| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375508 | A. BUILDING _____ B. WING _____ | 07/05/2016 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ROSE MANOR NURSING CENTER | 1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0153<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Let the resident or the resident's legal representative the right to access or purchase copies of all records.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff and family interviews, it was determined the facility failed to provide a copy of medical records when requested for one (#3) of one sampled resident whose family had requested records in the past three months.<br>The administrator (ADM) identified two additional residents who had requested medical records in the past three months resided in the facility.<br>Findings:<br>A medical records policy, revised 08/19/03, documented, .Resident Access to their Medical Record: A resident or legal representative has the right to review the medical record and to obtain copies .The resident my submit an oral or written request to review or obtain photocopies of the record .Review: Residents must have access to all their records (including medical, financial, etc. (et cetera)) upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request .Photocopies: The facility must respond to the resident's request for photocopies within 2 working days of written request. Residents are charged for photocopies. Residents or Legal Representatives are not to make copies of the record themselves. Staff will copy requested information .Prepayment for photocopies is preferred. Photocopy fees are based on the community standard and/or state statute. The community standard is based on the fee charged at the library or post office .<br>Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>No documentation of the resident's family having requested copies of their medical record was located in the resident's clinical record.<br>On 06/29/16 at 9:14 a.m., a confidential family interview was conducted for resident #3. During the interview the family stated they had sent the facility a request for their family's medical records a few weeks ago. He/She stated the facility had never sent anything back to them. He/She stated they faxed a signed request to the facility office.<br>On 07/05/16 at 10:36 a.m., the clinical director was asked if a family member/personal representative for resident #3 had requested any records from the facility. She stated the medical record had been requested by the resident's daughter.<br>At 10:40 a.m., the ADM was asked if a family member/personal representative for resident #3 had requested any records from the facility. The ADM stated the medical record had been requested from the corporate office by the resident's daughter. She stated she would have to check her e-mail to get the exact date.<br>At 10:44 a.m., the ADM returned stating the daughter had sent the request on June 16th 2016. She was asked if the family had received the records they requested. She stated she believed they had but did not know for certain. She was asked for the facility policy for when a family or representative requested medical records.<br>At 10:55 a.m. the ADM returned with the policy. She was asked who would be able to verify whether the resident's family had received a copy of the records. She provided the name for the medical records representative.<br>At 11:40 a.m., the medical records representative was interviewed and asked if the family of resident #3 had received the records they requested. She stated the copies were mailed to the resident's daughter on either Thursday, June 30th or Friday, July 1st 2016. |
| F 0157<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews, it was determined the facility failed to notify the physician when a resident experienced a change in condition for one (#3) of one sampled resident reviewed for physician notification.<br>The facility identified 81 residents resided in the facility.<br>Findings:<br>A resident's family or physician notification of change guideline, effective [DATE], documented, .Purpose - This is a guideline to know when it may be necessary to notify the resident's family or physician. The facility will inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or interested family member of the following events .An accident involving the resident, that 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. (that is) 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) .<br>Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>A comprehensive resident assessment had not been completed prior to the resident's discharge on [DATE].<br>A comprehensive care plan had not been fully developed prior to the resident's discharge on [DATE].<br>A nurse progress note, dated [DATE] at 10:45 a.m., documented, .Res (resident) resting in bed B/P (blood pressure) was taken at this time B/P was ,[DATE] RR (respiratory rate) 34 P (pulse) 57 O2 (oxygen) was 93% on 3 LPM (liters per minute) via NC (nasal cannula). Skin was warm and calmy (sic) to touch noted mottling to her feet and to her fingertips. Res was using her accessory muscles during respirations. This nurse notified hospice as well as daughter (name deleted) .<br>A nurse progress note, dated [DATE] at 11:30 a.m., documented, .Daughter (name deleted) here at bedside with Res .<br>A nurse progress note, dated [DATE] at 1:41 p.m., documented, .Res was noted to have no pulse no blood pressure and no heart rate. Hospice and family members at bedside. Hospice nurse notified funeral home as well as provider .<br>The hospice provider death summary, dated [DATE], documented, .Received a call from facility. Upon arrival CN (charge nurse) (name deleted) reports pt (patient) with low bp and diaphoretic. This nurse walked in to (sic) pt's room to perform assessment, pt's daughter and family friend at bed. Pt without vital signs or respirations. This nurse called MD (medical doctor) (name deleted) and unable to reach. MD (name deleted) called and notified of pt without vital signs or respirations .<br>No documentation of the resident having been assessed/monitored by facility nursing staff from [DATE] at 10:45 a.m. until the resident's death at 1:41 p.m. on [DATE] was located in the resident's clinical record.<br>No documentation of the physician having been notified of the resident's change in condition was located in the resident's |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0157<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>clinical record.<br>On [DATE] at 9:14 a.m., a confidential family interview was conducted for resident #3. He/She stated the day the resident died , they were called and informed the resident had experienced changes overnight. He/She stated when they arrived to the facility, the resident was guppy breathing. He/She stated they had read information about guppy breathing and mottling from the resident's prior hospice. He/She stated they removed the resident's covers and observed mottling on the resident's legs and a cut on her knee. He/She asked the nurse what had happened to the resident's knee. They stated they had no idea how the cut had happened. The family member stated the hospice provider did not arrive to the facility until after the resident had died .<br>On [DATE] at 2:14 p.m., the corporate nurse was asked to review the nurse/progress note dated [DATE] at 10:45 a.m. She was asked if there was a change in the resident's condition. She stated, It appears to be a change in condition. She stated, And, yes, the physician should have been notified. She asked if she could check the hospice notes. She reviewed the hospice records for that day and was unable to provide documentation the physician was contacted prior to the resident expiring that day. |
| F 0225<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews, it was determined the facility failed to thoroughly investigate an allegation of abuse for one (#2) of three sampled residents whose clinical records were reviewed for abuse.<br>The facility identified 81 residents resided in the facility.<br>Findings:<br>A Resident Abuse, Neglect and Misappropriation of Property policy, last revised 06/05/14, documented, The resident has the right to be free form (sic) verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion .The licensed nurse in charge should then assess the resident for evidence of harm related to the allegation .The nurse should take immediate steps to protect the resident from further incident during this time .The licensed nurse in chare (sic) of the unit shall then complete an incident report reflecting any and all findings from the assessment of the resident following the incident .A member of the administrative staff will then conduct a thorough investigation of the incident/allegation to obtain information about the incident and complete ODH-283 (Oklahoma Department of Health form) .Thorough investigations may include interviewing relevant staff, residents, families and/or other witnesses, reviewing chart information and contacting the physician .All investigation information is compiled onto the ODH-283 .<br>Resident #2 had [DIAGNOSES REDACTED].<br>A resident assessment, dated 04/30/16, documented resident #2 was usually able to make himself understood.<br>An Oklahoma State Department of Health (OSDH) incident report form, dated 05/20/16, documented an allegation abuse/mistreatment for [REDACTED]. The report documented, On 5/20/16, resident (name deleted) made an allegation of abuse against an unknown female staff member, stating She challenged me. She twisted my whole arm. Focused assessment completed, noted a nickle sized area of dark blue discoloration to the right hand between the index finger and the thumb. States, She cut me too. and pointed to the palm of his right hand. No observation of a cut or laceration to the right hand was made. Resident was also noted to have scattered petechial areas to the left hand. Resident was asked if he knew hwo (sic) the person was and hesitated, No. He was asked when the incident had occurred. Resident could not answer and then stated, Do you still work for the county? Dr. (doctor) and Family were made aware of the resident allegation. DHS (Department of Human Services) was notified. Other residents (name deleted) and (name deleted) were interviewed and assessed with [REDACTED]. Both residents denied any knowledge of anyone being mistreated or hurt by any of the female staff members .Upon completion of the investigation, the facility was unable to substantiate the allegation of abuse. The resident is often confused and requires cueing and reorientation. He can at times refuse ADL (activities of daily living) care. Interviews with the other residents yielded no further basis for the substantiation of the allegation. The facility has updated the residents(sic) plan of care to include his dementia. The facility has educated the family regarding signs and symptoms of abuse, and on the policies and procedures for reporting allegations of abuse, neglect and misappropriation .<br>The resident's clinical record was reviewed. No documentation regarding the allegations of abuse or bruising was located. No incident report was located for this incident.<br>On 06/29/16 at 12:50 p.m., the director of nursing (DON) was asked to locate an incident report or any further investigative documents for this incident. She stated, There are no further investigative papers. She stated, I did not make out an incident report. She stated, He didn't even tell the correct story. She stated, He had a little dime sized spot on his hand, but he self propels. She stated, The nurse didn't do an incident report.<br>She was asked what the policy was on incident reports. She stated, Any injuries, falls, res. (resident) to res. She stated, I did not do one on (resident's name deleted). She stated, You can quote me on that.<br>She was asked if there should have been an incident report. She stated, Yes. She stated she talked to staff, interviewed nurses, other residents, and checked his room. She was asked what staff members she interviewed regarding the allegation of abuse. She stated she would have to review the report. She reviewed the report and stated she didn't put the staff in the report.<br>At 2:20 p.m., the administrator (ADM) was asked what the policy was for investigating allegations of abuse. She stated they would interview the resident when possible, any hospice staff involved, other staff members working that area, and other residents on that hall. She stated staff would conduct as many interviews as possible to get a clear picture of the injury. She stated a head to toe assessment would also be completed for the resident involved.<br>She was asked how she determined who had been interviewed in an investigation. She stated we put initials of who we interviewed in the report. She was asked to review the OSDH report and identify if staff had been interviewed. She reviewed the report and stated she could not. She was asked if this was a thorough investigation if staff had not been interviewed. She stated, I can't say. She stated, Some of the information was omitted. She stated, The DON did not document staff interviews on there. She was asked how it would be determined a thorough investigation had been conducted if no staff members were documented on the investigative report. She stated you would have to interview the staff the DON interviewed. She was asked how you would know who she interviewed if it's not documented anywhere. She stated, You wouldn't. We don't keep any statements or anything else. |
| F 0226<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews, it was determined the facility failed to implement their abuse policy to ensure a thorough investigation of injuries of unknown origin following an allegation of abuse was conducted for one (#2) of three sampled residents whose clinical records were reviewed for abuse.<br>Findings:<br>A Resident Abuse, Neglect and Misappropriation of Property policy, last revised 06/05/14, documented, The resident has the right to be free form (sic) verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion .The licensed nurse in charge should then assess the resident for evidence of harm related to the allegation .The nurse should take immediate steps to protect the resident from further incident during this time .The licensed nurse in chare (sic) of the unit shall then complete an incident report reflecting any and all findings from the assessment of the resident following the incident .A member of the administrative staff will then conduct a thorough investigation of the incident/allegation to obtain information about the incident and complete ODH-283 (Oklahoma Department of Health form) |

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| F 0226<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>.Thorough investigations may include interviewing relevant staff, residents, families and/or other witnesses, reviewing chart information and contacting the physician .All investigation information is compiled onto the ODH-283 .<br>Resident #2 had [DIAGNOSES REDACTED].<br>A resident assessment, dated 04/30/16, documented resident #2 was usually able to make himself understood.<br>An Oklahoma State Department of Health (OSDH) incident report form, dated 05/20/16, documented an allegation abuse/mistreatment for [REDACTED]. The report documented, On 5/20/16, resident (name deleted) made an allegation of abuse against an unknown female staff member, stating She challenged me. She twisted my whole arm. Focused assessment completed, noted a nickle sized area of dark blue discoloration to the right hand between the index finger and the thumb. States, She cut me too. and pointed to the palm of his right hand. No observation of a cut or laceration to the right hand was made. Resident was also noted to have scattered petechial areas to the left hand. Resident was asked if he knew hwo (sic) the person was and hesitated, No. He was asked when the incident had occurred. Resident could not answer and then stated, Do you still work for the county? Dr. (doctor) and Family were made aware of the resident allegation. DHS (Department of Human Services) was notified. Other residents (name deleted) and (name deleted) were interviewed and assessed with [REDACTED]. Both residents denied any knowledge of anyone being mistreated or hurt by any of the female staff members .Upon completion of the investigation, the facility was unable to substantiate the allegation of abuse. The resident is often confused and requires cueing and reorientation. He can at times refuse ADL (activities of daily living) care. Interviews with the other residents yielded no further basis for the substantiation of the allegation. The facility has updated the residents(sic) plan of care to include his dementia. The facility has educated the family regarding signs and symptoms of abuse, and on the policies and procedures for reporting allegations of abuse, neglect and misappropriation .<br>The resident's clinical record was reviewed. No documentation regarding the allegations of abuse or bruising was located. No incident report was located for this incident.<br>On 06/29/16 at 12:50 p.m., the director of nursing (DON) was asked to locate an incident report or any further investigative documents for this incident. She stated, There are no further investigative papers. She stated, I did not make out an incident report. She stated, He didn't even tell the correct story. She stated, He had a little dime sized spot on his hand, but he self propels. She stated, The nurse didn't do an incident report.<br>She was asked what the policy was on incident reports. She stated, Any injuries, falls, res. (resident) to res. She stated, I did not do one on (resident's name deleted). She stated, You can quote me on that.<br>She was asked if there should have been an incident report. She stated, Yes. She stated she talked to staff, interviewed nurses, other residents, and checked his room. She was asked what staff members she interviewed regarding the allegation of abuse. She stated she would have to review the report. She reviewed the report and stated she didn't put the staff in the report.<br>At 2:20 p.m., the administrator (ADM) was asked what the policy was for investigating allegations of abuse. She stated they would interview the resident when possible, any hospice staff involved, other staff members working that area, and other residents on that hall. She stated staff would conduct as many interviews as possible to get a clear picture of the injury. She stated a head to toe assessment would also be completed for the resident involved.<br>She was asked how she determined who had been interviewed in an investigation. She stated we put initials of who we interviewed in the report. She was asked to review the OSDH report and identify if staff had been interviewed. She reviewed the report and stated she could not. She was asked if this was a thorough investigation if staff had not been interviewed. She stated, I can't say. She stated, Some of the information was omitted. She stated, The DON did not document staff interviews on there. She was asked how it would be determined a thorough investigation had been conducted if no staff members were documented on the investigative report. She stated you would have to interview the staff the DON interviewed. She was asked how you would know who she interviewed if it's not documented anywhere. She stated, You wouldn't. We don't keep any statements or anything else. |
| F 0309<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the failure of the facility to assess and monitor resident #3 following a change in condition related to level of consciousness.<br>The existence of the IJ was verified with the Oklahoma State Department of Health (OSDH).<br>At 5:35 p.m., the administrator (ADM), the director of nursing (DON) and the corporate nurse were notified of the existence of the IJ.<br>On [DATE] at 11:35 a.m., an acceptable plan of removal was received from the ADM. The plan of removal documented, 29 [DATE]<br>PLAN OF REMOVAL FOR IJ R/T (related to) Failure to Assess, Monitor, and Intervene<br>1. All licensed nursing staff will be re-educated regarding the facility policy on assessment, monitoring and intervention of a change in condition and on following physician ordered directives related to a change in condition on a case by case basis by 11:59p.m. (sic) on [DATE] or prior to to returning to work at the facility. All licensed nursing staff will further be re-educated on documenting q (every) shift for [MEDICATION NAME] (sic) patch placement and adverse reactions by 11:59p.m. (sic) on [DATE].<br>2. Residents identified as having a change in condition will be listed on communication board in PCC (Point Click Care software) along with the frequency of monitoring per facility policy or as directed by the physician.<br>3. DON and/or designee will audit nursing documentation and resident status following a significant error or change in condition daily in the Q2 (quality 2) meeting to ensure compliance.<br>(Name Deleted), Administrator.<br>On [DATE], four licensed practical nurses (LPNs) were interviewed. They were asked if they had been inserviced recently and what the inservice covered. All of the LPNs stated they had been inserviced recently about assessing, monitoring and intervening when residents had a change in condition, monitoring after a significant medication error or change in condition and physician notification.<br>The IJ was removed on [DATE] at 11:59 p.m., after all components of the plan of removal had been carried out. The deficient practice remained at a level of harm, at a pattern.<br>Based on record review and staff and family interviews, it was determined the facility failed to:<br>~ assess, monitor and intervene for a resident who experienced a change in level of consciousness following a significant medication error for one (#3) of seven sampled residents reviewed for assessing monitoring and intervening; and<br>~ assess and monitor a resident's [MEDICATION NAME] every shift for one (#1) of three sampled residents reviewed for [MEDICATION NAME]es.<br>The facility identified 81 residents resided in the facility.<br>Findings:<br>1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>A comprehensive resident assessment had not been completed prior to the resident's discharge on [DATE].<br>A comprehensive care plan had not been fully developed prior to the resident's discharge on [DATE].<br>A daily care plan, dated [DATE], documented the resident was continent, used a commode and had a [MEDICAL CONDITION] under the elimination section. It documented the resident was able to ambulate with the assistance of one staff member and required staff assistance with her wheelchair under the mobility section. It documented the resident was alert and oriented under the cognitive section.<br>A physician's orders [REDACTED].<br>A hospice physician's orders [REDACTED].D/C (discontinue) Fentany (sic) patch .[MEDICATION NAME] CR (controlled release) 12 h (hour) (MS ([MEDICATION NAME]) Contin) 30 mg (milligram) tablet take (one) tab by mouth every 12 h .<br>A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME] Extended Release 30 MG ([MEDICATION NAME] ER (extended release)) Give 1 tablet by mouth every 12 hours related to OTHER CHRONIC PAIN .<br>A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME]-100 Patch 72 Hour 100 MCG(microgram)/HR (hour) ([MEDICATION NAME]) Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with |

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F 0309

**Level of harm -** Immediate jeopardy

**Residents Affected -** Some

(continued... from page 3)
[MEDICATION NAME] 37.5 mcg to (equal) 137.5mcg. D/C when [MEDICATION NAME]. and remove per schedule .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME] Patch 72 Hour 37.5 MCG/HR Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with 100 mcg patch to (equal) 137.5mcg. May D/C when [MEDICATION NAME]. and remove per schedule .
An admission note, dated [DATE] at 1:00 p.m., documented, .Focused assessment r/t admission. Resident arrived via private vehicle with daughter accompanying her. Resident is coming from home admitted to LTC (long term care) and (hospice provider name deleted) under the care of (physician name deleted). Alert and oriented x(times)3. Wears glasses and has partial upper denture. Lungs CYS (unknown abbreviation) bilaterally. No open areas, redness noted to B/I (unknown abbreviation) buttocks and inner aspect of right foot, A & D (vitamin A and D ointment) applied. Noted with large hernia to right lower abdomen, daughter also reports hiatal hernia that is inoperable because is it (sic) to (sic) close to the heart and [MEDICAL CONDITION] to left lower abdomen. Noted with RLE (right lower extremity) ,[DATE] + (plus)[MEDICAL CONDITION]/ LLE (left
lower extremity) 1 + [MEDICAL CONDITION]. Continent of B&B (bowel and bladder). Resident is one person assist d/t (due/to) general weakness and has a hx (history) of fall 3 weeks ago per daughter. Tab (brand name) alarm and call light placed within reach. VS (vital signs) 97.5-,[DATE]-[DATE]% on RA (room air). (Physician name deleted) on call for (physician name deleted) notified of admission with order clarification to D/C [MEDICATION NAME] and start [MEDICATION NAME] mg q 12 hours
when medication arrives (per (physician name deleted) new script), DON (name deleted), pharmacy and daughter here and aware of admission.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 1:00 p.m. to [DATE] at 10:26 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:26 p.m., documented, .Focused assessment r/t admission. Res (resident) in bed A & O (alert and oriented) x3 pupils equal round reactive to light, T (temperature) 98.7 p (pulse) 71 bp (blood pressure) ,[DATE] r (respirations) 16 spo2 (peripheral capillary oxygen saturation) 96% RA (room air), lungs clear bil. (bilaterally), bs (bowel sounds) positive x 4 quads (quadrants) [MEDICAL CONDITION] to bil lower extremities. Res denies discomfort. voided x3, makes needs known, res ate 50% of supper and drank 360 cc (cubic centimeters) of fluids. res appears to be adjusting well at this time, family at bedside, call light in reach, alarm in place .
A nurse progress note, dated [DATE] at 3:45 a.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. v/s 97XXX[DATE]-,[DATE]-97% @ (at) RA. Resident resting in bed. [MEDICAL CONDITION] in
place and secure. Currently resting in bed with 0 (zero) c/o (complaints of) pain or discomfort. Call light in reach .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 3:45 a.m., to [DATE] at 2:18 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 2:18 p.m., documented, .Focused assessment r/t admission. Resident A & O x3. T97.9 p56 bp ,[DATE] r18 spo2 96% RA, lungs CTA (clear to auscultation), bowel sounds positive x 4 quads [MEDICAL CONDITION] to bil lower extremities. Resident noted with decreased LOC (level of consciousness)/slow to respond with eyes open and VS stable, and will monitor d/t change in medication and will pass on to oncoming nurse. Daughter here and aware of situation, call light in reach, alarm in place. VS 97.9-,[DATE]-,[DATE]% (sic) on RA .
A late entry nurse progress note, dated [DATE] at 2:20 p.m., documented, .Focused assessment r/t medication. (Physician name deleted) on call for (physician name deleted) notified that [MEDICATION NAME]es were not removed when [MEDICATION NAME]
started but have since been removed. Will continue to monitor .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:20 p.m. to [DATE] at 10:56 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:56 p.m., documented, .Focused assessment r/t admission. Resident A&Ox1, slow to respond, noted with increased lethargy this shift, skin color appears pale, LCTA (lungs clear to auscultation), BS active x 4, B/L (bilateral) LE (lower extremities) non-[MEDICAL CONDITION] noted, redness noted to coccyx A & D applied, redness noted to inner aspect of right foot, A & D applied, large hernia noted to right lower abdomen, [MEDICAL CONDITION] noted to left lower abdomen. Resident denies pain at this time. Daughter (name deleted) at bedside and aware of residents (sic) current condition. This nurse notified on call (physician name deleted) (on call for (physician name deleted)) of residents current condition and hospice status, received orders to notify hospice to come to facility and assess resident, no additional orders received. This nurse contacted (hospice name deleted) and informed of situation. (name deleted) LPN (licensed practical nurse) arrived to this facility @ 1900 (7 p.m.) and assessed resident, no orders received at this time, hospice nurse stated, Her vitals are stable, she is slow to respond but alert, she has no c/o pain, lets continue to monitor and call us back if any changes occur or you need anything else. Information passed on to on-coming nurse (name deleted) LPN. VS ,[DATE], T97.2, P53, R14, Spo2 97%RA .
A discontinued physician's telephone order, dated [DATE] at 3:08 p.m., documented, .[MEDICATION NAME] Patch 72 Hour 37.5 MCG/HR Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with 100 mcg
patch to (equal) 137.5mcg. May D/C when [MEDICATION NAME]. and remove per schedule .Discontinue Date / Reason .[MEDICATION
NAME] .
A discontinued physician's telephone order, dated [DATE] at 3:09 p.m., documented, .[MEDICATION NAME]-100 Patch 72 Hour 100
MCG/HR ([MEDICATION NAME]) Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN
.apply with [MEDICATION NAME] 37.5 mcg to (equal) 137.5mcg. D/C when [MEDICATION NAME]. and remove per schedule .Discontinue Date / Reason .[MEDICATION NAME] .
An admission note, dated [DATE] at 2:25 a.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. v/s 98XXX[DATE]-,[DATE]-95%@RA. Resident resting in bed. [MEDICAL CONDITION] in place
and secure. Currently resting in bed with 0 c/o pain or discomfort. Call light in reach .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:25 a.m. to [DATE] at 2:28 p.m. was located in he resident's clinical record.
A family/resident grievance form, dated [DATE], documented, .(name deleted), dtr (daughter), voices concern regarding 1) Medication Error R/T continued [MEDICATION NAME] Patch 2) change of hospice service 3) mother's condition .reported to team that her mother's cognition was not the same because she will not speak to her but in short answers. (DON name deleted) stated to Dtr that @ breakfast the resident was served by (DON name deleted) and she sat on the side of the bed and answered appropriately to any questions that were asked .She also stated she wont eat or drink for me, she just isn't the same. (DON name deleted) explained to the dtr that the incident was being investigated so that it did not occur again. Dtr stated I don't know why there was a change in her medication other than the hospice wouldn't cover it which makes me very upset because her (hospice agency prior to admission name deleted) was covering it.(quality manager staff name deleted) requested that she be able to go and see her mother to evaluate her.
Dtr (name deleted) refused and stated No, she wants to be left alone. All team members stated to daughter that she would continue to be monitored and any changes in condition would be called to the physician for further orders. Dtr (name deleted) stated, My mother is not a social person. She doesn't talk to people very often and she doesn't like to socialize. That's why I really liked (hospice agency prior to admission name deleted) and wanted to keep them because she was used to them, but I understand using (facility contracted hospice name deleted).2pm Daughter left facility. Resident alert + speaks to writer in short sentences. is watching T.V. (television) Denies any c/o distress or pain No SOB (shortness of breath) or sedation observed.(DON name deleted) .
A facility Medication Incident Report, dated [DATE], documented, .Resident (resident #3) .Physician (name deleted) Date of Incident [DATE] .Time of incident PM .What was physician's orders [REDACTED].O. (by mouth) Q (every) 12 (hour) .What was given? [MEDICATION NAME] Patch was not removed per order .Reason for Incident: Med (medication) aide gave 2 doses of [MEDICATION NAME] nurse found [MEDICATION NAME] Patch was still in place .What is the actual effect of the incident on the
resident? Increased sedation, How was the incident discovered? Resident assessment due to increased sedation .By whom? (nurse's name deleted) .When? [DATE] @ (at) 14:20 .Who notified the physician? (nurse's name deleted) .When? [DATE] @ 14:20 .What precautions can you take to prevent similar incident? Inserviced nurses/cma (certified medication aides) on [MEDICATION NAME] Patch Destruction .Administrator (name deleted) .Signature of Individual Filling Out This Report (name deleted) .Signature: Nurse Involved In Incident (name deleted) .Signature: Director of Nursing (name deleted) .Spoke with (nurse,name deleted) Stated she was under the belief that the [MEDICATION NAME] Patch was to be left on until MS came in. Explained that is why she did not remove the patch @ that time .
A facility In-Service Educational Program sheet, dated [DATE], documented, .Subject Of Discussion: [MEDICATION NAME] Patch

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F 0309

**Level of harm** - Immediate jeopardy

**Residents Affected** - Some

(continued... from page 4)
Destruction Sheet .Scope Of Meeting - Resume: All nurses and CMA are to Remove [MEDICATION NAME] Patches together and fill
out the correct Form (see attached) (symbol undetermined) is to cut/flush Patch . The form documented eleven staff signatures. The attached sheet, titled [MEDICATION NAME] PATCH COUNT/DESTRUCTION SHEET documented, PT. (patient) NAME .DR.
(doctor) .PATCH STRENGTH .RX (prescription) # .AMT. (amount) REC'D (received) .AMT. ON HAND .NURSE APPLYING PATCH .DATE
.NURSE DESTROYING PATCH .WITNESS .AMOUNT APPLIED .AMT REMAINING .
A facility In-Service Educational Program sheet, dated [DATE], documented, .Subject Of Discussion: [MEDICATION NAME] Charting .Scope Of Meeting - Resume: All residents with [MEDICATION NAME] Patch orders will have documentation each shift regarding current placement, verification that the correct amount is in place, any side effects such as increased lethargy, redness or swelling at the site. All [MEDICATION NAME] will be placed on the nurse's treatment carts in the lock box and will have the nurses perform an on shift and off shift count every shift. This is not optional . The form documented eight staff nurse signatures.
An active employee list was provided by the administrator. The list documented 16 active nurses (licensed practical nurses/registered nurses) were currently employed by the facility. The list documented 5 CMAs were currently employed by the facility.
A nurse progress note, dated [DATE] at 2:28 p.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. VS 97XXX[DATE]-,[DATE]-95%@RA. Resident resting in bed. [MEDICAL CONDITION] in place
and secure. Denies any c/o pain or discomfort. Call light within reach. Resident still remains slow to respond but more alert and talkative at this time .
A nurse progress note, dated [DATE] at 7:38 p.m., documented, .Focus assessment r/t admission to LTC. Resident resting in bed most of this shift, A&Ox1, slow to respond. [MEDICAL CONDITION] in place and secure. Resident denies pain or discomfort at this time. call light with in reach. VS ,[DATE], T97.3, P59, R15, Spo2 96%RA .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME]-50 Patch 72 Hour 50 MCG/HR ([MEDICATION NAME])
Apply 1 patch [MEDICATION NAME] one time a day related to OTHER CHRONIC PAIN .and remove per schedule .
A [MEDICATION NAME] count/destruction sheet, dated [DATE], documented a nurse applied a 50 MCG/HR patch and destroyed a [MEDICATION NAME] which was signed as witnessed by another staff member. It documented one patch was applied and the amount
remaining was four.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 7:38 p.m. to [DATE] at 2:23 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 2:23 p.m., documented, .Focus assessment r/t admission to LTC. Resident resting in bed most of this shift, A&Ox1, slow to respond. [MEDICAL CONDITION] in place and secure. Resident denies pain or discomfort at this time. Restarted on [MEDICATION NAME] his (sic) shift, no s/s (signs/symptoms) adverse reaction noted at this tome (sic). Daughter (name deleted) spoken to and made aware of resident decreased po (by mouth) intake and requiring more assistance. (hospice name deleted) nurse here to see resident and new orders received for PRN (as needed) tylenol, daughter (name deleted) notified. Call light within reach. VS ,[DATE], T97.4, P60, R18, Spo2 94%RA .
No documentation of the events surrounding the resident having been placed back on the [MEDICATION NAME] was located in the resident's clinical record.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:23 p.m. to [DATE] at 10:45 a.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:45 a.m., documented, .Res resting in bed B/P was taken at this time B/P was ,[DATE] RR (respiratory rate) 34 P 57 O2 (oxygen) was 93% on 3 LPM (liters per minute) via NC (nasal cannula). Skin was warm and calmy (sic) to touch noted mottling to her feet and to her fingertips. Res was using her accessory muscles during respirations. This nurse notified hospice as well as daughter (name deleted) .
A nurse progress note, dated [DATE] at 11:30 a.m., documented, .Daughter (name deleted) here at bedside with Res .
A nurse progress note, dated [DATE] at 1:41 p.m., documented, .Res was noted to have no pulse no blood pressure and no heart rate. Hospice and family members at bedside. Hospice nurse notified funeral home as well as provider .
The hospice provider death summary, dated [DATE], documented, .Received a call from facility. Upon arrival CN(charge nurse) (name deleted) reports pt (patient) with low bp and diaphoretic. This nurse walked in to (sic) pt's room to perform assessment, pt's daughter and family friend at bed. Pt without vital signs or respirations. This nurse called MD (medical doctor) (name deleted) and unable to reach. MD (name deleted) called and notified of pt without vital signs or respirations .
No documentation of the resident having been assessed/monitored by facility nursing staff from [DATE] at 10:45 a.m. until the resident's death at 1:41 p.m. on [DATE] was located in the resident's clinical record.
A [DATE] treatment administration record (TAR) documented a [MEDICATION NAME]-50 Patch 72 hour MCG/HR ([MEDICATION NAME])
was applied to the resident on [DATE] at 9:00 a.m. and was removed on [DATE] at 11:09 a.m.
A [DATE] Medication Administration Record [REDACTED].
It documented the resident received one 4 mg tablet of [MEDICATION NAME] at 10:45 p.m on [DATE], at 11:26 a.m. on [DATE] and
at 3:09 a.m. on [DATE]. The reason the medication was administered was not documented.
No documentation was located in the resident's clinical record to explain the reason the resident was given their as needed [MEDICATION NAME], and whether the resident was experiencing nausea or vomiting or both.
The [DATE] meal percentage report, documented on [DATE] the resident consumed 51% - 75% of her lunch and 26% - 50% of her dinner meal. On [DATE] the resident consumed 51% - 75% of her breakfast, lunch and dinner meals. On [DATE] the resident consumed 0 - 25% of her breakfast and dinner meals and consumed 0 - 25% of a meal replacement. She refused her lunch meal. On [DATE] the resident refused her breakfast meal. She consumed 26% - 50% of her lunch meal and 26% - 50% of a meal replacement. She consumed 0 - 25% of her dinner meal and 0 - 25% of a meal replacement. On [DATE] the resident refused her breakfast and lunch meal. She consumed 0 - 25% of her dinner meal and 0 - 25% of a meal replacement. On [DATE] the resident refused breakfast.
On [DATE] at 8:50 a.m., while the survey team was conducting an environmental tour of the facility, the DON asked to speak in private to a survey team member. She stated she knew why the survey team was there and knew what it was about. She stated resident #3 was on a [MEDICATION NAME]/[MEDICATION NAME] when she admitted to the facility. She stated she believed
the facility staff discontinued the patches and started the resident on [MEDICATION NAME] she believed that Saturday.
She stated she believed the first dose of [MEDICATION NAME] was given Saturday night and another dose was given the following morning. She stated that was when the nurse discovered the [MEDICATION NAME]es were still on. She stated the resident was lethargic. She stated the resident's doctor was notified. She stated the staff were performing frequent checks on the resident. She stated when the hospice came out to the facility, they took the resident off of the [MEDICATION NAME]es and started the [MEDICATION NAME]. She stated she was unsure of why. The DON stated she conducted an investigation
related to the medication error. She stated the nurse thought hospice wrote to discontinue the patch when the [MEDICATION NAME] came in. However the order was not followed.
The DON stated she completed an inservice. She stated the facility was watching all three residents on [MEDICATION NAME]es and checked the patches every shift on a daily basis. She stated the facility also moved the [MEDICATION NAME]es from the medication carts to the treatment carts in order for the nurses to complete the monitoring. She stated the resident's daughter reported the resident was nonresponsive. She stated the resident spoke to staff.
She stated the resident was upset the daughter put her in a nursing home. She stated the resident wouldn't eat, so the facility ordered supplements. She stated several days later the resident was speaking to the facility staff. She stated hospice had provided care to the resident. She stated the resident steadily declined several days after this. (No documentation was located in the resident's clinical record to reflect this.) She stated the facility completed a medication error and notified the physician about the patch having not been removed.
At 9:14 a.m., a confidential family interview was conducted for resident #3. The family member was asked to describe the events surrounding their family members stay at the facility. He/She stated the family member was admitted to the facility because they required around the clock nursing care at home which was expensive. He/She stated the hospice provider whom the facility staff told them they had to use stated they would not cover the [MEDICATION NAME]/[MEDICATION NAME]es which
his/her family member was on at home. They stated the hospice provider they had at home did cover the patches.
They stated they had taken their loved one to their primary care physician and obtained a hard script for the [MEDICATION NAME] pills. They stated when their loved one was admitted to the facility they had two [MEDICATION NAME]/ [MEDICATION

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| F 0309<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 5)<br>NAME]es on which had been placed the day prior to admission. He/She stated the admitting nurse was aware the resident had two [MEDICATION NAME]es in place on admission. He/She stated the admitting nurse stated they would confirm the physician's orders [REDACTED]. He/She stated the only reason the medication was changed from [MEDICATION NAME]es to the [MEDICATION<br>NAME] pills was because the hospice would not cover the patches and it would have cost over $600 per month.<br>He/She stated they believed that was what killed their loved one. They stated when they arrived at the facility the next morning, their loved one was lying on their back in bed choking on vomit and out of it. They stated when they asked what was wrong with their loved one the staff stated it could have been a result of transitioning to the nursing home. He/She stated they asked the nurse, Did you take those patches off? He/She stated the nurse never answered them. He/She stated then the nurse said they had removed the patches. The family asked when. The staff stated to the family they had just removed the patches and they were in the nurses' pocket. He/She stated they had told the nurse the resident was overdosed. He/She stated they were never able to have a conversation with the named resident again. They stated when the resident came into the facility she could verbalize her needs and even sign her own checks. He/She stated it all changed when the facility overdosed the resident. He/She stated, They pushed her over the edge.<br>He/She stated the resident's physician who had been treating her for her blood disorder (her hospice diagnosis) , had stated the normal aging process would kill the resident before the disease process would. He/She stated it was around the following Monday the DON, ADM and a third person came in and assured him/her they were conducting an investigation related to the medication error. He/She asked them not to speak in front of the resident because it would upset them. He/She stated they all went into the hall. The family member pointed out the nurse who made the medication error and informed the staff the nurse never notified hospice on her shift. He/She stated the facility had never followed up with them on the findings of the investigation. He/She stated the facility admitted they overdosed her. He/She stated the day the resident died , they were called and informed the resident had experienced changes overnight.<br>He/She stated when they arrived to the facility, the resident was guppy breathing. He/She stated they had read information about guppy breathing and mottling from the resident's prior hospice. He/She stated they removed the resident's covers and observed mottling on the resident's legs and a cut on her knee. He/She asked the nurse what had happened to the resident's knee. They stated they had no idea how the cut had happened. The family member stated the hospice provider did not arrive to the facility until after the resident had died . They stated when the resident was followed by a local hospice at home, the family could call them and they would be right out. They stated the hospice provider the facility used was located in Oklahoma City. The family member stated resident #3 had always said putting her in the nursing home was like Taking her to the pound. The family member stated, It's the worst mistake I ever made.<br>At 12:26 p.m., the DON was asked for all documentation related to the monitoring for oversedation for resident #3 following the medication error.<br>At 12:35 p.m., the DON stated she reviewed the notes. She stated the monitoring was in the progress note/nurse notes. She was asked to review the note on [DATE] at 2:18 p.m. which documented the resident had a decrease in level of consciousness, was slow to respond, would continue to monitor due to change in medication and would pass on to oncoming nurse. She was asked to review the late note on [DATE] at 2:20 p.m. which documented the physician was notified of the [MEDICATION NAME]es not being removed when the [MEDICATION NAME] was started, would continue to monitor. She was asked to review the next note which was completed at 10:56 p.m. She was asked if any monitoring related to the oversedation occurred between these notes. She stated no. The next note was in eight hours. She stated the staff probably charted every shift.<br>At 1:10 p.m., the DON returned and began to explain resident #3's [MEDICATION NAME] was later restarted and the resident's [MEDICATION NAME] was discontinued. She stated the resident's decline was not from the [MEDICATION NAME]. She stated the<br>resident was started back on a [MEDICATION NAME] because the resident's daughter did not want the [MEDICATION NAME] and<br>wanted the resident put back on the [MEDICATION NAME]. The DON stated the resident's daughter stated the facility hospice provider would not cover the [MEDICATION NAME]. The DON stated it did not make sense why hospice wouldn't cover the [MEDICATION NAME].<br>She was asked if resident #3 was involved in a medication error involving the [MEDICATION NAME]es. She stated yes the [MEDICATION NAME] was left on and yes the resident did have increased lethargy. The DON was shown the facility progress/nurse notes where the resident admitted to the facility alert and oriented x 3 and after the medication error occurred, the resident's level of consciousness was alert and oriented x 1. She was shown where the documentation never reflected the resident's level of consciousness returned to her baseline after the medication error occurred. She stated the fact was the increased lethargy was because the resident had the [MEDICATION NAME] and the [MEDICATION NAME] together.<br>The DON stated she had went in with the resident every morning and took her her breakfast. She stated the resident was eating after the medication error had occurred. She stated the resident did not really speak with people much.<br>At 1:45 p.m., LPN #1 was interviewed. The corporate nurse and the ADM were present during the interview. LPN #1 was asked to describe the events surrounding the placement of the [MEDICATION NAME] 50 MCG/HR patch on [DATE] where the TAR documented<br>the patch had been applied at 9:00 a.m. and removed at 11:09 a.m. She reviewed the TAR and stated she did apply the patch at 9:00 a.m. She stated she did not remember removing the patch that day. She stated she had to clarify the order and she believed when the order was clarified, the system put the patch was removed because a new order was generated. She was asked if the resident was admitted to the facility with [MEDICATION NAME]es on. She stated, She did 100 and 37.5. She stated the resident's daughter had brought in hard scripts from the physician for both [MEDICATION NAME] and [MEDICATION NAME]. LPN #1 stated she did not believe the physician wanted the resident on both medications. She stated she called and clarified with the physician the order was to discontinue the [MEDICATION NAME]es and start the [MEDICATION NAME] when it<br>came in.<br>LPN #1 was asked if she was present when the [MEDICATION NAME] arrived at the facility. She stated, No. She was asked to explain the events surrounding the [MEDICATION NAME] 50 MCG/HR |

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| F 0333<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Make sure that residents are safe from serious medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the failure of the facility to ensure residents were free of significant medication errors for resident #3 following a physician's orders [REDACTED].<br>The existence of the IJ was verified with the Oklahoma State Department of Health (OSDH).<br>At 5:35 p.m., the administrator (ADM), the director of nursing (DON) and the corporate nurse were notified of the existence of the IJ.<br>On [DATE] at 12:10 p.m., an acceptable plan of removal was received from the ADM. The plan of removal documented,<br>29 [DATE]<br>PLAN OF REMOVAL FOR IJ R/T (related to) SIGNIFICANT MED (MEDICATION) ERROR<br>1. All licensed nursing staff will be re-educated on removal of durageic (sic) patches per facility policy and on the facility policy for documentation following significant medication errors by 11:59 p.m. on [DATE] or prior to returning to work at the facility.<br>2. All CMAs (certified medication aides) were re-educated on [DATE] by 10:50a.m. (sic) regarding immediately notifying charge nurse of any medication errors. One CMA was unavailable and will be inserviced prior to returning to work at the facility.<br>3. All residents currently in the facility who have prescriptions for durageic (sic) patches will be assessed for signs of adverse effects and patches (sic) placement by a licensed nurse by 11:59p.m. (sic) on [DATE].<br>4. DON and/or designee will audit removal/destruction log daily in Q2 (quality 2) meeting for compliance related to facility compliance.<br>(Name Deleted), Administrator<br>On [DATE], four licensed practical nurses (LPNs) were interviewed. They were asked if they had been inserviced recently and what the inservice covered. All of the LPNs stated they had been inserviced recently about [MEDICATION NAME] documentation, monitoring after a significant medication error or change in condition and physician notification. Two CMAs were interviewed. They were asked if they had been recently inserviced and what the inservice covered. Both of the CMAs stated they had been inserviced recently about reporting significant medication errors to a charge nurse.<br>The IJ was removed on [DATE] at 10:45 a.m., after all components of the plan of removal had been carried out. The deficient practice remained at a level of harm, at a pattern.<br>Based on record review and staff and family interviews, it was determined the facility failed to ensure a [MEDICATION |

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F 0333

**Level of harm -** Immediate jeopardy

**Residents Affected -** Few

(continued... from page 6)
NAME]/[MEDICATION NAME] was removed as ordered prior to the administration of two doses of [MEDICATION NAME] which resulted
in a significant medication error for one (#3) of seven sampled residents reviewed for signifiant mediction errors.
The facility identified three residents resided in the facility with orders for [MEDICATION NAME]/[MEDICATION NAME]es.
The facilitily identified three residents with orders for [MEDICATION NAME].
The facility identified resident #3 as the only resident who had experienced a significant medication eror within the past three months.
Findings:
A medication error an adverse drug reaction reporting policy, revised [DATE], documented, .MISCELLANEOUS SPECIAL SITUATIONS
2. Medication Error and Adverse Drug Reaction Reporting
Policy .Significant medication errors and adverse drug reactions are assessed, documented and reported as appropriate to the resident's attending physician, the Quality Assessment and Assurance Committee, the pharmacy and Food and Drug Administration MedWatch Program.
Definitions .Adverse Dug Reaction: An undesirable or unintended harmful effect occurring as a result of a medication; an allergic reaction in a patient with no documented history of allergy to the medication.
Significant .Medication errors and adverse drug reactions that .require discontinuing a medication or modifying the dose .result in cognitive deterioration or impairment are life threatening result in death
Procedures .In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to protect the resident's safety and welfare .The physician's orders [REDACTED].The incident is described on the shift change report to alert staff of the need to monitor the resident .The following information is documented in the resident's medical record and on the incident report: .Resident's condition for 24 or 72 hours or as directed .The consultant pharmacist reviews all medication error reports .
1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
A comprehensive resident assessment had not been completed prior to the resident's discharge on [DATE].
A comprehensive care plan had not been fully developed prior to the resident's discharge on [DATE].
A daily care plan, dated [DATE], documented the resident was continent, used a commode and had a [MEDICAL CONDITION] under
the elimination section. It documented the resident was able to ambulate with the assistance of one staff member and required staff assistance with her wheelchair under the mobility section. It documented the resident was alert and oriented under the cognitive section.
A physician's orders [REDACTED].
A hospice physician's orders [REDACTED].D/C (discontinue) Fentany (sic) patch .[MEDICATION NAME] CR (controlled release) 12
h (hour) (MS ([MEDICATION NAME]) Contin) 30 mg (milligram) tablet take (one) tab by mouth every 12 h .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME] Extended Release 30 MG ([MEDICATION NAME] ER
(extended release)) Give 1 tablet by mouth every 12 hours related to OTHER CHRONIC PAIN .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME]-100 Patch 72 Hour 100 MCG(microgram)/HR (hour)
([MEDICATION NAME]) Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with
[MEDICATION NAME] 37.5 mcg to (equal) 137.5mcg. D/C when [MEDICATION NAME]. and remove per schedule .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME] Patch 72 Hour 37.5 MCG/HR Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with 100 mcg patch to (equal) 137.5mcg. May D/C when [MEDICATION NAME]. and remove per schedule .
An admission note, dated [DATE] at 1:00 p.m., documented, .Focused assessment r/t admission. Resident arrived via private vehicle with daughter accompanying her. Resident is coming from home admitted to LTC (long term care) and (hospice provider name deleted) under the care of (physician name deleted). Alert and oriented x(times)3. Wears glasses and has partial upper denture. Lungs CYS (unknown abbreviation) bilaterally. No open areas, redness noted to B/I (unknown abbreviation) buttocks and inner aspect of right foot, A & D (vitamin A and D ointment) applied. Noted with large hernia to right lower abdomen, daughter also reports hiatal hernia that is inoperable because is it (sic) to (sic) close to the heart and [MEDICAL CONDITION] to left lower abdomen. Noted with RLE (right lower extremity) ,[DATE] + (plus)[MEDICAL CONDITION]/ LLE (left
lower extremity) 1 + [MEDICAL CONDITION]. Continent of B&B (bowel and bladder). Resident is one person assist d/t (due/to) general weakness and has a hx (history) of fall 3 weeks ago per daughter. Tab (brand name) alarm and call light placed within reach. VS (vital signs) 97.5-,[DATE]-[DATE]% on RA (room air). (Physician name deleted) on call for (physician name deleted) notified of admission with order clarification to D/C [MEDICATION NAME] and start [MEDICATION NAME] mg q 12 hours
when medication arrives (per (physician name deleted) new script), DON (name deleted), pharmacy and daughter here and aware of admission.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 1:00 p.m. to [DATE] at 10:26 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:26 p.m., documented, .Focused assessment r/t admission. Res (resident) in bed A & O (alert and oriented) x3 pupils equal round reactive to light, T (temperature) 98.7 p (pulse) 71 bp (blood pressure) ,[DATE] r (respirations) 16 spo2 (peripheral capillary oxygen saturation) 96% RA (room air), lungs clear bil. (bilaterally), bs (bowel sounds) positive x 4 quads (quadrants) [MEDICAL CONDITION] to bil lower extremities. Res denies discomfort. voided x3, makes needs known, res ate 50% of supper and drank 360 cc (cubic centimeters) of fluids. res appears to be adjusting well at this time, family at bedside, call light in reach, alarm in place .
A nurse progress note, dated [DATE] at 3:45 a.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. v/s 97XXX[DATE]-,[DATE]-97% @ (at) RA. Resident resting in bed. [MEDICAL CONDITION] in
place and secure. Currently resting in bed with 0 (zero) c/o (complaints of) pain or discomfort. Call light in reach .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 3:45 a.m., to [DATE] at 2:18 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 2:18 p.m., documented, .Focused assessment r/t admission. Resident A & O x3. T97.9 p56 bp ,[DATE] r18 spo2 96% RA, lungs CTA (clear to auscultation), bowel sounds positive x 4 quads [MEDICAL CONDITION] to bil lower extremities. Resident noted with decreased LOC (level of consciousness)/slow to respond with eyes open and VS stable, and will monitor d/t change in medication and will pass on to oncoming nurse. Daughter here and aware of situation, call light in reach, alarm in place. VS 97.9-,[DATE]-,[DATE]% (sic) on RA .
A late entry nurse progress note, dated [DATE] at 2:20 p.m., documented, .Focused assessment r/t medication. (Physician name deleted) on call for (physician name deleted) notified that [MEDICATION NAME]es were not removed when [MEDICATION NAME]
started but have since been removed. Will continue to monitor .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:20 p.m. to [DATE] at 10:56 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:56 p.m., documented, .Focused assessment r/t admission. Resident A&Ox1, slow to respond, noted with increased lethargy this shift, skin color appears pale, LCTA (lungs clear to auscultation), BS active x 4, B/L (bilateral) LE (lower extremities) non-[MEDICAL CONDITION] noted, redness noted to coccyx A & D applied, redness noted to inner aspect of right foot, A & D applied, large hernia noted to right lower abdomen, [MEDICAL CONDITION] noted to left lower abdomen. Resident denies pain at this time. Daughter (name deleted) at bedside and aware of residents (sic) current condition. This nurse notified on call (physician name deleted) (on call for (physician name deleted)) of residents current condition and hospice status, received orders to notify hospice to come to facility and assess resident, no additional orders received. This nurse contacted (hospice name deleted) and informed of situation. (name deleted) LPN (licensed practical nurse) arrived to this facility @ 1900 (7 p.m.) and assessed resident, no orders received at this time, hospice nurse stated, Her vitals are stable, she is slow to respond but alert, she has no c/o pain, lets continue to monitor and call us back if any changes occur or you need anything else. Information passed on to on-coming nurse (name deleted) LPN. VS ,[DATE], T97.2, P53, R14, Spo2 97%RA .
A discontinued physician's telephone order, dated [DATE] at 3:08 p.m., documented, .[MEDICATION NAME] Patch 72 Hour 37.5 MCG/HR Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN .apply with 100 mcg
patch to (equal) 137.5mcg. May D/C when [MEDICATION NAME]. and remove per schedule .Discontinue Date / Reason .[MEDICATION
NAME] .
A discontinued physician's telephone order, dated [DATE] at 3:09 p.m., documented, .[MEDICATION NAME]-100 Patch 72 Hour 100
MCG/HR ([MEDICATION NAME]) Apply 1 patch [MEDICATION NAME] one time a day every 3 day(s) related to OTHER CHRONIC PAIN

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|---|---|---|---|
| | **375508** | A. BUILDING _____ B. WING _____ | **07/05/2016** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ROSE MANOR NURSING CENTER** | **1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0333

**Level of harm -** Immediate jeopardy

**Residents Affected -** Few

(continued... from page 7)
.apply with [MEDICATION NAME] 37.5 mcg to (equal) 137.5mcg. D/C when [MEDICATION NAME]. and remove per schedule .Discontinue Date / Reason .[MEDICATION NAME] .
An admission note, dated [DATE] at 2:25 a.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. v/s 98XXX[DATE]-,[DATE]-95%@RA. Resident resting in bed. [MEDICAL CONDITION] in place
and secure. Currently resting in bed with 0 c/o pain or discomfort. Call light in reach .
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:25 a.m. to [DATE] at 2:28 p.m. was located in he resident's clinical record.
A family/resident grievance form, dated [DATE], documented, .(name deleted), dtr (daughter), voices concern regarding 1) Medication Error R/T continued [MEDICATION NAME] Patch 2) change of hospice service 3) mother's condition .reported to team that her mother's cognition was not the same because she will not speak to her but in short answers. (DON name deleted) stated to Dtr that @ breakfast the resident was served by (DON name deleted) and she sat on the side of the bed and answered appropriately to any questions that were asked .She also stated she wont eat or drink for me, she just isn't the same. (DON name deleted) explained to the dtr that the incident was being investigated so that it did not occur again. Dtr stated I don't know why there was a change in her medication other than the hospice wouldn't cover it which makes me very upset because her (hospice agency prior to admission name deleted) was covering it.(quality manager staff name deleted) requested that she be able to go and see her mother to evaluate her.
Dtr (name deleted) refused and stated No, she wants to be left alone. All team members stated to daughter that she would continue to be monitored and any changes in condition would be called to the physician for further orders. Dtr (name deleted) stated, My mother is not a social person. She doesn't talk to people very often and she doesn't like to socialize. That's why I really liked (hospice agency prior to admission name deleted) and wanted to keep them because she was used to them, but I understand using (facility contracted hospice name deleted).2pm Daughter left facility. Resident alert + speaks to writer in short sentences. is watching T.V. (television) Denies any c/o distress or pain No SOB (shortness of breath) or sedation observed.(DON name deleted) .
A facility Medication Incident Report, dated [DATE], documented, .Resident (resident #3) .Physician (name deleted) Date of Incident [DATE] .Time of incident PM .What was physician's orders [REDACTED].O. (by mouth) Q (every) 12 (hour) .What was given? [MEDICATION NAME] Patch was not removed per order .Reason for Incident: Med (medication) aide gave 2 doses of [MEDICATION NAME] nurse found [MEDICATION NAME] Patch was still in place .What is the actual effect of the incident on the
resident? Increased sedation, How was the incident discovered? Resident assessment due to increased sedation .By whom? (nurse's name deleted) .When? [DATE] @ (at) 14:20 .Who notified the physician? (nurse's name deleted) .When? [DATE] @ 14:20 .What precautions can you take to prevent similar incident? Inserviced nurses/cma (certified medication aides) on [MEDICATION NAME] Patch Destruction .Administrator (name deleted) .Signature of Individual Filling Out This Report (name deleted) .Signature: Nurse Involved In Incident (name deleted) .Signature: Director of Nursing (name deleted) .Spoke with (nurse,name deleted) Stated she was under the belief that the [MEDICATION NAME] Patch was to be left on until MS came in. Explained that is why she did not remove the patch @ that time .
A facility In-Service Educational Program sheet, dated [DATE], documented, .Subject Of Discussion: [MEDICATION NAME] Patch Destruction Sheet .Scope Of Meeting - Resume: All nurses and CMA are to Remove [MEDICATION NAME] Patches together and fill
out the correct Form (see attached) (symbol undetermined) is to cut/flush Patch . The form documented eleven staff signatures. The attached sheet, titled [MEDICATION NAME] PATCH COUNT/DESTRUCTION SHEET documented, PT. (patient) NAME .DR.
(doctor) .PATCH STRENGTH .RX (prescription) # .AMT. (amount) REC'D (received) .AMT. ON HAND .NURSE APPLYING PATCH .DATE
.NURSE DESTROYING PATCH .WITNESS .AMOUNT APPLIED .AMT REMAINING .
A facility In-Service Educational Program sheet, dated [DATE], documented, .Subject Of Discussion: [MEDICATION NAME] Charting .Scope Of Meeting - Resume: All residents with [MEDICATION NAME] Patch orders will have documentation each shift regarding current placement, verification that the correct amount is in place, any side effects such as increased lethargy, redness or swelling at the site. All [MEDICATION NAME] will be placed on the nurse's treatment carts in the lock box and will have the nurses perform an on shift and off shift count every shift. This is not optional . The form documented eight staff nurse signatures.
An active employee list was provided by the administrator. The list documented 16 active nurses (licensed practical nurses/registered nurses) were currently employed by the facility. The list documented 5 CMAs were currently employed by the facility.
A nurse progress note, dated [DATE] at 2:28 p.m., documented, .Focused assessment r/t admission. Resident continues with monitoring r/t new admission to LTC. VS 97XXX[DATE]-,[DATE]-95%@RA. Resident resting in bed. [MEDICAL CONDITION] in place
and secure. Denies any c/o pain or discomfort. Call light within reach. Resident still remains slow to respond but more alert and talkative at this time .
A nurse progress note, dated [DATE] at 7:38 p.m., documented, .Focus assessment r/t admission to LTC. Resident resting in bed most of this shift, A&Ox1, slow to respond. [MEDICAL CONDITION] in place and secure. Resident denies pain or discomfort at this time. call light with in reach. VS ,[DATE], T97.3, P59, R15, Spo2 96%RA .
A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME]-50 Patch 72 Hour 50 MCG/HR ([MEDICATION NAME])
Apply 1 patch [MEDICATION NAME] one time a day related to OTHER CHRONIC PAIN .and remove per schedule .
A [MEDICATION NAME] count/destruction sheet, dated [DATE], documented a nurse applied a 50 MCG/HR patch and destroyed a [MEDICATION NAME] which was signed as witnessed by another staff member. It documented one patch was applied and the amount
remaining was four.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 7:38 p.m. to [DATE] at 2:23 p.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 2:23 p.m., documented, .Focus assessment r/t admission to LTC. Resident resting in bed most of this shift, A&Ox1, slow to respond. [MEDICAL CONDITION] in place and secure. Resident denies pain or discomfort at this time. Restarted on [MEDICATION NAME] his (sic) shift, no s/s (signs/symptoms) adverse reaction noted at this tome (sic). Daughter (name deleted) spoken to and made aware of resident decreased po (by mouth) intake and requiring more assistance. (hospice name deleted) nurse here to see resident and new orders received for PRN (as needed) tylenol, daughter (name deleted) notified. Call light within reach. VS ,[DATE], T97.4, P60, R18, Spo2 94%RA .
No documentation of the events surrounding the resident having been placed back on the [MEDICATION NAME] was located in the resident's clinical record.
No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 2:23 p.m. to [DATE] at 10:45 a.m. was located in the resident's clinical record.
A nurse progress note, dated [DATE] at 10:45 a.m., documented, .Res resting in bed B/P was taken at this time B/P was ,[DATE] RR (respiratory rate) 34 P 57 O2 (oxygen) was 93% on 3 LPM (liters per minute) via NC (nasal cannula). Skin was warm and calmy (sic) to touch noted mottling to her feet and to her fingertips. Res was using her accessory muscles during respirations. This nurse notified hospice as well as daughter (name deleted) .
A nurse progress note, dated [DATE] at 11:30 a.m., documented, .Daughter (name deleted) here at bedside with Res .
A nurse progress note, dated [DATE] at 1:41 p.m., documented, .Res was noted to have no pulse no blood pressure and no heart rate. Hospice and family members at bedside. Hospice nurse notified funeral home as well as provider .
The hospice provider death summary, dated [DATE], documented, .Received a call from facility. Upon arrival CN(charge nurse) (name deleted) reports pt (patient) with low bp and diaphoretic. This nurse walked in to (sic) pt's room to perform assessment, pt's daughter and family friend at bed. Pt without vital signs or respirations. This nurse called MD (medical doctor) (name deleted) and unable to reach. MD (name deleted) called and notified of pt without vital signs or respirations
.
No documentation of the resident having been assessed/monitored by facility nursing staff from [DATE] at 10:45 a.m. until the resident's death at 1:41 p.m. on [DATE] was located in the resident's clinical record.
A [DATE] treatment administration record (TAR) documented a [MEDICATION NAME]-50 Patch 72 hour MCG/HR ([MEDICATION NAME])
was applied to the resident on [DATE] at 9:00 a.m. and was removed on [DATE] at 11:09 a.m.
A [DATE] Medication Administration Record [REDACTED].
It documented the resident received one 4 mg tablet of [MEDICATION NAME] at 10:45 p.m on [DATE], at 11:26 a.m. on [DATE] and
at 3:09 a.m. on [DATE]. The reason the medication was administered was not documented.
No documentation was located in the resident's clinical record to explain the reason the resident was given their as needed

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|---|---|
| F 0333<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 8)<br>[MEDICATION NAME], and whether the resident was experiencing nausea or vomiting or both.<br>The [DATE] meal percentage report, documented on [DATE] the resident consumed 51% - 75% of her lunch and 26% - 50% of her dinner meal. On [DATE] the resident consumed 51% - 75% of her breakfast, lunch and dinner meals. On [DATE] the resident consumed 0 - 25% of her breakfast and dinner meals and consumed 0 - 25% of a meal replacement. She refused her lunch meal. On [DATE] the resident refused her breakfast meal. She consumed 26% - 50% of her lunch meal and 26% - 50% of a meal replacement. She consumed 0 - 25% of her dinner meal and 0 - 25% of a meal replacement. On [DATE] the resident refused her breakfast and lunch meal. She consumed 0 - 25% of her dinner meal and 0 - 25% of a meal replacement. On [DATE] the resident refused breakfast.<br>On [DATE] at 8:50 a.m., while the survey team was conducting an environmental tour of the facility, the DON asked to speak in private to a survey team member. She stated she knew why the survey team was there and knew what it was about. She stated resident #3 was on a [MEDICATION NAME]/[MEDICATION NAME] when she admitted to the facility. She stated she believed<br>the facility staff discontinued the patches and started the resident on [MEDICATION NAME] she believed that Saturday.<br>She stated she believed the first dose of [MEDICATION NAME] was given Saturday night and another dose was given the following morning. She stated that was when the nurse discovered the [MEDICATION NAME]es were still on. She stated the resident was lethargic. She stated the resident's doctor was notified. She stated the staff were performing frequent checks on the resident. She stated when the hospice came out to the facility, they took the resident off of the [MEDICATION NAME]es and started the [MEDICATION NAME]. She stated she was unsure of why. The DON stated she conducted an investigation<br>related to the medication error. She stated the nurse thought hospice wrote to discontinue the patch when the [MEDICATION NAME] came in. However the order was not followed.<br>The DON stated she completed an inservice. She stated the facility was watching all three residents on [MEDICATION NAME]es and checked the patches every shift on a daily basis. She stated the facility also moved the [MEDICATION NAME]es from the medication carts to the treatment carts in order for the nurses to complete the monitoring. She stated the resident's daughter reported the resident was nonresponsive. She stated the resident spoke to staff.<br>She stated the resident was upset the daughter put her in a nursing home. She stated the resident wouldn't eat, so the facility ordered supplements. She stated several days later the resident was speaking to the facility staff. She stated hospice had provided care to the resident. She stated the resident steadily declined several days after this. (No documentation was located in the resident's clinical record to reflect this.) She stated the facility completed a medication error and notified the physician about the patch having not been removed.<br>At 9:14 a.m., a confidential family interview was conducted for resident #3. The family member was asked to describe the events surrounding their family members stay at the facility. He/She stated the family member was admitted to the facility because they required around the clock nursing care at home which was expensive. He/She stated the hospice provider whom the facility staff told them they had to use stated they would not cover the [MEDICATION NAME]/[MEDICATION NAME]es which<br>his/her family member was on at home. They stated the hospice provider they had at home did cover the patches.<br>They stated they had taken their loved one to their primary care physician and obtained a hard script for the [MEDICATION NAME] pills. They stated when their loved one was admitted to the facility they had two [MEDICATION NAME]/ [MEDICATION NAME]es on which had been placed the day prior to admission. He/She stated the admitting nurse was aware the resident had two [MEDICATION NAME]es in place on admission. He/She stated the admitting nurse stated they would confirm the physician's orders [REDACTED]. He/She stated the only reason the medication was changed from [MEDICATION NAME]es to the [MEDICATION<br>NAME] pills was because the hospice would not cover the patches and it would have cost over $600 per month.<br>He/She stated they believed that was what killed their loved one. They stated when they arrived at the facility the next morning, their loved one was lying on their back in bed choking on vomit and out of it. They stated when they asked what was wrong with their loved one the staff stated it could have been a result of transitioning to the nursing home. He/She stated they asked the nurse, Did you take those patches off? He/She stated the nurse never answered them. He/She stated then the nurse said they had removed the patches. The family asked when. The staff stated to the family they had just removed the patches and they were in the nurses' pocket. He/She stated they had told the nurse the resident was overdosed. He/She stated they were never able to have a conversation with the named resident again. They stated when the resident came into the facility she could verbalize her needs and even sign her own checks. He/She stated it all changed when the facility overdosed the resident. He/She stated, They pushed her over the edge.<br>He/She stated the resident's physician who had been treating her for her blood disorder (her hospice diagnosis) , had stated the normal aging process would kill the resident before the disease process would. He/She stated it was around the following Monday the DON, ADM and a third person came in and assured him/her they were conducting an investigation related to the medication error. He/She asked them not to speak in front of the resident because it would upset them. He/She stated they all went into the hall. The family member pointed out the nurse who made the medication error and informed the staff the nurse never notified hospice on her shift. He/She stated the facility had never followed up with them on the findings of the investigation. He/She stated the facility admitted they overdosed her. He/She stated the day the resident died , they were called and informed the resident had experienced changes overnight.<br>He/She stated when they arrived to the facility, the resident was guppy breathing. He/She stated they had read information about guppy breathing and mottling from the resident's prior hospice. He/She stated they removed the resident's covers and observed mottling on the resident's legs and a cut on her knee. He/She asked the nurse what had happened to the resident's knee. They stated they had no idea how the cut had happened. The family member stated the hospice provider did not arrive to the facility until after the resident had died . They stated when the resident was followed by a local hospice at home, the family could call them and they would be right out. They stated the hospice provider the facility used was located in Oklahoma City. The family member stated resident #3 had always said putting her in the nursing home was like Taking her to the pound. The family member stated, It's the worst mistake I ever made.<br>At 12:26 p.m., the DON was asked for all documentation related to the monitoring for oversedation for resident #3 following the medication error.<br>At 12:35 p.m., the DON stated she reviewed the notes. She stated the monitoring was in the progress note/nurse notes. She was asked to review the note on [DATE] at 2:18 p.m. which documented the resident had a decrease in level of consciousness, was slow to respond, would continue to monitor due to change in medication and would pass on to oncoming nurse. She was asked to review the late note on [DATE] at 2:20 p.m. which documented the physician was notified of the [MEDICATION NAME]es not being removed when the [MEDICATION NAME] was started, would continue to monitor. She was asked to review the next note which was completed at 10:56 p.m. She was asked if any monitoring related to the oversedation occurred between these notes. She stated no. The next note was in eight hours. She stated the staff probably charted every shift.<br>At 1:10 p.m., the DON returned and began to explain resident #3's [MEDICATION NAME] was later restarted and the resident's [MEDICATION NAME] was discontinued. She stated the resident's decline was not from the [MEDICATION NAME]. She stated the<br>resident was started back on a [MEDICATION NAME] because the resident's daughter did not want the [MEDICATION NAME] and<br>wanted the resident put back on the [MEDICATION NAME]. The DON stated the resident's daughter stated the facility hospice provider would not cover the [MEDICATION NAME]. The DON stated it did not make sense why hospice wouldn't cover the [MEDICATION NAME].<br>She was asked if resident #3 was involved in a medication error involving the [MEDICATION NAME]es. She stated yes the [MEDICATION NAME] was left on and yes the resident did have increased lethargy. The DON was shown the facility progress/nurse notes where the resident admitted to the facility alert and oriented x 3 and after the medication error occurred, the resident's level of consciousness was alert and oriented x 1. She was shown whe |
| F 0514<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Keep accurate, complete and organized clinical records on each resident that meet professional standards**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on record review and staff interviews, it was determined the facility failed to ensure resident records were complete and accurate for the reason medication changes occurred and the reason as needed medications were administered for one (#3) of one sampled resident reviewed for complete and accurate records.<br>The facility identified 81 residents resided in the facility. |

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F 0514

**Level of harm -** Minimal harm or potential for actual harm

**Residents Affected -** Some

(continued... from page 9)

Findings:

A nursing documentation policy, effective [DATE], documented, .Purpose: Nursing documentation is complete, organized and addresses a resident's needs, problems, capabilities, and limitations, as well as resident responses. Documentation also reflects changes in condition, care provided, and outcomes of interventions .Policy .Accurately document the care provided to the resident and be at the time the care is given .

Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

A physician's orders [REDACTED].

A physician's telephone order, dated [DATE], documented, .[MEDICATION NAME]-50 Patch 72 Hour 50 MCG/HR (micrograms/hour)
([MEDICATION NAME]) Apply 1 patch [MEDICATION NAME] one time a day related to OTHER CHRONIC PAIN .and remove per schedule .

A [MEDICATION NAME] count/destruction sheet, dated [DATE], documented a nurse applied a 50 MCG/HR patch and destroyed a [MEDICATION NAME] which was signed as witnessed by another staff member. It documented one patch was applied and the amount
remaining was four.

No documentation of the resident having been assessed/monitored by facility staff from [DATE] at 7:38 p.m. to [DATE] at 2:23 p.m. was located in the resident's clinical record.

A nurse progress note, dated [DATE] at 2:23 p.m., documented, .Focus assessment r/t (related to) admission to LTC (long term care). Resident resting in bed most of this shift, A&O (alert and oriented) x (times) 1, slow to respond. [MEDICAL CONDITION] in place and secure. Resident denies pain or discomfort at this time. Restarted on [MEDICATION NAME] his (sic) shift, no s/s (signs/symptoms) adverse reaction noted at this tome (sic). Daughter (name deleted) spoken to and made aware of resident decreased po (by mouth) intake and requiring more assistance. (Hospice name deleted) nurse here to see resident and new orders received for PRN (as needed) tylenol, daughter (name deleted) notified. Call light within reach. VS (vital signs) ,[DATE], T (temperature) 97.4, P (pulse) 60, R (respirations) 18, Spo2 (peripheral capillary oxygen saturation) 94%RA (room air) .

No documentation of the events surrounding the resident having been placed back on the [MEDICATION NAME] was located in the resident's clinical record.

A nurse progress note, dated [DATE] at 10:45 a.m., documented, .Res (resident) resting in bed B/P (blood pressure) was taken at this time B/P was ,[DATE] RR (respiratory rate) 34 P 57 O2 (oxygen) was 93% on 3 LPM (liters per minute) via NC (nasal cannula). Skin was warm and calmy (sic) to touch noted mottling to her feet and to her fingertips. Res was using her accessory muscles during respirations. This nurse notified hospice as well as daughter (name deleted) .

A nurse progress note, dated [DATE] at 11:30 a.m., documented, .Daughter (name deleted) here at bedside with Res .

A nurse progress note, dated [DATE] at 1:41 p.m., documented, .Res was noted to have no pulse no blood pressure and no heart rate. Hospice and family members at bedside. Hospice nurse notified funeral home as well as provider .

The hospice provider death summary, dated [DATE], documented, .Received a call from facility. Upon arrival CN (charge nurse) (name deleted) reports pt (patient) with low bp and diaphoretic. This nurse walked in to (sic) pt's room to perform assessment, pt's daughter and family friend at bed. Pt without vital signs or respirations. This nurse called MD (medical doctor) (name deleted) and unable to reach. MD (name deleted) called and notified of pt without vital signs or respirations
.

No documentation of the resident having been assessed/monitored by facility nursing staff from [DATE] at 10:45 a.m. until the resident's death at 1:41 p.m. on [DATE] was located in the resident's clinical record.

No documentation of the events surrounding the [MEDICATION NAME]/[MEDICATION NAME] having been restarted was ever provided.

A comprehensive resident assessment had not been completed prior to the resident's discharge on [DATE].

A comprehensive care plan had not been fully developed prior to the resident's discharge on [DATE].

A [DATE] treatment administration record (TAR) documented a [MEDICATION NAME]-50 Patch 72 hour MCG/HR ([MEDICATION NAME])
was applied to the resident on [DATE] at 9:00 a.m. and was removed on [DATE] at 11:09 a.m.

A [DATE] Medication Administration Record [REDACTED].

It documented the resident received one 4 mg tablet of [MEDICATION NAME] at 10:45 p.m. on [DATE], at 11:26 a.m. on [DATE] and at 3:09 a.m. on [DATE]. The reason the medication was administered was not documented.

No documentation was located in the resident's clinical record to explain the reason the resident was given their as needed [MEDICATION NAME], and whether the resident was experiencing nausea or vomiting or both.

On [DATE] at 9:14 a.m., a confidential family interview was conducted for resident #3. He/She stated the day the resident died , they were called and informed the resident had experienced changes overnight. He/She stated when they arrived to the facility, the resident was guppy breathing. He/She stated they had read information about guppy breathing and mottling from the resident's prior hospice. He/She stated they removed the resident's covers and observed mottling on the resident's legs and a cut on her knee. He/She asked the nurse what had happened to the resident's knee.

They stated they had no idea how the cut had happened. The family member stated the hospice provider did not arrive to the facility until after the resident had died . They stated when the resident was followed by a local hospice at home, the family could call them and they would be right out. They stated the hospice provider the facility used was located in Oklahoma City. The family member stated resident #3 had always said putting her in the nursing home was like Taking her to the pound. The family member stated, It's the worst mistake I ever made.

At 1:45 p.m., LPN (licensed practical nurse) #1 was interviewed. The corporate nurse and the ADM (administrator) were present during the interview. LPN #1 was asked to describe the events surrounding the placement of the [MEDICATION NAME] 50 MCG/HR patch on [DATE] where the TAR documented the patch had been applied at 9:00 a.m. and removed at 11:09 a.m. She reviewed the TAR and stated she did apply the patch at 9:00 a.m. She stated she did not remember removing the patch that day. She stated she had to clarify the order and she believed when the order was clarified, the system put the patch was removed because a new order was generated. She was asked if the resident was admitted to the facility with [MEDICATION NAME]es on. She stated, She did 100 and 37.5. She stated the resident's daughter had brought in hard scripts from the physician for both [MEDICATION NAME] and [MEDICATION NAME]. LPN #1 stated she did not believe the physician wanted the
resident on both medications. She stated she called and clarified with the physician the order was to discontinue the [MEDICATION NAME]es and start the [MEDICATION NAME] when it came in.

LPN #1 was asked if she was present when the [MEDICATION NAME] arrived at the facility. She stated, No. She was asked to explain the events surrounding the [MEDICATION NAME] 50 MCG/HR patch placement on [DATE]. She stated the resident's [MEDICATION NAME] was supposed to be discontinued and the [MEDICATION NAME] was supposed to be applied. She was asked to
review the resident's MAR/TAR and identify when the last dose of [MEDICATION NAME] was given and when the [MEDICATION NAME]
was started. She reviewed the record and stated the last dose of [MEDICATION NAME] was given on the 7th at 8:00 a.m., and the [MEDICATION NAME] was started on the 8th at 9:00 a.m. She stated the patch was not started until the next day because the resident was slow to respond.

She was asked to explain the reason the resident was restarted on the [MEDICATION NAME]. She stated the resident was restarted on the [MEDICATION NAME] due to decreased level of consciousness. She stated she had spoken with the resident's daughter. She stated we thought maybe the [MEDICATION NAME] too strong. She stated when she contacted the physician, he stated he was comfortable putting the resident back on the [MEDICATION NAME]es. She stated the physician wanted to know why the resident's hospice would not cover the medication in the first place. LPN #1 stated she had spoken with the hospice and they would cover the [MEDICATION NAME]es. She was asked if she had documentation of this. She stated, I'd have to look.

She was asked to review the [MEDICATION NAME] medication destruction form which documented she had placed and removed/destroyed a [MEDICATION NAME] on [DATE]. The removal/destruction of the patch was also witnessed/signed by another
staff member. She was asked to explain the form. She stated she did not destroy a patch that day. She stated she did not understand the form. She was asked if there was a medication destruction form for the [MEDICATION NAME] removal on [DATE]. She stated, There was not one.

The DON (director of nursing) had arrived in the room during this interview. LPN #1 was asked if there was any documentation explaining the reason the [MEDICATION NAME] was changed initially to the [MEDICATION NAME] due to the family requesting it
be changed because of the cost. The DON stated no she did not because it was prior to admission.

At 2:14 p.m., the corporate nurse returned and stated, All we have documented is in PCC (point click care software). She was asked if the facility staff should have document the circumstances surrounding a medication change. She stated there should always be documentation to give a clear picture of what was going on with the resident. She reviewed the resident's clinical record. She stated, I didn't see any documentation from the 7th and that's when she got the order.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **375508** | A. BUILDING _____ B. WING _____ | **07/05/2016** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ROSE MANOR NURSING CENTER** | **1610 NORTH BRYAN AVENUE SHAWNEE, OK 74804** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0514<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 10)<br>She was asked to review the resident's MAR. She was asked if the MAR indicated [REDACTED]That's what's documented. She stated, I'm thinking it's because she was sedated. She stated, But it's not documented.<br>She was asked to review the nurse/progress note dated [DATE] at 10:45 a.m. She was asked if there was a change in the resident's condition. She stated, It appears to be a change in condition. She stated, And, yes, the physician should have been notified. She asked if she could check the hospice notes. She reviewed the hospice records for that day and was unable to provide documentation the physician was contacted prior to the resident expiring that day.<br>On [DATE] at 11:10 a.m., the ADM, DON, and the clinical director were asked if there was any additional documentation related to the reason the resident was given [MEDICATION NAME] several times and the reason the [MEDICATION NAME] held on<br>[DATE] at 8:00 p.m. The clinical director reviewed the documentation and stated she just put lethargy on the note surrounding the [MEDICATION NAME] held. She stated on the 8th when the [MEDICATION NAME] was given hospice was present. She<br>stated she did not see specifically the reason the staff had given the medication. She stated it was a medication aide not a nurse who had given the medication. She stated normally the medication aide would let the nurse know of the resident's condition and the nurse would follow up after the medication administration. She stated the nurse charted effective after the administration. She stated, The documentation may not be all that you're wanting. She stated the reason might be documented in the hospice notes.<br>She was asked if the nursing documentation identified whether or not the resident experienced nausea and or vomiting. She stated for the [MEDICATION NAME] administration on the 8th, she'd have to look at the hospice note. She stated for the administration on the 5th, she'd have to look at the hospice note. She stated on the administration on the 4th, the note documented the resident ate and drank at 10:26 p.m. and the [MEDICATION NAME] was given 20 minutes later. She stated she had no idea why the it was given or whether or not the resident had experienced nausea or vomiting.<br>At 12:07 p.m., the corporate nurse returned with copies of the hospice notes from [DATE]th, 5th and 7th 2016. She reviewed the notes and stated on the 4th the note did not specifically identify the resident requested [MEDICATION NAME]. She stated on the 5th, the hospice note documented the resident experienced vomiting with pill pass. She was asked if the facility staff documented this. She stated no, they just documented they gave the resident [MEDICATION NAME] and the effectiveness. She stated on the 7th, the hospice note documented the resident was talkative. She was asked if she was able to locate any documentation of the reason the [MEDICATION NAME] was administered. She stated, No, I didn't. |