

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 241-2345  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 241-2358

June 9, 2011

Susan Laninfa, Administrator  
Pine Heights At Brattleboro Center  
187 Oak Grove Avenue  
Brattleboro, VT 05301

Provider ID #:475023

Dear Ms. Laninfa:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on  
**May 11, 2011.**

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



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

PRINTED: 05/23/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/11/2011
NAME OF PROVIDER OR SUPPLIER  PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R			STREET ADDRESS, CITY, STATE, ZIP CODE 187 OAK GROVE AVENUE BRATTLEBORO, VT 05301		
(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	INITIAL COMMENTS	F 000			
F 281 SS=G	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide services that meet professional standards of quality for one resident. (Resident # 1) Findings include:</p> <p>Per record review on 5/11/11 Resident # 1, who is elderly and has had a long history of diarrhea and chronic kidney disease, was administered an opioid narcotic at an incorrect dose resulting in a period of hospitalization between 5/1/11 and 5/9/11, with a diagnosis of opioid overdose.</p> <p>On the afternoon of 4/29/11 Opium Tincture was delivered to the facility by the contracted pharmacy for Resident # 1. Because there was no written physician or telephone order (s) at the facility for this narcotic medication, it was sent back to the pharmacy. During the evening of 4/29/11 at 6 PM the physician visited the facility and wrote an order to 'Proceed with Tincture of Opium - trial as ordered.' The physician conferenced with the staff nurse regarding the resident's codeine allergy and stated that after</p>	F 281	<p>F-281</p> <ol style="list-style-type: none"> <li>1. Resident #1 has returned to the facility on 5/9/11</li> <li>2. All residents who receive medication are at risk to be effected by this alleged deficient practice.</li> <li>3. An initial audit of all residents' medication regimens will be completed by the nursing staff. Any doses that are outside the acceptable standard will be called to the MD for clarification. All unacceptable abbreviations shall be corrected to reflect nationally excepted standards. Completed by 6/4/11</li> <li>4. Memo to Pharmacy and Physicians informing them that this facility will no longer accept any physicians orders that do not conform to the nationally excepted list of abbreviations or do not conform to generally acceptable standards of practice for dosing. Completed by 5/27/11</li> </ol>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Susan K. [Signature]* TITLE *Administrator* (X6) DATE *6/2/11*

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 281	<p>Continued From page 1</p> <p>consulting with the pharmacist s/he would proceed with the Opium trial for the resident's symptoms of acute diarrhea.</p> <p>Per interview with the staff nurse on 5/11/11 at 1:20 PM who was on duty the evening of 4/29/11, s/he asked the physician to clarify the Opium order. The physician was unable to clarify the order stating to the nurse that s/he could not remember the 'strength of the dose' that s/he had ordered from the pharmacy. The nurse asked the physician if s/he should write the telephone order based on the pharmacy label and the physician said 'yes.'</p> <p>The medication arrived the evening of 4/29/11 with the label stating, 'Opium Tincture 10 mg/ml, take 6 mls [milliliters] PO [by mouth] QID [four times per day].' The nurse confirmed that s/he wrote a telephone order to this effect and sent it to the physician. In addition, s/he confirmed that although s/he was unfamiliar with the drug, s/he failed to call the on-call pharmacist for drug dosage parameters when the Nurses Drug Handbook (2009 Edition) failed to have any information listed for the medication. Per interview on 5/11/11 at 1:40 PM the nurse confirmed that, 'looking back, I should not have done that.' (taking the information off the label and sending it to the physician as a telephone order) In addition, the nurse confirmed s/he 'could have called the on-call pharmacist' to get information regarding the usual dosing instructions, but did not.</p> <p>Per interview on 5/11/11 at 11:15 AM the DNS (Director of Nursing Services) confirmed that they had obtained a copy of the prescription the</p>	F 281	<p>5. Nursing staff shall be re-educated as to their responsibility for safe administration of medication and the nationally excepted abbreviations. Completed by 6/7/11</p> <p>6. All interim orders and monthly orders shall be reviewed by the Clinical care coordinators to ensure continued compliance with this plan.</p> <p>7 An weekly random audit shall be performed by the DNS or designee to also ensure continued compliance with this plan. 6/3/11</p> <p>8. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee</p> <p><i>F281 POC Accepted 6/9/11 D. Chittenden RN / P. McStarn</i></p>		

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F 281	<p>Continued From page 2</p> <p>physician had faxed to the pharmacy as well as the fax that had been received by the pharmacy, and both faxed copies were reviewed by this surveyor. The prescription the physician sent to the pharmacy was written as .6 mls (point 6 mls) PO QID without a zero in front of the decimal point. The pharmacy filled the prescription as 6 mls (six mls) PO QID.</p> <p>The DNS confirmed that the prescription filled by the pharmacy was 6 mls (six mls) PO QID. In addition, this surveyor viewed the bottle sent by the pharmacy, which was still locked in the medication cart. The label read, 'Opium Tincture 10 mg/ml. Take 6 mls by mouth four times a day.' Per review of the Nursing Drug Handbook 2004 edition, 6 mls of Opium Tincture is the maximum daily dose for a 24 hour period.</p> <p>On 4/30/11 the resident received a total of 2 doses of the Opium Tincture at 6 mls, equaling 12 mls total. During that evening s/he became lethargic, his/her limbs were cold, s/he had involuntary twitching and his/her blood pressure and pulse were low. S/He was transferred to the hospital, sent back to the facility, then transferred back to the hospital when s/he was subsequently hospitalized for 9 days with a diagnosis of an opium overdose.</p> <p>Reference: 1. Per Nursing Drug Handbook 2004 edition: Opium Tincture: Adults dosage: 0.6 ml PO QID. Maximum, 6 ml daily 2. Geriatric Dosage Handbook (Lexi-Comp, the official drug reference for the American Pharmacists Association) 12 th Edition. Todd P.</p>	F 281		

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F 281	Continued From page 3 Semla PharmD BCPS, FCCP. Page 17. 'Safe Prescription Writing' states: "Always Place a zero before a naked decimal (0.5 ml is correct, .5 ml is incorrect."	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental and psychosocial well-being for one resident. (Resident # 1) Findings include:  Per record review on 5/11/11 Resident # 1 who is elderly and has had a long history of diarrhea and chronic kidney disease was administered an opioid narcotic at an incorrect dose resulting in a period of hospitalization between 5/1/11 and 5/9/11, with a diagnosis of opioid overdose.  On the afternoon of 4/29/11 Opium Tincture was delivered to the facility by the contracted pharmacy for Resident # 1. Because there was	F 309	F-309 1. Resident #1 has returned to the facility on 5/9/11 2. All residents who receive medication are at risk to be effected by this alleged deficient practice. 3. An initial audit of all residents' medication regimens will be completed by the nursing staff. Any doses that are outside the acceptable standard will be called to the MD for clarification. All unacceptable abbreviations shall be corrected to reflect nationally excepted standards. Completed by 6/4/11	

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F 309	<p>Continued From page 4</p> <p>no written physician or telephone order (s) at the facility for this narcotic medication, it was returned to the pharmacy. During the evening of 4/29/11 at 6 PM the physician visited the facility and wrote an order to 'Proceed with Tincture of Opium - trial as ordered.' The physician conferred with the staff nurse regarding the resident's codeine allergy and stated that after conferring with the pharmacist s/he would proceed with the Opium trial for the resident's symptoms of acute diarrhea.</p> <p>Per interview with the staff nurse on 5/11/11 at 1:20 PM who was on duty the evening of 4/29/11, s/he asked the physician to clarify the Opium order. The physician was unable to clarify the order stating to the nurse that s/he could not remember the 'strength of the dose' that s/he had ordered from the pharmacy. The nurse asked the physician if s/he should write the telephone order based on the label and the physician said 'yes.'</p> <p>The medication arrived the evening of 4/29/11 with the label stating, 'Opium Tincture 10 mg/ml, take 6 mis [milliliters] PO [by mouth] QID [four times per day].' The nurse confirmed that s/he wrote a telephone order to this effect and sent it to the physician. In addition,, s/he confirmed that although s/he was unfamiliar with the drug, s/he failed to call the on-call pharmacist for drug dosage parameters when the Nurses Drug Handbook (2009 Edition) failed to have any information listed for the medication. Per interview on 5/11/11 at 1:40 PM the nurse confirmed that, 'looking back, I should not have done that.' (taking the information off the label and sending it to the physician as a telephone order) In addition, the nurse confirmed s/he</p>	F 309	<p>4. Memo to Pharmacy and Physicians indicating that this facility will no longer accept any physicians orders that do not conform to the nationally excepted list of abbreviations or do not conform to generally acceptable standards of practice for dosing. completed by 5/27/11</p> <p>5. Nursing staff shall be re-educated as their responsibility for safe administration of medication and the nationally excepted abbreviations. Completed by 6/7/11</p> <p>6. All interim orders and monthly orders shall be reviewed by the Clinical care coordinators to ensure continued compliance with this plan.</p> <p>7 An weekly random audit shall be performed by the DNS or designee to also ensure continued compliance with this plan. 6/3/11</p>	

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F 309	<p>Continued From page 5</p> <p>'could have called the on-call pharmacist' to get information regarding the usual dosing instructions, but did not.</p> <p>Per interview on 5/11/11 at 11:15 AM the DNS (Director of Nursing Services) confirmed that they had obtained a copy of the prescription the physician had faxed to the pharmacy and it was written as .6mls PO QID. (point 6 mls by mouth four times a day) The fax that the pharmacy received from the physician, although difficult to read because of the faxed copy, was filled as 6 mls PO QID. (six mls by mouth four times a day) In addition, this surveyor viewed the bottle sent by the pharmacy, which was still locked in the medication cart. The label read, 'Opium Tincture 10 mg/ml. Take 6 mls by mouth four times a day.' Per review of the Nursing Drug Handbook 2004 edition, 6 mls of Opium Tincture is the maximum daily dose for a 24 hour period.</p> <p>On 4/30/11, the resident received a total of 2 doses of the Opium Tincture (at 6 mls), equaling 12 mls total. During that evening s/he became lethargic, his/her limbs were cold, s/he had involuntary twitching and his/her blood pressure and pulse were low. S/He was transferred to the hospital, sent back to the facility, then transferred back to the hospital when s/he was subsequently hospitalized for 9 days with a diagnosis of an opium overdose.</p> <p>Reference: Per Nursing Drug Handbook 2004 edition: Opium Tincture: Adults dosage: 0.6 ml PO QID.</p>	F 309	<p>8. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee</p> <p>F309 POC Accepted 6/9/11 D. Chittenden RN / P. McTarn</p>	

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F 309	Continued From page 6 Maximum, 6 ml daily.	F 309		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that one resident (Resident # 1) received the correct dosage of a narcotic medication to prevent an unanticipated decline in the resident's status, which resulted in a hospitalization.. Findings include:	F 329	F-329 1. Resident #1 has returned to the facility on 5/9/11 2. All residents who receive medication are at risk to be effected by this alleged deficient practice. 3. An initial audit of all residents' medication regimens will be completed by the nursing staff. Any doses that are outside the acceptable standard will be called to the MD for clarification. All unacceptable abbreviations shall be corrected to reflect nationally excepted standards. Completed by 6/4/11 4. Memo to Pharmacy and Physicians indicating that this facility will no longer accept any physicians orders that do not conform to the nationally excepted list of abbreviations or do not conform to generally acceptable standards of practice for dosing. completed by 5/27/11	

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F 329	<p>Continued From page 7</p> <p>Per record review on 5/11/11 Resident # 1 who is elderly and has had a long history of diarrhea and chronic kidney disease was administered an opioid narcotic at an incorrect dose resulting in a period of hospitalization between 5/1/11 and 5/9/11, with a diagnosis of opioid overdose.</p> <p>On the afternoon of 4/29/11 Opium Tincture was delivered to the facility by the contracted pharmacy for Resident # 1. Because there was no written physician or telephone order (s) at the facility for this narcotic medication, it was sent back to the pharmacy.</p> <p>During the evening of 4/29/11 at 6 PM the physician visited the facility and wrote an order to 'Proceed with Tincture of Opium - trial as ordered.' The physician conferenced with the staff nurse regarding the resident's codeine allergy and stated that after consulting with the pharmacist s/he would proceed with the Opium trial for the resident's symptoms of acute diarrhea.</p> <p>Per interview with the staff nurse on 5/11/11 at 1:20 PM who was on duty the evening of 4/29/11, s/he asked the physician to clarify the Opium order. The physician was unable to clarify the order stating to the nurse that 'they could not remember the 'strength of the dose' that s/he had ordered from the pharmacy. The nurse asked the physician if s/he should write the telephone order based on the label and the physician said 'yes.'</p> <p>The medication arrived the evening of 4/29/11 with the label stating, 'Opium Tincture 10 mg/ml, take 6 mls [milliliters] PO [by mouth] QID [four</p>	F 329	<p>5. Nursing staff shall be re-educated as their responsibility for safe administration of medication and the nationally excepted abbreviations. Completed by 6/7/11</p> <p>6. All interim orders and monthly orders shall be reviewed by the Clinical care coordinators to ensure continued compliance with this plan.</p> <p>7 An weekly random audit shall be performed by the DNS or designee to also ensure continued compliance with this plan. 6/3/11</p> <p>8. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee</p> <p><i>F329 POC Accepted 6/9/11 D. Chittenden RN   Annotate RN</i></p>	

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F 329	<p>Continued From page 8</p> <p>times per day).' The nurse confirmed that s/he wrote a telephone order to this effect and sent it to the physician. In addition,, s/he confirmed that although they were unfamiliar with the drug, s/he failed to call the on-call pharmacist for drug dosaging parameters when the Nurses Drug Handbook (2009 Edition) failed to have any information listed for the medication.</p> <p>Per interview on 5/11/11 at 1:40 PM the nurse confirmed that, 'looking back, I should not have done that.' (taking the information off the label and sending it to the physician as a telephone order) In addition, the nurse confirmed s/he 'could have called the on-call pharmacist' to get information regarding the usual dosing instructions, but did not.</p> <p>Per interview on 5/11/11 at 11:15 AM the DNS (Director of Nursing Services) confirmed that they had obtained a copy of the prescription the physician had faxed to the pharmacy and received by the pharmacy, which this surveyor reviewed. The prescription the physician sent to the pharmacy was written as .6mls (point 6 mls) PO QID without a zero in front of the decimal point. The DNS confirmed that the prescription filled by the pharmacy was 6 mls (six mls) PO QID. In addition, this surveyor viewed the bottle sent by the pharmacy, which was still locked in the medication cart. The label read, ' Opium Tincture 10 mg/ml. Take 6 mls (six mls) by mouth four times a day.' Per review of the Nursing Drug Handbook 2004 edition, 6 mls of Opium Tincture is the maximum daily dose for a 24 hour period.</p> <p>On 4/30/11 the resident received a total of 2 doses of the Opium Tincture (at 6 mls), equaling</p>	F 329			

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F 329	Continued From page 9 12 mls total. During that evening s/he became lethargic, his/her limbs were cold, s/he had involuntary twitching and his/her blood pressure and pulse were low. S/He was transferred to the hospital, returned to the facility the next morning, was transferred back to the hospital where he was admitted for 9 days for an opium overdose.  Reference: 1. Per Nursing Drug Handbook 2004 edition: Opium Tincture: Adults dosage: 0.6 ml PO QID. Maximum, 6 ml daily. 2. Geriatric Dosage Handbook (Lexi-Comp-The official drug reference for the American Pharmacists Association) 12th Edition. Todd P. Semla, PharmD, BCPS, FCCP. Page 17 states: Always place a zero in front of a naked decimal (0.5 ml is correct, .5ml is incorrect)	F 329		
F 425 SS=G	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	F-425 1. Resident #1 has returned to the facility on 5/9/11 2. All residents who receive medication are at risk to be effected by this alleged deficient practice. 3. An initial audit of all residents' medication regimens will be completed by the nursing staff. Any doses that are outside the acceptable standard will be called to the MD for clarification. All unacceptable abbreviations shall be corrected to reflect nationally excepted standards. Completed by 6/4/11	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/11/2011
NAME OF PROVIDER OR SUPPLIER  PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING & R		STREET ADDRESS, CITY, STATE, ZIP CODE 187 OAK GROVE AVENUE BRATTLEBORO, VT 05301		
(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 425	<p>Continued From page 10 on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for one resident. (Resident # 1) Findings include:</p> <p>Per record review on 5/11/11 Resident # 1 who is elderly and has had a long history of diarrhea and chronic kidney disease was administered an opioid narcotic at an incorrect dose resulting in a period of hospitalization between 5/1/11 and 5/9/11, with a diagnosis of opioid overdose.</p> <p>On the afternoon of 4/29/11 Opium Tincture was delivered to the facility by the contracted pharmacy for Resident # 1. Because there was no written physician or telephone order (s) at the facility for this narcotic medication, it was sent back to the pharmacy. During the evening of 4/29/11 at 6 PM the physician visited the facility and wrote an order to 'Proceed with Tincture of Opium - trial as ordered.' The physician conferenced with the staff nurse regarding the resident's codeine allergy and stated that after consulting with the pharmacist s/he would proceed with the Opium trial for the resident's symptoms of acute diarrhea.</p> <p>Per interview with the staff nurse on 5/11/11 at</p>	F 425	<p>4.Memo to Pharmacy and Physicians indicating that this facility will no longer accept any physicians orders that do not conform to the nationally excepted list of abbreviations or do not conform to generally acceptable standards of practice for dosing completed by 5/27/11</p> <p>5. Nursing staff shall be re-educated as their responsibility for safe administration of medication and the nationally excepted abbreviations. Completed by 6/7/11</p> <p>6. Seek out and secure contract with new pharmacy vendor.</p> <p>7. All interim orders and monthly orders shall be reviewed by the Clinical care coordinators to ensure continued compliance with this plan.</p> <p>8 An weekly random audit shall be performed by the DNS or designee to also ensure continued compliance with this plan.</p> <p>6/3/11</p> <p>9. Results shall be reported to QAA committee monthly x3 months then frequency will by determined by committee</p> <p>F425 POC Accepted 6/9/11 D.Chittenden RN   P.Motara</p>	

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F 425	<p>Continued From page 11</p> <p>1:20 PM who was on duty the evening of 4/29/11, s/he asked the physician to clarify the Opium order. The physician was unable to clarify the order stating to the nurse that 'they could not remember the 'strength of the dose' that s/he had ordered from the pharmacy. The nurse asked the physician if s/he should write the telephone order based on the label and the physician said 'yes.'</p> <p>The medication arrived the evening of 4/29/11 with the label stating, 'Opium Tincture 10 mg/ml, take 6 mls [milliliters] PO [by mouth] QID [four times per day].' The nurse confirmed that s/he wrote a telephone order to this effect and sent it to the physician. In addition,, s/he confirmed that although they were unfamiliar with the drug, s/he failed to call the on-call pharmacist for drug dosage parameters when the Nurses Drug Handbook (2009 Edition) failed to have any information listed for the medication. Per interview on 5/11/11 at 1:40 PM the nurse confirmed that, 'looking back, I should not have done that.' (taking the information off the label and sending it to the physician as a telephone order) In addition, the nurse confirmed s/he 'could have called the on-call pharmacist' to get information regarding the usual dosing instructions, but did not.</p> <p>Per interview on 5/11/11 at 11:15 AM the DNS (Director of Nursing Services) confirmed that they had obtained a copy of the prescription the physician had faxed to the pharmacy and received by the pharmacy, which this surveyor reviewed. The prescription the physician sent to the pharmacy was written as .6mls (point 6 mls) PO QID without a zero in front of the decimal point. The DNS confirmed that the prescription</p>	F 425		

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F 425	<p>Continued From page 12</p> <p>filled by the pharmacy was 6 mls (six mls) PO QID. In addition, this surveyor viewed the bottle sent by the pharmacy, which was still locked in the medication cart. The label read, ' Opium Tincture 10 mg/ml. Take 6 mls (six mls) by mouth four times a day.' Per review of the Nursing Drug Handbook 2004 edition, 6 mls of Opium Tincture is the maximum daily dose for a 24 hour period.</p> <p>On 4/30/11 the resident received a total of 2 doses of the Opium Tincture (at 6 mls), equaling 12 mls total. During that evening s/he became lethargic, his/her limbs were cold, s/he had involuntary twitching and his/her blood pressure and pulse were low. S/He was transferred to the hospital, returned to the facility the next morning, and was transferred back to the hospital where he was admitted for 9 days for an opium overdose.</p> <p>Reference: 1. Per Nursing Drug Handbook 2004 edition: Opium Tincture: Adults dosage: 0.6 ml PO QID. Maximum, 6 ml daily. 2. Geriatric Dosage Handbook (Lexi-Comp-The official drug reference for the American Pharmacists Association) 12th Edition. Todd P. Semla, PharmD, BCPS, FCCP. Page 17 states: Always place a zero in front of a naked decimal (0.5 ml is correct, .5ml is incorrect)</p>	F 425		