DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165104	A. BUILDING _____ B. WING _____	C 09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	901 WEST THIRD STREET DUBUQUE, IA 52001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 VKK 9/24/18	INITIAL COMMENTS Correction date 9/24/18 The following deficiency relates to the investigation of complaint #78033 and incident #78056. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C).	F 000	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with State and Federal regulations the facility has taken the following actions set forth in the plan of correction. All deficiencies will be or were corrected by September 24, 2018.	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interviews the facility failed to ensure residents are free of any significant medication errors. (Resident #1). The facility reported a census of 74 residents. Findings include: 1.According to the MDS (Minimum Data Set) dated 8/4/2018, Resident #1 had no cognitive impairment, required extensive assistance of two staff to transfer, diagnoses including UTI (urinary tract infection) in the past 30 days, heart failure, hypertension, diabetes, seizure disorder, depression, respiratory failure, kidney failure and encephalopathy. The resident received scheduled and as needed pain medication that included opioid medication. The Care Plan identified the resident had functional mobility and transfers limited by back pain. It directed staff to apply diathermy, electrical stimulation, manual therapy, massage therapy, and exercise therapy. It documented the resident	F 760	F 760: The facility does and will continue to ensure all patients, including patient #1, are free from any significant medication errors. Patient #1 continues to reside in the facility. Patient #1 and other patients with Fentanyl patches are monitored every shift for appropriate Fentanyl patch placement, removal and proper disposal by 2 nurses. Licensed nurses have received the following education: Medication Administration - Controlled Substance log guidelines Medication Administration - Transdermal drug guideline Application of Medicated Patches - Duragesic/Fentanyl	

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

Cassandra Johnson, Administrator | | 09/24/2018

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 760	Continued From page 1 also had problem with pain related to back pain and a history of neuropathy, hand pain, right ankle pain. It directed staff to administer medication per physician orders. The Physician orders dated 7/31/2018 included: Fentanyl Patch 25 mcg (micrograms) per hour patch, change every third day. Diagnosis: Pain. The Progress Notes dated 9/5/2018 revealed staff observed Resident #1 difficult to arouse, oxygen saturation at 80% with oxygen on at 2 liters per nasal cannula, opened eyes and gives one word answers. Facility called 911 and sent the resident to the Emergency Room. The resident admitted to the hospital ICU (Intensive Care Unit). The hospital Emergency Department record dated 9/5/2018, revealed Resident #1 arrived from the nursing home because of decreased responsiveness, and reportedly less responsive over the past 2-3 days. Patient had a similar episode in the past that was associated with Fentanyl overdose due to multiple Duragesic patches being left on. On 9/5/2018, three Fentanyl patches were found on the patient. The patient should have had only one 25 mcg/hr patch. Clinical Impression: Intentional Fentanyl overdose. The hospital History and Physical dated 9/5/2018 included: Patient found in nursing home with decreased responsiveness and brought in by ambulance. It is understood that the patient was found to have multiple Fentanyl patches, three were found. The patient is difficult to arouse, patient was given	F 760	Newly hired licensed nurses will recieve the same education prior to working on the floor. Education for current licensed nurses was completed on September 5, 2018. The DON and/or designee will audit all patients who have medicated patch orders 5 times per week for 2 weeks, 2 times per week for 2 weeks, then weekly for 2 weeks. The DON and/or designee will be monitoring all Fentanyl patches are placed and removed by 2 nurses, the patch placement is documented in the MAR and the patch was removed and disposed of in accordance with facility guidelines. All findings will be submitted to the QA&A committee with additional corrective action to be recommended as needed. Completion Date: September 24, 2018	

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F 760	Continued From page 2	F 760		

Narcan and on Bi-Pap and working hard to breathe.
Principal Problem: unresponsiveness, hypercarbic respiratory failure, acute encephalopathy, and overdose with Fentanyl patch.
Plan: Admit to ICU (Intensive Care Unit), level one, Bi-Pap, Narcan drip.
The hospital Discharge Summary dated 9/8/2018 included:
Follow up issues: Monitoring pain medication side effects and confirming that only one Fentanyl patch is being used.
Hospital Course: Admitted to ICU on Bi-Pap and Narcan drip for Fentanyl patch overdose. Three patches were found on his back, likely and oversight when they should have been removed prior to replacement every 72 hours. Patient eventually became alert and usual state of consciousness. Upon discharge, orders were carefully written to remove the patch prior to replacing it every 72 hours.

The facility Incident Report included:
Patient sent to Emergency Room (ER) for respiratory issues on the morning of 9/5/2018. It was reported per phone from the ER nurse that there were 3 Fentanyl patches found on the patient, one on the back dated 9/2/2018, and two on the chest area, one dated 8/27/2018 and one too smudged to make out the date.

During an interview on 9/11/2018 at approximately 10:30 a.m., Resident #1 reported he went to the hospital because he/she had three patches on and it made him/her in la la land. In July he/she had two patches on but he/she also had a urinary tract infection.

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F 760	Continued From page 3 During a phone interview on 9/11/2018 at 11:20 a.m., Resident #1's physician reported the July, 2018 incident where the resident went to the ER with two Fentanyl patches on, could have been attributed to the fact that the resident had a urinary tract infection. However, with regards to the September 5 incident , the resident had nothing else going on and the symptoms were due to having on three Fentanyl patches. During an interview on 9/7/2018 at 10:50 a.m., Staff A, DON (Director of Nursing) revealed after the July incident when Resident #1 went to the ER with 2 Fentanyl patches on, staff involved were educated. After the September 5 incident, they educated all nursing staff and implemented a new policy where two nurses administer the patch, two nurses remove and destroy the old patch every 72 hours. The hospital informed Staff A the resident had two patches on his/her chest and one on his/her back. During an interview on 9/7/2018 at 12:05 p.m., Staff B, RN (Registered Nurse), Unit Manager reported being called to Resident #1's room on 9/5/2018 and observed the resident staring and difficult to get a response with an oxygen saturation of 82 %. They called 911 and sent the resident to the ER. Staff B observed the resident's back and saw one patch and did not check the resident's chest. The resident had a history of respiratory failure. The facility implemented a new policy with two staff administering and removing the patches. The facility Medication Administration: Transdermal Drugs policy included: Purpose: To administer medication for systemic	F 760		

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F 760	Continued From page 4 or local effect by way of applying to skin. Procedure: 6. Examine patient's chest, back and shoulders for any residual medication patches. Remove previous patch and wipe away any remaining medication. Dispose of controlled substance medication patches by folding in half and discarding into sharps container. 7. Select and alternate placement site. 8. Label medication administration paper or disk with date, time and initials.	F 760		