STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB ROWAN, LLC	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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
E 000	Initial Comments An onsite recertification and complaint investigation survey was conducted from 08/18/24 through 08/21/24 . The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ZVH011.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 08/18/24 through 08/21/24. Intakes NC00215458 and NC00219443 were investigated. 1 of the 7 complaint allegations resulted in a deficiency. Immediate jeopardy was identified at: CFR 483.45 at tag F760 at a scope and severity J The tag F760 constituted substandard quality of care. Immediate jeopardy began on 08/19/24 and was removed on 08/21/24. An extended survey was conducted.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		9/13/24

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

Electronically Signed | 09/10/2024

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F 584	Continued From page 1 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a clean shower room for 1 of 1 shower room reviewed for a safe, clean, comfortable, and homelike environment. Findings included:	F 584	F-584 1. The shower room floors and walls were deep cleaned by the housekeeping director and regional director on 8/20/24 to ensure a clean, sanitary and orderly shower room. The personal items, dirty linens and sharps container were	

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F 584	Continued From page 2 An observation of the shower room conducted on 08/18/24 at 1:00 PM revealed a strong odor of feces, brown water and hair sitting in the shower. The walls of the shower appeared to have brown grime. In addition, two wheelchairs were in the shower room, multiple pairs of shoes were on the floor, a used razor was hanging on the sharps container door that was open and unlocked, and multiple body wash and shampoo bottles not labeled, and a used washcloth were sitting beside the sink. An observation and interview conducted with Nurse Aide #4 on 08/19/24 at 9:35 AM revealed the shower room was last used on 08/17/24 and the appearance of the shower room was not considered acceptable to her. Observation included an odor of feces, the sharps container door was open and unlocked, shoes were located on the floor, and the shower had brown grime on the wall and hair and dirt on the shower floor. NA #4 indicated one pair of shoes on the floor belonged to a resident. NA #4 indicated staff had been educated to clean and organize shower room after every shower and it was common for second shift to leave the shower room is disarray. NA #4 stated nursing staff and housekeeping were responsible for cleaning the shower room. During an observation and interview with Nurse Aide (NA) #5 on 08/20/24 at 11:24 AM revealed urine and grime on the walls of the shower room, the sharps container door was open and unlocked. Multiple unlabeled bottles of shampoo and body wash were noted beside the sink. NA #4 stated nursing staff were educated to clean after every shower, but second shift consistently did not clean up. NA #5 further revealed she rarely saw housekeeping in the shower room to	F 584	removed. 2. The shower room will be checked daily and every shift by the assigned hall nurse and c.n.a. to ensure a tidy and sanitary shower room. The assigned housekeeper will clean the shower room daily, and deep clean the shower room weekly. 3. An in-service was conducted on 9/6/24 by the Director of Nursing for Housekeeping and Nursing on Safe, Clean, Comfortable homelike environment with focus on the Shower Room. 4. The Housekeeping Director will check the shower room daily to ensure the shower room is clean, tidy and free of clutter. The Infection Preventionist will monitor the shower room weekly for proper sanitation and report the findings to the QAPI (Quality Assurrance Performance Improvement) committee monthly for three months then quarterly thereafter for continuous quality improvement.	

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F 584	Continued From page 3 assist with cleanliness. NA #5 stated nursing staff and housekeeping were responsible for cleaning the shower room. An observation and interview conducted with the Director of Housekeeping and Regional Housekeeping on 08/20/24 at 11:35 AM. He stated the appearance of the shower room was unacceptable. Urine and grime were observed on the walls, the sharps container door was unlocked and opened, and multiple bottles of unlabeled shampoo and body wash were noted. The Director of Housekeeping revealed he had recently just become the housekeeping director and was not sure if housekeeping had a schedule to clean the shower room. He stated he would have a schedule created to make sure housekeeping was cleaning the shower room. It was indicated that the shower room would need to be deep cleaned and sanitized immediately. An interview conducted with the Administrator on 08/21/24 at 3:00 PM revealed she was not aware the shower room was observed to have environmental concerns. The Administrator further revealed she expected for nursing staff and housekeeping to keep the shower room clean and organized.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		9/13/24

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F 658	Continued From page 4 Based on record review and interviews with resident and staff, the facility failed to prevent a medication error when Nurse #1 failed to complete the 5 rights of medication administration before she administered medications prescribed for Resident #26's roommate (Resident #18) to Resident #26 during the morning medication pass on 08/19/24. This was for 1 of 5 residents reviewed for professional standards/safe administration of medications (Resident #26). Findings included: Resident #26 was admitted to the facility on 04/26/24, with diagnoses to include cerebrovascular disease, acute ischemic heart disease, hypertension (HTN), bipolar disorder, depression, atrial fibrillation, and convulsions. Review of Resident #26's quarterly Minimum Data Set (MDS) dated 08/02/24 revealed Resident #26 was cognitively intact. Review of Resident #18's active medication orders included d-mannose 500 mg daily (an antibacterial), benztropine 1 mg (an antitremor medication), docusate 100 mg (a stool softener), fexofenadine 180 mg (an antihistamine), magnesium oxide 400 mg (an antireflux medication), polyethylene glycol 17 grams (a laxative), vitamins a,c,e-zinc-copper 2,148 mc-113 mg-45 mg-17.4 mg (a supplement), lactobacillus acidophilus 1 billion cell-250 mg (a probiotic), and vitamin D3 (a supplement). A combined interview was conducted with Nurse #1 and Nurse #2 on 08/19/24 at 9:34 am. Nurse #2 revealed Resident #26 received her roommate's (Resident #18's) medications in	F 658	F-658 Professional Standards On 8/19/24, Nurse #1 was in-serviced by the director of nursing on the 5 Rights of Medication Administration and removed from duty. On 8/19/24, Nurse #2 was in-serviced by the director of nursing on (1) The 5 Rights of Medication Administration, (2) New process for nurse orientation and (3) Understanding of joint medication administration is not permitted. In addition, Nurse #2 had a Medication Administration Skills Observation completed by the Unit Manager on 8/19/24 with zero medication error reported 2. On 8/19/24, The Unit Manager began Medication Pass Observation for all nurses and medication aides on duty and will continue until all nurses and medication aides have been observed to meet the professional standards/safe administration of medications. Any discrepancies/errors during the observation will be addressed immediately with 1:1 education on professional standards/safe administration of medications and repeat skills observation will be completed. 3. On 8/19/24 all nurses and medication aides were in-serviced by the director of nursing on Proper Medication Administration (The 5 Rights) and	

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F 658	Continued From page 5 addition to Resident #26's own medications. Nurse #1 stated she "went to the wrong bedside" when she administered Resident #18's medications to Resident #26. Nurse #1 indicated she had not asked Resident #26 her name at the time she administered Resident #18's medications to Resident #26. Nurse #2 reported she (Nurse #2) prepared the medications for Resident #18 and Resident #26 and Nurse #1 administered medications for both residents to Resident #26. Nurse #2 stated she notified Nurse #3 of the error, and Nurse #3 notified the physician. Review of the medication error report completed by Nurse #3, the charge nurse, on 08/19/24 (with no completion time noted) was reviewed. The report indicated Nurse #2 reported she had administered incorrect to Resident #26 on 08/19/24 at 9:00 am. An interview with Nurse #3, the Charge Nurse, on 08/19/24 at 9:41 am revealed Nurse #3 was notified of the medication error by Nurse #2 and Nurse #1. Nurse #3 stated she notified the physician, the Administrator, and the Director of Nursing (DON) immediately. Nurse #3 stated that Resident #26 should have been identified by both Nurse #1 and Nurse #2 (had they used the 5 rights), and Resident #26 should not have received Resident # 18's medications in addition to Resident #26's own medications. During an interview on 08/19/24 at 9:32 am, Resident #26 stated she received her roommate's (Resident #18's) medications on 08/19/24 at 9:00 am. Resident #26 reported Nurse #1 failed to ask Resident #26 her name before administering Resident #18's medications to her. In addition,	F 658	reinforced medication administration is not to be conducted jointly during nurse orientation, or any other time. 4. Nurses and medication aides will have a Medication Pass Observation conducted randomly by the unit manager and/or pharmacist monthly for three months, then quarterly thereafter. Findings will be reviewed by the QAPI (Quality Assurance and Performance Improvement) committee for continuous quality improvement.	

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F 658	Continued From page 6 Resident #26 stated she informed Nurse #1 that she did not take her medications in pudding, however Nurse #1 instructed Resident #26 to take the medications. A telephone interview with the Physician on 08/19/24 at 10:22 am confirmed she had been informed of the medication error by Nurse #3. In a follow-up interview with Resident #26 on 08/19/24 at 10:28 am, Resident #26 stated she received Resident #18's medications before Resident #26 received her own medications; Resident #26 further revealed she informed Nurse #1 she did not normally take her medications in pudding, and Nurse #1 did not ask Resident #26 her name before administering the medications nor earlier in Nurse #1's shift.	F 658		
F 760 SS=J	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 record review, and resident, staff, Nurse Practitioner (NP), and physician interviews, the facility failed to protect a resident from a significant medication error when Nurse #1 administered medications prescribed for Resident #26's roommate (Resident #18), as well as Resident #26's own medications, to Resident #26 during the morning medication pass on 08/19/24. The medications administered to Resident #26 included her prescribed dose of carvedilol 3.125 milligram (mg) (a blood pressure medication) and Resident #18's dose of carvedilol 12.5 mg.	F 760	F-760 Significant Med Errors On 8/19/24 Resident #26 was seen by the Nurse Practitioner and on 8/20/19 was seen and assessed by the Medical Director, it is noted that Resident #26 had no adverse effects, was stable and at baseline from the medication error.	9/13/24

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F 760	Continued From page 7 Resident #26 received her prescribed dose of clopidogrel 75 mg (a blood thinner) and Resident #18's dose of apixaban 5 mg (an anticoagulant). Resident #26 received her prescribed dose of aspirin 81 mg (a nonsteroidal anti-inflammatory drug) and Resident #18's dose of aspirin 81 mg. Resident #26 also received other medications which were not prescribed to her, including Resident #18's dose of hydralazine (a blood pressure medication), Resident #18's dose of levetiracetam (an anticonvulsant), and Resident #18's dose of aripiprazole (an antipsychotic). Resident #26 required an immediate (STAT) electrocardiogram (EKG, a test to record the electrical activity of the heart) and STAT labs including a complete blood count with differential (CBC w/diff), a complete metabolic panel (CMP), a creatinine phosphokinase (CPK), and a prothrombin time/international normalized ratio (PT/INR). Resident #26's vital signs (VS) were monitored hourly for 8 hours, then every 2 hours for 8 hours, then every shift. This was for 1 of 5 residents reviewed for medication errors (Resident #26). The medication error placed Resident #26 at an increased risk of experiencing complications such as hypotension (low blood pressure) and increased anticoagulation (thinning) of her blood. Increased monitoring was required to ensure that in the event of a significant change, Resident #26 would be discharged to a higher level of care. Immediate jeopardy began on 08/19/24 when Resident #26 was administered medications prescribed for another resident. The immediate jeopardy was removed on 08/21/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and	F 760	On 8/19/24, Nurse #1 was in-serviced by the director of nursing on the 5 Rights of Medication Administration and removed from duty. On 8/19/24, Nurse #2 was in-serviced by the director of nursing on (1) The 5 Rights of Medication Administration, (2) New process for nurse orientation and (3) Understanding of joint medication administration is not permitted. In addition, Nurse #2 had a Medication Administration Skills Observation completed by the Unit Manager on 8/19/24 with zero medication error reported 2. On 8/19/24, The Unit Manager began Medication Pass Observation for all nurses and medication aides on duty and will continue until all nurses and medication aides have been observed to meet the professional standards/safe administration of medications. Any discrepancies/errors during the observation will be addressed immediately with 1:1 education on professional standards/safe administration of medications and repeat skills observation will be completed until zero medication error rate is achieved. 3.On 8/19/24 all nurses and medication aides were in-serviced by the director of nursing on Proper Medication Administration (The 5 Rights) and	

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F 760	Continued From page 8 severity "D" (no actual harm with potential for more than minimal harm) to ensure monitoring systems put into place are effective. The findings included: Resident #26 was admitted to the facility on 04/26/24, with diagnoses to include cerebrovascular disease, acute ischemic heart disease, hypertension (HTN), bipolar disorder, depression, atrial fibrillation, and convulsions. Resident #26's quarterly Minimum Data Set (MDS) dated 08/02/24 revealed Resident #26 was cognitively intact. A review of the active morning medication orders for Resident #26 included aspirin 81 mg daily, carvedilol 3.125 mg twice a day, and clopidogrel 75 mg daily. A review of the medication administration record (MAR) for 08/19/24 revealed Resident #26 received her prescribed medications at 8:21 am, as evidenced by initials for Nurse #2. Resident #26 received aspirin 81 mg, carvedilol 3.125 mg, and clopidogrel 75 mg. A review of Resident #18's active medication orders included aspirin 81 mg daily, carvedilol 12.5 mg daily, apixaban 5 mg every 12 hours, hydralazine 10 mg every 12 hours, levetiracetam 500 mg every 12 hours, and aripiprazole 10 mg daily. A combined interview was conducted with Nurse #1 and Nurse #2 on 08/19/24 at 9:34 am. Nurse #2 revealed Resident #26 received her roommate's (Resident #18's) medications in	F 760	reinforced medication administration is not to be conducted jointly during nurse orientation, or any other time. 4. Nurses and medication aides will have a Medication Pass Observation conducted randomly by the unit manager and/or pharmacist monthly for three months, then quarterly thereafter. Findings will be reviewed by the QAPI (Quality Assurance and Performance Improvement) committee for continuous quality improvement.	

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F 760	Continued From page 9	F 760		

addition to Resident #26's own medications. Nurse #1 reported that she "went to the wrong bedside" when she administered Resident #18's medications to Resident #26. Nurse #1 stated she had not asked Resident #26 her name at the time she administered Resident #18's medications to Resident #26. Nurse #2 reported she (Nurse #2) prepared the medications for Resident #18 and Resident #26 and Nurse #1 administered medications for both residents to Resident #26. Nurse #2 stated she informed Nurse #3 of the error, and Nurse #3 notified the physician.

A review of the progress note completed by Nurse #3 on 08/19/24 at 9:00 am stated the physician was made aware of medications given to Resident #26 and provided new orders to include vital signs every hour for the current shift, then every two hours for the next two shifts, then every shift for 24 hours, a STAT EKG, and STAT CBC, CMP, PT/INR, and CPK labs.

A review of the medication error report completed by Nurse #3, the charge nurse, on 08/19/24 (with no completion time noted) was reviewed. The report indicated Nurse #2 reported administering incorrect and extra doses of oral medications (including apixaban 5 milligrams, aspirin 81 milligrams, hydralazine 10 milligrams, levetiracetam 500 milligrams, and aripiprazole 10 milligrams to Resident #26 on 08/19/24 at 9 am.

An interview with Nurse #3, the Charge Nurse, on 08/19/24 at 9:41 am revealed Nurse #3 was informed of the medication error by Nurse #2 and Nurse #1. Nurse #3 stated she notified the physician immediately, as well as the Administrator and the Director of Nursing (DON).

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F 760	Continued From page 10	F 760		

Nurse #3 stated that Resident #26 should have been identified by both Nurse #1 and Nurse #2, and Resident #26 should not have received Resident # 18's medications in addition to Resident #26's own medications.

During an interview on 08/19/24 at 9:32 am, Resident #26 stated she received her roommate's (Resident #18's) medications on 08/19/24 at 9:00 am. Resident #26 reported Nurse #1 failed to ask Resident #26 her name before administering Resident #18's medications to her. In addition, Resident #26 stated she informed Nurse #1 that she did not take her medications in pudding, however Nurse #1 instructed Resident #26 to take the medications.

During an interview on 08/19/24 at 10:28 am Resident #18 reported she received her prescribed medications on the morning of 08/19/24.

A telephone interview with the Physician on 08/19/24 at 10:22 am confirmed she had been informed of the medication error by Nurse #3. The physician stated she ordered a STAT EKG and STAT labs, along with vital signs every hour for 8 hours, then every 2 hours for 8 hours, then every shift - with no end date until further notice. The Physician stated nurses were expected to give the correct medications to the correct residents, to notify the physician of errors (as Nurse #3 did), and to closely monitor Resident #26 due to the medication error. The Physician shared that NP #1 would assess Resident #26 on 08/19/24.

In a follow-up discussion with Resident #26 on 08/19/24 at 10:28 am, Resident #26 stated she

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F 760	Continued From page 11	F 760		

received Resident #18's medications before Resident #26 received her own medications; she informed Nurse #1 she did not normally take her medications in pudding, and Nurse #1 did not ask her/Resident #26 her name before administering the medications or earlier in Nurse #1's shift.

An interview was conducted with NP #1 on 08/19/24 at 1:18 pm, who stated that she was informed of the medication error by the physician. NP #1 shared she had assessed Resident #26, on 08/19/24, who was a little sleepy (but easily awakened), with no shortness of breath or dizziness and at her baseline level cognitively. NP #1 shared that Resident #26's EKG was normal, and the laboratory results remained pending. NP #1 reported Resident #26 was at a risk for bleeding, bruising, and hypotension due to the doses of apixaban 5 milligrams, aspirin 81 milligrams, hydralazine 10 milligrams, levetiracetam 500 milligrams, and aripiprazole 10 milligrams given to her in error. NP #1 stated she provided orders to monitor Resident #26's blood pressure, heart rate, as well as for bleeding and bruising.

A review of the Physician's Progress Note dated 08/20/24 at 11:35 am revealed Resident #26 was seen and assessed by the physician following a medication error on 08/19/24. The Physician noted Resident #26 received her roommate's aripiprazole (10 mg), aspirin (81 mg), carvedilol (12.5 mg), apixaban (5 mg), hydralazine (10 mg), levetiracetam (500 mg), in addition to Resident #26's own medications - which included aspirin (81 mg), carvedilol (3.125 mg), and clopidogrel (75 mg),. The physician stated that she was contacted by nursing staff immediately after the medication error occurred, and gave orders for

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	345288	A. BUILDING _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB ROWAN, LLC	1404 S SALISBURY AVENUE SPENCER, NC 28159

(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
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STAT labs to include CBC, CMP, CPK, and PT/INR, as well as an order for a STAT EKG. The physician advised staff to hold Resident #26's evening dose of carvedilol. The physician's assessment revealed that Resident #26, who was without concerns or complaints, appeared to be at her baseline. Resident #26's plan included a repeat of her STAT labs (CBC, CMP, CPK, and PT/INR) in 1 week, VS every shift, and close monitoring. The physician contacted Resident #26's son and explained the plan of care for Resident #26.

A follow-up interview with the Physician was conducted on 08/20/24 at 11:40 am, at which time she shared she examined Resident #26 on 08/20/24 at 11:30 am and had no new concerns. The Physician stated she ordered repeat labs (to include STAT CBC w/diff, CMP, PT/INR, and CPK) in 1 week and VS every shift for an additional week for Resident #26.

The facility Administrator and DON were notified of Immediate Jeopardy on 08/19/24 at 6:03 pm.

The facility implemented the following corrective action plan for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 8/19/24, at approximately 9:00 AM, Nurse #1, administered Resident #26 her prescribed medications, aspirin 81 mg, Coreg 3.125 mg, plavix 75 mg, Trileptal 150 mg.
Resident #26 also received Resident #18 medications to include aripiprazole 10 mg, aspirin 81 mg, benztropin 1 mg, coreg 12.5 mg, eliquis 5

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mg, hydralazine 10 mg, levetiracetam 500 mg.

On 8/19/24 the Medical Director was immediately notified by the Unit Manager and new orders were received for vital signs every hour for first shift, then vital signs every 2 hours for second shift, then every shift for 24 hours. In addition, Stat EKG (electrocardiogram), Stat CBC (complete blood count), CMO (Comprehensive Metabolic panel), PT/INR (Protime/International Normalized Ratio), CPK (Creatine Phosophokinase).

The medication Coreg 3.125 mg will be held until tomorrow 8/20/24 until Medical Director can examine Resident #26.
A Medication Error report was completed, and family notified.

The Nurse Practitioner examined Resident #26 and reported the EKG was reviewed and is normal. Labs were collected and are pending.

PT/INR results revealed INR 0.9, normal range 0.9-1.1 and PT 9.7 range 9.9-11.8
.
All labs will be repeated on 8/20/24.

Nurse #2 was interviewed by the Administrator. It was determined that medications had been administered properly for all other residents on the medication pass. Five other residents had already received medication (rooms 100, 102, 104). No other residents were determined to be at risk.

No other residents have suffered a serious adverse outcome as a result of the noncompliance.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

An in-service was immediately conducted on 8/19/24 by the Director of Nurses on Proper Medication Administration (The 5 Rights) for all nurses and medication aides, and to reinforce medication administration is not to be conducted jointly at any other time. All nurses educated on 8/19/24. Any not educated will be removed from schedule until education is performed. Director of Nursing/Designee will keep in-service records and ensure all staff have received education before returning to work.
Joint Medication Administration is not allowed. This topic was included in the in-service mentioned above.

The Unit Manager immediately conducted on 8/19/24 a Medication Pass Observation for all nurses on duty and will continue until all nurses have a medication pass skills observation.

Nurse #1 was removed from duty until further notice.

The root cause analysis is Nurse #1, and the nurse on duty administered medications jointly, causing Resident #26 to receive Resident #18 medications as well.

IJ Removal Date: 8/21/24

On 08/21/24, the facility's credible allegation of immediate jeopardy removal was validated on-site by record review, observations, and interviews. Individual interviews with a sample of

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residents revealed they received their prescribed medications without concerns. A medication administration observation was conducted on 08/21/24. The observation consisted of administration of medications for 4 different residents, by 1 nurse and 1 medication aide. The nurse and the medication aide were observed implementing the rights of medication administration before administering the medications from start to finish. No concerns were identified. Interviews with nurses and the medication aide revealed they were required to complete in-services for the 5 rights of medication administration and the facility's new process for medication administration.

A review of the in-service documents dated 08/19/24 and 08/20/24 noted the DON completed the in-person in-services for the 5 rights of medication administration and the facility's new process for medication administration with nurses and medication aides. An interview with the DON on 08/21/24 revealed that the in-services would be provided to Nurse #1 and all other nurses and medication aides that had not worked since the medication error, as well as to any new nurses and medication aides before they were allowed to administer medications.

The immediate jeopardy removal date of 08/21/24 was validated.