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| WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY | 640 W ELLSWORTH ST<br>COLUMBIA CITY, IN 46725 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00427464 and IN00428695. This visit resulted in a Partially Extended Survey - Substandard Quality of Care-Immediate Jeopardy.<br><br>Complaint IN00427464 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00428695 - Federal/state deficiencies related to the allegations are cited at F684 and F760.<br><br>Survey dates: February 20, 21, and 22, 2024<br><br>Facility number: 000071<br>Provider number: 155150<br>AIM number: 100273140<br><br>Census Bed Type:<br>SNF/NF: 31<br>Total: 31<br><br>Census Payor Type:<br>Medicaid: 15<br>Other: 16<br>Total: 31<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed February 27, 2024 | F 0000 | | |
| F 0684<br>SS=J<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to | | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on interview and record review, the facility failed to ensure respiratory status was effectively assessed after a medication error for 1 of 3 residents reviewed for change of condition. See F760 for additional information regarding Resident Q. This deficient practice resulted in a change in the resident's condition and subsequent death (Resident Q).<br><br>The Immediate Jeopardy began on 2/16/24 when Resident Q was administered MS Contin 30 mg (extended-release morphine tablet) (an opioid pain medication) that was not prescribed for her. The facility failed to adequately assess and monitor the resident for respiratory depression after identifying the medication error. This resulted in a change of condition and death of the resident. The Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Immediate Jeopardy on February 21, 2024 at 12:48 P.M. The Immediate Jeopardy was removed on February 22, 2024.<br><br>Findings include:<br><br>A complaint reported to the Indiana Department of Health dated 2/19/24 indicated, on 2/16/24 at 8:00 a.m., a facility nurse had accidentally administered another resident's MS Contin (long-acting morphine) 30 mg. The report indicated the facility notified the family on 2/16/24 at 10:00 a.m., of the medication error and told the family that staff would monitor the resident's | F 0684 | As requested by state and federal law, the facility, Waters of Columbia City, is respectfully submitting the following credible allegation of compliance to request removal of the Immediate Jeopardy citation, which was issued on February 21, 2024 related to failure to adequately assess after a medication error and follow up timely in a change of condition. .F-684<br><br>**Disclaimer Statement:** The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the allegation of compliance because it is requested by state and federal law. The facility may disagree with and dispute the alleged deficiency as stated in the Immediate Jeopardy Template. This includes but is not limited to the alleged content, summary, the chronological timing of sequence of events, and the description of care including medication administration to the specified | 02/24/2024 |

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| | condition. The report indicated the facility notified the family, on 2/16/24 at 5:30 p.m., that the resident was not breathing and was later pronounced dead.<br><br>On 2/20/24 at 2:54 P.M., Resident Q's family member was interviewed. The family member indicated they were notified of the medication error at 10:00 a.m. on 2/16/24. They were told staff would monitor the resident for 72 hours and notify them and the doctor of any changes in her condition. The family hadn't heard back from the facility until 5:30 p.m. when they were notified the resident had stopped breathing and attempts were being made to resuscitate her. The family member indicated they hadn't been told what medication had been given in error in the morning, and had they known, the family member would have insisted the resident be sent to the hospital immediately. The family member indicated upon their arrival to the facility, the EMS and Sheriff's department continued resuscitative efforts, but hadn't been told the resident had been given MS Contin in error. After being informed Resident Q had received MS Contin in error, paramedics administered Narcan however, the family member alleged it was too late and the resident died.<br><br>On 2/20/24 at 11:15 A.M., Resident Q's clinical record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD) with dependence on supplemental oxygen, chronic respiratory failure with hypoxia (low levels of oxygen in the body), type 2 diabetes with diabetic neuropathy (nerve damage with symptoms of pain and numbness in the legs), and chronic pain syndrome. Resident Q was admitted to the facility for rehabilitation following hospitalization for sepsis due to urinary tract infection. Her goal was to discharge back home following therapy. | | resident. The facility reserves its right to continue disputing, appealing, and contesting this alleged deficiency, and any actions related to and arising therefrom in any forum as needed.<br><br>**According to the Immediate Jeopardy Template, the facility failed to ensure medications were administered as ordered to prevent a significant medication error.**<br><br>**Corrective action taken for resident affected by the deficient practice:**<br>Nurse #1 was immediately interviewed and suspended pending investigation on 02/16/24 following the discovery of the potential medication error, thus removing the potential to affect other residents. Nurse #1 has not worked since 02/16/24. Resident (#1) was admitted to the facility on 01/25/2024 with a medical history that included but is not limited to: Sepsis, Chronic Respiratory Failure with Hypoxia, COPD, DMII with Diabetic Neuropathy, Morbid Obesity, Asthma, CHF, CKD Stage III, Obstructive Sleep Apnea, HTN at the time of the potential medication error. Resident (#1) passed on 02/16/24.<br><br>The Nurse Practitioner was notified by Nurse #1 of the medication error on 2/16/2024, no | |

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| | A Physician Order Summary Report, dated 1/25/24 through 2/18/24, indicated Resident Q was not prescribed MS Contin or other opioid pain medications. She was prescribed Gabapentin (an anticonvulsant CNS depressant medication) for pain related to diabetic neuropathy, which had been increased on 2/12/24, from 200 mg to 300 mg (milligrams) by mouth 3 times per day. Side effects of Gabapentin included sedation and respiratory depression.<br><br>According to FDA.gov, on 12/19/2019, The U.S. Food and Drug Administration (FDA) is warning that serious breathing difficulties may occur in patients using gabapentin who have respiratory risk factors. These include the use of opioid pain medicines and other drugs that depress the central nervous system, and conditions such as chronic obstructive pulmonary disease (COPD) that reduce lung function. The elderly are also at higher risk.<br><br>The website www.myamericanurse.com on 2/21/24 indicated: "Opioid naïve patients are those not chronically receiving opioid analgesics on a daily basis...these patients are at higher risk for oversedation and aspiration, especially if they receive opioids in inappropriate dosages...Risk factors for oversedation and respiratory depression include: lack of recent opioid use, pulmonary disorders, older than age 60, and use of other central nervous depressants. Monitoring patients receiving opioids: Routine monitoring of vital signs may fail to detect early signs of respiratory depression. Many nurses focus on pulse oximetry, blood pressure, and respiratory rate when assessing a patient for opioid-related oversedation and respiratory depression. Pulse oximetry also may not provide accurate | | new orders given.<br>The Medical Director was notified on 2/17/2024 by the Administrator.<br><br>Nurse # 1 assessed Resident #1 for changes in condition after the error until the end of her shift.<br><br>Nurse # 2 did not assess the Resident after 2 pm. Nurse # 2 was re-educated and in-serviced by the Corporate RN. All nursing staff were educated by the corporate nurse.<br><br>**How other residents of the facility were identified to potentially be affected:**<br><br>All residents were assessed for change of condition. These were completed by the DON/Designee by 2/17/2024.<br><br>**What measures were put into place and what systemic changes will be made to ensure the deficient practice does not recur:**<br>On 2/16/2024 and 2/17/2024 Licensed Nurses were in- serviced on the following:<br><br>1. Change of Condition<br>2. Timeliness of Assessment after a change of condition.<br>3. Physician Notification<br>4. Narcotic Adverse Reactions | |

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| | information, especially in a patient receiving oxygen...In opioid-naïve patients, respiratory rate is a poor predictor of respiratory depression; it may be normal despite significant hypoventilation...The most commonly monitored parameters of respiratory function are respiratory rate and oxygen saturation yet significant hypercapnia (high levels of carbon dioxide in the blood) may arise before oxygen desaturation occurs. Patients may fall asleep and slip into respiratory depression...Signs of hypercapnia include flushed skin, fast breathing, difficulty breathing, headache, confusion, and sleepiness...Respiratory depression can occur even when the patient can be aroused and speak with and answer questions yet may be over sedated so if the patient appears to be sleeping or resting comfortably, be sure to check arousability. Patients who are sedated from opioids may experience nausea and vomiting after eating and then suffer aspiration. To prevent this, don't give patients solid foods until they can tolerate clear liquids and nausea and vomiting have subsided...."<br><br>Nursing Notes, completed on the night shift, dated 2/14/24, indicated Resident Q was on continuous oxygen at 2 liters per nasal cannula, had shortness of breath and orthopnea (shortness of breath while laying down). Lung assessments indicated her lungs were clear, but breath sounds were diminished in both bases. The note indicated Resident Q denied increased shortness of breath, but did not include documentation to show the staff effectively monitored the resident for breathing.<br><br>Nursing Notes, completed on the night shift, dated 2/15/24, indicated Resident Q was on continuous oxygen at 2 liters per nasal cannula, | | 5. Signs and Symptoms of drug overdose<br>6. Documentation<br>7. Respiratory Assessment<br><br>Staff knowledge of the in-serving will be measured by a POST TEST requiring 100% accuracy of the answers to “pass.”<br><br>Any licensed nurse that is unable to complete education due to LOA on or before 2/17/24, will be required to complete education and a post-test prior to working or administering medications to residents.<br><br>Any newly hired nurses or QMA’s will be educated on hire/return and competence validated prior to administering medications to any resident.<br><br>Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.<br><br>**How the corrective actions will be monitored to ensure the deficient practice does not recur:**<br>An Ad-Hoc QAPI Meeting was held by the Administrator, the Interdisciplinary Team and Medical | |

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| | had shortness of breath and orthopnea (shortness of breath while laying down). Lung assessments indicated her lungs were clear, but breath sounds were diminished in both bases. The note indicated Resident Q denied increased shortness of breath, but did not include documentation to show the staff effectively monitored the resident for breathing abnormality.<br><br>Nursing Notes, completed on the night shift, dated 2/16/24, indicated Resident Q was on continuous oxygen at 2 liters per nasal cannula, had shortness of breath and orthopnea (shortness of breath while laying down). Lung assessments indicated her lungs were clear, but breath sounds were diminished in both bases. The note indicated Resident Q denied increased shortness of breath, but did not include documentation to show the staff effectively monitored the resident for breathing abnormality.<br><br>An SBAR (Situation, Background, Assessment/Appearance, and Review/Notify), Communication Form, dated 2/16/24 at 8:00 a.m., indicated the resident's Nurse Practitioner (NP) was notified Resident Q had been given an unprescribed MS Contin tablet. The form indicated the facility reported to the NP that Resident Q exhibited no signs or symptoms of adverse reaction to the opioid medication. The NP recommended for the nursing staff to monitor the resident's mental status and/or vital signs and report any changes.<br><br>Nurse progress notes, dated 2/16/24 between 8:00 a.m. and 9:29 a.m. did not include documentation to show the resident was effectively monitored for adverse signs and symptoms of MS Contin administration or respiratory depression, the subsequent nurse progress notes indicated the | | Director on 02/16/24 to review and approved the Plan of Removal and Allegation of Compliance.<br><br>The ADON/Designee will complete the Audit Tool “Medication Error/Assessment daily x 2 weeks, weekly x 2 weeks, and monthly x 5 months or until substantial compliance is achieved.<br><br>The QAPI Committee will review the audit tools on a monthly basis and will determine compliance. Any concerns will have been addressed. If indicated, additional Action Plans will be recommended and/or written by the QAPI Committee. All Action Plans will be monitored weekly by the Administrator to ensure substantial compliance.<br><br>Date of Compliance: 2/17/2024 | |

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| | following:<br><br>-At 9:30 a.m., the resident was alert and oriented with no adverse effects from the medication erroneous administration of MS Contin. She continued on continuous oxygen at 2 liters per nasal cannula continuously, but was reminded to keep it in her nose because she frequently removed it. Resident Q was trying to bring up phlegm. Her lungs were clear with diminished breath sounds which were baseline findings for the resident. Her vital signs were P (pulse) 68, R (respirations) 16, and BP (blood pressure) 126/74. Neuro (neurological) checks were within normal limits and would continue to be monitored. The progress note did not include documentation to show the resident was assessed for signs of medication intoxication.<br><br>-11:00 a.m., Follow Up for Med Error: Resident Q was sitting in her wheelchair, was alert and oriented, vital signs were P 68, R16, and BP 122/68. Neuro checks were within normal limits, and she had no signs of adverse reaction from the MS Contin administration. The note did not include documentation to show the resident was assessed for signs of medication intoxication.<br><br>-12:06 p.m., continued follow up of medication error: Resident Q was alert and oriented. She sat in her wheelchair in her room eating lunch. Her vital signs were P 68, R 16, and BP 118/66. Neuro checks were within normal limits. When asked, the resident indicated she was feeling ok and the "buzz had worn off".<br><br>-1:53 p.m., Follow Up for Med Error: Resident Q was alert and oriented and able to make needs known to staff. She had no complaints related to the medication error, her vital signs were P 66, R | | | |

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| | 16, BP 110/66 and neuro checks remained within normal limits, but no oxygen saturation had been obtained. Resident Q was lying in bed and resting quietly.<br><br>The clinical record did not include documentation to show the resident was effectively monitored for adverse signs and symptoms of MS Contin administration or for signs and symptoms of signs and symptoms of respiratory depression, on 2/16/24 between 1:53 p.m. and 5:20 p.m.<br><br>-5:20 p.m., the NP was notified Resident Q was having abnormal breath sounds and audible gurgling sounds. The NP ordered to check the resident's oxygen saturation and if hypoxic (low blood oxygen), send the resident to the ER.<br><br>-5:22 p.m., RN 8 went to check the Resident Q's oxygen saturation and observed the resident vomit orange tinted liquid. The resident became unresponsive with no pulse or respirations, CPR was initiated, and 911 called. The family was immediately notified of the resident's condition. No Oxygen saturation was obtained.<br><br>On 2/20/24 at 11:45 A.M., Resident Q's roommate, identified as interviewable, indicated on Friday, 2/16/24 before lunch, her roommate began spitting up and making "gagging" noises about mid-morning. After lunch, the resident continued coughing, gagging, and "gurgling". The roommate put on her call light, yelled out for staff to come in and check her roommate, but the staff did not respond.<br><br>On 2/20/24 at 1:49 P.M., CNA 2 (Certified Nurse Aid) was interviewed. The CNA had cared for Resident Q during the day on 2/16/24. She was transferred to the bed and while lying in the bed, | | | |

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| | had some coughing and rattling noises. CNA 2 indicated Resident Q's arms were floppy, she couldn't lift her arms to help put her shirt on. This was a change for her. CNA 2 indicated Resident Q would inhale air, then when exhaled, she made gurgling noises and sounded like she was "drowning". CNA 2 informed LPN 7 of the coughing and gurgling noises. CNA 2 indicated she was not sure LPN 7 assessed Resident Q after being informed of her condition, and she was not instructed to monitor the resident's condition.<br><br>A written witness statement, dated 2/17/24 by CNA 3, indicated she had cared for Resident Q on 2/15/24 from 2-10 p.m. and hadn't noticed any change in condition. Resident Q had been her usual "normal" self. On 2/16/24, she cared for Resident Q from 6 a.m. to 2 p.m. CNA 3 observed Resident Q to be very sleepy with difficulty keeping her eyes open. Resident Q had been coughing and her breathing was "rattly". This was new for the resident. CNA 3 indicated she did not notify the nurse of the change. CNA 3 was not instructed to monitor the resident during shift change.<br><br>On 2/20/24 at 2:14 P.M., CNA 4, assigned to care for Resident Q on 2/16/24 from 2-6 p.m., indicated she was informed the resident had been given a medication she wasn't prescribed. At approximately 3:30 p.m., she overheard the resident's roommate calling out for help. She went into the room; the roommate was very upset. The roommate said the resident was gagging, coughing, and having a hard time breathing. CNA 4 observed Resident Q lying in bed with her head elevated. She was awake and coughing, gagging, and bringing up phlegm. The CNA elevated the head of Resident Q's bed until she was sitting straight up and left the room to get a basin. She | | | |

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| | returned to the room and placed the basin on her overbed table and then left the room. She indicated she couldn't remember telling the charge nurse about Resident Q's condition.<br><br>On 2/20/24 at 3:07 P.M., LPN 7 (Licensed Practical Nurse) indicated on 2/16/24 at 8:00 a.m., she was passing medications and accidentally gave Resident Q another resident's dose of MS Contin 30 mg. LPN 7 told the resident she had been given a pill belonging to another resident and she would closely monitor her for any ill effects. LPN 7 indicated she monitored Resident Q's vital signs closely throughout the day and hadn't observed any changes in her condition. She indicated she had not monitored her oxygen saturation or for other signs of respiratory depression such as flushed skin, fast breathing, difficulty breathing, headache, confusion, and sleepiness.<br><br>On 2/20/24 at 3:25 P.M., RN 8 indicated she took over for LPN 7 at 2:00 p.m. on 2/16/24. RN 8 indicated there was no documentation to review, because the resident had not been monitored on 2/16/24 between 2:00 p.m. and 4:55 p.m. She indicated there was an emergency with another resident, and she wasn't able to see Resident Q until 4:55 p.m. RN 8 was aware of the medication error involving Resident Q. When RN 8 went into the room she observed Resident Q lying in her bed with the head of the bed elevated and she was coughing. RN 8 went out to the medication cart to see if Resident Q had any medication for her cough but did not assess her breath sounds or oxygen saturation. RN 8 called the NP and informed her of Resident Q's coughing. When she went back into Resident Q's room to inform the resident what the NP ordered and observed Resident Q coughing with audible gurgles. RN 8 did not assess Resident Q's breath sounds or | | | |

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| | oxygen saturation. RN 8 called the NP again and told her of the gurgling respirations. The NP instructed RN 8 to check the resident's oxygen saturation level and if hypoxic (low blood oxygen), send the resident to the ER. RN 8 re-entered the room at 5:20 p.m. to obtain the resident's oxygen saturation level and observed the resident spitting up orange colored liquid. RN 8 indicated she was unable to obtain an Oxygen saturation, RN 8 called for assistance and got the crash cart (emergency resuscitation equipment). At 5:25 p.m., Resident Q's pulse and respirations ceased, CPR was started and 911 called.<br><br>On 2/21/24 at 9:40 A.M., the Nurse Practitioner indicated LPN 7 texted her on 2/16/24 around 8:00 a.m. to inform her of a medication error. The text indicated Resident Q had been given MS Contin 30 mg by mouth. The resident had no allergies to the medication and the nurse was going to monitor the resident closely. She replied "ok" in answer, but wasn't notified of any change in Resident Q's condition throughout the day. The NP indicated she hadn't ordered specific monitoring instructions because she assumed the facility had policies and procedures in place for monitoring residents following a medication error. She expected the facility would have assessed Resident Q's vital signs, respirations, mental status changes, and oxygen saturations every hour for 24 hours. There was no documentation to indicate the NP had been made aware Resident Q was receiving gabapentin.<br><br>On 2/21/24 at 11:00 A.M., the Rehabilitation Director indicated Resident Q had been receiving physical therapy services with her last treatment completed on 2/16/24 prior to lunch. She indicated Resident Q's treatment had been shortened that day due to the resident being more tired and | | | |

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| | nauseated after her morning medications. The Rehabilitation Director indicated she notified LPN 7.<br><br>A current copy of an undated facility policy, titled "Change in Resident's Condition or Status", was provided by the Administrator on 2/21/24 at 3:44 P.M., and stated: "The nurse will notify the resident's attending physician when there is a significant change in the resident's physical, mental or psychological status ...A significant change in condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions, impacts more than one area of the resident's health status ...The nurse will record in the resident's medical record any changes in the resident's medical condition or status."<br><br>In an interivew on 2/21/24 at 3:44 P.M., a facility policy regarding monitoring after a medication error was requested, but the Administrator indicated the facility did not have a policy.<br><br>The Immediate Jeopardy that began on 2/16/24 was removed and the deficient practice corrected on 2/22/24 when the facility re-educated nursing staff on medication administration, opioid drug overdose, change in condition, and respiratory assessments but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>This tag relates to Complaint IN00428695.<br><br>3.1-37 | | | |

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| F 0760 SS=J Bldg. 00 | 483.45(f)(2)<br>Residents are Free of Significant Med Errors<br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>Based on interview and record review, the facility failed to ensure Resident Q did not receive an opioid medication that was ordered for another resident and failed to ensure Resident Q was effectively monitored for signs and symptoms of adverse reaction for 1 of 3 residents reviewed for significant medication errors. This deficient practice resulted in Resident Q becoming unresponsive and the resident expired (Resident Q).<br><br>The Immediate Jeopardy began on 2/16/24 when Resident Q was administered a MS Contin 30 mg (extended release morphine) (an opioid medication for pain) tablet not prescribed for her. The facility failed to adequately assess and monitor the resident's condition after identifying the medication error. This resulted in a change of condition and death of the resident. The Administrator, Director of Nursing and Regional Nurse Consultant were notified of the Immediate Jeopardy on February 21, 2024 at 12:48 P.M. The Immediate Jeopardy was removed on February 22, 2024.<br><br>Findings include:<br><br>A report to the Indiana Department of Health on 2/19/24 indicated Resident Q had accidentally been given another resident's MS Contin 30 mg tablet at 8:00 a.m.. The facility notified the family on 2/16/24 at 10:00 a.m. of the medication error and were told staff would monitor the resident's condition. On 2/16/24 at 5:30 p.m., the facility notified the family the resident was not breathing | F 0760 | As requested by state and federal law, the facility, Waters of Columbia City, is respectfully submitting the following credible allegation of compliance to request removal of the Immediate Jeopardy citation, which was issued on February 21, 2024 related to a medication error.<br><br>**Disclaimer Statement:** The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegation in the notification of Immediate Jeopardy. The facility is completing the allegation of compliance because it is requested by state and federal law. The facility may disagree with and dispute the alleged deficiency as stated in the Immediate Jeopardy Template. This includes but is not limited to the alleged content, summary, the chronological timing of sequence of events, and the description of care including medication administration to the specified resident. The facility reserves its right to continue disputing, appealing, and contesting this alleged deficiency, and any actions related to and arising | 02/24/2024 |

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| | and pronounced dead.<br><br>MS Contin manufacturers prescribing information, retrieved from the website www.accessdata.fda.gov indicated Warnings and Precautions which included: "Serious, life-threatening, or fatal respiratory depression may occur in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients: patients with significant chronic obstructive pulmonary disease or cor pulmonale, and those with a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression are at increased risk of decreased respiratory drive including apnea, even at recommended dosages of MS CONTIN. Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status. Carbon dioxide (CO2) retention from opioid-induced respiratory depression can exacerbate the sedating effects of opioids. Monitor patients closely for respiratory depression, especially within the first 24-72 hours of initiating therapy...The starting dose for patients who are not opioid tolerant is MS CONTIN 15 mg orally every 12 hours. Use of higher starting doses in patients who are not opioid tolerant may cause fatal respiratory depression...MS CONTIN is an extended-release tablet containing morphine sulfate. Morphine is released from MS CONTIN somewhat more slowly | | therefrom in any forum as needed.<br><br>**According to the Immediate Jeopardy Template, the facility failed to ensure medications were administered as ordered to prevent a significant medication error.**<br><br>**Corrective action taken for resident affected by the deficient practice:**<br>Nurse #1 was immediately interviewed and suspended pending investigation on 02/16/24 following the discovery of the potential medication error, thus removing the potential to affect other residents. Nurse #1 has not worked since 02/16/24. Resident (#1) was admitted to the facility on 01/25/2024 with a medical history that included but is not limited to: Sepsis, Chronic Respiratory Failure with Hypoxia, COPD, DMII with Diabetic Neuropathy, Morbid Obesity, Asthma, CHF, CKD Stage III, Obstructive Sleep Apnea, HTN at the time of the potential medication error. Resident (#1) passed on 02/16/24.<br><br>The Nurse Practitioner was notified by Nurse #1 of the medication error on 2/16/2024, no new orders given.<br>The Medical Director was notified on 2/17/2024 by the Administrator.<br><br>Nurse # 1 assessed Resident #1 | |

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| | than from immediate-release oral preparations...."<br><br>On 2/20/24 at 11:15 A.M., Resident Q's record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD) with dependence on supplemental oxygen, chronic respiratory failure with hypoxia (low levels of oxygen in the body), type 2 diabetes with diabetic neuropathy (nerve damage with symptoms of pain and numbness in the legs), and chronic pain syndrome. The resident was admitted to the facility for rehabilitation following hospitalization for sepsis due to urinary tract infection. Her goal was to be discharged back home following therapy.<br><br>A current admission Minimum Data Set (MDS) assessment, dated 1/28/24, indicated Resident Q was moderately cognitively impaired and had physical limitations on one side.<br><br>A care plan dated resident was at risk for respiratory distress due to COPD. No interventions were listed on the care plan.<br><br>An admission assessment, dated 1/25/24, indicated Resident Q was alert and oriented, had clear lungs, and no shortness of breath or respiratory distress.<br><br>A Physician Order Summary Report, dated 1/25/24 through 2/18/24, indicated Resident Q was not prescribed MS Contin or other opioid pain medications.<br><br>An SBAR (Situation Background Appearance Review and Notify) Communication Form, dated 2/16/24 at 8:00 a.m., indicated the resident's Nurse Practitioner (NP) was notified Resident Q had been given a tablet of MS Contin at 8:00 a.m. that was not prescribed for her. The resident had no | | for changes in condition after the error until the end of her shift.<br><br>**How other residents of the facility were identified to potentially be affected:**<br>All residents have the potential to be affected by this finding. Narcotic count sheets were audited on 02/16/24 to verify accurate count recorded and matching count of medications. Physician's Orders were validated to match the Medication Administration Record and administration times were verified to be within acceptable range. All residents were assessed for change of condition. These were completed by the DON/Designee by 2/17/2024.<br><br>**What measures were put into place and what systemic changes will be made to ensure the deficient practice does not recur:**<br>On 2/16/2024 and 2/17/2024 Licensed Nurses and Qualified Medication Aides were in- serviced on the following by the Corporate Nurse:<br>1. Medication Administration<br>2. Guideline with the 10 Rights related medication administration.<br>3. Following Physician Order<br>4. Change of Condition<br>5. Physician Notification<br>6. Narcotic Adverse Reactions | |

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| | signs or symptoms of an adverse reaction to the medication at the time of the error notification. The form indicated recommendations from the NP were to monitor and report any changes in the resident's mental status and/or vital signs.<br><br>The Nurse progress notes, dated 2/16/24 between 8:00 a.m. and 9:29 a.m. did not include documentation to show the Resident was effectively monitored for adverse signs and symptoms of MS Contin or respiratory depression, the subsequent nurse progress notes indicated the following:<br><br>-At 9:30 a.m., Resident Q was alert and oriented with no adverse effects from the erroneous administration of MS Contin. She continued on oxygen at 2 liters per nasal cannula continuously, but was reminded to keep it in her nose because she frequently removed it. Resident Q was trying to bring up phlegm. Her lungs were clear with diminished breath sounds which were baseline findings for the resident. Her vital signs were P (pulse) 68, R (respirations) 16, BP (blood pressure) 126/74. Neuro (neurological) checks were within normal limits and would continue to be monitored.<br><br>-11:00 a.m., Follow Up for Med Error: Resident Q was up sitting in her wheelchair, was alert and oriented, vital signs were P 68, R 16, BP 122/68. Neuro checks were within normal limits, and she had no signs of adverse reaction from the MS Contin administration.<br><br>-12:06 p.m., continued follow up of medication error: Resident Q was alert and oriented. She sat in her wheelchair in her room eating lunch. Her vital signs were P 68, R 16, BP 118/66. Neuro checks were within normal limits. When asked, the resident indicated she was feeling ok and the | | 7. Signs and Symptoms of Drug Overdose.<br>8. Documentation<br>9. Respiratory Assessment<br><br>Staff knowledge of the in-serving will be measured by a POST TEST requiring 100% accuracy of the answers to “pass.”<br><br>Any licensed nurse or QMA that is unable to complete education due to LOA on or before 2/17/24, will be required to complete education and a post-test prior to working or administering medications to residents.<br><br>Any newly hired nurses or QMA’s will be educated on hire/return and competence validated prior to administering medications to any resident.<br><br>Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated.<br><br>Licensure verification for licensed nurses and Qualified Medication Aides was completed 02/17/24 by the Administrator/Designee.<br><br>**How the corrective actions will be monitored to ensure the deficient practice does not** | |

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| | "buzz had worn off".<br><br>-1:53 p.m., Follow Up for Med Error: Resident Q was alert and oriented and able to make needs known to staff. She had no complaints related to the medication error, her vital signs were P 66, R 16, BP 110/66 and neuro checks remained within normal limits. Resident Q was lying in bed and resting quietly.<br><br>The clinical record did not include documentation to show the resident was effectively monitored for signs and symptoms of respiratory depression, on 2/16/24 between 1:53 p.m. and 5:20 p.m.<br><br>On 2/20/24 at 3:25 P.M., RN 8 indicated there was no documentation to reveiw, becasue the resident had not been monitored on 2/16/24 between 2:00 p.m. and 4:55 p.m.<br><br>-5:20 p.m., the NP was notified Resident Q was having abnormal breath sounds and audible gurgling sounds. Orders were given to obtain a chest x-ray, administer Rocephin (antibiotic) 1 gram IM (intramuscularly) and Lasix (water pill) 40 mg IM STAT (Immediately). The NP ordered to check the resident's oxygen saturation and if hypoxic ( low blood oxygen), send the resident to the ER.<br><br>-5:22 p.m., RN 8 went to check the Resident Q's oxygen saturation and observed the resident vomit orange tinted liquid. The resident became unresponsive with no pulse or respirations, CPR was initiated, and 911 called. The family was immediately notified of the resident's condition. No Oxygen saturation was obtained.<br><br>On 2/20/24 at 11:45 A.M., Resident Q's roommate, identified as interviewable, indicated on Friday, | | **recur:**<br>An Ad-Hoc QAPI Meeting was held by the Administrator, the Interdisciplinary Team and Medical Director on 02/16/24 to review and approved the Plan of Removal and Allegation of Compliance.<br><br>The ADON/Designee will complete the Audit Tools that were created on 02/16/24 to include monitoring of medication delivery including following physician's orders, narcotic count and accuracy of count compared to actual medication daily x 2 weeks weeks, weekly x 2 weeks, and monthly x 5 months or until substantial compliance is achieved.<br><br>The DON/Designee will complete the Audit Tool "Medication Error Assessments" daily x 2 weeks, weekly x 2 weeks, and monthly x 5 months or until substantial compliance is achieved.<br><br>The DON/Designee will Complete a Medication Observation starting on 2/17/2024 Daily on with 1 random staff member on a random shift x 2 weeks, then 3 random nursing staff members on a random shift weekly x 2 weeks, then 3 random nursing staff members on a random shift monthly x 5 months or until substantial compliance is achieved. | |

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| | 2/16/24 before lunch, her roommate began spitting up and making "gagging" noises about mid-morning. After lunch, the resident continued coughing, gagging, and "gurgling". The roommate put on her call light, yelled out for staff to come in and check her roommate, but the staff did not respond.<br><br>On 2/20/24 at 1:49 P.M., CNA 2 (Certified Nurse Aid) was interviewed. The CNA had cared for Resident Q during the day on 2/16/24. She indicated Resident Q had been gotten up for breakfast in her room. Resident Q had "seemed her normal self" and hadn't recalled the resident coughing or gagging. After breakfast, the CNA was told by the nurse the resident was bringing up phlegm, but she hadn't observed it. Resident Q remained in her wheelchair, in her room for lunch. After lunch, between 1-1:30 p.m., CNA 2 and CNA 3 asked the resident if she wanted to lay down. Resident Q refused but agreed to allow the CNAs to put her in bed and change her. She was transferred to the bed and while lying in the bed, had some coughing and rattling noises. CNA 2 indicated Resident Q's arms were floppy, she couldn't lift her arms to help put her shirt on. This was a change for her. Resident Q was assisted into her wheelchair. She continued to have rattling noises. CNA 2 indicated Resident Q would inhale air, then when exhaled, she made gurgling noises and sounded like she was "drowning". CNA 2 informed the nurse of the coughing and gurgling noises. CNA 2 indicated right after the resident had been gotten up, LPN 7 told the CNAs to lay Resident Q down but hadn't been able to do so due to caring for other residents.<br><br>A written witness statement, dated 2/17/24 by CNA 3, indicated she had cared for Resident Q on 2/15/24 from 2-10 p.m. and hadn't noticed any | | The QAPI Committee will review the audit tools on a monthly basis and will determine compliance. Any concerns will have been addressed. If indicated, additional Action Plans will be recommended and/or written by the QAPI Committee. All Action Plans will be monitored weekly by the Administrator to ensure substantial compliance.<br><br>Date of Compliance: 02/17/2024 | |

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| | change in condition. Resident Q had been her usual "normal" self. On 2/16/24, she cared for Resident Q from 6 a.m. to 2 p.m. CNA 3 observed Resident Q to be very sleepy with difficulty keeping her eyes open. Resident Q had been coughing and her breathing was "rattly". This was new for the resident. CNA 3 indicated she did not notify the nurse of the change. CNA 3 was not instructed to monitor the resident during shift change.<br><br>On 2/20/24 at 2:02 P.M., RN 5 indicated, on 2/16/24, he was responsible for residents on the other hallway but had been asked by Resident Q's nurse (LPN 7) to assist her in transferring the resident into bed. He assisted the nurse to place Resident Q back into bed at approximately 1:45 p.m. He indicated the resident sounded "raspy" but hadn't heard any coughing. He was only in the room briefly and exited as soon as the resident was placed in bed.<br><br>On 2/20/24 at 2:14 P.M., CNA 4, assigned to care for Resident Q on 2/16/24 from 2-6 p.m., indicated she was informed the resident had been given a medication she wasn't prescribed. At approximately 3:30 p.m., she overheard the resident's roommate calling out for help. She went into the room; the roommate was very upset. The roommate said the resident was gagging, coughing, and having a hard time breathing. CNA 4 observed Resident Q lying in bed with her head elevated. She was awake and coughing, gagging, and bringing up phlegm. The CNA elevated the resident head of her bed until she was sitting straight up and left the room to get a basin. She returned to the room and placed the basin on her overbed table and then left the room. When questioned, she couldn't remember telling the charge nurse about the incident due to an | | | |

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| | emergency with another resident shortly after leaving the resident's room.<br><br>On 2/20/24 at 3:07 P.M., LPN 7 (Licensed Practical Nurse) indicated on 2/16/24 at 8:00 a.m., she was passing medications and accidentally gave Resident Q another resident's dose of MS Contin 30 mg. She identified the error within minutes and returned to Resident Q's room to see if she had swallowed the MS Contin. LPN 7 told the resident she had been given a pill belonging to another resident and she would closely monitor her for any ill effects. LPN 7 immediately texted the NP of the medication error. Resident Q had no allergies to MS Contin and couldn't recall ever taking the medication. LPN 7 informed the NP she would be monitoring the resident closely. The NP texted back "okay", but no further orders were given. LPN 7 called and left a message for Resident Q's emergency contact to return her call. LPN 7 indicated she monitored Resident Q's vital signs closely throughout the day and hadn't observed any changes in her condition. She indicated she used a neurological checklist form to keep a record of when vital signs were checked and had looked in on the resident frequently during the day. Resident Q's emergency contact returned LPN 7's call at 10:00 a.m. The emergency contact was told of the medication error, staff were monitoring her closely and she'd had no effects from the medication at that time. LPN 7 informed the emergency contact Resident Q had some spitting up of phlegm but indicated this had been an ongoing issue.<br><br>On 2/20/24 at 3:25 P.M., RN 8 indicated she took over for LPN 7 at 2:00 p.m. on 2/16/24. She indicated there was an emergency with another resident, and she wasn't able to see Resident Q until 4:55 p.m. RN 8 was aware of the medication | | | |

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| (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 |
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| | error involving Resident Q, RN 8 went into the room to give Resident Q's roommate her medications. Upon entering the room, she observed Resident Q lying in her bed with the head of the bed elevated and she was coughing. RN 8 went out to the medication cart to see if Resident Q had any medication for her cough. RN 8 called the NP and informed her of Resident Q's coughing. Orders were given to obtain a chest x-ray and administer 1 gram of Rocephin ( an antibiotic) IM. At 5:10 p.m., she went back into Resident Q's room to inform the resident what the NP ordered and observed Resident Q coughing with audible gurgles. RN 8 called the NP again and told her of the gurgling respirations. Orders were given to obtain a chest x-ray STAT (immediately), give the Rocephin and Lasix (diuretic) 40 mg IM STAT. The NP instructed RN 8 to check the resident's oxygen saturation level and if hypoxic (low blood oxygen), send the resident to the ER. RN 8 re-entered the room at 5:20 p.m. to obtain the resident's oxygen saturation level and observed the resident spitting up orange colored liquid. RN 8 indicated she was unable to obtain an Oxygen saturation, RN 8 called for assistance and got the crash cart (emergency resuscitation equipment). At 5:25 p.m., Resident Q's pulse and respirations ceased, CPR was started and 911 called.<br><br>On 2/21/24 at 9:40 A.M., the Nurse Practitioner indicated LPN 7 texted her on 2/16/24 around 8:00 a.m. to inform her of a medication error. The text indicated Resident Q had been given MS Contin 30 mg by mouth. The resident had no allergies to the medication and the nurse was going to monitor the resident closely. She replied "ok" in answer, but wasn't notified of any change in Resident Q's condition throughout the day. The NP indicated she hadn't ordered specific monitoring instructions because she assumed the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155150 | A. BUILDING 00<br>B. WING | 02/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| | facility had policies and procedures in place for monitoring residents following a medication error. She expected the facility would have assessed Resident Q's vital signs, respirations, mental status changes, and oxygen saturations every hour for 24 hours.<br><br>On 2/21/24 at 11:00 A.M., the Rehabilitation Director indicated Resident Q had been receiving physical therapy services with her last treatment completed on 2/16/24 prior to lunch. She indicated Resident Q's treatment had been shortened that day due to the resident being more tired and nauseated after her morning medications. The Rehabilitation Director indicated she notified LPN 7.<br><br>On 2/21/24 at 3:44 P.M., the Administrator provided a current copy of the facility's Medication Administration Guidelines. The guidelines indicated 10 guidelines for administering medications. This included giving the medication to "the right resident, the right medication, the right dose, the right time and the right route...Standards of Practice include knowing indication for medication being given, side effects of the medication and nursing implications for administering the medication...."<br><br>The Immediate Jeopardy that began on 2/16/24 was removed and the deficient practice corrected on 2/22/24 when the facility re-educated licensed nursing staff on medication administration, opioid drug overdose, and respiratory assessments but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>This tag relates to Complaint IN00428695. | | | |

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| | 3.1-48(c)(2) | | | |