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| F 000 | INITIAL COMMENTS<br><br>A complaint survey was conducted from 10/31/22 through 11/02/22. 1 of the 34 complaint allegations was substantiated resulting in a deficiency. 2 of 34 complaint allegations were substantiated but did not result in deficiencies. The following intakes were investigated NC00186013, NC00188207, NC00188929, NC00191436, NC00193096, NC00193152, NC00193800, NC00193192. Intake# NC00194111 resulted in immediate jeopardy. Event ID# YVL911. Past-noncompliance was identified at:<br><br>CFR 483.45 at tag F 760 at a scope and severity J.<br>The tag F760 constituted Substandard Quality of Care.<br><br>Non-compliance began on 09/05/22. The facility came back in compliance effective 09/13/22. A partial extended survey was conducted. | F 000 | | |
| F 760 SS=J | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interviews with staff, the facility physician and the Medical Director, the facility failed to administer the correct medications to a resident when Nurse #1 administered medications to Resident #7 that were prescribed for Resident #11. Resident #7 received 5 medications which included Eliquis (blood thinner), Gabapentin (for nerve pain), Metoprolol | F 760 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/17/2022

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 | F 760 | | |

(for blood pressure), Trazodone (antidepressant) and Clonazepam (for anxiety). Resident #7 was assessed by Nurse #1 on 9/6/22 at 12:10AM to have a heart rate of 48 and at 12:15AM a heart rate of 45. Resident #7 was transported to the Emergency Department (ED) for evaluation of altered mental status (AMS) and bradycardia (low heart rate). She was monitored in the intensive care unit (ICU) and it took her almost 2 days to become more alert. This failure occurred for 1 of 2 sampled residents reviewed for significant medication errors.

The findings included:

Resident #7 was admitted to the facility on 6/21/22 with diagnoses including atrial fibrillation, coronary artery disease (CAD), hypertension (HTN), renal insufficiency, diabetes mellitus (DM), Non-Alzheimer's dementia, seizure disorder and encephalopathy.

The admission Minimum Data Set (MDS) assessment dated 6/28/22 assessed Resident #7 with moderate impairment in cognition.

Review of the physician's orders for Resident #7 for September 2022 revealed the following routine medications:
Gabapentin 100 milligrams (mg) once daily at bedtime for pain
Eliquis 2.5mg twice daily for anticoagulant
Metoprolol 50mg twice daily for blood pressure
Hydralazine 25mg every 8 hours for blood pressure
Aspirin 81mg once daily for anticoagulant
Amlodipine 10mg once daily for blood pressure

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| F 760 | Continued From page 2<br>A list of bedtime medications, that Resident #7 received in error on 9/5/22 that were prescribed for Resident #11, was provided by the DON on 11/2/22 included the following:<br>Eliquis 5mg for blood thinner<br>Gabapentin 100mg for nerve pain<br>Metoprolol Tartrate 25 mg for blood pressure<br>Trazadone 50mg 1.5 tabs (total 75mg) for sleep<br>Clonazepam 1mg for anxiety<br><br>Review of Resident #7's medical record revealed documentation completed by Nurse #1 dated 9/6/22 at 12:55AM. Nurse #1 documented that Resident #7 had a change in condition with the following assessment findings:<br>-Seemed different than usual<br>-Blood pressure 132/76<br>- Heart rate 72<br>- Respiratory rate 18<br>- Oxygen saturation 97%<br>-Relevant medical history: Dementia, Diabetes<br>- Code Status: Do not resuscitate<br>- Primary Care Provider Feedback: Primary Care Provider responded with recommendations to monitor and send out for any acute changes<br>- Medication error called for further evaluation<br><br>During a phone interview with Nurse #1 on 10/31/22 at 4:25PM revealed she administered the wrong meds to Resident #7. She stated she was sharing a medication cart with another nurse and did not know she had pulled medications for Resident #11 and left them in a cup in the medication cart. As she was pulling Resident #7's medications, the DON told her to place protective eyewear on. She stepped away from the medication cart to put on her protective eyewear. When she returned to the medication cart, she pulled a cup of medications and gave | F 760 | | |

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the medications to Resident #7. She stated she did not realize the wrong meds were given until at the end of the shift Nurse #2 asked her where the meds were for Resident #11. She realized she gave Resident #7 the medications prescribed for Resident #11 around 11:00PM on 9/5/22. Resident #7 was sent out to the hospital around midnight the morning of 9/6/22. Nurse #1 confirmed the DON notified the on-call physician around midnight on 9/6/22.

Nurse #2 was not available for an interview during the investigation.

The Emergency Medical Services (EMS) report dated 9/6/22 revealed they received a call at 12:20AM and EMS arrived at the facility at 12:25AM. Upon arrival to the patient at 12:28AM the patient was found unconscious and unresponsive to tactile stimuli supine in bed. At 12:39AM, her blood pressure was 194/82, heart rate 86, strong, irregular, respirations 16 and shallow. At 12:50AM, blood pressure was 192/111, heart rate 78, strong, irregular, respirations 16 and shallow. EMS departed the facility with Resident #7 at 12:50AM and arrived at the hospital emergency department (ED) at 12:54AM.

The hospital discharge summary dated 9/10/22 revealed Resident #7 was admitted to the hospital on 9/6/22 with accidental overdose, altered mental status and bradycardia. Documentation revealed Resident #7 received additional Eliquis (blood thinner) total of 7.5 milligrams (mg), gabapentin 200mg (for nerve pain), metoprolol (for blood pressure) 75mg, trazodone (for sleep) 50mg, and clonazepam (for anxiety) 1mg. Resident #7 had received her own

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| F 760 | Continued From page 4<br>medications which included mirtazapine (for depression) 7.5mg and Vimpat (for seizures) 100mg. In the ED, her heart rate was in the 40's and she was transferred to the intensive care unit (ICU) for cardiac monitoring. She was closely monitored in the ICU and it took her almost 2 days to become more alert. Upon discharge from the hospital, Resident #7's heart rate was 74.<br><br>An interview was conducted with the Director of Nursing (DON) on 10/31/22 at 5:34PM. The DON stated she was working in the facility the night of 9/5/22 when Nurse #1 notified her that she gave Resident #7 another resident's medications. The DON notified the on-call physician service. The physician assistant gave orders to monitor the resident. When Nurse #1 assessed Resident #7 at 12:10AM, her blood pressure was 112/51, heart rate 48, respirations 16, oxygen saturation 97%. They decided to send her to the hospital because of the low heart rate. The DON stated the concern was that Nurse #1 had been distracted. Earlier in the evening, the DON noticed that Nurse #1 was not wearing protective eyewear. She asked Nurse #1 to put on her protective eyewear. Nurse #1 left the medication cart to get her protective eyewear. Before she was distracted by the DON, Nurse #1 reported she had pulled some of Resident #7's medications and placed them in a cup and labeled the cup with Resident #7's name. The medication cup was placed in the right side of the drawer of the medication cart before she left the cart to get her eyewear. When she returned to the med cart, she took a medication cup from the middle drawer that did not have a name on it. At the end of the night when Nurse #1 and Nurse #2 counted narcotics, Nurse #1 notified the DON that Nurse #2 asked for the cup of medications for | F 760 | | |

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Resident #11. Nurse #2 had placed the pre-poured medications for Resident #11 in the medication cart after Resident #11 refused the medications. The medications that were placed in the cart by Nurse #2 for Resident #11 were not in the cart. The DON stated the medication error was because Nurse #1 had been distracted, and Nurse #1 and Nurse #2 shared a medication cart that night. The DON stated that no pulled medications should have been stored in the medication cart. If a resident refused medications, they should have been discarded and not placed in a cup and put in the medication cart.

An interview with the facility physician was conducted on 10/31/22 at 2:25PM. He stated he was familiar with Resident #7. He clarified he was not the medical director. He stated he was aware that the facility notified the physician assistant with the on-call service of the medication error around midnight on 9/6/22. He stated his greatest concern was that the additional metoprolol (for blood pressure) and trazodone (for sleep) that Resident #7 received would have dropped her blood pressure and the trazadone would have caused her to sleep. He stated it took 2 days for her to become more alert while she was hospitalized. He stated his concern wound have been hypotension, changes in her mental status, drowsiness, and heart block or even death if she had not been sent to the hospital.

A phone interview was conducted with the Medical Director on 11/2/22 at 12:57PM. He stated he was on vacation at the time of the medication error. The facility notified the on-call physician assistant around midnight the morning of 9/6/22 regarding a change in Resident #7's

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status. The DON notified him the next day about the medication error. He stated he had a conversation with the DON a day after the incident occurred. He stated he did not think the event that occurred was a systemic issue but an isolated event. The root cause analysis indicated the nurse walked away from the medication cart and then there was confusion about which medication cup Nurse #1 gave to Resident #7. Of the 2 patients, Resident #7 received Resident #11's medications. He and the DON discussed a remedy going forward. Nurses should finish what they are doing before leaving the medication cart. He stated he was involved in the Quality Assurance process anytime there was a quality issue. He stated at every Quality Assurance and Performance Improvement (QAPI) meeting, he asked the question, "Are there any concerns about any nursing processes, including medication errors." He stated there have been no other incidents occur.

The Administrator was informed of immediate jeopardy on 11/1/22 at 6:44PM.

The facility provided the following corrective action plan with a completion date of 9/13/22:

On 9/5/22 Nurse #1 gave medications prescribed for Resident #11 to Resident #7 in error. The medications given in error included Trazodone 50mg (for sleep), Eliquis 5mg (blood thinner), Metoprolol Tartrate 25mg (for blood pressure) and Clonazepam 1mg (for anxiety). Nurse #1 assessed Resident #7 and reported her findings to the DON. The physician on-call service was notified, and an order was received to monitor Resident #7. Upon Nurse #1 completing vital signs, resident had a pulse rate in the 40's. Nurse

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#1 was concerned and felt Resident #7 needed to be sent to the emergency room for the low pulse. Nurse #1 contacted the DON. The DON instructed Nurse #1 to check resident's baseline pulse to see if this was her normal baseline, and she appeared sleepy and slow to respond while Nurse #1 performed vital signs The DON instructed Nurse #1 to send Resident #7 to the hospital for an evaluation. The physician and responsible party were notified. At 12:25AM, EMS arrived at the facility and Resident #7 was transported to the hospital.

Upon investigation of the incident, it was determined that Nurse #1 and Nurse #2 both pre-poured medications on 9/5/22. Both nurses worked on the same medication cart and had residents to medicate. Therefore, the medication cart was shared by Nurse #1 and Nurse #2. Nurse #1 pre-poured medications for Resident #7 and Nurse #2 per-poured medications for Resident #11. Resident #11 initially refused the bedtime medications, so Nurse #2 stored the pre-poured medications in an unlabeled medication cup in the medication cart to offer at a later time. While Nurse #1 was preparing medications for Resident #7, she was distracted by another employee and needed to pause medication administration to address an issue. Nurse #1 stored the pre-poured medications for Resident #7 in a cup labeled with Resident #7's name, in the same medication cart which stored unlabeled pre-poured (in med cup) medications for Resident #11. When Nurse #1 returned to the medication cart, she pulled the unlabeled medication cup for Resident #11 prepared by Nurse #2 and administered to Resident #7.

Immediately following the transport of Resident

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| F 760 | Continued From page 8<br>#7 to the hospital, the following corrective action plan was put into place:<br>1. Nurse #1 and Nurse #2 were educated face-to-face by the DON on medication administration, avoiding medication errors specifically as it related to distractions during medication pass, pre-pouring medications and the five right of medication administration. A teach-back method was utilized by the DON to ensure competency of the education provided.<br>2. Beginning 9/6/22 through 9/13/22, medication pass observations with teach-back competencies were conducted with licensed nurses, including agency nurses, by the DON and/or Unit Manager.<br>3. Beginning 9/6/22, the licensed nurses were provided education verbally by the DON and/or via the facility electronic learning system (Relias) on the following:<br>- "Medication Administration in Acute Care" with emphasis on the 5 rights of medication administration to ensure accuracy of medication administration and documentation.<br>- "Avoiding Common Medication Errors" which included how to handle(defer) distractions during medication pass, the 5 rights of medication administration not pre-pouring medications.<br>4. Any licensed nurse not educated by 9/13/22 was not allowed to work until educated. Newly hired licensed nurses were trained by the DON or designee during their orientation period.<br>5. As a precaution, an additional medication cart was ordered by the DON on 9/12/22. The additional medication cart was delivered to the facility on 9/22/22.<br>6. The facility contract pharmacy nurse consultant performed random medication administration observations with licensed nurses monthly for 2 months (September and October 2022). No variances were noted. Any medication variances | F 760 | | |

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| F 760 | Continued From page 9<br>will continue to be addressed and re-education provided by the DON or designee.<br>7. Beginning 9/16/22, the DON or designee performed random weekly audits of the medication administration documentation and medication administration process for 8 weeks. The medication administration audit focused on ensuring no pre-poured medications were observed in the medication cart, the 5 rights of medication administration were observed and how the nurse handled distractions and/or interruptions during medication pass (if applicable). Re-education was provided as needed.<br><br>An Ad-HOC Quality Assurance Meeting was held on 9/6/22 at 2:00PM to discuss corrective action for the deficient practice. The phone meeting was attended by the Administrator, Director of Nursing, Medical Director, Vice President of Compliance, Regional Clinical Director, Vice President of Clinical Services and the Vice President of Operations.<br><br>Results of all audits were reviewed during the Quality Assurance and Performance Improvement (QAPI) meetings on 9/29/22 and 10/19/22. The QAPI committee reviewed the audits to make recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond the two (2) months. The QAPI committee will continue to monitor thru December 2022.<br><br>The facility's alleged correction date of 9/13/22 was verified by the following:<br><br>On 11/2/22, the facility's corrective action plan with correction date of 9/13/22 was validated | F 760 | | |

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on-site by record review, observations, and interviews with nursing staff.

Medication pass was conducted on 10/31/22. No concerns related to the medication errors were identified. It consisted of 25 medications, 3 different residents and 1 nurse. The nurses were observed implementing the 5 rights of medication administration, they did not pre-pour medications and they deferred distractions and interruptions until they completed med pass.

The medication records of sampled residents were reviewed with a focus on medication errors. No concerns were identified.

Interviews with nurses revealed they were required to complete an in-service related to medication errors. The nurses confirmed they were educated in person, and they completed a computer module which included the 5 rights of medication administration, to discard all medications that were not administered, not to pre-pour medications and store in the medication cart and to defer all distractions and interruptions until the medication pass is completed.

Review of the in-service records revealed the DON completed the in person in-services with the nurses and all nurses completed the computer module on medication administration by 9/13/22. Agency nurses who had no access to the computer module completed a paper module. All nurses who had not worked prior to 9/13/22 or were newly employed were in-serviced before they were allowed to work.  A total of 23 nurses completed the in-services from 9/6/22 through 10/10/22.

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| F 760 | Continued From page 11<br>Review of the monitoring tools revealed the management staff had completed audits and monitoring per the audit tools and monitoring documentation provided. | F 760 | | |