STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE HEALTH AND REHABILITATION	91 VICTORIA ROAD ASHEVILLE, NC 28801

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 04/09/24 through 04/10/24. Event ID# FS1P11. The following intakes were investigated: NC00214722 and NC00214814. Intake NC00214722 resulted in immediate jeopardy. 1 of the 9 complaint allegations resulted in deficiency. After an administrative review of the F760 citation the facility was notified of immediate jeopardy on 4/17/24. 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 02/17/24 and was removed on 02/20/24. A partial extended survey was conducted.	F 000		
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 reviews, and interviews with resident, staff and Medical Director, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 which included Risperidone (antipsychotic medication),	F 760	1) On 4/9/24, NC State agency conducted an on-site complaint survey investigation and on 4/17/24 an immediate jeopardy was cited for F760 related to a significant medication error for Resident #1. On 4/18/24, the facilities	4/29/24

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

Electronically Signed | 05/01/2024

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F 760	Continued From page 1 Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat hypertension), and Amlodipine (a medication used to treat hypertension). Nurse #1 identified the error and Resident #1 was sent to the emergency department (ED) on 2/17/24 for further evaluation due to elevated heart rate and hypotension (low blood pressure). While in the ED, Resident #1 complained of having chest pain and feeling weak. An electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia). Resident #1 was admitted into the hospital for observation due to the prolonged effect of antihypertensives and being hypotensive on presentation. Resident #1 was discharged back to the facility on 2/19/24 at her baseline with no new orders. This deficient practice affected 1 of 3 residents reviewed for significant medication errors (Resident #1). Immediate jeopardy started on 2/17/24 when Resident #1 was administered medications prescribed for Resident #2. Immediate jeopardy was removed on 2/20/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective.	F 760	credible allegation (CA) was approved with an alleged date of immediate jeopardy removal effective 2/20/24. Resident #1 readmitted to the facility on 2/19/24 and will continue to receive medication as ordered. 2) On 4/16/24, the Regional Director of Clinical Services (RDCS) completed a medication administration observation utilizing form CMS-20056 Medication Administration Observation to monitor that residents are being administered medication as ordered. Monitoring included observations of two (2) licensed nurses and two (2) medication aides for five (5) random residents to include a total of thirty-three (33) medication administration observations. 33 of 33 medications were administered without error during the observation. On 4/29/24, the RDCS completed an audit of medication error incident reports from 1/1/2024 □4/29/24 per the electronic medical record (EMR) Risk Management report and no additional incidences of residents being administered another residents' medications were identified. 3) On 4/11/24, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted to discuss the root cause of 1) the facilities failure to prevent a significant medication error for Resident #1 and 2) the facilities failure to implement an effective plan of correction to prevent other residents from the potential of being administered medications not prescribed to them by the	

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F 760	Continued From page 2 The findings included: Resident #1 was admitted to the facility on 2/6/24 with diagnoses that included Parkinson's disease. Resident #1 did not have hypertension listed as a diagnosis. The admission Minimum Data Set (MDS) assessment dated 2/13/24 indicated Resident #1 was cognitively intact and did not receive antipsychotic medications. The February 2024 physician orders for Resident #1 indicated the following medications: - Amantadine (anti-dyskinetic medicine) 100 milligrams (mg) 1 tablet by mouth one time a day for Parkinson's disease - Magnesium oxide (dietary supplement) 400 mg 1 tablet by mouth one time a day for supplement - Melatonin (hormone that plays a role in sleep) 3 mg 1 tablet by mouth one time a day at bedtime for sleep - Spironolactone (diuretic) 25 mg 1 tablet by mouth one time a day for blood pressure, fluid - Carbidopa-Levodopa (dopamine promoter) ER (extended release) 25-100 mg 1.5 tablet by mouth four times a day for Parkinson's disease A review of Resident #1's Medication Administration Record for 2/17/24 indicated she last received a dose of Carbidopa-Levodopa at 6:00 AM but she did not receive any of her scheduled 8:00 AM medications which included Amantadine, and Spironolactone. Resident #2 was admitted to the facility on 11/14/23. The February 2024 physician orders for Resident	F 760	physician. Root cause determined that 1) Nurse #1 failed to effectively redirect another resident during medication administration which led to not confirming the right medications were given to the right resident per the seven (7) rights of medication administration resulting in a significant medication error for Resident #1 and 2) the plan of correction did not include appropriate monitoring measures to include medication administration observations to validate staff competency. On 4/15/24, the RDCS provided education to the Director of Nursing (DON) and Charge nurses on completing medication administration observations with facility and agency licensed nurses and medication aides to ensure effective skills competency validations and on EMR monitoring of the eMAR and Risk Management portal. EHR education included review of eMAR for documentation of medication administration as ordered and review of Risk Management medication error incident reports for accuracy, completeness and follow-up as appropriate. Newly hired DONs and Charge Nurses will receive education prior to conducting skills competency validations. On 4/18/24, the RDCS provided education to the DON on monitoring and tracking medication administration education and competencies utilizing the Master Education Log and on completing effective, ongoing monitoring. Newly hired DONs will receive education during orientation.	

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F 760	Continued From page 3 #2 indicated the following medications: - Amlodipine (calcium channel blocker) 10 mg 1 tablet by mouth one time a day for hypertension - Furosemide (diuretic) 40 mg 1 tablet by mouth one time a day for fluid, hypertension - Lisinopril (angiotensin-converting enzyme inhibitor) 20 mg 1 tablet by mouth one time a day for heart/blood pressure - Risperidone (antipsychotic) 2 mg 1 tablet by mouth two times a day for schizophrenia An incident report dated 2/17/24 at 10:00 AM documented by Nurse #1 indicated Nurse #1 went into Resident #1's room to get her name and asked her for her date of birth. Vital signs were taken. When Nurse #1 went back to the medication cart, another resident (Resident #2) approached her with grievances from the previous night and demanded his medications and was unwilling to wait. Then Resident #1 who Nurse #1 was currently with also wanted her medications and was given the wrong medications (which belonged to Resident #2). An on-call physician and Resident #1's family member were notified. The Director of Nursing, Unit Manager, and Administrator were also notified. Vital signs were taken again, and Resident #1 was kept comfortable. EMS (emergency medical services) was called with a detailed report. The incident report did not specify what medications were given to Resident #1. A phone interview with Nurse #1 on 4/9/24 at 11:44 AM revealed she couldn't remember all the details of how the medication error happened, but she was in the middle of the morning medication pass on 2/17/24. Nurse #1 stated she remembered both Resident #1 and Resident #2	F 760	From 4/11/24 □ 4/19/24, the RDCS, DON and Charge nurses provided education to facility and agency licensed nurses and medication aides on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors during medication administration. In addition to education, medication administration observations were completed to validate competency. Facility and agency licensed nurses and medication aides who did not receive education and competency validation by 4/19/24 will receive prior to next shift worked. Effective 4/29/24, the facility and agency orientation packets and checklists will include education on the seven (7) rights of medication administration to avoid medication errors, strategies to reduce distractions during medication administration to include redirection of other residents, and validation of competency per medication administration observation. Medication administration education and competency will be completed during orientation, annually and as needed. The DON will be responsible for monitoring the completion of agency and facility education and competency evaluations for licensed nurses and medication aides utilizing the electronic Master Education Log. 4) Beginning 4/20/24, the DON will complete medication administration observation audits of three (3) licensed	

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F 760	Continued From page 4 came up to her medication cart at the same time and asked for their medications. Nurse #1 pulled Resident #2's medications and while Resident #1 asked about her medications, Nurse #1 got confused and accidentally gave her Resident #2's medications. Nurse #1 stated it was less than 10 minutes after she had administered the medications and when she started to document the medications in the medication administration record that she realized that she had made a medication error by administering Resident #2's medications to Resident #1. Nurse #1 stated she immediately notified the Unit Manager, the Director of Nursing (DON), and the Administrator. After obtaining Resident #1's vital signs and noting that her heart rate was elevated, Nurse #1 notified an on-call physician who gave her an order to send Resident #1 to the hospital. Nurse #1 stated it took her less than 45 minutes from the time she administered the wrong medications to Resident #1 to the time that she was sent to the ED. A progress note dated 2/17/24 at 10:54 AM by an on-call physician indicated she was contacted by Nurse #1 on 2/17/24 at 9:04 AM about a transfer notification due Resident #1 having received Risperidone 2 mg, Furosemide 40 mg, Lisinopril 20 mg and Amlodipine 10 mg in error and was sent to the emergency room (ER). Vital signs were heart rate 110 beats per minute (normal range 60 to 100), blood pressure 147/95 (normal is less than 120/80), respiratory rate 16 (normal range 12 to 16), temperature 98.1 (normal is around 98.6), and oxygen saturation 95% (normal range between 95% to 100%). This note was electronically signed by the on-call physician on 2/17/24 at 9:30 AM.	F 760	nurses or medication aides for a minimum of five (5) medications for three (3) random residents and will complete EMR audits of the eMAR and Risk Management Portal to ensure medications are administered and documented as ordered, that staff effectively respond to potential distractions, and that an accurate incident report is completed with appropriate follow-up in the event of a medication error. Medication observation to be completed utilizing the Medication Administration Observation audit tool at a frequency of three (3) times weekly for four (4) weeks, then two (2) weekly for eight (8) weeks, then monthly for two (2) months. eMAR and Risk Management monitoring will be completed for five (5) random residents with the same frequency. The DON will discuss the results of monitoring during monthly QAPI meetings and changes will be made to the plan as necessary to ensure residents are free from significant medication errors. 5) Compliance Date: 4/29/24	

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An interview with Resident #1 on 4/9/24 at 9:48 AM revealed she remembered having received the wrong medications in February. Resident #1 stated it happened during the morning medication pass when the nurse put four pills in a cup, and she gave the cup to her. Resident #1 stated she later found out that three of the pills in the medication cup were blood pressure medications which were supposed to be for another resident. Resident #1 stated she knew something was wrong when the nurse went back after she had swallowed the medications to ask her whether she had already swallowed them, and after she told the nurse that she did, the nurse's face didn't look right. The nurse went down the hall, told someone, called EMS and they sent her to the hospital. Resident #1 further stated she remembered her heart was racing at that time and she stayed at the hospital for observation for two days. At the hospital, they gave her intravenous fluids and put her on a heart monitor. Resident #1 stated at one point while she was at the hospital, her blood pressure got too low, and the hospital doctor told her that one of the pills she accidentally took worked against her Parkinson's disease medications.

The hospital records dated 2/17/24 indicated Resident #1 arrived at the Emergency Department (ED) at 10:22 AM and was evaluated after a medication mix-up where the resident got someone else's medications. She was hypotensive with systolic blood pressure in the 70s (normal range 110 to 119) and diastolic blood pressure in the 40s (normal range 60 to 90). She was having chest pain and felt weak. She was at her baseline with her Parkinson's. In the ED, electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular

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heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia) on 2/17/24. Resident #1's laboratory tests indicated her potassium level was 3.7 millimoles per liter (normal value 3.6 to 5.2) and her magnesium level was 1.8 milligrams per deciliter (normal value 1.7 to 2.2). She was referred for admission due to the prolonged nature of antihypertensives and being hypotensive on presentation. It was documented that the hypotension secondary to the medication mix-up could have been an interaction between the agonist of the Risperidone and the antagonist of the Carbidopa-Levodopa. Her blood pressure improved, and Resident #1 was admitted for observation and monitoring after receiving fluids at the ED. Resident #1 was discharged back to the facility on 2/19/14 at her baseline with no new orders.

An interview with the Unit Manager (UM) on 4/9/24 at 2:36 PM revealed she remembered being notified by Nurse #1 that she had accidentally administered Resident #2's medications to Resident #1 on 2/17/24. The UM stated they obtained Resident #1's vital signs which showed an elevated heart rate. Resident #1 also complained to them that she didn't feel right. They notified the on-call physician and received an order to send her out to the hospital. They called 911 and notified the Administrator and the DON. From what Nurse #1 reported to her, both Resident #2 and Resident #1 were at the medication cart at the same time. Resident

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#2 was upset and demanded for his medications while Resident #1 asked Nurse #1 about her medications as well. The UM stated there was a lot going on at the medication cart and Nurse #1 got turned around and accidentally gave the wrong medications to Resident #1.

A phone interview with the Medical Director (MD) on 4/9/24 at 4:04 PM revealed Resident #1 receiving Resident #2's medications was a significant medication error because the medications were not ordered for her, and she did not have indications for them. The MD stated that the hypotension was caused by the antihypertensives that she received. He also stated that he wouldn't be as concerned with the interactions with her Parkinson's medications as much as the hypotension brought on by the antihypertensives. He further stated that this medication error should have been avoided and it was something they did not want to happen again.

A phone interview with the former Director of Nursing (DON) on 4/9/24 at 4:29 PM revealed she received a phone call from Nurse #1 on 2/17/24 notifying her about a medication error involving Resident #1. The DON stated Nurse #1 told her that both Resident #1 and Resident #2 were at the medication cart. Resident #2 was becoming aggressive and demanded his medications while Resident #1 also wanted her medications at the same time. While holding the medication cup with Resident #2's medications and walking Resident #1 back to her room, Nurse #1 inadvertently gave the cup of Resident #2's medications to Resident #1. The DON stated that she instructed Nurse #1 to get a set of vital signs on Resident #1 and call 911. The DON

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stated she immediately started education on the rights of medication administration and on how to handle distractions during medication pass. The DON stated Nurse #1 should have stopped her medication pass with all the distractions at her medication cart at that time. She stated that Nurse #1 unfortunately made the medication error due to her being distracted.

An interview with the Administrator on 4/10/24 at 10:18 AM revealed she was notified about the medication error involving Resident #1, but she couldn't recall a lot of the details because the incident was handled by the former DON.

The Administrator was notified of immediate jeopardy (IJ) on 4/17/24 at 12:57 PM.

The facility provided the following immediate jeopardy removal plan.

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 2/17/24, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 during the morning medication pass which included Risperidone (antipsychotic medication), Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat high blood pressure), and Amlodipine (a medication used to treat high blood pressure).

On 2/17/24, the Director of Nursing (DON) received a call from Nurse #1 regarding giving the wrong medications to Resident #1. On-call

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physician was immediately notified and instructed Nurse #1 to assess vitals and mental status for changes in condition and send to hospital if observed. During the monitoring, Resident #1's heart rate had increased therefore Emergency Medical Services (EMS) was called and Resident #1was transferred to the hospital for evaluation.

Resident #1 was sent to the emergency department (ED) for an evaluation. She was referred for admission due to the prolonged nature of antihypertensives and being hypotensive on presentation. It was documented that the hypotension secondary to the medication mix-up could have been an interaction between the agonist of the Risperidone and the antagonist of the Carbidopa-Levodopa. Her blood pressure improved, and Resident #1 was admitted for observation and monitoring after receiving fluids at the ED. Resident #1 returned to the facility on 2/19/24 with no new orders.

Nurse #1 completed a medication error report on 2/17/24 for Resident #1 as appropriate.

On 2/17/24, the DON discussed details of incident with Nurse #1 and immediately provided reeducation on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors.

All residents are at risk for a medication administration error.

On 2/17/24, the DON and facility licensed nurses immediately assessed all current facility residents for changes in vital signs and/or altered mental status and no additional concerns were identified.

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On 2/17/24, the Regional Director of Clinical Services (RDCS) completed an audit per the electronic medical record (EMR) of the 1) Medication Administration Audit Report for all current facility resident's medication administration records (MARs) for 2/17/24 first shift (7am-3pm) to ensure medications were administered as ordered without omissions or documented "Code 9" (other/see nurses notes) which could indicate an issue such as a medication error or giving a resident the wrong medication. No additional medication errors were identified, including residents being administered the wrong medication.

An audit of medication error incident reports from 1/1/2024 - 2/17/2024 were also audited on 2/17/24 by the RDCS per the EMR Risk Management report and no additional incidences of residents being administered the wrong medications were identified.

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:

On 2/19/24, the Regional Director of Clinical Services (RDCS) completed an audit of all current resident orders and of medications on the medication on the carts and medication rooms to ensure that medications are available for administration as ordered by the physician. No concerns identified.

On 2/17/24, the DON notified the Administrator, Staff Development Coordinator (SDC), Regional Director of Clinical Services (RDCS), Vice

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President of Operations (VPO), Vice President of Clinical and Quality (VPCQ) and Medical Director Resident #1's medication error. An ad hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted via telephone to discuss the root cause of facilities failure to prevent a significant medication error. Root cause determined that Nurse #1 failed to effectively redirect another resident during medication administration which led to not confirming the right medications were given to the right resident per the seven (7) rights of medication administration leading to a significant medication error for Resident #1. Immediate corrective actions were discussed and established to ensure no other residents were at risk. Immediate corrective actions to ensure no other current facility residents were at risk for medication errors included full-house assessments for changes in vital signs and/or altered mental status, review of MARs to ensure medications were administered as ordered for all current residents and education to facility and agency licensed nurses and medication aides on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors during medication administration.

On 2/18/24, the DON and Staff Development Coordinator (SDC) provided education in person and verbally via telephone to facility and agency licensed nurses and medication aides on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors during medication administration. Facility and agency licensed nurses and medication aides who did not receive

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education on 2/18/24 will receive education prior to administering medications. The DON and/or SDC will be responsible for monitoring the daily nursing schedule, notifying, and providing education in person or verbally via telephone prior to next shift worked for facility and agency licensed nurses and medication aides who did not receive education on 2/18/24 and for tracking completion of education utilizing the electronic Master Education Log.

Effective 2/18/24, the facility updated the facility and agency orientation packet and checklist to include education on the seven (7) rights of medication administration to prevent medication errors and on redirecting other residents during medication administration to reduce distractions and medication errors. The facility orientation packet will continue to include medication skills competency for licensed nurses and medication aides upon hire, annually and as needed. The DON and/or SDC will be responsible for monitoring the completion of agency and facility education for licensed nurses and medication aides and will utilize the electronic Master Education Log to track compliance.

On 2/19/24, the Administrator met with the Interdisciplinary Team (IDT) including but not limited to, the DON, Unit Managers, Social Services Director and Medical Director to discuss the medication error and root cause analysis of the facilities failure to prevent a significant medication error and to discuss any recommended changes to the corrective plan implemented on 2/17/24. No recommended changes were made.

Effective 2/19/24, the Administrator will be

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ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 2/20/2024

On 4/10/24 the facility provided a corrective action plan with a completion date of 2/19/24 for the significant medication error that occurred on 2/17/24. This was reviewed and it was determined the corrective action plan did not meet all the criteria for past noncompliance specifically in the area of audits/monitoring. The corrective action plan did not include observations nurses and medication aides during medication pass to ensure residents were administered medications per the 7 rights of medication administration.

On 4/10/24, the facility's credible allegation of immediate jeopardy removal was validated on-site by record review, observations, and interviews with nursing staff.

A medication administration observation was conducted on 4/9/24. No concerns related to the medication errors were identified. The observation consisted of 26 medications, 3 different residents and 1 nurse and 2 medication aides. The nurse and the medication aides were observed implementing the rights of medication administration, and deferring distractions and interruptions until they completed the medication pass.

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

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F 760	Continued From page 14 Interviews with nurses and medication aides revealed they were required to complete an in-service related to medication errors. They confirmed they were educated in person on the 7 rights of medication administration and how to handle distractions and interruptions until the medication pass is completed. A review of the in-service records revealed the DON completed the in person in-services with the nurses and medication aides. All nurses and medication aides who had not worked prior to 2/19/24 or were newly employed were in-serviced before they were allowed to work. The immediate jeopardy removal date of 2/20/24 was validated.	F 760		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		4/12/24

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systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

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(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and

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F 867	Continued From page 17 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with resident, staff and Medical Director, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigation survey conducted on 3/3/22 and the recertification and complaint investigation survey conducted on 6/1/22. This was for a repeat deficiency in the area of significant medication errors that was originally cited on 3/3/22 during the complaint survey, and subsequently recited during the recertification and complaint investigation survey on 6/1/22 and the complaint survey completed on 4/10/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F760 - Based on record reviews, and interviews	F 867	1) On 4/9/24, NC State agency conducted an on-site complaint survey investigation and on 4/17/24 an immediate jeopardy was cited for F760 related to a significant medication error for Resident #1. On 4/18/24, the facilities credible allegation (CA) was approved with an alleged date of immediate jeopardy removal effective 2/20/24. Resident #1 readmitted to the facility on 2/19/24 and will continue to receive medication as ordered. 2) On 4/11/24, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted by the facility QAPI Committee including the Administrator, Director of Nursing (DON), Social Worker, Regional Director of Clinical Services (RDCS), VP of Clinical & Quality (VPCQ) and Medical Director to discuss the root cause of 1) the facilities failure to prevent a significant medication	

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F 867	Continued From page 18 with resident, staff and Medical Director, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 which included Risperidone (antipsychotic medication), Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat hypertension), and Amlodipine (a medication used to treat hypertension). Nurse #1 identified the error and Resident #1 was sent to the emergency department (ED) on 2/17/24 for further evaluation due to elevated heart rate and hypotension (low blood pressure). While in the ED, Resident #1 complained of having chest pain and feeling weak. An electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia). Resident #1 was admitted into the hospital for observation due to the prolonged effect of antihypertensives and being hypotensive on presentation. Resident #1 was discharged back to the facility on 2/19/24 at her baseline with no new orders. This deficient practice affected 1 of 3 residents reviewed for significant medication errors (Resident #1). During the recertification survey on 6/1/22, the facility failed to prevent significant medication errors whey they failed to acquire and administer Copaxone pre-filled syringes (used to treat multiple sclerosis) and as a result the resident missed 5 doses and when pain medications were not administered as ordered by the physician.	F 867	error for Resident #1 and 2) the facilities failure to implement an effective plan of correction to prevent repeat citations related to significant medication errors. Root cause determined that 1) Nurse #1 failed to effectively redirect another resident during medication administration which led to not confirming the right medications were given to the right resident per the seven (7) rights of medication administration resulting in a significant medication error for Resident #1 and 2) the plan of correction did not include appropriate monitoring measures to include medication administration observations to validate staff competency. 3) On 4/11/24, the Regional Director of Nursing provided education to the QAPI Committee on maintaining an effective QAPI program to prevent repeat citations for F760. A review of the Medication Administration Policy and of medication errors cited on 2/17/24 for Resident #1 and for 2/25/22 complaint survey and 6/1/22 recertification survey was completed to discuss additional strategies and the addition of a Medication Safety sub-committee to maintain an effective QAPI program to prevent future citations. On 4/11/24, the QAPI Committee met to discuss implementation of a Medication Safety sub-committee to expand ongoing efforts in identifying and preventing significant medication errors to ensure residents receive medications as ordered and per the seven (7) rights of medication administration. The Medication Safety	

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F 867	Continued From page 19 During the complaint investigation survey on 3/3/22, the facility failed to prevent significant medication errors when medications were not administered as ordered. An interview with the Administrator on 4/10/24 at 11:46 AM revealed they held monthly QA meetings where each department head reported on certain areas they are were monitoring, and where they reviewed current performance improvement plans that were in place. The Administrator stated one factor for the repeat issue of significant medication errors was the turnover in staffing particularly the nurses and medications aides. She stated that it was hard to keep regular staff and the facility still depended on agency staffing. Another factor was that the facility faced challenges with the resident population being younger compared to other facilities and having increased behaviors in the facility's resident population.	F 867	sub-committee will meet at least monthly and minutes will be maintained by the Administrator. Minutes will include review of current strategies to prevent medication errors, root cause of successes and failures and implementation of additional interventions to maintain an effective Medication Safety program to ensure residents are free from significant medication errors. 4) The RDCS and/or VPCQ will attend and review QAPI meetings and minutes, including the Medication Safety sub-committee meetings monthly for three (3) months or longer as needed to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations as appropriate to maintain compliance with QAA improvement activities. Completion Date: 4/12/24	