Plan of Correction For Survey Conducted on 3.4.2025
Provider #205134
FALLBROOK COMMONS
91 Merrymeeting Drive, Portland Me 04103

Plan of Correction F760 483.45(f)(2)

F 760 Residents are Free of Significant Med Errors, 483.45(f)(2)

This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a resident was free from a significant medication error when controlled medications were administered in excess of prescribed doses ordered by a physician for 1 of 3 (#3).

Corrective action for Resident #3, guardian was notified of medication error, Provider notified of medication error. Resident with no ill effects noted from receiving extra dose of medications. Nurse involved in medication incident was a nurse working for an agency and no longer provides service to the facility. The Med-tech involved in the incident will receive education regarding medication errors.

The facility will identify other residents having the potential to be affected by the same deficient practice, the facility will conduct an audit on each unit spanning the time period of 3.4.25-3.21.25. The audit (Table 1) will review the MARS, bound books and order history looking for discrepancies that could indicate a deficient practice or error. If there are any discrepancies found with the audit each one will be individualy investigated and evaluated for potential error or diversional activity and facility protocol/procedure will be followed.

The systemic changes that will be made will be the following. The facility will follow the QAPI process. The facility will develop a PIP with goal of less than 2 medication errors per month within the facility. The facility will use the PDSA tool. The QA/ infection prevention nurse or designee will assist with providing education and training. All Fallbrook Licensed staff (nurses and CMT's) and regularly schedule agency staff will be required to view the 3 part videos series through Omnicare located at (https://www.omnicare.com/medication-webcasts). Staff will be required to view the video series and then complete the quiz with the attestation statement that they have completed the education. The quiz (Table 2) will be returned to the IP/QA nurse.

The Facility will monitor the corrective action with the auditing process. The IP/QA nurse or designee will audit the med pass of at least 10 residents per/week x6 weeks. Then audits will be reduced to 5 residents per month. The Audit form Medication Administration Audit Form will be Utilized (Table 3).

The date certain for substantial Compliance will be April 18, 2025.

Plan of Correction F842 483.20(f)(5), 483.70(h)(1)-(5)

F 842 Resident Records - Identifiable Information 483.20(f)(5), 483.70(h)(1)-(5)

This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for medication errors (Resident #3).

Corrective action for Resident #3, guardian was notified of medication error, Provider notified of medication error. Resident with no ill effects noted from receiving extra dose of medications. Nurse involved in medication incident was a nurse working for an agency and no longer provides service to the facility. The Med-tech involved in the incident will receive education regarding medication errors.

The facility will identify other residents having the potential to be affected by the same deficient practice, the facility will conduct an audit on each unit spanning the time period of 3.4.25-3.21.25. The audit will review the Mars, bound books

and order history looking for discrepancies that could indicate a deficient practice or error. If there are any discrepancies found with the audit each one will be individual investigated and evaluated for potential error or diversional activity and facility protocol/procedure will be followed.

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The Facility will monitor the corrective action with the auditing process. The Nurse Manager or designee will Audit 10 records Monthly, Utilizing the Medication Error Report (table 4) and will share any findings with the QAPI committee.

The date certain for substantial Compliance will be April 18, 2025.

Table 1(F760, F842) FALLBROOK INTIAL MEDICATION ERROR REPORT (audit form, copy include)

Table 2 (F760, F842) Medication Administration and Preventing Errors Quiz (copy included)

Table 3 (F760, F842) Medication Administration Audit Form (Copy included)

Table 4 (F842) Fallbrook Commons Medications Error Report (copy Included)

F842 (Table 2) **FALLBROOK COMMONS INTIAL MEDICATION ERROR REPORT (UNIT)**

Room #	Resident Name	Medications	Bound book review	Errors Noted	Date	Initials

Manager or designee Signature_____ Date: _____

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Table 2.

Medication Administration and Preventing Errors Quiz

Name: _____ Date: _____

- I have viewed the **Medication Pass Fundamentals:** 3-Part Video Series at https://www.omnicare.com/resources/medication-webcasts/ ___ (Initials)

1. How many checks need to be completed when administering medication to a resident?

A. 2
B. 3
C. None because you know what they need
D. 5

2. It is ok to use the narcotic book to check against the bingo card or medication bottle.
   True or False

3. If a resident has a patch of any kind, if you can't find the old one, you should...(Check all that apply)
   A. Put the new patch on
   B. Check the resident's body to see if the old patch is in a different spot than documented
   C. Do not apply the new patch
   D. Call the provider

4. If you find a medication error, and you are a licensed nurse, what is the correct course of action?
   A. Report it to the supervisor or nurse manager
   B. Report it to the director of nursing
   C. Report it to the person who made the error
   D. Complete the risk report, assess the resident and report to provider/family and supervisor

5. A resident takes digoxin, but their pulse is 52, and there are no pulse parameters in the order. What should you do?

A. Give the medication
B. Hold the medication
C. Complete an SBAR
D. Notify the provider to see if pulse parameters are required and if the medication should be given

6. A resident has a new order for Lasix, but has no cardiac history, no edema and no s/s CHF. He has never taken it before. What should you do?
   A. Add CHF to diagnoses
   B. Give the medication
   C. Clarify the medication and diagnosis with provider
   D. Hold the medication

7. It is OK to pre-pour medications if it is a busy shift.

True or False

8. There is an order for Topamax, but you have never heard of the medication. What should you do?
   A. Have another staff give the medication
   B. Hold the medication
   C. Give the medication
   D. Look the medication up in the drug handbook

Signature: _____

Table 3

F 760, F842
483.45

Medication Administration Audit Form

Staff Name: _____ Unit: _____ Date: _____

Techniques Observed	Met	Not met	N/A	Notes
Med cart: no missing supplies; clean locked or visible				
Fluids and foods are covered/dated				
Resident identified per policy				
Privacy maintained and positioned properly				
For eds with parameters, VS are taken prior to administration				
Correct med verified by visual check of med, label and MAR; 3 checks				
Items dated when opened				
Liquid meds measured accurately, shaken, and/or diluted when appropriate				
Crushed properly and only if indicated				
Observed that meds are swallowed				
Medication record is charted properly				
Medication not left on bedside table or on cart				
Proper hand hygiene maintained				
Controlled medications are documented properly at time of administration Bare hands are not used to touch or handle medications				

Name of Auditor: _____

Signature of Auditor: _____

F842 (Table 4) **FALLBROOK COMMONS MEDICATION ERROR REPORT (UNIT)**

Room #	Resident Name	Medications	Bound book review	Errors Noted	Date	Initials

Complete Monthly

Manager or designee Signature______________________________ Date: ____

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