CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NONE	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA MENS COLONY	N Hwy 1, SAN LUIS OBISPO, CA 93409 SAN LUIS OBISPO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00213591 - Substantiated Representing the Department of Public Health: Surveyor ID # 09671, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. T22 DIV5 CH1 ART-3-70263(g)(2) Pharmaceutical Service General Requirements (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory therapists. The order shall include the name of the drug, the dosage and the frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be		1. In order to prevent serious injury or death to a patient, Staff A was reassigned to a non-patient care position pending the outcome of the incident investigation and administrative review, and until Staff A's competency for medication administration could be verified. It should be noted that Staff A has not provided patient care since 10/20/09. Responsible: Director of Nursing (DON)/Chief Nurse Executive (CNE) Administrative review is continuing. Staff A continues to be reassigned to a non-patient care position. 2. California Men's Colony nursing policy and procedure titled, "Medication Administration Standards" was reviewed, and it was determined that no changes were required regarding medication administration in the acute care hospital. Responsible: DON/CNE	10/21/09 05/09/11 10/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/11 & 24/11

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Plan of Correction accepted 5/11/2011 - HH.
Facility notified.

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	Continued From page 1 written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatments shall be administered as ordered. Based on observation, interview, record review, facility document review and review of the Coroner's Report, the facility failed to implement their own policy to assure the right medication is given to the right patient; the licensed nurse failed to give Patient 2 the right medication. Patient 1 received Patient 2's dose of methadone and died as a result. THE NON-COMPLIANCE WITH ONE OR MORE OF THE REQUIREMENTS OF LICENSURE CAUSED OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO A PATIENT AND CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF THE HEALTH &SAFETY CODE, SECTION 1280.1. Findings: Record review revealed Patient 1 was a 76 year old who was confined to Room 211 - bed D. Patient 2 was in the same room in bed C, directly next to		3. Simulated, oral medication administration competency training and validation review was initiated with acute care hospital Registered Nurses on 11/11/09. Responsible: DON/CNE 4. California Men's Colony Registered Nurses shall be competency validated for oral medication administration. Responsible: DON/CNE 5. Compliance for medication administration for pain medication effectiveness will be monitored through the pain assessment documentation audit, which is completed monthly by the Shift Charge Nurses. Responsible: DON/CNE 6. Development of California Men's Colony, Health Care Services Patient Safety Committee to reduce potential medical/health care errors and develop the CMC Patient Safety Plan. Responsible: Chief Executive Officer, Health Care (CEO, HC)	05/09/10 9/18/10 06/20/10 & ongoing 04/12/11

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CEO 5/11-24/11

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	Continued From page 2 Patient 1. Patient 2 was to receive his regular 40 mg dose of Methadone on [redacted]/2009 at approximately 8 PM. Patient 2 complained to staff he did not receive his normal dose of Methadone. Patient 1 had no orders for Methadone and was stable in the evening hours of [redacted]/2009. At 5:20 am on [redacted]/2009 Patient 1 was found unresponsive, cold to the touch with his mouth open. CPR was initiated for 20 minutes but was unsuccessful and death was pronounced by Staff G, the MOD (Medical Officer of the Day) at 5:50 AM. The Coroners Report stated that on [redacted]/2009 at approximately 0800 hours, a Senior Deputy Coroner received a call from Staff J at CMC. Staff J told the Senior Deputy Coroner there was a chance the decedent had received a dose of methadone intended for another patient in the same room. A presumptive test of the urine was done and it was positive for Methadone. The Senior Deputy Coroner contacted Staff J and informed him the deceased had methadone in his system. The Coroner's Report further revealed the toxicology report was positive for Methadone. The cause of death was, Accidental Methadone Overdose (minutes) with Other Significant Condition contributing to death: Diabetes Mellitus, Atherosclerotic Heart Disease, Dilated Cardiomyopathy and Chronic Renal disease. The Senior Deputy Coroner said in an interview on 1/20/2010 at 1 PM Patient 1 was not prescribed Methadone and a 40 mg dose to a non tolerant user would not be within safety recommendations.			

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	Continued From page 3 The Coroner's Report states that medication administration records show that Staff A gave Patient 2 his 8 PM dose of Methadone. However, according to Patient 2, he complained to Staff A that he did not receive his Methadone dose and Staff A responded that he would come back and give it to him later - but never did. At around 12:45 AM, Patient 2 complained to Staff I on the next shift that he had not received his methadone. The inventories of narcotics indicate that only the prescribed amounts of Methadone were delivered during the shift. Documentation from Staff I on 10/21/2009 at 9 am states that Patient 2 complained he did not get his 8 PM dose of Methadone and indicates possibility that Patient 1 inadvertently received it. Lastly, the Coroner's report states there was no indication that Patient 2 gave his dose of methadone to Patient 1 and confirms Patient 2's complaint about not receiving his normal dose. The Senior Deputy Coroner's report indicated that based upon the facts and circumstances, it was likely Patient 1 received the dose of methadone that was intended for Patient 2. A review of the training record for Staff A showed he is an active Registered Nurse and that he had passed the facility Basic Medication Test on 10/16/2006, a Competency Medication Administration on 7/17/2007, Controlled Medication Administration on 9/28/2007 and Medication Accountability on 6/9/2008.			

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	Continued From page 4 A review of the facility policy Chapter 27 defines a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in control of the health care professional. Additionally, A medication error occurs when the medication are not administrated to the right patient. Staff A, a licensed Registered Nurse, was in charge of patient care and delivery of medications for Patient 1 and 2 on the evening shift of [redacted]/2009. Patient 2 complained he did not get his regular dose of Methadone and Patient 1died from a Methadone overdose. The facility's failure to administer as ordered Patient 2's Methadone dose constitutes non-compliance with one or more requirements of licensure and has caused or was likely to cause serious injury or death to a patient. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).			

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