alternated between the right and left chest.	F 333		

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Review of Resident #5's "Controlled Substance Record" for the Fentanyl patch identified the dates and times nursing staff obtained a patch; the number of patches remaining; and the nurse who obtained (signed out) the patch. The controlled substance record identified nursing staff members obtained a Fentanyl patch for Resident #5 at 8 a.m. and 6 p.m. on 01/11/14. Review of Resident #5's MAR lacked documentation of the administration of a Fentanyl patch at 6 p.m. on 01/11/14.

During interview on 02/11/14 at 5:45 p.m. a nurse manager (#2) stated she lacked awareness of how Resident #5 received two Fentanyl patches on 01/11/14, unless one of them "fell off in the shower." The nurse stated Certified Nursing Assistants (CNAs) are instructed to let the nurse know if a patch falls off during bathing. The manager stated she was unaware if there was an incident report on the missing patch.

During interview on 02/11/14 between 5:45 p.m. and 6 p.m., an administrative nurse (#1) stated the Fentanyl patch scheduled for Resident #5 at 8 a.m. was administered to the roommate, Resident #4. The administrative nurse stated the nurse making the error did not work that unit very often and was a "prn" [as needed - fill in] nurse. Review of the nurses' staffing schedule between December 11, 2013 and February 11, 2014 showed the facility scheduled the "prn" nurse between six to 10 days in a two week period. The nurse stated to her knowledge no incident report was completed; however, she informed the nurse there should be an incident report. The nurse (#1) stated an incident report would include the investigation of the incident. A request for

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F 333	Continued From page 17 additional information, including the facility's investigation of the incident, the contributing and causative factors were requested and not provided. The administrative nurse stated corrective action included education and performance improvement with the nurse causing the error, and education to all the nurses. During interview on 02/12/14 at 9:15 a.m. an administrative nurse (#1) and nursing manager (#2): * confirmed no incident report was completed for Resident #5's missed dose of Fentanyl at 8 a.m. on 01/11/14 or dose administered at 6 p.m. * incident reports are required to be completed at the time of the incident * an incident report was done initially for Resident #4, but the nurse completing the report chose the wrong category (an example offered: a fall verses a fall with injury), so the nurse was requested to fill out another one. The nurse manager stated the nurse who applied the patch to Resident #4 wrote a progress note in Resident #4's record which she thought would automatically transfer over to Resident #4's incident report * would expect documentation on Resident #4's and #5's MAR to reflect the administered dose and missed dose of Fentanyl. * if medication is not given at the time scheduled, would expect this identified on the MAR * stated the nurse looked for the patch "all over" Resident #4's body and couldn't find it. The nurse failed to make a report at the time regarding not finding the previously applied patch on Resident #4 * identified photographs as a means of resident identification during medication pass; however, record review identified no photo available of Resident #4. After the error occurred the facility	F 333		

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F 333	Continued From page 18 changed the process to ensure every resident had a photograph with the resident's MAR; however, during observation of medication pass on the afternoon of 02/11/14 Resident #4's MAR lacked a photograph. During interview on the afternoon of 02/11/14, a staff nurse (#3) stated resident identification is by a picture of the resident with the MAR "normally." The nurse stated residents also have the option to wear arm bands. During interview on the afternoon of 02/11/14, a staff nurse (#4) stated for identification of residents during medication pass in the dining room she carries the resident's picture, and asks the residents their name. The nurse stated for residents within their room, she will do several checks including resident's name on door; arm bracelet if wearing; and photo identification. Review of the inservice training and skills checklist provided for the nursing staff following the incidents on 01/11/14 occurred on both days of survey. The nurse's schedule identified 34 nurses worked on the units between 01/22/14 and 02/04/14. Review of individual nurse's education and skills demonstration records identified 11 of the 34 nurses had not received the education and return demonstration. The skills checklist included "Identify patient by calling name, checking ID [identification] and photograph." Facility staff incorrectly administered an opioid pain medication to Resident #4 medication to Resident #5. This may have resulted in unresolved pain for Resident #5, and resulted in decreased level of consciousness and lethargy	F 333		

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F 333	Continued From page 19 for Resident, as well as an admission to the ED and the administration of emergency Narcan.	F 333		
F9999	FINAL OBSERVATIONS Based on observation, record review, review of facility policy and procedure, review of professional references, and staff interview, the complainant issues were validated.	F9999		