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	49E004	A. BUILDING _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 2/15/23 through 2/16/23. One complaint was investigated. Complaint VA00057806 was substantiated with deficiencies cited. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this ninety certified bed facility was seventy-six at the time of the survey. The survey sample consisted of four current resident reviews (Residents #2 through #5) and one closed record review (Resident #1).	F 000		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice during medication administration for one of five residents in the survey sample (Resident #1), resulting in an opioid overdose, which required hospitalization. The findings include: Registered nurse (RN) #1 failed to compare the morphine on-hand to Resident #1's physician's order prior to giving the medication, resulting in the administration of a 100 mg (milligram) dose,	F 658	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/22/2023

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rather than the 10 mg dose ordered by the physician. Recognition that a higher concentration of liquid morphine was selected than that listed on the physician's order was not made until after administration of the medication. Resident #1 experienced an emergency transfer and hospitalization for treatment of the medication overdose.

Resident #1 was admitted to the facility with diagnoses that included lung cancer, chronic respiratory failure, dementia with behaviors, gastroenteritis, dermatitis, bronchitis, depression, insomnia, history of pneumonia and anxiety. The minimum data set (MDS) dated 1/11/23 assessed Resident #1 with severely impaired cognitive skills.

Nursing notes on 2/9/23 documented, "...resident continues to be declining, continues to have SOB [shortness of breath] even with cont. [continuous] oxygen at 3L [liters per minute] and scheduled breathing treatments...MD [physician] notified of current condition, New orders obtained to increase prednisone...New order for morphine 10 mg PRN q 4hrs [as needed every 4 hours] for SOB...[3:06 p.m.]...Spoke with MD and RP and in agreement to give morphine for SOB..."

Resident #1's clinical record documented a physician's order dated 2/9/23 for morphine solution 10 mg/ 5 ml (milliliters) amount to give "10 mg" orally every 4 hours as needed for shortness of breath.

A nursing note, dated 2/10/23 at 9:56 a.m. documented, "This nurse notified of wrong dose given: MD and RP [responsible party] were notified. MD gave order to send to ED

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[emergency department] for eval. [evaluation] VS [vital signs]: 100/70 BP [blood pressure] and O2 [oxygen saturation] 97 on 2L [liters per minute]. VS then checked again [BP] 80/58 [O2 sat] 87 [oxygen saturation at] 2L. EMS was called. Resident was remaining alert and talking drinking well...SOB had resolved..."

The emergency department record dated 2/10/23 documented, "... per EMS, patient was given 100 mg liquid morphine instead of the prescribed dose of 10 mg morphine. Given at approx [approximately] 0940 [9:40 a.m.]. pt [patient] was given Narcan enroute..." The emergency department history documented, "...presents to the ED somnolent, obtunded that has improved after Narcan administration at 1021 [10:21 a.m.]. Patient as [was] accidentally overdosed on morphine given at the...nursing home. Yesterday on 2/9/23, patient was prescribed Morphine 10 mg/5 ml solution. He is dosed to get 10 mg every 4 hours for shortness of breath. Patient was given 100 mg this morning at 0945 [9:45 a.m.]. Patient is demented at baseline and cannot contribute to much of this history besides denying chest pain, abdominal pain, shortness of breath..." Per the hospital documentation, Resident #1 was administered a second dose of Narcan in the emergency department and was admitted to the intensive care unit for continued Narcan administration and monitoring.

Resident #1 discharged back to the nursing home on 2/11/23. The hospital discharge summary dated 2/11/23 documented, "...with advanced dementia chronic hypoxic respiratory failure and lung cancer having declined any further work-ups or treatments being conservatively managed at...nursing home had an order at the facility for

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10 mg of oral morphine was accidentally given at 100 mg. Got Narcan in route from EMS. Upon arrival to the emergency department was hemodynamically stable...Started on Narcan drip due to the amount of opiates. Protecting his airway. Narcan drip turned things around nicely...Awake oriented to his baseline...Stable for discharge to skilled facility..."

Resident #1 was re-admitted to the facility on 2/11/23, with the orders for prednisone and morphine discontinued. A nursing note on 2/11/23 documented, "...Resident noted to have a lot of fluid in face/hands/arms...very wet gurgly breathing when lying flat, resident with head up did not sound wet...Resident O2 obtained and noted at 64%, oxygen at 4L came up to 86%. Order obtained to send resident back to ED..." Per hospital documentation, Resident #1 was re-admitted to the hospital on 2/11/23 for acute/chronic respiratory failure with hypoxemia, aspiration pneumonitis, accidental overdose, and possible sepsis.

The facility summary dated 2/10/23 documented that Resident #1 was administered an incorrect dose of morphine and was admitted to the hospital on 2/10/23 for treatment of the overdose. The facility's synopsis of the 2/10/23 overdose, dated 2/14/23, documented, "...it was determined [Resident #1] was administered 100 mgs of Morphine when he should have received 10 mgs of Morphine. This medication error occurred as a result of [RN #1] entering the room to assess another issue...[Resident #1] began to yell out 'I can't Breathe'...[Resident #1] received a breathing treatment and was still showing no signs of relief. [Resident #1] was transferred to w/c [wheelchair] for upright sitting position, still no

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signs of relief...had a new order for morphine on 2/9/23 for shortness of breath. The medication had not been received from pharmacy...[RN #1] and [licensed practical nurse #1] immediately went to the Pyxis system and pulled morphine from the emergency supply. 5 ml was drawn per the order...was administered to [Resident #1]. [RN #1] returned to the med [medication] cart upon preparing to document dosage, [RN #1] realized a different formulary was in our Pyxis from the MD order. The order was for 10 mg per 5 ml and our emergency supply was 100 mg per 5 ml...Narcan was on hand but not administered as [Resident #1] showed no symptoms and remained asymptomatic while waiting on first responders. [Resident #1] was transported to the ER [emergency room]...returned to the facility on 2/11/23 ...was sent back to the ER...due to low O2 saturation and respiratory distress...Education has been provided to [RN #1] to verify strength of stat morphine pulled per MD order to determine if conversion of dosage is required..."

On 2/15/23 at 11:30 a.m., RN #1, who administered the 100 mg dose of morphine to Resident #1, was interviewed. RN #1 stated that licensed practical nurse (LPN) #1 asked her to assess the resident #1's left eye redness. RN #1 stated she and LPN #3 went to the resident #1's room to assess the eye on the morning of 2/10/23. RN #1 stated that while the aides were performing incontinence care, she observed Resident #1 was visibly short of breath and "gurgling." RN #1 stated that they sat the resident up, adjusted his oxygen, and LPN #3 administered a prescribed breathing treatment. RN #1 stated that the breathing treatment provided little relief with the resident #1 stating he could not breath. RN #1 stated that she went to

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LPN #1 to get the morphine prescribed for shortness of breath, but LPN #1 informed her the prn morphine order was entered yesterday (2/9/23) and had not arrived yet from pharmacy. RN #1 stated that she and LPN #1 went to the emergency supply device (Pyxis) to obtain oral morphine for Resident #1. RN #1 stated that she retrieved a 30 ml bottle of oral morphine solution from the emergency supply, returned to the medication cart, looked at the medication order on the medication administration record (MAR) that listed the concentration of 10 mg/5 ml and to give 10 mg. RN #1 stated that she poured 5 ml from the bottle of morphine into a medicine cup, went to LPN #1, and asked her to verify the 5 ml. RN #1 stated that she went to the resident #1's room, verified there was 5 ml in the medicine cup with LPN #3, and then administered the medication to Resident #1. RN #1 stated that she went back to the medication cart to document the administration, looked at the bottle of morphine used and "realized I gave 100 mg instead of 10 mg." RN #1 stated that when she looked at the label to document the administration, she recognized the error, and immediately knew she had given the wrong dose. RN #1 stated she told LPN #1 that she had given the resident too much morphine. RN #1 stated Narcan was on hand and LPN #3 monitored the resident's vital signs until EMS arrived. RN #1 stated the resident was alert at baseline and was transferred to the hospital for evaluation and treatment. RN #1 stated concerning the error, "I did not confirm the dose on the bottle with the order on the MAR. I was trying to get it [morphine] to him as quick as I could because he was in respiratory distress." RN #1 stated she had LPN #1 and LPN #3 verify that she had 5 ml in the medicine cup, but she nor the other nurses compared the bottle label to

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the order. RN #1 stated the 100 mg/5 ml concentration was "the usual" supply in the Pyxis. RN #1 stated that she failed to compare the label on the bottle of morphine to the physician's order until after she administered the medication. RN #1 stated that she looked only at the order and was thinking 5 ml when she prepared the medicine. RN #1 stated that if she had compared the medicine label to the order, she would have known to only give 0.5 ml of the 100 mg/5 ml concentration, instead of 5 ml.

On 2/15/23 at 11:30 a.m., LPN #1 was interviewed about Resident #1's medication error of 2/10/23. LPN #1 stated that RN #1 reported to her that resident #1 was short of breath and she needed the prn morphine. LPN #1 stated she went with RN #1 to the emergency supply device and assisted her with retrieving the bottle of morphine. LPN #1 stated she never reviewed the order and did not witness RN #1 pour the medication. LPN #1 stated she verified that 5 ml was in the medicine cup. LPN #1 stated, "I never saw the order. I didn't know how the order read. I did not look at the label on the bottle." LPN #1 stated that RN #1 came to her a few minutes later and stated she had given Resident #1 too much morphine.

On 2/15/23 at 11:52 a.m., LPN #3 that was with RN #1 during the morphine administration was interviewed. LPN #3 stated that she went with RN #1 to assess a reported eye issue with Resident #1 and as the aides were changing him, resident #1 became short of breath. LPN #3 stated that she administered a breathing treatment in addition to adjusting oxygen and sitting the resident upright. LPN #3 stated that resident #1 still had breathing difficulty, despite

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the interventions, and RN #1 left the room to get the morphine. LPN #3 stated RN #1 came back into the resident's room with the dose of oral morphine and said the dose was 10 mg. LPN #3 stated, "I said yes, 10 mg. I put the order in the day before." LPN #3 stated that she did not look at the bottle of morphine used for the dose, but she witnessed RN #1 administer the oral solution to Resident #1. LPN #3 stated that RN #1 came to her a few minutes later and said that she had given the wrong dose of morphine. LPN #3 stated that Narcan was retrieved from the Pyxis emergency supply but the physician ordered to immediately send the resident to the emergency room. LPN #3 stated that she monitored the resident continuously until EMS arrived and the resident was alert and talking. LPN #3 stated the 100 mg/5 ml morphine concentration was "the usual" dosage provided in the emergency supply.

On 2/15/23 at 2:07 p.m., the director of nursing (DON) was interviewed about Resident #1's morphine dosage error. The DON stated that she was off on 2/10/23 but RN #1 called her, reported she made a mistake, and that she had administered Resident #1 a 100 mg dose of morphine instead of the ordered 10 mg. The DON stated that Narcan was available, the physician notified, and the resident sent to the hospital for treatment. When questioned further, the DON stated there had been no medication errors in the facility for at least the past year. The DON stated that there was no history of any medication errors or care concerns involving RN #1. The DON stated that she told RN #1 not to administer anymore medications on 2/10/23 because of the error and that RN #1 had been upset about the incident. The DON stated that RN #1 was educated on 2/13/23 about always

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checking to ensure the correct dosage and compliance with the physician's order when retrieving/administering medications from the emergency supply. When questioned about the proper procedure, the DON stated that RN #1 should have compared the bottle label to the order prior to administration of morphine to the resident and that RN #1 failed to compare the order to the concentration that was available in the emergency supply. The DON stated that if unsure or if there were any questions about dosing, especially regarding an opioid, nurses had access to the pharmacy and could also call the provider for clarification. The DON stated this error was made because the nurse failed to compare the label to the order, adjust the amount given, and/or seek clarification about the dosing prior to administration of the medicine. The DON stated in this situation that Resident #1 was having difficulty breathing and, in human error, RN #1 did not look at the concentration of the morphine that she was administering. The DON stated that RN #1 did not typically work on the floor but "...jumped in to help." When asked, the DON stated that this error was preventable if the label and order had been compared and adjustments and/or clarification made prior to preparing and administering the medicine.

On 2/16/23 at 10:45 a.m., RN #1 was interviewed again about the medication error. RN #1 stated that there was no issue with calculating the proper dose. RN #1 stated that in the "heat of the moment" she was trying to get the medication to the resident quickly due his respiratory distress. RN #1 stated that she was "assuming" she had the concentration on the order instead of actually checking the label. RN #1 stated with the 100 mg/5 ml concentration from the emergency

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supply, she should have administered 0.5 ml instead of 5 ml. RN #1 stated, "It was an oversight on my part."

On 2/16/23 at 11:20 a.m., the consultant pharmacist (other staff #1) was interviewed about the Resident #1's medication error. The pharmacist stated that the 30 ml bottle of morphine solution with the 100 mg/5 ml concentration was the only concentration available for supply in the emergency Pyxis device. The pharmacist stated that consultation was available to nursing 24 hours per day if there was a question about dosage or amounts to administer. The pharmacist stated that the 10 mg dose of morphine could have been administered correctly from the bottle of 100 mg/5 ml, if 0.5 ml was administered.

The facility's policy titled Medication Administration - General Guidelines (effective 10/1/17) documented, "Medications are administered as prescribed in accordance with good nursing principles and practices..." Step 4 of the policy documented regarding the "eight rights" of medication administration, "EIGHT RIGHTS - Right resident, right drug, right dose, right route, right time, right documentation, right reason, right response, are applied for each medication being administered. A triple check of the first 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away...Check #1: Select the Medication - label, container, and contents are checked for integrity, and compared against the medication administration record

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(MAR) by reviewing the first 5 Rights...Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the first 5 Rights...Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the first 5 Rights...The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident medication administration schedule (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule..."

The facility's policy titled Oral Medication Administration (effective 6/9/15) documented in procedures for administering medications, "...Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications to each resident..."

The Nursing 2022 Drug Handbook on page 1004 describes morphine as an opioid analgesic used for the management of moderate to severe pain. This reference documents oral morphine has a black box warning stating, "Take care when administering morphine oral solution to avoid dosing errors because of confusion among different concentrations and between milligrams and milliliters, which could result in accidental overdose and death..." (1)

The following QAPI Action Plan, dated 3-14-23,

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F 658	Continued From page 11 was provided for review: Resident sent to ER for evaluation following accidental Morphine overdose 1. Correction for identified resident/system - resident sent to ER for evaluation 2. How will you identify other potential residents and correct them if needed? - Audit was performed for any Morphine pulled from Pyxis system for resident use in the last 30 days with no other residents identified. 3. System Changes: what are you going to do differently to minimize recurrence? - all Morphine take from Pyxxis require 2 nurses to pull. Additional changes both nurses will review Morphine at med cart with MAR to ensure proper dosage pulled prior to administering Morphine. Education provided to all nurses by DON/designee. 4. Monitoring - RN supervisor or designee to audit Pyxis system to ensure 2 nurses to verify with MAR prior to administering Morphine. Weekly audits x 12 weeks x 3 months. Audits will be reviewed in monthly QA meetings for review/recommendations. These findings were reviewed with the administrator and director of nursing on 2/16/23 at 11:50 a.m. Subsequently, evidence of nursing education was requested and provided. Based on facility documentation, a determination of Past Noncompliance was made. (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 658		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		

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F 760	Continued From page 12 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure one of five residents (Resident #1) was free from a significant medication error, which resulted in an opioid overdose requiring hospitalization. The findings include: Resident #1 was administered a 100 mg (milligram) dose of oral morphine solution, ten times the physician's order that required a 10 mg dose. The medication error resulted in an emergency transfer and hospitalization of Resident #1 for treatment of the overdose. Registered nurse (RN) #1 failed to compare the morphine on-hand to Resident #1's physician's order prior to giving the medication resulting in the administration of a 100 mg (milligram) dose rather than the 10 mg dose ordered by the physician. Recognition that a higher concentration of liquid morphine was used than that listed on the physician's order was not made until after administration of the medication. Resident #1 was admitted to the facility with diagnoses that included lung cancer, chronic respiratory failure, dementia with behaviors, gastroenteritis, dermatitis, bronchitis, depression, insomnia, history of pneumonia and anxiety. The minimum data set (MDS) dated 1/11/23 assessed Resident #1 with severely impaired cognitive skills.	F 760	Past noncompliance: no plan of correction required.	

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Nursing notes on 2/9/23 documented, "...resident continues to be declining, continues to have SOB [shortness of breath] even with cont. [continuous] oxygen at 3L [liters per minute] and scheduled breathing treatments...MD [physician] notified of current condition, New orders obtained to increase prednisone...New order for morphine 10 mg PRN q 4hrs [as needed every 4 hours] for SOB...[3:06 p.m.]...Spoke with MD and RP and in agreement to give morphine for SOB..."

Resident #1's clinical record documented a physician's order dated 2/9/23 for morphine solution 10 mg/ 5 ml (milliliters) amount "10 mg" orally every 4 hours as needed for shortness of breath.

A nursing noted on 2/10/23 at 9:56 a.m. documented, "This nurse notified of wrong dose given: MD and RP [responsible party] were notified. MD gave order to send to ED [emergency department] for eval. [evaluation] VS [vital signs]: 100/70 BP [blood pressure] and O2 [oxygen saturation] 97 on 2L [liters per minute]. VS then checked again [BP] 80/58 [O2 sat] 87 [oxygen saturation at] 2L. EMS was called. Resident was remaining alert and talking drinking well...SOB had resolved..."

The emergency department record dated 2/10/23 documented, "... per EMS, patient was given 100 mg liquid morphine instead of the prescribed dose of 10 mg morphine. Given at approx [approximately] 0940 [9:40 a.m.]. pt [patient] was given Narcan enroute..." The emergency department history documented, "...presents to the ED somnolent, obtunded that has improved after Narcan administration at 1021 [10:21 a.m.]. Patient as [was] accidentally overdosed on

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morphine given at the...nursing home. Yesterday on 2/9/23, patient was prescribed Morphine 10 mg/5 ml solution. He is dosed to get 10 mg every 4 hours for shortness of breath. Patient was given 100 mg this morning at 0945 [9:45 a.m.]. Patient is demented at baseline and cannot contribute to much of this history besides denying chest pain, abdominal pain, shortness of breath..." Resident #1 was administered a second dose of Narcan in the emergency department and was admitted to the intensive care unit for continued Narcan administration and monitoring.

Resident #1 discharged back to the nursing home on 2/11/23. The hospital discharge summary dated 2/11/23 documented, "...with advanced dementia chronic hypoxic respiratory failure and lung cancer having declined any further work-ups or treatments being conservatively managed at...nursing home had an order at the facility for 10 mg of oral morphine was accidentally given at 100 mg. Got Narcan in route from EMS. Upon arrival to the emergency department was hemodynamically stable...Started on Narcan drip due to the amount of opiates. Protecting his airway. Narcan drip turned things around nicely...Awake oriented to his baseline...Stable for discharge to skilled facility..."

The resident was re-admitted to the facility on 2/11/23 with orders for prednisone and morphine discontinued. A nursing note on 2/11/23 documented, "...Resident noted to have a lot of fluid in face/hands/arms...very wet gurgly breathing when lying flat, resident with head up did not sound wet...Resident O2 obtained and noted at 64%, oxygen at 4L came up to 86%. Order obtained to send resident back to ED..."

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Per hospital documentation, Resident #1 was re-admitted to the hospital on 2/11/23 for acute/chronic respiratory failure with hypoxemia, aspiration pneumonitis, accidental overdose, and possible sepsis.

A facility summary of 2/10/23 documented that Resident #1 was administered an incorrect dose of morphine and was admitted to the hospital on 2/10/23 for treatment of the overdose. The facility's synopsis of the 2/10/23 overdose, dated 2/14/23 documented, "...it was determined [Resident #1] was administered 100 mgs of Morphine when he should have received 10 mgs of Morphine. This medication error occurred as a result of [RN #1] entering the room to assess another issue...[Resident #1] began to yell out 'I can't Breathe'...[Resident #1] received a breathing treatment and was still showing no signs of relief. [Resident #1] was transferred to w/c [wheelchair] for upright sitting position, still no signs of relief...had a new order for morphine on 2/9/23 for shortness of breath. The medication had not been received from pharmacy...[RN #1] and [licensed practical nurse #1] immediately went to the Pyxis system and pulled morphine from the emergency supply. 5 ml was drawn per the order...was administered to [Resident #1]. [RN #1] returned to the med [medication] cart upon preparing to document dosage, [RN #1] realized a different formulary was in our Pyxis from the MD order. The order was for 10 mg per 5 ml and our emergency supply was 100 mg per 5 ml...Narcan was on hand but not administered as [Resident #1] showed no symptoms and remained asymptomatic while waiting on first responders. [Resident #1] was transported to the ER [emergency room]...returned to the facility on 2/11/23 ...was sent back to the ER...due to low

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O2 saturation and respiratory distress...Education has been provided to [RN #1] to verify strength of stat morphine pulled per MD order to determine if conversion of dosage is required..."

On 2/15/23 at 11:30 a.m., RN #1, who administered the 100 mg dose of morphine to Resident #1, was interviewed. RN #1 stated that licensed practical nurse (LPN) #1 asked her to assess the resident #1's left eye redness. RN #1 stated she and LPN #3 went to the resident #1's room to assess the eye on the morning of 2/10/23. RN #1 stated that while the aides were performing incontinence care, she observed Resident #1 was visibly short of breath and "gurgling." RN #1 stated that they sat the resident up, adjusted his oxygen, and LPN #3 administered a prescribed breathing treatment. RN #1 stated that the breathing treatment provided little relief with the resident #1 stating he could not breath. RN #1 stated that she went to LPN #1 to get the morphine prescribed for shortness of breath, but LPN #1 informed her the prn morphine order was entered yesterday (2/9/23) and had not arrived yet from pharmacy. RN #1 stated that she and LPN #1 went to the emergency supply device (Pyxis) to obtain oral morphine for Resident #1. RN #1 stated that she retrieved a 30 ml bottle of oral morphine solution from the emergency supply, returned to the medication cart, looked at the medication order on the medication administration record (MAR) that listed the concentration of 10 mg/5 ml and to give 10 mg. RN #1 stated that she poured 5 ml from the bottle of morphine into a medicine cup, went to LPN #1, and asked her to verify the 5 ml. RN #1 stated that she went to the resident #1's room, verified there was 5 ml in the medicine cup with LPN #3, and then administered the

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medication to Resident #1. RN #1 stated that she went back to the medication cart to document the administration, looked at the bottle of morphine used and "realized I gave 100 mg instead of 10 mg." RN #1 stated that when she looked at the label to document the administration, she recognized the error, and immediately knew she had given the wrong dose. RN #1 stated she told LPN #1 that she had given the resident too much morphine. RN #1 stated Narcan was on hand and LPN #3 monitored the resident's vital signs until EMS arrived. RN #1 stated the resident was alert at baseline and was transferred to the hospital for evaluation and treatment. RN #1 stated concerning the error, "I did not confirm the dose on the bottle with the order on the MAR. I was trying to get it [morphine] to him as quick as I could because he was in respiratory distress." RN #1 stated she had LPN #1 and LPN #3 verify that she had 5 ml in the medicine cup, but she nor the other nurses compared the bottle label to the order. RN #1 stated the 100 mg/5 ml concentration was "the usual" supply in the Pyxis. RN #1 stated that she failed to compare the label on the bottle of morphine to the physician's order until after she administered the medication. RN #1 stated that she looked only at the order and was thinking 5 ml when she prepared the medicine. RN #1 stated that if she had compared the medicine label to the order, she would have known to only give 0.5 ml of the 100 mg/5 ml concentration, instead of 5 ml.

On 2/15/23 at 11:30 a.m., LPN #1 was interviewed about Resident #1's medication error of 2/10/23. LPN #1 stated that RN #1 reported that resident #1 was short of breath and she needed the morphine. LPN #1 stated that she went with RN #1 to the emergency supply device

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and assisted her with retrieving the bottle of morphine. LPN #1 stated that she never reviewed the order and did not witness RN #1 pour the medication. LPN #1 stated that she verified that 5 ml was in the medicine cup. LPN #1 stated, "I never saw the order. I didn't know how the order read. I did not look at the label on the bottle." LPN #1 stated that RN #1 came to her a few minutes later and stated she had given Resident #1 too much morphine.

On 2/15/23 at 11:52 a.m., LPN #3 that was with RN #1 during the morphine administration was interviewed. LPN #3 stated that she went with RN #1 to assess a reported eye issue with Resident #1 and as the aides were changing him, the resident became short of breath. LPN #3 stated that she administered a breathing treatment in addition to adjusting oxygen and sitting the resident upright. LPN #3 stated that the resident still had breathing difficulty despite the interventions and RN #1 left the room to get the as needed morphine. LPN #3 stated that RN #1 came back into the resident's room with the dose of oral morphine and said the dose was 10 mg. LPN #3 stated, "I said yes, 10 mg." LPN #3 stated, "I put the order in the day before." LPN #3 stated that she did not look at the bottle of morphine used for the dose, and she witnessed RN #1 administer the oral solution to Resident #1. LPN #3 stated that RN #1 came to her a few minutes later and said that she had given the wrong dose of morphine. LPN #3 stated the Narcan was retrieved from the Pyxis emergency supply, but the physician stated to immediately send the resident to the emergency room. LPN #3 stated that she monitored the resident continuously until EMS arrived and the resident #1 was alert and talking. LPN #3 stated the 100

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mg/5 ml morphine concentration was "the usual" provided in the emergency supply.

On 2/15/23 at 2:07 p.m., the director of nursing (DON) was interviewed about Resident #1's morphine dosage error. The DON stated that she was off on 2/10/23, but RN #1 called her, reported she made a mistake, and that she had administered Resident #1 a 100 mg dose of morphine instead of the ordered 10 mg. The DON stated Narcan was available, the physician notified, and the resident sent to the hospital for treatment. The DON stated there had been no medication errors in the facility for at least the past year. The DON stated there was no history of any medication errors or care concerns involving RN #1. The DON stated that she told RN #1 not to administer anymore more medications on 2/10/23 because of the error and because RN #1 was upset about the incident. The DON stated RN #1 was educated on 2/13/23 about always checking to ensure the correct dosage and compliance with the physician's order when retrieving/administering medications from the emergency supply. When questioned, the DON stated that RN #1 should have compared the bottle label to the order prior to administration of morphine to the resident. The DON stated that RN #1 failed to compare the order to the concentration that was available in the emergency supply. The DON stated if unsure, or if there were any questions about dosing, especially regarding an opioid, nurses had access to pharmacy and could call the provider for clarification. The DON stated that this error was made because the nurse failed to compare the label to the order, adjust the amount given and/or seek clarification about the dosing prior to administration of the medicine. The DON stated

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that in this situation the resident was having difficulty breathing and in human error, the nurse did not look at the concentration of the morphine she was administering. The DON stated that RN #1 did not typically work on the floor but "jumped in to help." The DON stated that this error was preventable if the label and order had been compared and adjustments and/or clarification made prior to preparing and administering the medicine.

On 2/16/23 at 10:45 a.m., RN #1 was interviewed again about the medication error. When questioned further, RN #1 stated there was no issue with calculating the proper dose. RN #1 stated in the "heat of the moment" she was trying to get the medication to the resident quickly due his respiratory distress. RN #1 stated she was "assuming" she had the concentration on the order, instead of actually checking the label. RN #1 stated that with the 100 mg/5 ml concentration from the emergency supply, she should have administered 0.5 ml instead of 5 ml. RN #1 stated, "It was an oversight on my part."

On 2/16/23 at 11:20 a.m., the consultant pharmacist (other staff #1) was interviewed about the Resident #1's medication error. The pharmacist stated that the 30 ml bottle of morphine solution with the 100 mg/5 ml concentration was the only concentration available for supply in the emergency Pyxis device. The pharmacist stated that consultation was available to nursing 24 hours per day if there was a question about dosage or amounts to administer. The pharmacist stated that the 10 mg dose of morphine could have been administered correctly from the bottle of 100 mg/5 ml bottle if 0.5 ml were administered.

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The facility's policy titled Medication Administration - General Guidelines (effective 10/1/17) documented, "Medications are administered as prescribed in accordance with good nursing principles and practices..." Step 4 of the policy documented regarding the "eight rights" of medication administration, "EIGHT RIGHTS - Right resident, right drug, right dose, right route, right time, right documentation, right reason, right response, are applied for each medication being administered. A triple check of the first 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away...Check #1: Select the Medication - label, container, and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the first 5 Rights...Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the first 5 Rights...Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the first 5 Rights...The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident medication administration schedule (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule..."

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The facility's policy titled Oral Medication Administration (effective 6/9/15) documented in procedures for administering medications, "...Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications to each resident..."

The Nursing 2022 Drug Handbook on page 1004 describes morphine as an opioid analgesic used for the management of moderate to severe pain. This reference documents oral morphine has a black box warning stating, "Take care when administering morphine oral solution to avoid dosing errors because of confusion among different concentrations and between milligrams and milliliters, which could result in accidental overdose and death..." (1)

The following QAPI Action Plan, dated 3-14-23, was provided for review:

Resident sent to ER for evaluation following accidental Morphine overdose
1. Correction for identified resident/system - resident sent to ER for evaluation
2. How will you identify other potential residents and correct them if needed? - Audit was performed for any Morphine pulled from Pyxis system for resident use in the last 30 days with no other residents identified.
3. System Changes: what are you going to do differently to minimize recurrence? - all Morphine take from Pyxxis require 2 nurses to pull. Additional changes both nurses will review Morphine at med cart with MAR to ensure proper dosage pulled prior to administering Morphine. Education provided to all nurses by

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DON/designee.
4. Monitoring - RN supervisor or designee to audit Pyxis system to ensure 2 nurses to verify with MAR prior to administering Morphine. Weekly audits x 12 weeks x 3 months. Audits will be reviewed in monthly QA meetings for review/recommendations.

These findings were reviewed with the administrator and director of nursing on 2/16/23 at 11:50 a.m. Subsequently, evidence of nursing education was requested and provided. Based on facility documentation, a determination of Past Noncompliance was made.

(1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.