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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation for complaint CI MS # 18074 at the facility from 9/20/2021 to 9/22/2021. During the complaint investigation, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated CI MS #18074 for resident medications improperly administered resulting in one resident requiring intravenous (IV) fluids and one resident requiring IV fluids and emergency evaluation at the local hospital. The SA cited F658 and F760 all at a "G" level. The census was 59 and license for 80 beds.	F 000		
F 658 SS=G	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: Based on staff interviews, resident interview, record review and facility policy review, the facility failed to provide treatment and care in accordance with professional standards of practice for administration of medication for two (2) of seven (7) resident care plans reviewed. Resident #1 and Resident #5. Findings Include: Record review of the facility's policy, "Care Plan-Comprehensive", undated, revealed, "Policy Statement: It is the policy of this facility to develop comprehensive care plan for each resident that	F 658	1. Resident #1 was assessed by the Nurse Practitioner on 9/3/21. Resident #1 was sent to the hospital on 9/3/21 and returned to the facility on 9/3/21 with no negative outcomes. Licensed Practical Nurse (LPN) #1 was in-serviced one on one by the Regional Nurse Consultant on 9/3/21. Resident #5 was evaluated by LPN #4. LPN #4 obtained an order to administer intravenous (IV) fluids on 9/12/21. Resident #5 had no negative outcomes. LPN #3 terminated on 9/12/21. LPN #2 provided one on one education by the Director of Nursing	11/1/21

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

Electronically Signed | 10/20/2021

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F 658	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Procedure...2 ...e. Identify the professional services that are responsible for each element of care ..." Record review of the facility's policy, "Resident's Rights", dated 11/23/2016, "...(iv) The right to receive the services and/or terms included in the plan of care..." Review of the facility's policy, "Medication Administration-General Guidelines", dated November 1, 2008, revealed, "Policy: Medications are administered as prescribed with good principles and practices ...B. Administration...2) Medications are administered in accordance with written orders of the attending physician ...4) Medications are administered when they are prepared. Medications are not pre-poured. 5) Medications are administered without unnecessary interruptions. 6) The person who prepares the dose for administration is the person who administrators the dose. 7) Residents are identified before medication is administered. Methods of identification include a. checking identification band, b. checking photograph attached to the medical record, c. calling resident by name ...". Resident #1 Record review of Resident #1's Care Plan revealed "Focus: The resident has hypertension (HTN) r/t (related to) unknown etiology. Goal: The resident will remain free from s/sx (signs/symptoms) of hypertension through the review date. Interventions: Administer medication, supplements as ordered ..."	F 658	(DON) on 9/12/21. 2. All residents have the potential to be affected by the deficit practice cited. 3. All licensed nurses were in-serviced regarding care plans and medication administration beginning on 9/3/21 and ending on 10/21/21 by the DON and Regional Nurse Consultant. All licensed nurses received directed in-service education regarding services provided to meet professional standards related to medication administration and residents are free of significant medication errors by the Pharmacy Consultant on 10/19/21. All licensed nurses educated upon hire regarding medication administration beginning 10/18/21 and will be ongoing for all new hires. 4. Beginning 10/18/21 the Minimum Data Set (MDS) nurse will audit the medical records of five resident's monthly times three to ensure nurses are following the care plans. The MDS nurse will take immediate action if necessary and document findings. The DON will perform medication pass audits weekly times four beginning 9/3/21 and monthly times three beginning 10/8/21, and take immediate action as necessary and document findings. The DON will report findings from weekly medication pass audits to the Quality Assurance and Performance Improvement (QAPI)Committee for review, revision, or resolution of the plan beginning 10/29/21 and ending 3/25/22. QAPI Committee minutes will be reviewed by the Regional Director of Operations or Regional Nurse Consultant beginning 10/25/21 and ending 3/25/22.	

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Record review of Resident #1's Care Plan revealed "Focus: (Formal Name Resident #1) has Hyperlipidemia ...Interventions: Administer medications as ordered. Monitor for side effects ..."

Record review of Resident #1's Care Plan revealed "Focus: The resident is on ASA (aspirin) therapy r/t HTN ...Interventions: Administer medications as ordered by physician ..."

On 9/20/21 at 3:44 PM, in an interview with Licensed Practical Nurse (LPN) #1 stated Resident #2 was asleep and would not take her medication. She stated she placed Resident #2's medication in the top drawer of the medication cart. She stated she pulled Resident #1 ' s medications. She stated a Certified Nursing Assistant (CNA) came and asked her to help pull up a resident up in bed. She stated she placed Resident #1 ' s medication in the top drawer and locked the cart. She stated when she returned to the cart, she picked up the wrong medication cup by accident and gave Resident #1, Resident # 2's medication. She stated all of Resident #2's morning medications were given to Resident #1. She stated the Regional Nurse Consultant (RNC) was in the building and filled out an incident report. She went to the Nurse Practitioner (NP) who was in the facility, and told her what had happened. She stated the NP gave her an order to check blood pressure (BP) every 30 minutes and compare for the next two hours. She stated when she checked Resident #1's BP the 2nd time it was dropping and she phoned the NP and got an order to send the resident to the hospital and called an ambulance. She stated the NP gave her an order to start intravenous (IV) fluids and

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Registered Nurse (RN) #1 started the IV. She stated Resident #1 left by ambulance at 1500 (3 PM). She stated Resident #1 was seen at a local hospital. She stated Resident #1 could have had mood changes but the resident did not have any changes in mood. She stated her actions could have caused a problem. She stated the Synthroid could cause a change in his thyroid level. She stated the medications could cause the resident to have a change in his heart rhythm. She stated she checked all Resident #1's vital signs and they were all within normal range but she did not document the oxygen level and respirations.She stated she identifies a resident by room number, name, birthday and verbally calls the resident by name before she gives them their medications. She stated she did all the above, but that day she just had the wrong cup of medications in her hand.

On 9/21/21 at 10:30 AM, in an interview with the Regional Nurse Consultant (RNC) she stated LPN #1 told her what had happened. She stated she told she her to tell the NP. She stated she went and talked to Resident #1. Resident #1 denied any side effects of the medication. She stated she got an order to start intravenous (IV) fluids and that she and RN #1 started the IV fluids. She stated the NP gave them an order to send the resident to the hospital. She stated she told LPN #1 to check vital signs and call 911. She stated LPN #1 should have done all vital signs and documented them. She stated LPN #1 was not sent home nor was she suspended. She stated she did a 1:1 in-service with LPN #1 on medication and wrote her up. She stated by LPN #1 giving Resident #1 the wrong medications, it caused his BP to drop. She stated it could have caused him to have mental changes as well from

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the medication error.

On 9/21/21 at 11:24 AM, in an interview with the Director of Nursing (DON) stated LPN #1 should have done all vital signs, including respirations and oxygen level. She stated if the nurse did not document it then she did not do it. She stated LPN #1's actions could have caused the Resident to have an allergic reaction to the medication. She stated the resident could have had a drop in BP and pulse. She stated the resident could have had a decrease in level of consciousness, nausea, vomiting and diarrhea. She stated there is no excuse for the medication error. She stated a nurse should always check right route, date, time, and dosage on all medication passes.

Review of the Performance Improvement Project meeting (PIP) revealed it was completed on 9/10/21, related to medication errors.

On 9/22/21 at 11:11 AM, in an interview with Resident #1 stated he had been sent to the hospital one time. Resident #1 stated they gave him the wrong medication. He stated his blood pressure dropped from the medication.

On 9/23/21 at 12:13 PM, during a phone interview with the NP revealed she was in the facility when LPN #1 gave Resident #1 the wrong mediations. She stated she gave an order for intravenous (IV) fluids and also told LPN #1 to monitor vital signs every hour for the next four (4) hours. She stated that LPN #1 came back to her and she gave an order to send Resident #1 out to the local hospital. She gave an order for the RNC to start an IV and call 911. She assessed resident and no distress was noted. She stated the resident's BP dropped. She stated the resident's heart rate

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could have slowed down.

On 9/24/21 at 2:23 PM, in a phone interview with the Pharmacist, he stated Resident #1 was given three (3) anti-hypertensive medications. He stated the medications could cause the resident's BP to drop. He stated the risk factors are limited due to the fact the resident only received one dose of the medications. He stated the medication could cause the resident not to feel good. He stated the Seroquel could rarely cause any type of physical harm. He stated the resident would probably become less engaging and lethargic. He stated the resident would have to be given the medications over a long period of time to have an effect. He stated the resident would have to be given Depakote for 10 days to have an effect. He stated Seroquel takes two hours to get in the blood stream and it would not have a long-term effect on the resident. He stated for Depakote to cause liver failure the resident would have to be given it for 6 months. He stated the nurse realized she made a mistake and got an order for IV fluids to keep the BP up. He stated the biggest risk is the resident had potential for falls. Resident #1's risk factors was low based on medications she received.

Record review of the Order Summary Reported dated , September 22,2021, for Resident #1 revealed Aspirin tablet chewable 81 milligrams (MG)by mouth give one tablet one time a day, Folic Acid 1 MG by mouth one time a day, Klor-Con 10 Extended Release 10 milliequiveliants (MEQ) (Potassium Chloride ER) give 10 meq one time a day by mouth, Vitamin B1 tablet (Thiamine HCl) Give 200 mg by mouth one time a day, and Famotidine tablet 20 MG by mouth two times a day.

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Record review of Resident #1's September 2021 Medication Administration Record revealed Aspirin tablet chewable 81 milligrams (MG)by mouth give one tablet one time a day, Folic Acid 1 MG by mouth one time a day, Klor-Con 10 Extended Release 10 milliequiveliants (MEQ) (Potassium Chloride ER) give 10 meq one time a day by mouth, Vitamin B1 tablet (Thiamine HCl) Give 200 mg by mouth one time a day, and Famotidine tablet 20 MG by mouth two times a day was documented as given on 9/3/21 by LPN #1

Record review of Resident #2's Order Summary Report dated 9/13/21 revealed Resident # 2 had orders for the following medications: Apixaban tablet 5 MG one by mouth two times a day, Cozaar tablet 50 MG one by mouth in the morning, Meloxicam tablet 15 MG one by mouth one time a day, Aspirin EC tablet delayed Release 81 MG by mouth daily, Fexofenadine HCl tablet 180 mg by mouth one time a day, Seroquel tablet 400 MG one by mouth two times a day, Potassium Chloride ER tablet extended Release 10 MEQ one tablet by mouth two times a day , Multivitamin tablet give one tablet by mouth one time a day, Lasix tablet 20 MG one tablet by mouth two times a day, Lopressor tablet 50 MG one tablet by mouth two times a day, Depakote ER Extended Release 24 hour 500 MG one tablet by mouth two times a day.

Record review of the Health Status Note by LPN #1 dated 9/3/21 at 13:08 (1:08 PM), revealed Resident #1's blood pressure was 87/54 at 12:30 PM. NP gave orders to start Intravenous (IV) normal saline. The IV was started by RN #1 at 12:50 PM. BP was rechecked at 12:56 it was

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93/56 and heart rate was 61. Will continue to monitor.

Record review of the Health Status Note dated 9/3/21 at 17:05 (5:05 PM) revealed BP 86/53 heart rate 65 at 13:39 (1:39 PM), BP 85/60 HR 65 at 1400 (2:00 PM) and BP 76/50 and HR 61 at 14:27 (2:27 PM).

Record review of the Health Status Note revealed Resident #1 was discharged from the hospital on 9/3/21 at 21:30.

Record review of the Admission Record for Resident #1 revealed he was admitted to the facility on 9/8/20 with diagnoses Alcohol Abuse uncomplicated, Hyperlipidemia, Essential primary Hypertension, and Lack of Coordination.

Record review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/21, Section C, revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated Resident #1 had moderate cognitive impairment.

Review of the Physician diagnosis for Resident #1 revealed Alcohol Abuse uncomplicated, Hyperlipidemia, Essential primary Hypertension, and lack of coordination.

Resident #5

Record review of the incident report dated 9/12/21, prepared by the DON, revealed LPN #4 gave morning medication at 8:16 AM and two (2) hours later LPN #3 gave the same medications at 10:55 AM to Resident #5.

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Record review of LPN #2's handwritten investigation statement dated 9/13/21, revealed LPN #2 pre pulled the medication for Resident #5 on 9/11/21 and placed the cup in the medication cart with Resident #5's name on it for LPN #3 to give to the resident on 9/12/21.

Record review of a Progress Note dated 9/12/21 at 10:50 AM, written by the DON revealed, "I received a phone call from (Formal name of LPN #3).She states that she accidentally gave resident a second dose of her medication and was not aware that resident had already received meds from another nurse. I instructed nurse to do vital signs on pt immediately and call MD and RP to notify. I notified Administrator, (Formal Name)."

Record review of a Progress Note dated 9/12/21 at 14:30 (2:30 PM), written by the DON, revealed,"Received call from nurse (Formal name LPN#3) stating that resident's BP is now 89/53. Instructed that I would call (Formal name of Physician) to notify of BP. Called (Formal name of Physician) and received order to give resident 1000 cc's (Cubic centimeters) of .45 Normal Saline at 125cc/hr (hour) and to continue to monitor. Order obtained and RN on duty notified of order."

Record review of a Progress Note dated 9/13/21, at 8:00 AM revealed Resident #5 had been at the nursing station all morning with her head on the desk and had only eaten only a few bites of her breakfast and stated that she was not hungry. Her BP was 85/51 and her AM BP meds were held.

Record review of a Progress Note dated 9/13/21,

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at 12:13 PM revealed Resident #5 remained at the nursing station and had only eaten only a few bites of her lunch.

Record review of a Progress Note dated 9/14/21, at 8:01 AM revealed Resident #5 was found in the dining room vomiting.

On 9/21/21 at 11:49 AM, in an interview with the DON stated LPN #2 asked LPN #3 to work for her on 9/12/21. LPN #3 agreed to work for LPN #2. LPN #2 was trying to help LPN #3 out by pre pulling medications and placing them in a cup, which is against facility policy. She stated the resident could have had adverse effects from receiving a double dose of medications. She stated it could have affected the residents BP, respiration, pulse and oxygen (O2) issues. Psychotropic medications can cause a decrease in level of consciousness, dizziness, and weakness. She stated LPN #3 should have never given medications she did not prepare. She stated LPN #3 did not know what was in the cup, since she did not prepare it. She stated Resident #5 was on the 400 hall and was moved to the 300 hall. She stated the nurse on the 300 hall had already given Resident #5's medication and signed the Medication Administration Record (MAR). She stated LPN #3 did not check the MAR or check with nurse on the 300 hall before giving medications. She stated, "I don't know what kind of nurse would do that." She stated when a resident is moved to another hall the nurse on the that hall gives the medication. She stated LPN #3 did not check the MAR, compare the drugs in the cup with the MAR, or check to see if the MAR was signed nor did she ask the nurse on the 300 hall before giving the resident medication. She stated she has tried to contact

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LPN #3 by text message and phone call and has not been able to reach her. She stated she has tried three times to reach LPN #3. She stated LPN #3 text her and asked if she was on the schedule or not. She stated she text LPN #3 back and said no.

On 9/21/21 at 12:11 PM, in a phone interview with LPN #3 she stated LPN #2 asked me to work for her. She put the medication in the cup for me to give to the residents. She stated she thought Resident #5 was still on the hall. She stated she watched LPN #2 put the pills in the cup the day before. She stated she did not know the facility policy. She stated moving residents to other halls happens all the time. She stated the nurse on the hall was supposed to go down the hall where the resident has been moved to give the resident medications. She stated she checked the MAR, and it was not signed. She stated she thought the resident was still her resident. She stated she looked at the MAR and compared it to the medication in the cup. She stated she knows the pills and what they look like. She stated she knows the pills in the cup were correct pills for the resident. The pills she administered were Anastrozole tablet 1 MG by mouth daily, Aspirin tablet 81 MG by mouth daily, Azithromycin tablet 500 MG by mouth daily, Cardizem LA tablet Extended Release 24 hour 240 MG by mouth daily, Digoxin 0.125 MG by mouth daily, Ethambutol HCl tablet 400 MG three tablets by mouth daily, Losartan Potassium HCTZ 100-25 by mouth daily, Rifampin capsule 300 MG by mouth daily, Synthroid tablet 88 MCG by mouth daily, Cyproheptadine HCl tablet 4 MG by mouth one tablet two times a day, Eliquis tablet 5 MG by mouth one tablet two times a day, Metoprolol Tartrate tablet 50 MG one tablet by mouth two

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times a day. Medication was given on 9/12/21 at 8:16 AM by LPN #4. She stated she should have not given the resident the pills. She stated she was not aware the other nurse had given the pills to Resident #5 already. She stated she did not know the resident's medication cards had been pulled and put on the other cart. She stated she asked the nurse about Resident #5's medications after she had given Resident #5 the medication and the nurse told her she had already given them. She stated her actions could have caused the resident to go downhill. She stated the resident's BP could have bottomed out and pulse could have dropped low. She stated the Physician gave an order to check Resident #5's vital signs every 2 hours. She stated the DON told her to count the cart down and leave the facility.

On 9/21/21 at 12:55 PM, in an interview with LPN #2, stated on 9/11/21 she pulled up medication and put it in a cup for LPN #3 to give on 9/12/21. She stated that was against policy. She stated she was trying to help LPN #3 out since she was doing her a favor by working her shift. She stated by doing that LPN #3 did not know what she was giving the residents. She stated the medications could have spilled in the medication cart. She stated Resident #5's BP and heart rate could have dropped and she could have been sent to the hospital. She stated that it could have caused harm to the resident. She stated the DON wrote her up. She stated the DON did a medication pass with her. She stated the error could have been avoided if LPN #3 had checked to see if Resident #5 had received her medications. She stated LPN #4 gave Resident #5's medications the first time.

On 9/21/21 at 1:11 PM, in an interview with LPN

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#4 stated she had the 100 and 300 halls on 9/12/21 and she gave Resident #5 her morning medications around 8 AM and she held the resident's BP medication because it was low. She stated she always signs the MAR as she goes and she signed the MAR right after giving Resident #5 her medications. She stated she has never pre pulled medication and placed them in the cup for another nurse to give. She stated that is against policy. She stated when a nurse gives BP medication and does not check the BP, that could cause the resident's BP to bottom out. She stated LPN #3 called the MD, DON, and family. She stated LPN #3 asked her if she had given Resident #5 her medication after LPN #3 had given the second dose.

On 9/22/21 at 12:03 PM, in an interview with LPN #2 she stated she pre pulled 10- 15 residents' medication on 9/11/21 for LPN #3 to give on 9/12/21.

Record review of the Admission Record for Resident #5 revealed Resident #5 was admitted to the facility on 7/28/21 with diagnoses that included Disseminated Mycobacterium Avium-Intracellular Complex, Non-ST elevation Myocardial Infarction, Altered mental status, Atrial Fibrillation, Type 2 Diabetes Mellitus, Dementia with out behavioral disturbance, Heart Failure. An additional diagnosis of Hypotension was added with an onset date of 9/16/21.

Record review of the admission MDS with an ARD dated 8/4/21 does not reveal a BIMS score.

Record review of Resident #5 Order Summary report dated, September 2021, revealed Anastrozole tablet 1 MG by mouth daily, Aspirin

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tablet 81 MG by mouth daily, Azithromycin tablet 500 MG by mouth daily, Cardizem LA tablet Extended Release by mouth daily, Diflucan tablet 150 MG by mouth daily, Digoxin 0.125 MG by mouth daily, Ethambutol HCl tablet 400 MG three tablets by mouth daily, Losartan Potassium HCTZ 100-25 by mouth daily, Rifampin capsule 300 MG by mouth daily, Synthroid tablet 88 MCG by mouth daily, Cyproheptadine HCl tablet 4 MG by mouth one tablet two times a day, Eliquis tablet 5 MG by mouth one tablet two times a day, Metoprolol Tartrate tablet 50 MG one tablet by mouth two times a day.

Review of Resident #5 Medication Administration Record (MAR) September 2021 revealed Anastrozole tablet 1 MG by mouth daily, Aspirin tablet 81 MG by mouth daily, Azithromycin tablet 500 MG by mouth daily, Cardizem LA tablet Extended Release 24 hour 240 MG by mouth daily, Digoxin 0.125 MG by mouth daily, Ethambutol HCl tablet 400 MG three tablets by mouth daily, Losartan Potassium HCTZ 100-25 by mouth daily, Rifampin capsule 300 MG by mouth daily, Synthroid tablet 88 MCG by mouth daily, Cyproheptadine HCl tablet 4 MG by mouth one tablet two times a day, Eliquis tablet 5 MG by mouth one tablet two times a day, Metoprolol Tartrate tablet 50 MG one tablet by mouth two times a day. Medication was given on 9/12/21 at 8:16 AM by LPN #4.

Record review of Resident #5's current Comprehensive Care Plans revealed she has history of breast cancer and a history of joint replacement surgery, decreased mobility, mood problem related to altered mental status, diuretic therapy related to hypertension, anticoagulant therapy related to Atrial fibrillation, antibiotic

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therapy, history of Mycobacterium Avium-Intracellular Complex of the right wrist, alteration in hematological status related to history of Malignant Neoplasm of breast, Diabetes Mellitus, Hypotension, Heart failure, and abnormal bleeding and bruising of skin related to use of aspirin daily. The intervention for all the above diagnoses is administer medications as prescribed by physician.

On 9/22/21 at 12:42 PM, in an interview with Administrator stated she is aware of the medication incidents. She stated they have had in-services with the nurses. She stated she has told the nurses do not do anything untill they check it. She stated LPN #2 should never place medications in a cup for another nurse to give. She stated each nurse should pull their own medications and give to the resident. She stated they did a Quality Assurance and Performance Improvement (QAPI) on medication after the first incident on 9/3/21. We have had meetings and in-service on medications. She stated they have had in-services on staff never to give medications from another nurse. She stated they have observed medication pass. She stated she has checked the medication carts to make sure nurse are not pre-pulling medications. She stated the Medical Director is planning to do an in-service with staff.

On 9/22/21 at 4:13 PM, in an interview with LPN #6 Care Plan nurse stated the Comprehensive Care Plan is developed to let nursing staff know the plan of care. The staff should follow care plan when giving care. She stated if care plan is not followed the Resident would not be getting the right care. Medications should be administered per Physician orders. She stated that is on the

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F 760 SS=G	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 observation, staff interviews, resident interview, resident resident representative interview, record review, and facility policy review, the facility failed to ensure Residents were free from significant medication errors which resulted in two (2) resident which became hypotensive requiring intravenous fluid administration and one resident requiring transport to the emergency department for two (2) of seven (7) sampled residents. Residents #1 and #5. Findings Include: Review of the facility's policy, "Medication Administration-General Guidelines", dated November 1, 2008, revealed, "Policy: Medications are administered as prescribed with good principles and practices ...B. Administration...2) Medications are administered in accordance with written orders of the attending physician ...4) Medications are administered when they are prepared. Medications are not pre-poured. 5) Medications are administered without unnecessary interruptions. 6) The person who prepares the dose for administration is the person who administrators the dose. 7) Residents are identified before medication is administered. Methods of identification include a. checking identification band b. checking photograph	F 760	1. Resident #1 was assessed by the Nurse Practitioner on 9/3/21. Resident #1 was sent to the hospital on 9/3/21 and returned to the facility on 9/3/21 with no negative outcomes. Licensed Practical Nurse (LPN) #1 was in-serviced one on one by the Regional Nurse Consultant on 9/3/21. Resident #5 was evaluated by LPN #4. LPN #4 obtained orders to administer intravenous (IV) fluids on 9/12/21. Resident #5 had no negative outcomes. LPN #3 terminated on 9/12/21. LPN #2 provided one on one education by the Director of Nursing (DON) on 9/12/21. 2. All residents have the potential to be affected by the deficit practice cited. 3. All licensed nurses were in-serviced regarding care plans and medication administration beginning on 9/3/21 and ending on 10/21/21 by the DON and Regional Nurse Consultant. All licensed nurses received directed in-service training regarding services provided to meet professional standards related to medication administration and residents are free of significant medication errors by the Pharmacy Consultant on 10/19/21. All licensed nurses educated upon hire	11/1/21

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F 760	Continued From page 16 attached to the medical record c. calling resident by name ...". Resident #1 Record review of an incident dated 9/3/21, LPN#1 "Nursing Description: On the hall doing med pass at 0759. Pulled the meds for resident (Formal Name Resident #2). Went into the Pt room and she would not take them at the time. I decided to continue with my med pass and go on to the next resident. To try again in a couple of minutes. I pulled (Formal Name Resident #1's) medicine at this time. (Formal Name Resident #2) medicine was still on the cart at the time. Instead of picking up(Formal Name Resident #1's) medicine and putting it in the cart and locking it. I picked up (Formal Name Resident #2's) medication. I realize the incident once I made it back to the cart and opened it. I checked for any drug reactions and reviewed the medications he received. I immediately reported it to the Nurse Practitioner (NP) who was in the building at the time. Pt (patient) was checked every 30 to see if there was a change in level of consciousness (LOC). Pt remained the same. His still oriented and alert. Resident Description: Resident Unable to give Description. Immediate Action Taken: Description: I reported it to the Nurse Practitioner (Formal Name) that was present in the building at the time. She advised that I retake the Pt blood pressure and recheck the Pt every 2 hours for the next 4 hours. The first set of vitals that were taken at 0700 read as follows: 97.2 117/86 70 18 96. I continued to monitor the Pt for any changes for LOC and behaviors but the Pt remained the same. I rechecked Pt BP at 0920 it was 142/67 HR 78. I advised the Certified Nursing Assistant (CNA) to push fluids. At 1130 his BP was 101/60	F 760	regarding medication administration beginning 10/18/21 and will be ongoing for all new hires. 4. The DON will perform medication pass audits weekly times four beginning 9/3/21 and monthly times three beginning 10/8/21, and take immediate action as necessary and document findings. The DON will report findings from weekly medication pass audits to the Quality Assurance and Performance Improvement (QAPI)Committee for review, revision, or resolution of the plan beginning 10/29/21 and ending 3/25/22. QAPI Committee minutes will be reviewed by the Regional Director of Operations or Regional Nurse Consultant beginning 10/29/21 and ending 3/25/21.	

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HR 73. I told the NP she ordered for the Pt to be sent out for fluids and further evaluation related to the drop in BP.I called (Formal Name of Local Hospital) and gave them report.(Formal Name of Ambulance Company) was called and family was called but it went straight to voicemail. Pt is still alert and oriented x 4. Pt is aware of the situation. No c/o (complaints) of distress noted..."

On 9/20/21 at 3:44 PM, in an interview with Licensed Practical Nurse (LPN) #1 stated Resident #2 was asleep and would not take her medication. She stated she placed Resident #2's medication in the top drawer of the medication cart. She stated she pulled Resident #1 ' s medications. She stated a Certified Nursing Assistant (CNA) came and asked her to help pull up a resident up in bed. She stated she placed Resident #1 ' s medication in the top drawer and locked the cart. She stated when she returned to the cart, she picked up the wrong medication cup by accident and gave Resident #1, Resident # 2's medication. She stated all of Resident #2's morning medications were given to Resident #1. She stated the Regional Nurse Consultant (RNC) was in the building and filled out an incident report. She went to the NP who was in the facility, and told her what had happened. She stated the NP gave her an order to check blood pressure (BP) every 30 minutes and compare for the next two hours. She stated when she checked Resident #1's BP the 2nd time it was dropping and she phoned the NP and got an order to send the resident to the hospital and called an ambulance. She stated the NP gave her an order to start intravenous (IV) fluids and Registered Nurse (RN) #1 started the IV. She stated Resident #1 left by ambulance at 1500 (3PM). She stated Resident #1 was seen at a local

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hospital. She stated Resident #1 could have had mood changes but the resident did not have any changes in mood. She stated her actions could have caused a problem. She stated the Synthroid could cause a change in his thyroid level. She stated the medications could cause the resident to have a change in his heart rhythm. She stated she checked all Resident #1's vital signs and they were all within normal range but she did not document the oxygen level and respirations. She stated she tried to call the family but RR#1 did not answer the phone and she did not leave a voice message. She stated she did not know to call the other family listed in the chart. She stated she tried to call the RR the entire day but she did not document each time she tried to call family. She stated she told the oncoming nurse, LPN #5, that she did not reach the family and the oncoming nurse was supposed to continue to try calling the family. She stated it is very important that family is contacted. She stated the family should know everything that is going on with the resident. She stated she identifies a resident by room number, name, birthday and verbally calls the resident by name before she gives them their medications. She stated she did all the above, but that day she just had the wrong cup of medications in her hand.

On 9/21/21 at 10:30 AM, in an interview with the Regional Nurse Consultant (RNC) she stated LPN #1 told her what had happened. She stated she told she her to tell the NP. She stated she went and talked to Resident #1. Resident #1 denied any side effects of the medication. She stated she got an order to start intravenous (IV) fluids and that she and RN #1 started the IV fluids. She stated the NP gave them an order to send the resident to the hospital. She stated she

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told LPN #1 to check vital signs and call 911. She stated LPN #1 should have done all vital signs and documented them. She stated LPN #1 was not sent home nor was she suspended. She stated she did a 1:1 in-service with LPN #1 on medication and wrote her up. She stated by LPN #1 giving Resident #1 the wrong medications, it caused his BP to drop. She stated it could have caused him to have mental changes as well, from the medication error.

On 9/21/21 at 11:05 AM, in an interview with Resident #1's Resident Representative (RR) stated the staff told her Resident #1 had been sent to the hospital. She stated the staff told her he was given the wrong medication. She stated Resident #1 told her they gave him the wrong medication and his BP went up. She stated she was told by the nurse that the resident was given the wrong medication and his BP dropped.

On 9/21/21 at 11:24 AM, in an interview with the Director of Nursing (DON) stated LPN #1 should have done all vital signs, including respirations and oxygen level. She stated if the nurse did not document it then she did not do it. She stated LPN #1's actions could have caused the Resident to have an allergic reaction to the medication. She stated the resident could have had a drop in BP and pulse. She stated the resident could have had a decrease in level of consciousness, nausea, vomiting and diarrhea. She stated there is no excuse for the medication error. She stated a nurse should always check right route, date, time, and dosage on all medication passes. She stated LPN #1 should have given report to the oncoming nurse to contact the family.

On 9/21/21 at 12:55 PM, in an interview with

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Administrator in Training stated we had a Quality Assurance and Performance Improvement (QAPI) meeting scheduled for 9/21/21, but we canceled due to the Medical Director (MD) not being able to attend meeting. He stated the QAPI has been rescheduled for 9/24/21. He stated they did a PIP in reference to Resident #1.

Review of the Performance Improvement Plan (PIP) revealed it was completed on 9/10/21, related to medication errors.

On 9/22/21 at 11:11 AM, in an interview with Resident #1 stated he had been sent to the hospital one time. Resident #1 stated they gave him the wrong medication and his blood pressure dropped from the medication.

On 9/23/21 at 12:13 PM, during a phone interview with the NP revealed she was in the facility when LPN #1 gave Resident #1 the wrong mediations. She stated she gave an order for intravenous (IV) fluids and also told LPN #1 to monitor vital signs every hour for the next four (4) hours. She stated that LPN #1 came back to her and she gave an order to send Resident #1 out to the local hospital. She gave an order for the RNC to start an IV and call 911. She assessed resident and no distress was noted. She stated the resident's BP dropped. She stated the resident's heart rate could have slowed down.

On 9/24/21 at 2:23 PM, in a phone interview with the Pharmacist, he stated Resident #1 was given three (3) anti-hypertensive medications. He stated the medications could cause the resident's BP to drop. He stated the risk factors are limited due to the fact the resident only received one dose of the medications. He stated the

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medication could cause the resident not to feel good. He stated the Seroquel could rarely cause any type of physical harm. He stated the resident would probably become less engaging and lethargic. He stated the resident would have to be given the medications over a long period of time to have an effect. He stated the resident would have to be given Depakote for 10 days to have an effect. He stated Seroquel takes two hours to get in the blood stream and it would not have a long-term effect on the resident. He stated for Depakote to cause liver failure the resident would have to be given it for 6 months. He stated the nurse realized she made a mistake and got an order for IV fluids to keep the BP up. He stated the biggest risk is the resident had potential for falls. Resident #1's risk factors was low based on medications she received.

Record review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/21, Section C, revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated Resident #1 had moderate cognitive impairment.

Record review of the Health Status Note by LPN #1 dated 9/3/21 at 13:08 (1:08 PM), revealed Resident #1's blood pressure was 87/54 at 12:30 PM. NP gave orders to start Intravenous (IV) normal saline. The IV was started by RN #1 at 12:50 PM. BP was rechecked at 12:56 it was 93/56 and heart rate was 61. Will continue to monitor.

Record review of the Health Status Note dated 9/3/21 at 17:05 (5:05 PM) revealed BP 86/53 heart rate 65 at 13:39 (1:39 PM), BP 85/60 HR 65 at 1400 (2:00 PM) and BP 76/50 and HR 61 at

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14:27 (2:27 PM).

Record review of the Health Status Note revealed Resident #1 was discharged from the hospital on 9/3/21 at 21:30.

Record review of an in-service, titled Medication Pass and Reordering Medication completed by the pharmacist revealed the inservice was completed on 9/16/21. LPN #1's signature was included on the sign-in sheet.

Record review of the Admission Record for Resident #1 revealed he was admitted to the facility on 9/8/20 with diagnoses Alcohol Abuse uncomplicated, Hyperlipidemia, Essential primary Hypertension, and Lack of Coordination.

Record review of the Order Summary Reported dated, September 22, 2021, for Resident #1 revealed Aspirin tablet chewable 81 milligrams (MG) by mouth give one tablet one time a day, Folic Acid 1 MG by mouth one time a day, Klor-Con 10 Extended Release 10 milliequiveliants (MEQ) (Potassium Chloride ER) give 10 meq one time a day by mouth, Vitamin B1 tablet (Thiamine HCl) Give 200 mg by mouth one time a day, and Famotidine tablet 20 MG by mouth two times a day.

Record review of Resident #1's September 2021 Medication Administration Record revealed Aspirin tablet chewable 81 milligrams (MG)by mouth give one tablet one time a day, Folic Acid 1 MG by mouth one time a day, Klor-Con 10 Extended Release 10 milliequiveliants (MEQ) (Potassium Chloride ER) give 10 meq one time a day by mouth, Vitamin B1 tablet (Thiamine HCl) Give 200 mg by mouth one time a day, and

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Famotidine tablet 20 MG by mouth two times a day was documented as given on 9/3/21 by LPN #1.

Record review of Resident #2's Order Summary Report dated 9/13/21 revealed Resident # 2 had orders for the following medications: Apixaban tablet 5 MG one by mouth two times a day, Cozaar tablet 50 MG one by mouth in the morning, Meloxicam tablet 15 MG one by mouth one time a day, Aspirin EC tablet delayed Release 81 MG by mouth daily, Fexofenadine HCl tablet 180 mg by mouth one time a day, Seroquel tablet 400 MG one by mouth two times a day, Potassium Chloride ER tablet extended Release 10 MEQ one tablet by mouth two times a day , Multivitamin tablet give one tablet by mouth one time a day, Lasix tablet 20 MG one tablet by mouth two times a day, Lopressor tablet 50 MG one tablet by mouth two times a day, Depakote ER Extended Release 24 hour 500 MG one tablet by mouth two times a day.

Review of the hospital Discharge Summary revealed no new orders, resident was discharged (D/C) same day resident went to the hospital. Resident #1 was diagnosed with hypotension -drug related.

Resident #5

Record review of the incident report dated 9/12/21, prepared by the DON, revealed LPN #4 gave morning medication at 8:16 AM and two (2) hours later LPN #3 gave same medication at 10:55 AM to Resident #5.

Record review of LPN #2's handwritten investigation statement dated 9/13/21 revealed

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LPN #2 pre pulled the medication for Resident #5 on 9/11/21 and placed the cup in medication cart with Resident #5's name on it for LPN #3 to give to the resident on 9/12/21.

Record review of a progress note dated 9/12/21 at 10:50 AM, written by the DON revealed, "I received a phone call from (Formal name of LPN #3).She states that she accidentally gave resident a second dose of her medication and was not aware that resident had already received meds from another nurse. I instructed nurse to do vital signs on pt immediately and call MD and RP to notify. I notified Administrator, (Formal Name)."

Record review of a progress note dated 9/12/21 at 14:30 (2:30 PM), written by the DON, revealed, "Received call from nurse (Formal name LPN#3) stating that resident's BP is now 89/53. Instructed that I would call (Formal name of Physician) to notify of BP. Called (Formal name of Physician) and received order to give resident 1000 cc's (Cubic centimeters) of .45 Normal Saline at 125cc/hr (hour) and to continue to monitor. Order obtained and RN on duty notified of order."

Record review of a progress noted dated 9/13/21, at 8:00 AM revealed Resident #5 had been at the nursing station all morning with her head on the desk and had only eaten only a few bites of her breakfast and stated that she was not hungry. Her BP was 85/51 and her AM BP meds were held.

Record review of a progress noted dated 9/13/21, at 12:13 PM revealed Resident #5 remained at the nursing station and had only eaten only a few bites of her lunch.

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Record review of a progress noted dated 9/14/21, at 8:01 AM revealed Resident #5 was found in the dining room vomiting.

Record review of a document on facility letterhead dated 9/28/21 revealed LPN#3 was sent home at approx 4:40 PM on 9/12/21 and was terminated from the nursing department at (Formal Name of Facility). The document was signed by the DON.

On 9/21/21 at 11:49 AM, in an interview with the DON stated LPN #2 asked LPN #3 to work for her on 9/12/21. LPN #3 agreed to work for LPN #2. LPN #2 was trying to help LPN #3 out by pre pulling medications and placing them in a cup, which is against facility policy. She stated the resident could have had adverse effects from receiving a double dose of medications. She stated it could have affected the residents BP, respiration, pulse and oxygen (O2) issues. Psychotropic medications can cause a decrease in level of consciousness, dizziness, and weakness. She stated LPN #3 should have never given medications she did not prepare. She stated LPN #3 did not know what was in the cup, since she did not prepare it. She stated Resident #5 was on the 400 hall and was moved to the 300 hall. She stated the nurse on the 300 hall had already given Resident #5's medication and signed the Medication Administration Record (MAR). She stated LPN #3 did not check the MAR or check with nurse on the 300 hall before giving medications. She stated, "I don't know what kind of nurse would do that." She stated when a resident is moved to another hall the nurse on the that hall gives the medication. She stated LPN #3 did not check the MAR, compare the drugs in the cup with the MAR, or check to

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see if the MAR was signed nor did she ask the nurse on the 300 hall before giving the resident medication. She stated she has tried to contact LPN #3 by text message and phone call and has not been able to reach her. She stated she has tried three times to reach LPN #3. She stated LPN #3 text her and asked if she was on the schedule or not. She stated she text LPN #3 back and said no.

On 9/21/21 at 12:11 PM, in a phone interview with LPN #3 she stated LPN #2 asked me to work for her. She put the medication in the cup for me to give to the residents. She stated she thought Resident #5 was still on the hall. She stated she watched LPN #2 put the pills in the cup the day before. She stated she did not know the facility policy. She stated moving residents to other halls happens all the time. She stated the nurse on the hall was supposed to go down the hall where the resident has been moved to give the resident medications. She stated she checked the MAR, and it was not signed. She stated she thought the resident was still her resident. She stated she looked at the MAR and compared it to the medication in the cup. She stated she knows the pills and what they look like. She stated she knows the pills in the cup were correct pills for the resident. The pills she administered were Anastrozole tablet 1 MG by mouth daily, Aspirin tablet 81 MG by mouth daily, Azithromycin tablet 500 MG by mouth daily, Cardizem LA tablet Extended Release 24 hour 240 MG by mouth daily, Digoxin 0.125 MG by mouth daily, Ethambutol HCl tablet 400 MG three tablets by mouth daily, Losartan Potassium HCTZ 100-25 by mouth daily, Rifampin capsule 300 MG by mouth daily, Synthroid tablet 88 MCG by mouth daily, Cyproheptadine HCl tablet 4 MG by mouth

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one tablet two times a day, Eliquis tablet 5 MG by mouth one tablet two times a day, Metoprolol Tartrate tablet 50 MG one tablet by mouth two times a day. Medication was given on 9/12/21 at 8:16 AM by LPN #4. She stated she should have not given the resident the pills. She stated she was not aware the other nurse had given the pills to Resident #5 already. She stated she did not know the resident's medication cards had been pulled and put on the other cart. She stated she asked the nurse about Resident #5's medications after she had given Resident #5 the medication and the nurse told her she had already given them. She stated her actions could have caused the resident to go downhill. She stated the resident's BP could have bottomed out and pulse could have dropped low. She stated the Physician gave an order to check Resident #5's vital signs every 2 hours. She stated the DON told her to count the cart down and leave the facility.

On 9/21/21 at 12:55 PM, in an interview with LPN #2, stated on 9/11/21 she pulled up medication and put it in a cup for LPN #3 to give on 9/12/21. She stated that was against policy. She stated she was trying to help LPN #3 out since she was doing her a favor by working her shift. She stated by doing that LPN #3 did not know what she was giving the residents. She stated the medications could have spilled in the medication cart. She stated Resident #5's BP could have dropped and she could have been sent to the hospital. She stated that it could have caused harmed the resident. She stated the DON wrote her up. She stated the DON did a medication pass with her. She stated the error could have been avoided if LPN #3 had checked to see if Resident #5 had received her medications. She stated LPN #4 gave Resident #5's medications the first time.

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On 9/21/21 at 1:11 PM, in an interview with LPN #4 stated she had the 100 and 300 halls on 9/12/21 and she gave Resident #5 her morning medications around 8 AM and she held the resident's BP medication because it was low. She stated she always signs the MAR as she goes and she signed the MAR right after giving Resident #5 her medications. She stated she has never pre pulled medication and placed them in the cup for another nurse to give. She stated that is against policy. She stated when a nurse gives BP medication and does not check the BP, that could cause the resident's BP to bottom out. She stated LPN #3 called the MD, DON, and family. She stated LPN #3 asked her if she had given Resident #5 her medication after LPN #3 had given the second dose.

On 9/22/21 at 12:03 PM, in an interview with LPN #2 she stated she pre pulled 10- 15 residents' medication on 9/11/21 for LPN #3 to give on 9/12/21.

On 9/22/21 at 12:42 PM, in an interview with the Administrator revealed she is aware of the medication incidents. She stated they have had in-services with the nurses. She stated she has told the nurses do not do anything till they check it. She stated LPN #2 should never place medications in a cup for another nurse to give. She stated each nurse should pull their own medications and give to the resident. She stated they did a Quality Assurance and Performance Improvement (QAPI) on medication after the first incident on 9/3/21. We have had meetings and in-service on medications. She stated they have had in-services on staff never to give medications from another nurse. She stated they have

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observed medication pass. She stated she has checked the medication carts to make sure nurses are not pre-pulling medications. She stated the Medical Director is planning to do an in-service with staff.

Record review of the Admission Record for Resident #5 revealed Resident #5 was admitted to the facility on 7/28/21 with diagnoses that included Disseminated Mycobacterium Avium-Intracellular Complex, Non-ST elevation Myocardial Infarction, Altered mental status, Atrial Fibrillation, Type 2 Diabetes Mellitus, Dementia with out behavioral disturbance, Heart Failure. An additional diagnosis of Hypotension was added with an onset date of 9/16/21.

Record review of the admission MDS with an ARD dated 8/4/21 does not reveal a BIMS score.

Record review of Resident #5 Order Summary report dated, September 2021, revealed Anastrozole tablet 1 MG by mouth daily, Aspirin tablet 81 MG by mouth daily, Azithromycin tablet 500 MG by mouth daily, Cardizem LA tablet Extended Release by mouth daily, Diflucan tablet 150 MG by mouth daily, Digoxin 0.125 MG by mouth daily, Ethambutol HCl tablet 400 MG three tablets by mouth daily, Losartan Potassium HCTZ 100-25 by mouth daily, Rifampin capsule 300 MG by mouth daily, Synthroid tablet 88 MCG by mouth daily, Cyproheptadine HCl tablet 4 MG by mouth one tablet two times a day, Eliquis tablet 5 MG by mouth one tablet two times a day, Metoprolol Tartrate tablet 50 MG one tablet by mouth two times a day.

Review of Resident #5 Medication Administration Record (MAR) September 2021 revealed

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