STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065386	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado State Veterans Nursing Home - Rifle	851 E 5th St Rifle, CO 81650

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure timely physician visits for four (#9, #10, #12 and #13) of five residents reviewed for new admission physician visits out of 13 sample residents. Specifically, the facility failed to ensure the physician evaluated Resident #9, Resident #10, Resident #12 and Resident #13 within 30 days following admission to the facility. Findings include: I. Facility policy and procedure The Physician Visits and Delegation policy, revised 5/6/24, was provided by the nursing home administrator (NHA) on 6/5/24 at 1:48 p.m. It revealed in pertinent part, The physician should: -See the resident within 30 days of initial admission to the facility; -The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by the physician or physician delegate as appropriate by state law; and, -Review the resident's total program of care including medications and treatments at each visit. II. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician's order (CPO), diagnoses included heart failure, atrial fibrillation (irregular heart rhythm), edema, bladder dysfunction, pelvic pain and hypertension. The 4/30/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident had an indwelling catheter and was prescribed antidepressants and diuretic medications. B. Record review (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #9's electronic medical record (EMR) revealed the physician did not see the resident until 4/2/24, 57 days after the resident was admitted to the facility. III. Resident #12 A. Resident status Resident #12, age 79, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included hypertension, idiopathic progressive neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), sleep apnea and osteomyelitis. The 6/5/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident was prescribed opioid and antiplatelet medications. B. Record review -A review of Resident #12's EMR revealed the physician did not see the resident until 4/2/24, 47 days after the resident was admitted to the facility. IV. Resident #13 A. Resident status Resident #13, age 85, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia with behavioral disturbances, adjustment disorder, bipolar disorder, diabetes, hypertension and osteoarthritis. The 6/6/24 MDS assessment revealed the resident had severely impaired cognition with a BIMS score of six out of 15. The resident was prescribed antipsychotic, antidepressant, diuretic, opioid and hypoglycemic medications. B. Record review -A review of Resident #13's EMR revealed the physician did not see the resident until 4/2/24, 47 days after the resident was admitted to the facility. V. Resident #10 Resident #10, age less than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included heart failure, atrial fibrillation, dementia, benign prostatic hyperplasia, conjunctivitis and hypertension. The 6/5/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. The resident had an indwelling catheter and was prescribed antidepressants and anticoagulant medications. B. Record review (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #10's EMR revealed the physician did not see the resident until 4/2/24, 42 days after the resident was admitted to the facility. VI. Staff interviews The director of nursing (DON) was interviewed on 6/6/24 at 9:02 p.m. The DON said residents should be seen timely by the physician following admission to the facility. The DON said the facility had talked to the residents' physician about the requirement to see the residents within 30 days of admission. The medical director (MD) was interviewed on 6/6/24 at 12:58 p.m. The MD said the facility had some issues in regards to the physician seeing residents within the first 30 days after admission and the frequency of physician's visits. The MD said she was working with the resident's physician to establish a more consistent schedule for physician visitation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on interviews, observations and record review, the facility failed to ensure one (#1) of five residents out of 13 sample residents was free from significant medication errors. On 5/16/24, when Resident #1 was no longer able to swallow oral medication prescribed for pain relief, registered nurse (RN) #1 consulted with the resident's hospice provider and primary care practitioner for alternative medication orders. Nurse practitioner (NP) #1 called in a prescription for liquid morphine sulfate 20 milligrams (mg)/5 milliliters (ml), give 3.75 ml (which equaled 15 mg) and entered the new order into the resident's electronic medical record (EMR). RN #1 obtained a bottle of liquid morphine sulfate solution from the facility's emergency stock medication supply and proceeded to administer the medication to RN #1. RN #1 failed to perform a dosage check on the bottle of morphine sulfate solution obtained from the facility's backup medication stock and compare it to the order written by NP #1. RN #1 drew up and administered 3. 75 ml of the morphine sulfate solution and gave the medication to the resident. -However, the dosage of the morphine sulfate solution obtained from the facility's backup medication stock was 20 mg/1 ml, which resulted in Resident #1 receiving five times (75 mg) the amount of morphine sulfate ordered by NP #1. RN #1 failed to follow professional standards of nursing practice and perform the seven rights of medication administration to ensure safe and effective care and treatment of a resident in her care. As a result of RN #1's failure to complete a dosage check on the medication before administering the prescribed medication, Resident #1 received an excessively high dose of morphine sulfate solution (five times the prescribed dose of medication), which likely caused the acceleration of the resident's passing away. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/3/24 to 6/6/24, resulting in the deficiency being cited as past noncompliance with a correction date of 5/26/24. I. Situation of serious harm The facility failed to ensure Resident #1 was administered the correct dose of morphine sulfate solution when RN #1 failed to perform the seven rights of medication administration and check the medication label to confirm the dosage of the medication obtained from the facility's backup medication stock was the same dosage ordered by NP #1. RN #1's failure to follow NP #1's prescribed order for pain medication led to Resident #1 being given an excessively high dose of morphine sulfate on 5/15/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review and interviews during the complaint investigation confirmed the deficient practice had been corrected and the facility was in substantial compliance at the time of the survey from 6/3/24 to 6/6/24. II. Facility plan On 6/3/24 the nursing home administrator (NHA) provided the facility's investigation, report of findings and records of corrective action related to the morphine sulfate solution overdose incident. The incident occurred on 5/15/24 at 7:07 p.m. On 5/16/24 an investigation was initiated upon discovery of the incident and remained ongoing pending a determination of the nurse's employment status. The facility initiated several corrective action measures including: On 5/16/24 the pharmacy consultant alerted the facility that Resident #1 was prescribed morphine sulfate solution in a concentration that was higher than the dose the facility had in its emergency backup medication stock. The pharmacy consultant recommended the facility perform a dosage check to ensure the nurses were aware of the difference in the dosage concentration of the morphine sulfate solution that was ordered by NP #1 versus the dosage concentration of the medication that was in the facility's backup medication stock. At the time of the pharmacy alert, the resident had already passed away. On 5/16/24 the facility's administration immediately interviewed RN #1, who had administered the first and only dose of the newly prescribed morphine sulfate. On 5/16/24, upon verification that RN #1 had administered an incorrect dose of morphine sulfate, RN #1 was immediately suspended, pending the outcome of the investigation. On 5/16/24, immediately upon the discovery that RN #1 had made a significant medication error, the facility administration took the following measures to place corrective actions to prevent future errors in the administration of liquid morphine sulfate. On 5/16/24 the facility conducted an audit of all residents receiving liquid morphine sulfate solution to ensure the medication orders were accurate and matched the liquid morphine sulfate medication provided by the pharmacy for each resident. On 5/16/24 the facility reported RN #1's performance was reported to the State Licensing Board for review, The licensing board opened an investigative case on 5/21/24. On 5/16/24 the facility's administration reviewed the facility's policy for Medication Administration for accuracy. No changes were required to the policy. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/17/24 the facility contacted hospice providers and other prescribers to educate the prescribers about the availability of the liquid morphine sulfate solution concentration that the facility had in the emergency backup medication stock. The facility requested the prescribers to prescribe effective medication dosages for morphine sulfate solution in concentrations of 20 mg/1 ml (the dosage concentration that was in the facility's backup medication stock). On 5/17/24 The facility contacted the pharmacy to ensure there was a system in place for the pharmacy to perform a medication check on all morphine sulfate solution orders to ensure accurate dosing of the initial physician's order of liquid morphine sulfate to a resident. On 5/20/24 the facility contacted Resident #1's hospice provider for guidance and other resources for the accurate administration of liquid morphine sulfate. The hospice nurse provided the facility with a resource for morphine sulfate solution conversions. The resource provided a conversion chart for various dosage concentrations of morphine sulfate solution to the dose that the facility had on hand (20 mg/1 ml) in their backup medication stock. The resource further provided instructions on how to administer and calculate dosage per medication concentration for accurate administration. By 5/26/24 all licensed nurses were educated and provided instructions on the proper administration of liquid morphine in various concentrations, including how to calculate the proper dosage of the medication if the medication on hand was not the concentration ordered by the prescriber. In addition, the nurses were instructed in methods of proper medication administration, including following the seven rights of medication administration. The facility would discuss the incident and monitor the corrective actions in the Quality Assurance and Performance Improvement meetings to determine if further corrective actions were needed. Interviews and record reviews during the complaint investigation from 6/3/24 to 6/6/24 revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place. III. Professional reference According to the Food and Drug Administration (FDA) Highlight of Prescribing Information Morphine Sulfate Oral Solution - Scheduled II controlled substance, retrieved on 5/10/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022195s002lbl.pdf, Morphine oral solution is available in 10 mg per 5 ml, 20 mg per 5 ml and 100 mg per 5 ml (20 mg/ml) concentrations. Take care to avoid dosing errors due to confusion between different concentrations and between mg and ml. Warnings and Precautions: Risk of Medication Errors: Use caution when prescribing, dispensing, and administering to avoid dosing errors due to confusion between different concentrations and between mg and ml, which could result in accidental overdose and death. Respiratory depression: Increased risk in elderly, debilitated patients, those suffering from conditions accompanied by hypoxia, hypercapnia, or upper airway obstruction. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Elderly patients (aged [AGE] years or older) may have increased sensitivity to morphine sulfate. Acute overdose with morphine sulfate is manifested by respiratory depression, a decrease in respiratory rate and/or tidal volume (airflow through the lungs), Cheyne-Stokes respiration (fast shallow breathing followed by slow heavier breathing and no breath), and cyanosis (shortage of oxygen in the blood and bluing of the skin), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity (condition of being soft and limp), cold and clammy skin, constricted pupils, and, in some cases, pulmonary edema, bradycardia (slowing heart rate), hypotension (low blood pressure), cardiac arrest and death. IV. Facility policies and procedures The Medication Administration policy, revised on 10/20/23, was provided by the NHA on 6/3/24 at 1:13 p.m. The policy read in pertinent part, It is the policy of (facility name) that medications are administered by licensed nurses as ordered by the licensed provider and in accordance with professional standards of practice, in a manner to prevent errors, contamination, and/or infection. The nurse is responsible for following the seven (7) rights of medication administration: -Right resident; -Right medication; -Right dose; -Right time; -Right route; -Right documentation; and, -Right to refuse. Review the medication administration record (MAR) to identify the medication to be administered. The MAR is used to reflect current orders for administration of medications and as documentation of medication administration. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Refer to drug reference material if unfamiliar with the medication such as the mechanism of action or common side effects. V. Significant medication error A. Resident status (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1, over the age of 65, was admitted on [DATE] and passed away on 5/15/24. According to the May 2024 computerized physician orders (CPO), diagnoses included congestive heart failure, atrial fibrillation, aortic stenosis, pulmonary hypertension and chronic pain. The 4/15/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment documented the resident was receiving opioid and antidepressant medications. The assessment documented the resident was receiving hospice care. B. Record review The facility investigation, dated 5/16/24, documented the following: On 5/16/24 at approximately 12:45 p.m., the consultant pharmacist (CP) alerted facility staff that there could have been a potential discrepancy between a medication order for morphine sulfate and the actual medication administration of the resident because the facility did not have the morphine sulfate dosage concentration that was ordered available at the facility in the emergency back up medication stock and the pharmacy had not yet delivered the ordered dosage concentration to the facility. Facility leadership initiated an immediate investigation and attempted to reach RN #1, who was the nurse who signed as having administered the resident's medication immediately after the prescriber placed the order. As a part of the investigation, RN #1 was interviewed by the director of nursing (DON) and NHA on 5/16/24 at 4:06 p.m. RN #1 was asked to explain the administration of liquid morphine sulfate prescribed to Resident #1 on 5/15/24. RN #1 said she administered a total of 3.75 ml of the liquid morphine sulfate from the 20 mg/ 1 ml dosage concentration bottle she had obtained from the facility's emergency backup medication stock. The NHA asked RN #1 to explain in detail how she measured out the dose of liquid morphine and RN #1 said she drew up the medication from the available morphine sulfate backup medication stock using a one ml syringe. RN #1 said she filled the syringe four times until she measured out 3.75 ml and poured each syringe full of liquid medication into a cup for administration. During the interview the DON read the morphine sulfate solution order from the MAR (20 mg/5 ml, give 3.75 ml), pointing out that was not the concentration the facility had in the backup medication stock. When the DON informed RN #1 that giving 3.75 ml of the facility's available dosage concentration meant that Resident #1 received 75 mg of morphine versus the prescribed dose of 15 mg that was ordered, RN #1 said she did not even notice that the order read 20 mg/5ml and assumed that the prescriber wrote the order for the standard dose that the facility had in the emergency backup medication stock. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN #1 was interviewed a second time on 5/16/24 at approximately 4:15 p.m., by the NHA, DON and a higher level of the administrative staff. RN #1 gave the same interview information and said she did not read the order or perform a dosage check and she instead assumed that the order was for morphine sulfate at a dosage concentration of 20 mg/1 ml because that was what the facility had available in the backup medication stock. Immediately following the interview, RN #1 was placed on administrative leave pending investigation. A review of Resident #1's EMR revealed the following information: A medical provider note, dated 5/15/24 at 10:59 a.m., revealed the resident was seen by NP #1 on 5/14/24, at the request of the resident's son, to evaluate and manage acute concerns when the resident reported she did not feel well. Resident #1 reported nausea after eating lunch but denied cough, congestion or breathing difficulties. The resident was using oxygen continuously at a flow rate of 3.5 liters per minute (LPM). Resident #1 was seen again by NP #1 on 5/15/24 after breakfast and continued to complain of not feeling well and not wanting to get out of bed. NP #1 recommended lab work to assess changes in condition. The resident was taking several medications for pain relief including MS Contin (morphine sulfate) oral tablet extended release15 mg two times a day for pain, duloxetine oral capsule delayed release 60 mg one time a day for chronic pain, lidocaine external patch 4 percent for pain relief of an affected area, naproxen sodium oral tablet 220 mg two times a day for arthritis pain and hydrocodone-acetaminophen oral tablet 5-325 mg every six hours as needed for pain. The physical exam revealed the resident was alert with no apparent distress and poor memory, her pupils were equal size and there was no jugular vein distention noted. The resident had normal respiration effort in the left lung but had crackling sounds in the right lung and an irregular cardiac murmur (a whooshing sound made by rapid, choppy blood flow through the heart). The resident had fluid retention in both lower extremities and both lower extremities were pale and cool to the touch. The resident's other skin areas were warm and dry. The resident's mood was euthymic (calm and tranquil). A medical provider note dated 5/15/24 at 7:01 p.m. documented RN #1 called NP #1 and informed her the patient was unable to safely take MS Contin oral tablets related to her current condition. NP #1 documented a change in morphine orders to give the resident a one-time dose of liquid morphine sulfate solution that evening and then, beginning the next day, orders for liquid morphine sulfate solution 15 mg twice a day. The May 2024 MAR documented an order for morphine sulfate solution entered on 5/15/24 at 6:59 p.m. by NP #1 and confirmed by RN #1 at 7:01 p.m. The order read, Morphine sulfate oral solution 20 mg/5 ml. Controlled drug. Give 3.75 ml by mouth one time only for chronic pain until 5/16/24. The May 2024 MAR displayed a black box warning that read in pertinent part, To reduce the risk of respiratory depression, proper dosing and titration of morphine are essential. Risk of medication errors (oral solution). Ensure accuracy when prescribing, dispensing, and administering morphine sulfate oral solution. Dosing errors due to confusion between mg and ml, and other morphine solutions of different concentrations, can result in accidental overdose and death. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing note, dated 5/15/24, read in pertinent part, At approximately 8:45 p.m., the certified nurse aide (CNA) alerted this nurse that there was a change in the resident's condition. The resident's skin was observed to be a waxy color and the resident took no breaths in 90 seconds. There was a faint heartbeat detected with a stethoscope. At 8:50 p.m. the resident no longer had a detectable pulse, heart sounds, breath sounds, or blood pressure. The resident's pupils were fixed and dilated. A narcotic count sheet started for Resident #1's liquid morphine sulfate solution documented that RN #1 initiated the first dose of morphine sulfate at 7:05 p.m. The form documented the morphine sulfate bottle had 30 ml of medication and the medication concentration was 20 mg/ 1 ml. RN #1 documented and signed that she drew up and gave Resident #1 3.75 ml of the morphine sulfate leaving 26.25 ml in the bottle. -However, the above amount given (3.75 ml) from the bottle of morphine sulfate was incorrect and excessive. The prescriber's order read Morphine sulfate 20 mg/5 ml give 3.75 ml. -Giving an amount of 3.75 ml at a concentration of 20 mg/1 ml meant Resident #1 received 75 mg of morphine instead of the prescribed dose of 15 mg of morphine, which was five times the prescribed dose. The May 2024 MAR revealed RN #1 gave the resident the incorrect dose of morphine sulfate at 7:07 p.m. VI. Staff interviews RN #1 was interviewed on 6/4/24 at 1:00 a.m. RN #1 said the pharmacy filled prescribed medications, however, the facility had an emergency backup medication stock for situations when a resident needed to start a medication right away and could not wait for the pharmacy to process and deliver the medication, as it could take hours or days. RN #1 said morphine sulfate solution 20 mg/1 ml was the only concentration of morphine sulfate solution available in the backup medication stock. RN #1 said when a nurse obtained morphine sulfate solution from the backup medication stock, the nurse was to verify the dosage concentration and compare it to the physician's order for accuracy. She said the verification process should occur each time the medication was administered to ensure accurate medication administration. RN #1 said she had recently received education on performing the seven rights of medication administration and was also educated on how to calculate the proper medication doses based on different concentrations of morphine sulfate solution to ensure the accuracy of the medication administered to a resident matched the prescriber's orders. The CP was interviewed on 6/4/24 at 12:36 p.m. The CP said orders were usually entered into the resident's EMR and transferred to the MAR so the nurse could administer the medication at the proper dosage, frequency, time and route. He said once a medication order was entered into the EMR, a second person, usually a nurse from the facility, was to check and verify the entered order for accuracy. The CP said after the second check was completed, the computerized system automatically sent the order electronically to the pharmacy where the pharmacist would perform a triple check to verify the order and screen for any drug interactions, warnings or inaccuracies. The CP said the third check occurred during normal business hours. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The CP said if the third check revealed any concerns, the facility would be alerted of the concern. The CP said it was then up to the facility staff to contact the prescriber for further potential recommendations related to the alert and to act appropriately in coordination with the prescriber to avoid any drug interactions. The CP said the pharmacists were also available for further consultation if needed. The CP said when the physician's order for Resident #1's morphine sulfate solution at a concentration of 20 mg/5 ml was received by the pharmacy, he was concerned because he knew the nursing facility did not have the 20 mg/5 ml dosage concentration in the backup medication stock. He said the facility only had morphine sulfate solution 20 mg/1 ml in the backup medication stock and if the nurse gave the prescribed amount of 3. 75 ml at the concentration of 20 mg/1 ml it would have been too much medication and would have caused an overdose of Resident #1. RN #1 was interviewed a second time on 6/4/24 at 3:02 p.m. RN #1 said she went to Resident #1's room around 6:45 p.m. to give the resident her medication. Resident #1 said she was ready to take her medications but was unable to swallow her pills so she called the resident's medical provider and requested an order for liquid morphine sulfate. RN #1 said NP #1 answered the phone call and said she would enter a new medication order for liquid morphine sulfate solution. RN #1 said the order showed up on the resident's MAR a few minutes later and she obtained the medication from the facility's backup medication stock. RN #1 said she went to the facility's backup medication stock and obtained a bottle of morphine sulfate solution in the dosage concentration of 20 mg/1 ml from the backup medication stock. RN #1 said the only morphine sulfate solution the facility had in its backup medication stock was in the dosage concentration of 20 mg/1 ml. RN #1 said at approximately 7:05 p.m., she drew up and gave Resident #1 what she thought was the prescribed dose of 3.75 ml of the morphine sulfate solution. RN #1 said when she obtained the medication from the facility's backup medication stock and went to administer the medication to Resident #1, she failed to check the order with the morphine sulfate solution on hand and did not notice that the physician's order was for a different dosage concentration than the available dosage concentration of morphine sulfate solution. She said she drew up 3.75 ml as the order indicated and administered it to the resident. RN #1 said the proper steps in medication administration were to read the physician's order to confirm that the medication on hand was the correct medication and the correct dose. She said she would also make sure to check the resident's name and make sure the resident did not have related medical allergies RN #1 said after giving Resident #1 the liquid morphine sulfate,she looked in on her a couple of times and noticed that her breathing was labored. She said a little after 8:00 p.m., the CNA informed her Resident #1 was not breathing. She said when she assessed Resident #1 she had a weak heartbeat and was not breathing. RN #1 said as the night went on she began to think more about the events of the evening and started to question the amount of morphine sulfate solution she had administered to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065386	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorado State Veterans Nursing Home - Rifle	851 E 5th St Rifle, CO 81650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN #1 said following her shift, she had a discussion about the medication error with the DON. She said they discussed the incident in detail and she received education regarding medication administration. RN #1 said going forward she would perform the seven rights of medication administration and would verify all medication administrations for accuracy. RN #1 said she would also ask another nurse to double-check the physician's order with her to ensure she administered the medication correctly. NP #1 was interviewed on 6/4/24 at 3:50 p.m. NP #1 said, on 5/15/24 at approximately 7:00 p.m., she received a call from RN #1 who told her Resident #1 was unable to swallow her medication and she wanted to know if she could switch the MS Contin oral tablets over to a liquid form of morphine sulfate. NP #1 said she told RN #1 she would enter an order for liquid morphine sulfate. NP #1 said she did not discuss anything further with RN #1. The medical director (MD) was interviewed on 6/6/24 at 12:58 p.m. The MD was aware that Resident #1 was given an overdose of morphine sulfate by RN #1. The MD said, following the incident, she talked at length with the DON and the NHA about the potential causes and developed a plan of correction. The MD said the physician's order was written correctly by a provider but it was written at a strength that was not commonly used and at a dosage concentration that was not immediately available to the facility. She said the administration of the incorrect dose of morphine sulfate solution was RN #1's error as she did not check the medication strength with the physician's order before administering the medication to Resident #1. The DON was interviewed on 6/4/24 at 1:25 p.m. The DON said once she was notified by the pharmacist that there was a concern about Resident #1's morphine sulfate solution order and a potential for a medication error, she began an immediate investigation. She said the investigation revealed Resident #1 was given an incorrect dose of morphine sulfate solution. The DON said RN #1, who gave the incorrect dosage of morphine sulfate, was placed on immediate suspension. The DON said she provided immediate education to all licensed nurses on properly verifying all physician's orders for accuracy and how to calculate proper morphine doses if the provider ordered a morphine dosage concentration different from the morphine available in the facility's backup medication stock. The DON said the facility also talked to the medical providers to educate them about the facility's available dosage concentration of morphine sulfate solution. The NHA was interviewed on 6/6/24 at 3:01 p.m. The NHA said the details of the medication error incident would be presented at the next quality assurance quality improvement (QAPI) meeting. The NHA said the QAPI committee was expected to review the investigation findings and complete corrective actions to determine if further corrective actions were needed.