STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255139	A. BUILDING _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BATESVILLE	154 WOODLAND ROAD BATESVILLE, MS 38606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a Complaint Survey at the facility from 02/17/22 through 02/24/22 for Complaint Investigations (CI) MS #18519 for facility staffing, dignity and respect, nursing services, resident medications not given according to physician's instructions and resident client/patient neglect. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited F609, F760 and F842. CI MS #18434 for no pressure sore precautions taken by the facility, resident assessment, and quality of care was unsubstantiated.

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/23/21, when the facility failed to ensure a resident was free of significant medication errors when he was admitted on 12/23/21. The resident's medications were inaccurately entered into the medical record and the resident received medications on the morning of 12/24/21 that were not prescribed for the resident. He was administered eight (8) hypertensive medications, one (1) antidepressant and two (2) diabetic medications. The incident resulted in serious harm for Resident #1, and he required immediate need for a higher level of care, evaluation and monitoring and was sent to the local emergency room department.

This incident placed Resident #1 and all residents in a situation that caused or was likely to cause serious injury, harm, impairment, or death.

On 2/23/22, the SA notified the Administrator of the IJ and SQC and provided the facility with the

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

Electronically Signed | 03/25/2022

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F 000	Continued From page 1 IJ template. The SQC and IJ existed at: 42 CFR(s): §483.45(f)(2) - Residents are free of any significant medication errors (F760) Scope/Severity "J". 42 CFR(s) §483.70(i)(1) Medical records (F842) Scope/Severity "J". F609 was also cited at a "D". Based on the facility's implementation of corrective actions on 12/24/2021- 12/28/2021, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 12/28/2021, prior to the SA's entrance on 2/17/2022.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		3/30/22

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F 609	Continued From page 2 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, resident's family interview, staff interviews, record review, and facility policy review, the facility failed to notify the State Agency (SA) when the facility failed to administer the correct medications for one (1) of four (4) residents reviewed. Resident #1. Findings include: Record review of facility policy titled "Abuse, Neglect, Misappropriation, Exploitation Policy", dated January 2019, revealed, "Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws...Immediately reporting all alleged violations to the Administrator, designee, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes ..." An interview with Resident #1's Resident	F 609	1. Report of medication error was reported to the State Agency by Nursing home Administrator on 2/24/22 at approximately 6:22p.m. Resident and Resident's Responsible Party were interviewed about incident Care Plans for this affected resident were reviewed and updated as deemed necessary. 2.All Residents have the potential to be affected by the deficient practice. To determined if other residents might have been effected by this practice, an audit was performed by Director of Nursing Services and Assistant Director of nursing services on 12/28/2021 for the frame of 12/6/2021 to 12/28/2021. No other reportable were discovered. 3. All nurses and administrative staff were educated by Administrator and Director of Clinical Educator on February 23, 2022 on the State requirements of reporting Tag F609-Reporting of alleged Violations of	

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F 609	Continued From page 3 Representative (RR) on 2/22/22 at 1:50 PM, revealed Resident #1 was admitted to the facility on 12/23/21 around 8:00 PM to 9:00 PM. The next morning he was given multiple medications that were not his. His attempts to refuse the medications were unsuccessful. The resident became dizzy and his hands were numb. He was taken to the hospital by ambulance for treatment in the emergency room. The RR met the resident in the emergency room and stated he was so sick. He told her he did not think he was going to survive it. He received intravenous fluids to flush the drugs out of his system and to improve his blood pressure. An interview with the Director of Nursing (DON) on 2/22/22 at 3:00 PM, confirmed the medication error occurred on 12/24/2021 during the morning medication pass. She stated the Admission Coordinator printed the information from the hospital prior to the resident's arrival to the facility, but she was unable to print the orders. The other information for Resident #1 printed, but the Admission Coordinator had to copy and paste the orders onto a Word Document. She stated she was unsure how the packet of information for Resident #1 had Resident #2's orders in it, but Licensed Practical Nurse (LPN) #2 entered this information (Resident #2's medications) into the computer orders for Resident #1. The error was discovered on 12/24/2021, when one medication ordered incorrectly for Resident #1 was not in the medication cart so Licensed Practical Nurse (LPN) #1 went to the Admission Coordinator to ask for a required hard copy prescription for Gabapentin for Resident #1 so the resident could receive the medication. The Admission Coordinator printed off orders for Resident #1 and it was determined that the medications were	F 609	Abuse and neglect. Specifically, medication errors that result in bodily harm and/or transfer to a higher level of care. All nurses were educated that they are required to report any medication error immediately to Administration. On 12/28/2021, Monitoring on nurses notes and risk management events will be reviewed daily as part of Clinical Meeting to determine if there is any reportable event. On 12/24/2021, Ad Hoc Quality Assurance and Performance was completed by Nursing Home Administrator, Director of Nursing Services, Assistant Director of Nursing, Director of Clinical Educator, Director of Clinical Operations, and Medical Director and monitoring was initiated. 4. Any adverse findings will be immediately report to the Nursing Home Administrator, investigated and report to the State Agency as deemed necessary. Audits will be completed by Director of Nursing, Assistant Director of Nursing, and Director of Clinical Educator, Unit Manager on admission and the following day during Clinical Start Up to assure that the correct medication orders were entered correctly. This performance improvement process will be addressed in Quality Assurance and Performance Improvement for a minimum of three months beginning January 19, 2022	

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F 609	Continued From page 4	F 609		

different than those entered the previous day and different from those just administered by LPN #1. The DON stated she checked Resident #1's chart and she found the Face Sheet and lab sheets for Resident #1 and the orders for another resident (Resident #2) were mixed in the middle of Resident #1's Face Sheet and lab sheets. The resident required treatment in the emergency room.

An interview with the Director of Nursing on 2/23/22 at 10:05 AM, confirmed that on 12/24/2021, the medication error occurred and led to emergency room treatment for Resident #1. She stated she notified the company's Corporate Nurse and they discussed the medication error and whether or not it should be reported. She stated they discussed this back and forth and it was decided that reporting was not needed since medication errors are not reportable. She confirmed the facility failed to report the incident that led to resident harm to the State Agency.

An interview with the Administrator on 2/23/22 at 10:45 AM, confirmed the facility had a medication error that led to Resident #1 requiring emergency room treatment and this was not reported to the State Agency (SA). She stated the DON and the company's Corporate Nurse discussed this and she was unsure who decided that this medication error was not a reportable event. The Administrator confirmed the incident should have been reported, but the facility failed to report the incident to the State Agency.

An interview with the company's Corporate Nurse on 2/23/2022 at 1:35 PM, revealed she was notified of the incident that occurred with

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Resident #1's medication administration error on 12/24/2021. She confirmed that Resident #1 needed medical treatment in the emergency room. She stated when this incident occurred, she, the facility administration staff, and her supervisors discussed the situation and decided not to report due to this being a medication error and medication errors are not reported. She confirmed since the resident required treatment in the emergency room, this should have been reported and she accepted the responsibility for not reporting this to the State Agency.

An interview by telephone with Resident #1 on 2/23/22 at 7:26 PM, revealed the resident was admitted to the facility the evening before he was given the wrong medication. Resident #1 stated he repeatedly told the nurse that he does not take many medications and those medications were not his, but the nurse insisted that the doctor had ordered these for him, so he reluctantly took the medicines. Soon after he took the medications, he was dizzy and his hands and feet were numb and tingling and he was sent to the emergency room for treatment.

Record review of Admission Record revealed Resident #1 was admitted to the facility on 12/23/2021 and was discharged on 1/3/2022 with diagnoses that included Nondisplaced Dome Fracture of Left Acetabulum, Benign Prostatic Hyperplasia (BPH) without Lower Urinary Tract Symptoms, and Hypertension.

Record review of Resident #1's hospital discharge summary revealed the resident was admitted to the hospital on 12/18/2021 and discharged on 12/23/2021. Diagnoses: Displaced Left Acetabulum Fracture, Left Pelvis Hematoma,

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Hypertension, Benign Prostatic Hyperplasia (BPH). Medications ordered at discharge: Finasteride 5 milligram (mg) tablet daily, Metoprolol Succinate 25 mg daily, Tamsulosin 0.4 mg daily, Triamterene-Hydrochlorothiazide 37.5-25 mg capsule daily, Hydrocodone-Acetaminophen 5-325 mg tablet every 4 hours as needed for pain.

Record review of Resident #1's orders Order Summary Report revealed that on admission on 12/23/21 these medications were entered in the resident's electronic orders: Bumetanide Tablet 1 MG (milligram) Give 1 (one) tablet two times a day related to Essential (Primary) Hypertension; Clonidine HCl 0.2 MG tablet Give 1 tablet by mouth three times a day related to Essential (Primary) Hypertension; Isosorbide Mononitrate ER Tablet Extended Release 24 hour 120 MG Give one tablet by mouth 1 time a day related to Essential (Primary) Hypertension; Gabapentin Capsule 100 mg capsules Give two capsules by mouth three times a day related to Fracture of Pelvis; Amlodipine Besylate Tablet 5 MG Give one tablet one time a day related to Essential Primary Hypertension; Atorvastatin Calcium Tablet 80 MG tablet Give one tablet by mouth nightly for Hyperlipidemia; Carvedilol Tablet 12.5 MG Give one tablet two times a day related to Essential (Primary) Hypertension; Escitalopram OxalateTablet 10 MG Give one tablet by mouth one time a day related to Adverse Effect of Unspecified Antidepressants; Ferrous Sulfate Tablet Delayed Release 324 MG 65 Fe (iron) Give 1 tablet by mouth two times a day related to Fracture of other parts of pelvis; Glimepiride Tablet 4 MG Give 1 tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Hydralazine HCl Tablet 100 MG Give 1 tablet by

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mouth three times a day related to Essential (Primary) Hypertension; Insulin NPH(Human) (Isophane)Suspension 100 units/ml (milliliter) Inject 12 unit subcutaneously in the morning related to Type 1 Diabetes Mellitus; Insulin NPH 100 units/ml Inject 6 unit subcutaneously in the evening related to Type 1 Diabetes Mellitus; Lisinopril Tablet 20 MG Give one tablet by mouth one time a day related to Essential (Primary) Hypertension; Loperamide HCl Liquid 1 MG/5ML Give 10 ml every 8 hours as needed for Diarrhea; Metformin HCl Tablet 1000 Mg Give one tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Spironolactone Tablet 25 MG Give 1 tablet daily related to Essential (Primary) Hypertension.

Record review of Resident #1's electronic Medication Administration Record revealed on 12/24/2021 at 6:30 AM, the resident received Glimepiride tablet and refused insulin. For the 9:00 AM medication pass, the resident received: Amlodipine Besylate, Escitalopram Oxalate, Isosorbide Mononitrate, Lisinopril, Spironolactone, Bumetanide, Carvedilol, Ferrous Sulfate, Metformin, Clonidine, Hydralazine HCl.

Record review of the Physician Documentation from the local emergency department dated 12/24/21 at 10:24 AM revealed, "HPI (History/Physical) ...Presents with complaints of Blood Pressure Problem ... Blood pressure on arrival to the emergency department at 10:24 AM was 76/42 ... EKG and lab work were done in the emergency department. Lab interpretation: Normal except CHLORIDE 111; BUN (Blood Urea Nitrogen) 30;Creatinine 1.44;Calcium 7.9; Total Protein 5.1; Albumin 2.4. ECG (electrocardiogram) Clinical Impression:

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F 609	Continued From page 8 Abnormal EKG (electrocardiogram) without significant change ... Intravenous (IV) fluid was started, and resident received 1000 ml of Lactated Ringers via IV. Record revealed the resident received Lomotil 2 tablets for diarrhea ... Glucose level was 71. Diagnosis was hypotension due to drugs and weakness". After treatment, the resident was discharged and returned to facility on 12/24/21. Record review of Medication Error incident report dated 12/24/21 at 9:00 AM revealed "Incident Description: Resident was missing Gabapentin ...Resident chart checked for script. None noted ...Admission coordinator was notified of resident needing a hard copy ...She called the hospital to request one ...Discharge med list was provided. List was different from meds on MAR(Medication Administration Record) ...Resident started to feeling light headed and stated that his fingers and hands were feeling numb ...MD (Medical Doctor) notified of medication error ...Order was given to send to the ER (emergency room) ..." Record review of Resident #1's Minimum Data Set (MDS) Section C-Cognitive, dated 12/30/2021, revealed the resident's Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F 609		
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 staff, family and resident interview,	F 760	Past noncompliance: no plan of	3/24/22

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F 760	Continued From page 9	F 760		

record review and facility policy review the facility failed to ensure that a resident was free from a significant medication error when another resident's medications were inaccurately entered into the medical record and administered to Resident #1 causing serious harm that required treatment at a local hospital for one (1) for four (4) residents reviewed. Resident #1.

During the survey, the State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/23/21, when the facility failed to ensure a resident was free of significant medication errors when he was admitted on 12/23/21. The resident's medications were inaccurately entered into the medical record and the resident received medications on the morning of 12/24/21 that were not prescribed for the resident. The resident was administered eight (8) hypertensive medications, one (1) antidepressant and two (2) diabetic medications. The incident resulted in serious harm for Resident #1. He required immediate need for a higher level of care, evaluation and monitoring and was sent to the local emergency room. This incident placed Resident #1 and all residents in a situation that caused or was likely to cause serious injury, harm, impairment, or death.

On 02/23/2022 at 6:10 PM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ template.

Based on the facility's implementation of corrective actions on 12/28/2021 and SA review, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 12/28/2021, prior to the SA's entrance on

correction required.

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Findings include:

Record review of the facility policy titled, "Physician's Orders," undated, revealed, " ...Manual Process 1. Physician Verbal and Telephone Orders that have been validated by a licensed nurse as accurate will be entered into the center's electronic record system in the individual patient's record.. 3. After entry, the licensed nurse accepting the order will validate accuracy of the order entry, print from the patient's electronic record, sign, and place in the patient's paper clinical record under the Physician's Order tab ..."

Record review of the "Medication Administration Competency Audit-Oral Meds," revealed " ... 2. Check each label with order on eMAR (electronic medical record) ... Applies 6 (six) Rights of Medication Administration. Medication, Route, Time, Patient, Dosage, Documentation ..."

Record review of Medication Error Incident Report and investigation for Resident #1 revealed LPN #1 was listed as preparing the report. The nursing description listed as: "Resident was missing Gabapentin 100 mg during morning medication pass. Pharmacy notified. Pharmacy stated that resident will need a hard copy. Resident's chart was checked for script. None noted. Admission coordinator was notified of resident needing a hard copy. She called the hospital to request one. Hospital informed her that resident was not on Gabapentin upon discharge. Discharge med list was provided. List was different from meds on MAR (Medication Administration Record)." The resident description

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listed as: "After resident took the medications, he stated that he wasn't on as many medications before going into the hospital. I informed resident that I would have the FNP (Family Nurse Practitioner) to go over his medications with him and discuss what he was on prior to him being admitted to the hospital and she could change them accordingly. Resident started feeling lightheaded and stated that his fingers and hands were feeling numb." Immediate action taken listed as: "FNP and MD (Medical Doctor) notified of medication error. They were informed that resident was experiencing hypotension and numbness of fingers and hands. Order was given to send to the ER for evaluation."

An interview with Resident #1's Resident Representative (RR) on 2/22/22 at 1:50 PM, revealed Resident #1 had fallen and was hospitalized for a fractured pelvis, and after discharge from the hospital on 12/23/2021 between 8:00 PM to 9:00 PM, he was admitted to the facility for therapy. The next morning, on 12/24/2021, RR was talking to the resident by phone, and he informed her that the nurse made him take twelve (12) medication pills that were not his and someone on staff also tried to give him a shot of Insulin, but he told her he did not take Insulin. The RR was told by the resident that he told the nurse several times that he was not on that many medications, but she insisted they were ordered for him and he had to take them. She stated the resident told the nurse, "If these meds kill me, it is your fault," and the nurse responded with "No, it's not." RR stated that when the resident, who was coherent, was repeatedly telling the nurse that these were not his medications, the nurse should have listened to him and checked the record. Soon after he took

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the medications, the resident was on the phone with the RR and said he was feeling dizzy and had numbness of his hands and he knew it was the medications he had taken. The RR was still on the phone with the resident when he was telling her this, so she immediately called the facility and spoke to the Admission Coordinator to tell her something was wrong with the resident and they needed to check on him and send him to the hospital. He was sent to the Emergency Room by ambulance and she met him there. He received intravenous fluids to flush the drugs out of his system and improve his blood pressure. When released from the Emergency Room, the RR wanted to take the resident home with her, but he was weak and returned to the facility. The RR stated the resident was mentally competent and able to communicate his needs and he was very aware of his medications and needed care. The RR stated a Physical Therapist was either in the room or near the room when the medication administration occurred, and she probably heard the discussion between the resident and the nurse and the resident refusing to take the medication.

An interview with the Director of Nursing (DON) on 2/22/22 at 3:00 PM, confirmed a medication error occurred with Resident #1. She stated that the Admission Coordinator printed the information from the hospital before the resident arrived at the facility. She stated on top of Resident #1's packet was the Face Sheet and in the back of the packet were the labs and in the middle were the pages with the hospital discharge orders that were Resident #2's orders. The Admission Coordinator was having a problem printing the orders from the hospital site, so she copied and pasted the orders onto a word document. She

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stated she was unsure how the packet of information for Resident #1 had the hospital discharge orders of Resident #2. The Admission Coordinator gave the packet for Resident #1 (with Resident #2's orders) to Licensed Practical Nurse (LPN) #2 and she entered the orders into Resident #1's electronic orders. The DON stated the error was found when one medication (Gabapentin) was not in the med cart so LPN #1 went to the Admission Coordinator to ask for a hard copy of the prescription so Resident #1 could receive this med. The Admission Coordinator printed off orders for Resident #1 and it was determined that the meds were different than those entered the previous day and different from those just administered to Resident #1 by LPN #1. She stated she looked in Resident #1's record and found the face sheet and lab sheets of Resident #1 and the orders for Resident #2. She confirmed the facility failed to prevent the medication error that led to harm and emergency room treatment for Resident #1.

A phone interview on 2/22/22 at 3:30 PM with Licensed Practical Nurse (LPN) #1 revealed she was giving Resident #1 his morning meds on 12/24/21. She stated he took his medications then he told the nurse that the hospital must have ordered him some extra medicines since he does not normally take that many meds. She stated one of his meds (Gabapentin) was not in the med cart since a hard copy prescription was needed for pharmacy to fill so she went to the Admission Coordinator to have her get needed information from the hospital. She stated a copy of orders were printed off by the Admission Coordinator and it was noted to be different from the other med list and different from the meds she had just administered. She stated the error was realized

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and she went to check on Resident #1 whose blood pressure and glucose was dropping. He was dizzy and had numbness of hands. She stated Resident #1 was sent to the emergency room (ER) for treatment. She stated the resident did not refuse his meds and if he had refused, she would not have insisted he take them and she would have documented the refusal. She stated when she administered meds, the resident's picture was verified and the medications were verified with the orders in the computer. She stated the medications she gave were in the med cart in pharmacy cards with Resident #1's name. She stated she had been in-serviced in the past on medication administration and has been in-serviced on medication administration, entering medication orders and reporting since this incident. She stated she was in-serviced on the new procedure for receiving orders and putting orders in the computer and reporting.

An interview on 2/22/22 at 4:10 PM with LPN #2, revealed prior to Resident #1's arrival to the facility, the Admission Coordinator brought her the printed packet for Resident #1 with orders and hospital information. She stated the packet had the face sheet on top and there were some other hospital reports at the back of the packet for Resident #1. She stated the orders were in the center of the packet and looked different than they normally did, and did not have resident's name on pages, so she took the packet to the Admission Coordinator's office to ask her about the packet and the order sheet looking different. The Admission Coordinator showed her on the computer that the print button on the hospital web site for the order page was not working, so she copied and pasted the orders on a word

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document. She stated she made a mistake and did not look at the papers closely enough and just trusted what the Admission Coordinator said and she did not notice another Resident #2's name on one page. She put the orders into the computer and sent to the pharmacy by confirming orders. She stated this led to a medication error and Resident #1 being sent to the ER for treatment. She stated she has been in-serviced on medication administration in the past and since this incident she has been in-serviced on medication administration, reporting, verifying orders, and the new procedure for putting in orders, and they will not be put in until the resident arrives with paperwork.

An interview on 2/23/22 at 9:45 AM, with the Nurse Practitioner (NP) revealed she was off when Resident #1 was admitted. She stated she and the Medical Doctor (MD) were notified of the medication administration error and gave orders to send the resident to the ER for evaluation. She stated she was told there was a cross up of the medication sheets for this resident and another resident.

An interview on 2/23/22 at 10:30 AM, with the Admission Coordinator revealed on 12/23/2021, there was a mix up with two (2) residents' hospital discharge orders. She stated Resident #2's orders got in the packet with Resident #1's information. She stated she printed the discharge records from the hospital site, but the site would not allow her to print the orders so she copied and pasted the orders onto a word document so she could include them in the packet. She stated she was unsure how Resident #2's medication orders were put into Resident #1's packet, but it may have been on her desk or printed information

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incorrectly. She stated the mistake was not discovered until the next morning after the resident received medications. She stated LPN #1 came to her office to tell her she needed a hard copy of prescription for Gabapentin so the pharmacy would send medication. She stated she printed the orders for Resident #1 and realized there were no meds that needed a prescription. LPN #1 realized these orders on the newly printed order sheet were not the medications that she had just administered and went to assess the resident. She stated the MD, Nurse Practitioner (NP), DON, and Administrator were notified. She stated the family was then calling the facility to have staff check on Resident #1 and the resident was sent to the ER. She stated she was in-serviced on how packets are provided to the nurses, orders not entered until the resident was in the facility, and verified that the resident's name was on each page. She stated she should have verified the right resident's information with resident's name on each page was placed in the packet to have prevented the medication error.

An interview on 2/23/22 at 10:45 AM, with the Administrator confirmed the facility had a medication error that caused harm to Resident #1 requiring treatment in the emergency room.

An interview on 2/23/22 at 11:00 AM, with the Physical Therapist (PT) revealed she was in Resident #1's room, getting the resident ready to walk, when the medication administration occurred. She stated LPN #1 walked into the resident's room with the medications in a medication cup and the resident stated, "I don't know about these meds being mine" and nurse informed him they were the ones in the chart. She

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stated Resident #1 stated he "does not take all of these meds," and the nurse stated these are the ones ordered for you to take. The PT stated that Resident #1 stated again that he does not take all of those meds and the nurse said they were his meds. The PT stated the resident was hesitant to take these and said, "I will take these. I know I just got out of the hospital. If something happens to me and this kills me, it is on you." The PT stated the nurse told him something like "no, I'm just doing my job and giving you meds that are ordered for you". The PT stated the conversation was friendly and not hostile, but the resident was extremely hesitant to take the medications. She stated the nurse appeared certain those meds had been ordered for Resident #1. After the nurse left, the resident got up and walked about 10-15 minutes to the door and back twice. Then he sat in his chair and was eating his breakfast when the PT left the room. The PT stated he appeared fine at that time, but a while later she heard that the resident was not feeling well, and she became concerned it was due to the medications and that maybe they were not his.

An interview on 2/23/2022 at 1:35 PM, with the company's Corporate Nurse revealed she was notified of the event that occurred with Resident #1's medication administration error. She stated she has the understanding that the Admission Coordinator was trying to get Resident #1's report and orders from the hospital's web site and clicked on the wrong resident in the computer and copied and pasted Resident #2's orders and placed in Resident #1's record. She confirmed that Resident #1 was harmed from the medication administration error and needed medical treatment in the emergency room.

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A phone interview on 2/23/22 at 3:55 PM with LPN #3, revealed she worked the night shift of 12/23/2021 until the morning of 12/24/2021 and she administered Resident #1 medications around 6:00 AM on 12/24/2021. She stated he received the Glimepiride by mouth, which he took without question, and was scheduled for insulin as well. She stated his blood sugar was 107 so she told the resident his blood sugar result and told him he could take his insulin or refuse his insulin at that glucose level. She stated the resident said, "I'd better not take the insulin," so she did not give it and she documented he refused to receive the Insulin. She stated he did not mention that he was not a diabetic and was not on insulin, he only refused to take it since nurse gave an option. LPN #3 stated she had received in-services on medication administration, verifying orders, reporting and entering orders with discharge papers since the incident. She stated the medication she administered was in a medication card with the resident's name on it that came from the pharmacy during the night.

A phone interview on 2/23/22 at 7:26 PM, with Resident #1 revealed he remembers the incident with the medication administration well and said it was "terrible" and "the worst thing that had happened in my life". He stated he had come to the facility from the hospital on the evening before this incident. He was in his room about to get therapy from the therapist and LPN #1 came in his room with a cup full of pills. He told her he only takes a few medicines, so he knew those were not his and stated the nurse "stood there and argued with me" and told me these were my medicines. He stated he told her 2-3 times that these were not his medicines, but she kept telling

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me to "go ahead and take them". He stated the nurse told him that his doctor ordered the meds and he asked her which doctor and she told him his MD. He stated he had seen his MD for a while and he had never ordered that many medications for him. He stated he told the nurse, "I'll go ahead and take them, but if it kills me, it's your fault", and the nurse turned around with a "rude attitude" and said, "No, it's not. I'm just giving you the medicines that are ordered for you." He stated he reluctantly took the medication. He stated a nurse (he was not sure if it was this nurse or another nurse) had tried to get him to take a shot of insulin, but he told her no because he was not on insulin and she did not insist he take that. After he took the pills, he was in the bathroom and blacked out for a minute and when he came to, he knocked on the door and called out for help since he could not move off the toilet or stand up. He stated his hands and feet were numb and tingling and he was dizzy and someone came and helped him to the bed. He knew he was still, but he felt like he was spinning around and his numbness and tingling was getting more intense. He was taken to the hospital to be treated to get the drugs out of his system. He stated he did not think he was "going to live through it" and does not want anyone else to ever have to go through this. He stated he returned to the facility that night after the ER visit due to the care he was requiring, and he wanted to finish therapy and get back home "before they kill me".

Record review of the SBAR Change of Condition Note dated 12/24/21 at 10:01 AM revealed, "Resident complained of feeling lightheaded. He stated that he started feeling dizzy when he was coming from the bathroom. BP (blood pressure)

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89/59, BS (blood sugar) 98. Resident was lying in bed on his back. He stated he know he isn't moving but it feels like he is. Resident's feet were elevated. He stated that both of his hands felt like they were going numb."

Record review of Resident #1's hospital discharge summary revealed the resident was admitted to the hospital on 12/18/2021 and discharged on 12/23/2021. Diagnoses: Displaced Left Acetabulum Fracture, Left Pelvis Hematoma, Hypertension, Benign Prostatic Hyperplasia (BPH). Medications ordered at discharge: Finasteride 5 milligram (mg) tablet daily, Metoprolol Succinate 25 mg daily, Tamsulosin 0.4 mg daily, Triamterene-Hydrochlorothiazide 37.5-25 mg capsule daily, Hydrocodone-Acetaminophen 5-325 mg tablet every 4 hours as needed for pain.

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 12/23/2021 and discharged on 1/3/2022 with diagnoses that included, Nondisplaced Dome Fracture of Left Acetabulum, Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, Hypertension, Muscle Weakness, Adverse Effect of Unspecified Antidepressants.

Record review of Resident #1's Order Summary Report revealed that on admission on 12/23/21 these medications were entered in the resident's electronic orders: Bumetanide Tablet 1 MG (milligram) Give 1 (one) tablet two times a day related to Essential (Primary) Hypertension; Clonidine HCl 0.2 MG tablet Give 1 tablet by mouth three times a day related to Essential (Primary) Hypertension; Isosorbide Mononitrate ER Tablet Extended Release 24 hour 120 MG

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Give one tablet by mouth 1 time a day related to Essential (Primary) Hypertension; Gabapentin Capsule 100 mg capsules Give two capsules by mouth three times a day related to Fracture of Pelvis; Amlodipine Besylate Tablet 5 MG Give one tablet one time a day related to Essential Primary Hypertension; Atorvastatin Calcium Tablet 80 MG tablet Give one tablet by mouth nightly for Hyperlipidemia; Carvedilol Tablet 12.5 MG Give one tablet two times a day related to Essential (Primary) Hypertension; Escitalopram Oxalate Tablet 10 MG Give one tablet by mouth one time a day related to Adverse Effect of Unspecified Antidepressants; Ferrous Sulfate Tablet Delayed Release 324 MG 65 Fe (iron) Give 1 tablet by mouth two times a day related to Fracture of other parts of pelvis; Glimepiride Tablet 4 MG Give 1 tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Hydralazine HCl Tablet 100 MG Give 1 tablet by mouth three times a day related to Essential (Primary) Hypertension; Insulin NPH(Human) (Isophane)Suspension 100 units/ml (milliliter) Inject 12 unit subcutaneously in the morning related to Type 1 Diabetes Mellitus; Insulin NPH 100 units/ml Inject 6 unit subcutaneously in the evening related to Type 1 Diabetes Mellitus; Lisinopril Tablet 20 MG Give one tablet by mouth one time a day related to Essential (Primary) Hypertension; Loperamide HCl Liquid 1 MG/5ML Give 10 ml every 8 hours as needed for Diarrhea; Metformin HCl Tablet 1000 Mg Give one tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Spironolactone Tablet 25 MG Give 1 tablet daily related to Essential (Primary) Hypertension.

Record review of electronic Medication Administration Record for Resident #1 revealed

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on 12/24/2021 at 6:30 AM documentation indicated Resident#1 received Glimepiride tablet and refused insulin. The documentation for the 9:00 AM medication pass revealed Resident #1 received: Amlodipine Besylate, Escitalopram Oxalate, Isosorbide Mononitrate, Lisinopril, Spironolactone, Bumetanide, Carvedilol, Ferrous Sulfate, Metformin, Clonidine, Hydralazine HCl.

Record review of the Physician Documentation from the local emergency department dated 12/24/21 at 10:24 AM, revealed, HPI (History/Physical) ...Presents with complaints of Blood Pressure Problem ... Blood pressure on arrival to the emergency department at 10:24 AM was 76/42 ... EKG and lab work were done in the emergency department. Lab interpretation: Normal except CHLORIDE 111; BUN 30;Creatinine 1.44;Calcium 7.9; Total Protein 5.1; Albumin 2.4. ECG Clinical Impression: Abnormal EKG without significant change ... Intravenous (IV) fluid was started, and resident received 1000 ml of Lactated Ringers via IV. Record revealed the resident received Lomotil 2 tablets for diarrhea ... Glucose level was 71. Diagnosis was hypotension due to drugs and weakness. After treatment, the resident was discharged and returned to facility on 12/24/21.

Record review of Resident #1's Minimum Data Set (MDS) Section C-Cognitive, dated 12/30/2021, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the Resident #1 was cognitively intact.

Record review of in-services and sign in sheets titled "It 's a Golden FACT: We are all about Medication Safety" dated 5/22/19 revealed content included the 5 Rights of Medication

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Administration and Preventing Drug Transcription Errors. LPN #1 and LPN #2 ' s signatures were listed on the in-service record as attending the in-service.

Record review of a nurse sign in sheet dated 1/9/20 revealed "Routine Med Pass and New Admit Documentation" was handwritten on the in-service record as content. LPN #1 and LPN #2 ' s signatures were listed on the in-service record as attending the in-service.

Record review of a sign in sheet titled "Complete Nurses Skill Check Off ' s-Five Rights of Medication Pass" dated 5/30/19 through 6/7/19 revealed LPN #1 and LPN#2 ' s signatures were listed on the in-service record as attending the in-service.

Immediate Jeopardy Corrective Action Removal Plan February 23, 2022, for F842 and F760:

On February 23, 2022, at 6:10 PM the State Agency notified the facility administrator of an Immediate Jeopardy (IJ) related to the facility's failure to ensure Resident #1 was free from significant medication errors. On 12/24/21 the facility failed to ensure orders upon admission were accurately entered into the correct resident ' s record resulting in Resident #1 being administered medications prescribed for Resident #2. The medications included eight (8) hypertensive medications, one (1) Antidepressant, and two (2) Diabetic Medications. As a result, Resident #1 was transferred to the hospital for treatment and evaluation. The Immediate Jeopardy template was provided to the administrator.

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To the best of my knowledge and belief, as an agent of Batesville Health and Rehabilitation Center, the following corrective action removal Plan constitutes a written plan demonstrating actions the center took upon awareness of the deficient practice thus removing the Immediate Jeopardy cited on February 23, 2022.

Immediate Actions for All Residents Potentially Affected:

1. Resident # 1 was evaluated by the Licensed Practical Nurse (LPN) charge nurse on 12/24/2021. The resident voiced not feeling well. The Medical Director, Nurse Practitioner and family were notified. An order was obtained by the nurse, and the patient was sent to Local Medical Center emergency room via ambulance at 10:01 A.M. for a higher level of care, evaluation and monitoring. The resident returned at 9:04 PM with no adverse effects noted from the medication error.

2. Upon return to the center, the physician orders were reviewed by two nurses prior to placing them in Electronic Medical Record. This occurred on 12/24/2021.

3. A root cause analysis of the medication error was initiated immediately by the Director of Nursing. This occurred on 12/24/2021.

4. The employee making the transcription error was provided 1:1 coaching and counseling by the Administrator and the Director of Nursing regarding the importance of obtaining signed physician discharge orders prior to admission to the facility. This occurred on 12/24/2021.

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5. The nurse that made the error received 1:1 education regarding safe medication administration, including the rights of medication administration on 12/24/2021 by Director of Nursing Services (DNS).

6. The Director of Nursing Services and Assistant Director of Nursing Services began in services on 12/24/2021 for all nurses regarding safe medication administration (including medication transcription, reconciliation, and administration), resident rights, and abuse/neglect. No nurses are allowed to work without completion of this training.

7. The Director of Nursing Service (DNS) and Assistant Director of Nursing Services (ADNS) reviewed previous two week ' s admissions to ensure orders transcribed into the record accurately. There were no additional errors noted. This occurred on 12/28/2021

8. An ad hoc Quality Assurance Process Improvement meeting was initiated post the medication error on 12/24/2021 with the Administrator, The Director of Nursing, the Assistant Director of Nursing (Infection Preventionist), and the Medical Director to discuss the incident and develop a plan to include monitoring of medication transcription and medication administration errors going forward.

9. Beginning 12/24/2021, the facility will assure that each patient has a signed copy of physician discharge orders on admission to the facility.

10. Beginning 12/28/2022, each new patient's orders are reconciled by a minimum of two nurses and reviewed each morning during clinical

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start up by the Director Nursing Services, Assistant Director of Nursing/ Infection Preventionist, and/or designees to assure the medication regimen and orders are correct.

In summary, upon awareness, the center acted swiftly with the corrective actions, team member in-services, and ensured auditing measures were in place to monitor the plan developed utilizing the QAPI process to address the identified deficient practice immediately and all actions were completed on or before December 28, 2021. The facility alleges the past non-compliance Immediate Jeopardy was removed on December 28, 2021.

State Agency Validation of Immediate Actions for All Residents Potentially Affected:

1. The State Agency (SA) validated through record review of physician orders, progress notes, and hospital emergency room visit records and through interviews with the Director of Nursing, Licensed Practical Nurse #1, Nurse Practitioner, Resident Representative, and Resident #1. Resident # 1 was evaluated by the Licensed Practical Nurse (LPN) charge nurse on 12/24/2021. The resident voiced not feeling well. The Medical Director, Nurse Practitioner and family were notified. An order was obtained by the nurse, and the patient was sent to Local Medical Center emergency room via ambulance at 10:01 A.M. for a higher level of care, evaluation and monitoring. The resident returned at 9:04 PM with no adverse effects noted from the medication error.

2. The SA validated through record review of physician orders and electronic medication

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administration record, and interview with the Director of Nursing. Upon return to the center, the physician orders were reviewed by two nurses prior to placing them in Electronic Medical Record. This occurred on 12/24/2021.

3. The SA validated through record review of the incident report and interview with the Director of Nursing. A root cause analysis of the medication error was initiated immediately by the Director of Nursing. This occurred on 12/24/2021.

4. The SA validated through record review of in-service provided to LPN #2 and through interviews with LPN #2 and the Director of Nursing. The employee making the transcription error was provided 1:1 coaching and counseling by the Administrator and the Director of Nursing regarding the importance of obtaining signed physician discharge orders prior to admission to the facility. This occurred on 12/24/2021.

5. The SA validated through record review of in-service provided to LPN #1 and through interviews with LPN #1 and the Director of Nursing. The nurse that made the error received 1:1 education regarding safe medication administration, including the rights of medication administration on 12/24/2021 by Director of Nursing Services (DNS).

6. The SA validated through record review of in-service sign in sheets and through interviews with the Director of Nurses, LPN #1, LPN #2, LPN #3, and other facility nursing staff. The Director of Nursing Services and Assistant Director of Nursing Services began in services on 12/24/2021 for all nurses regarding safe medication administration (including medication

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transcription, reconciliation, and administration), resident rights, and abuse/neglect. No nurses are allowed to work without completion of this training.

7. The SA validated through record review of hospital discharge orders, facility orders, and electronic medication administration records for Resident #2, Resident #3, Resident #4, and through interviews with the Director of Nursing, and through interviews with Resident #3 and Resident #4, who are both cognitively intact. The Director of Nursing Service (DNS) and Assistant Director of Nursing Services (ADNS) reviewed previous two week's admissions to ensure orders transcribed into the record accurately. There were no additional errors noted. This occurred on 12/28/2021

8. The SA validated through record review of the Quality Assurance meeting sign in sheet and through interviews to confirm contents of meeting with the Director of Nursing, Administrator, and through other staff members that attended the meeting. An ad hoc Quality Assurance Process Improvement meeting was initiated post the medication error on 12/24/2021 with the Administrator, The Director of Nursing, the Assistant Director of Nursing (Infection Preventionist), and the Medical Director to discuss the incident and develop a plan to include monitoring of medication transcription and medication administration errors going forward.

9. The SA validated through interviews with LPN #1, LPN #2, LPN #3, Director of Nursing, and Admission Coordinator. Beginning 12/24/2021, the facility will assure that each patient has a signed copy of physician discharge orders on

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F 760	Continued From page 29 admission to the facility. 10. The SA validated through interviews with LPN #1, LPN #2, LPN #3, and Director of Nursing and record review of accuracy of resident's orders. Beginning 12/28/2022, each new patient's orders are reconciled by a minimum of two nurses and reviewed each morning during clinical start up by the Director Nursing Services, Assistant Director of Nursing/ Infection Preventionist, and/or designees to assure the medication regimen and orders are correct.	F 760		
F 842 SS=J	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		3/24/22

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 31 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff, family and resident interview, record review and facility policy review the facility failed to ensure that a resident's medical record was accurately documented when another resident's medications were entered into the medical record and administered to Resident #1 causing serious harm that required treatment at a local hospital for one (1) for four (4) residents reviewed. Resident #1. During the survey, the State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/23/21, when the facility failed to ensure a resident was free of significant medication errors when he was admitted on 12/23/21. Resident #2's medications were entered into the medical record of Resident #1 and administered to Resident #1 on 12/24/21. The resident was administered eight (8) hypertensive medications, one (1) antidepressant and two (2) diabetic medications. The incident resulted in serious harm for Resident #1. He required immediate need for a higher level of care, evaluation and monitoring and was sent to the local emergency room. This incident placed Resident #1 and all residents in a situation that caused or was likely to cause serious injury, harm, impairment, or death. On 02/23/2022 at 6:10 PM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ template. Based on the facility's implementation of corrective actions on 12/28/2021 and SA review,	F 842	Past noncompliance: no plan of correction required.	

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the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 12/28/2021, prior to the SA's entrance on 02/17/2022.

Findings include:

Record review of the facility policy titled, "Physician's Orders," undated, revealed " ... Manual Process 1. PHYSICIAN Verbal and Telephone Orders that have been validated by a licensed nurse as accurate will be entered into the center's electronic record system in the individual patient's record... 3. After entry, the licensed nurse accepting the order will validate accuracy of the order entry, print from the patient's electronic record, sign, and place in the patient's paper clinical record under the Physician's Order tab ..."

Record review of the "Medication Administration Competency Audit-Oral Meds," undated, revealed " ... 2. Check each label with order on eMAR (electronic medical record) ... Applies 6 (six) Rights of Medication Administration. Medication, Route, Time, Patient, Dosage, Documentation ..."

Record review of facility policy titled,"Scanning and Uploading Documents Into the Patient's Electronic Record," dated 02-13, revealed, "Guidelines: The HIMC is responsible for scanning documents into the patient's electronic record. However, other team members have access to upload documents as well. The guidelines below should be followed by all team members. All records must be scanned to ensure complete information is available to care for our patients/residents

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An interview on 2/22/22 at 1:50 PM, with Resident #1's Resident Representative (RR) , revealed Resident #1 had fallen and was hospitalized for a fractured pelvis, and after discharge from the hospital on 12/23/2021 between 8:00 PM to 9:00 PM, he was admitted to the facility for therapy. The next morning, on 12/24/2021, the RR was talking to the resident by phone, and he informed her that the nurse made him take twelve (12) medication pills that were not his and someone on staff also tried to give him a shot of insulin , but he told her he did not take insulin. The RR was told by the resident that he told the nurse several times that he was not on that many medications, but she insisted they were ordered for him and he had to take them. She stated the resident told the nurse, "If these meds kill me, it is your fault," and the nurse responded with "No, it's not." RR stated that when the resident, who was coherent, was repeatedly telling the nurse that these were not his medications, the nurse should have listened to him and checked the record. Soon after he took the medications, the resident was on the phone with the RR and said he was feeling dizzy and had numbness of his hands and he knew it was the medications he had taken. The RR was still on the phone with resident when he was telling her this, so she immediately called the facility and spoke to the Admission Coordinator to tell her something was wrong with the resident and they needed to check on him and send him to the hospital. He was sent to the Emergency Room by ambulance and she met him there. He received intravenous fluids to flush the drugs out of his system and improve his blood pressure. When released from the emergency room, the RR wanted to take the resident home with her, but he was weak and returned to the facility. The

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RR stated the resident was mentally competent and able to communicate his needs and he was very aware of his medications and needed care. The RR stated a Physical Therapist was either in the room or near the room when the medication administration occurred, and she probably heard the discussion between the resident and the nurse and the resident refusing to take the medication.

On 2/22/22 at 3:00 PM, an interview with the Director of Nursing (DON) confirmed a medication error occurred with Resident #1. She stated that the Admission Coordinator printed the information from the hospital before the resident arrived at the facility. She stated on top of Resident #1's packet was the face sheet and in the back of the packet were the labs and in the middle were the pages with the hospital discharge orders that were Resident #2's orders. The Admission Coordinator was having a problem printing the orders from the hospital site, so she copied and pasted the orders onto a word document. She stated she was unsure how the packet of information for Resident #1 had the hospital discharge orders of Resident #2. The Admission Coordinator gave the packet for Resident #1 (with Resident #2's orders) to Licensed Practical Nurse (LPN) #2 and she entered the orders into Resident #1's electronic orders. The DON stated the error was found when one medication (Gabapentin) was not in the med cart so LPN #1 went to the Admission Coordinator to ask for a hard copy of the prescription so Resident #1 could receive this med. The Admission Coordinator printed off orders for Resident #1 and it was determined that the meds were different than those entered the previous day and different from those just

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administered to Resident #1 by LPN #1. She stated she looked in Resident #1's record and found the face sheet and lab sheets of Resident #1 and the orders for Resident #2. She confirmed the facility failed to prevent the medication error that led to harm and emergency room treatment for Resident #1.

A phone interview on 2/22/22 at 3:30 PM, with Licensed Practical Nurse (LPN) #1 revealed she was giving Resident #1 his morning meds on 12/24/21. She stated he took his medications then he told nurse that the hospital must have ordered him some extra medicines since he does not normally take that many meds. She stated one of his meds (Gabapentin) was not in med cart since a hard copy prescription was needed for pharmacy to fill so she went to the Admission Coordinator to have her get needed information from hospital. She stated a copy of orders were printed off by the Admission Coordinator and it was noted to be different from the other med list and different from the meds she had just administered. She stated the error was realized and she went to check on the resident whose blood pressure and glucose was dropping. He was dizzy and had numbness of his hands. She stated Resident #1 was sent to the ER for treatment. She stated the resident did not refuse his meds, and, if he had refused, she would not have insisted he take them and she would have documented the refusal. She stated when administering meds the picture is matched to the name and the medications in the cart and the computer and this was done. She stated she had been in-serviced in the past on medication administration and has been in-serviced on medication administration, entering medication orders and reporting since this incident. She

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stated she was in-serviced on the new procedure for receiving orders and putting orders in the computer and reporting.

On 2/22/22 at 4:10 PM, during an interview with LPN #2, revealed the Admission Coordinator brought her the printed packet for Resident #1 with orders and hospital information. She stated the resident had not yet arrived at the facility. She stated the packet had the face sheet on top and there were some other hospital reports at the back of packet for Resident #1. She stated the orders were in the center of the packet and looked different than they normally did, and did not have resident's name on pages, so she took the packet to the Admission Coordinator's office to ask her about the packet and the order sheet looking different. The Admission Coordinator showed her on the computer that the print button on the hospital web site for the order page was not working, so she copied and pasted the orders on a word document. She stated she made a mistake and did not look at the papers closely enough and just trusted what the Admission Coordinator said and she did not notice another resident's name (Resident #2) on one page. She stated she put the orders into the computer and sent to pharmacy by confirming orders. She stated this led to a medication error and Resident #1 being sent to the ER for treatment. She stated she has been in-serviced on medication administration in the past and since this incident she has been in-serviced on medication administration, reporting, verifying orders, and the new procedure for putting in orders, and they will not be put in until the resident arrives with the paperwork.

An interview on 2/23/22 at 9:45 AM, with the

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Nurse Practitioner (NP) revealed she was off when Resident #1 was admitted. She stated she and the Medical Doctor (MD) were notified of the medication administration error and gave orders to send Resident #1 to the ER for evaluation. She stated she was told there was a cross up of the medication sheets for this resident and another resident.

An interview on 2/23/22 at 10:30 AM, with the Admission Coordinator revealed on 12/23/2021, there was a mix up with two (2) residents' hospital discharge orders. She stated Resident #2's orders got in the packet with Resident #1's information. She stated she printed the discharge records from the hospital site, but the site would not allow her to print the orders so she copied and pasted the orders onto a word document so she could include them in the packet. She stated she was unsure how Resident #2's medication orders were put into Resident #1's packet, but it may have been on her desk or printed information incorrectly. She stated the mistake was not discovered until the next morning after the resident received medications. She stated LPN #1 came to her office to tell her she needed a hard copy of prescription for Gabapentin so pharmacy would send medication. She stated she printed the orders for Resident #1 and realized there were no meds that needed a prescription. LPN #1 realized these orders on the newly printed order sheet were not the medications that she had just administered and went to assess the resident. She stated the MD, Nurse Practitioner (NP), DON, and Administrator were notified. She stated the family was then calling the facility to have staff check on resident and the resident was sent to the ER. She stated she was in-serviced on how packets are provided

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to the nurses, orders not entered until the resident was in the facility, and verified that the resident's name was on each page. She stated she should have verified the right resident's information with resident's name on each page was placed in packet to have prevented medication error.

An interview on 2/23/22 at 10:45 AM, with the Administrator confirmed the facility had a medication error that caused harm to Resident #1 requiring treatment in the emergency room.

An interview on 2/23/2022 at 1:35 PM, with the company's Corporate Nurse revealed she was notified of the event that occurred with Resident #1's medication administration error. She stated she had the understanding that the Admission Coordinator was trying to get Resident #1's report and orders from the hospital's web site and clicked on the wrong resident in the computer and copied and pasted Resident #2's orders and placed in Resident #1's record. She confirmed that Resident #1 was harmed from the medication administration error and needed medical treatment in the emergency room.

A phone interview on 2/23/22 3:55 PM, with LPN #3 revealed she worked the night shift of 12/23/2021 until the morning of 12/24/2021 and she administered Resident #1's medications around 6:00 AM of 12/24/2021. She stated he received the Glimepiride by mouth, which he took without question, and was scheduled for insulin as well. She stated his blood sugar was 107 so she told the resident his blood sugar result and told him he could take his insulin or refuse his insulin at that glucose level. She stated the resident said, "I'd better not take the insulin," so

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she did not give it and documented he refused to receive the insulin. She stated he did not mention that he was not a diabetic and was not on insulin, he only refused to take it since nurse gave an option. She stated she had received in-services on medication administration, verifying orders, reporting and entering orders with discharge papers. She reported the medication she administered was in a medication card with the resident's name on it that came from pharmacy during the night.

A phone interview on 2/23/22 at 7:26 PM, with Resident #1 revealed he remembers the incident with the medication administration well and said it was "terrible" and "the worst thing that had happened in my life". He stated he had come to the facility from the hospital on the evening before this incident. He was in his room about to get therapy from the therapist and LPN #1 came in his room with a cup full of pills. He told her he only takes a few medicines, so he knew those were not his and stated the nurse "stood there and argued with me" and told me these were my medicines. He stated he told her 2-3 times that this was not his medicine, but she kept telling me to "go ahead and take them". He stated the nurse told him that his doctor ordered the meds and he asked her which doctor and she told him MD. He stated he told the nurse, "I'll go ahead and take them, but if it kills me, it's your fault", and the nurse turned around with a "rude attitude" and said, "No, it's not. I'm just giving you the medicines that are ordered for you." He stated he reluctantly took the medication. He stated a nurse (he was not sure if it was this nurse or another nurse) had tried to get him to take a shot of Insulin, but he told her no because he was not on insulin and she did not insist he take that. After

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he took the pills, he was in the bathroom and blacked out for a minute and when he came to, he knocked on the door and called out for help since he could not move off the toilet or stand up. He stated his hands and feet were numb and tingling and he was dizzy and someone came and helped him to the bed. He knew he was still, but he felt like he was spinning around and his numbness and tingling was getting more intense. He was taken to the hospital to be treated to get the drugs out of his system. He stated he did not think he was "going to live through it" and does not want anyone else to ever have to go through this. He stated he returned to the facility that night after the ER visit due to the care he was requiring, and he wanted to finish therapy and get back home "before they kill me".

Record review of hospital discharge summary revealed the resident was admitted to the hospital on 12/18/2021 and discharged on 12/23/2021. Diagnoses: Displaced Left Acetabulum Fracture, Left Pelvis Hematoma, Hypertension, Benign Prostatic Hyperplasia (BPH). Medications ordered at discharge: Finasteride 5 milligram (mg) tablet daily, Metoprolol Succinate 25 mg daily, Tamsulosin 0.4 mg daily, Triamterene-Hydrochlorothiazide 37.5-25 mg capsule daily, Hydrocodone-Acetaminophen 5-325 mg tablet every 4 hours as needed for pain.

Record review of the Admission Record revealed the resident was admitted to the facility on 12/23/2021 and discharged on 1/3/2022 with diagnoses including Nondisplaced Dome Fracture of Left Acetabulum, Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, Hypertension, Muscle Weakness, Adverse Effect

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of Unspecified Antidepressants.

Record review of Resident #1's orders Order Summary Report revealed that on admission on 12/23/21 these medications were entered in residents electronic orders: Bumetanide Tablet 1 MG (milligram) Give 1 (one) tablet two times a day related to Essential (Primary) Hypertension; Clonidine HCl 0.2 MG tablet Give 1 tablet by mouth three times a day related to Essential (Primary) Hypertension; Isosorbide Mononitrate ER Tablet Extended Release 24 hour 120 MG Give one tablet by mouth 1 time a day related to Essential (Primary) Hypertension; Gabapentin Capsule 100 mg capsules Give two capsules by mouth three times a day related to Fracture of Pelvis; Amlodipine Besylate Tablet 5 MG Give one tablet one time a day related to Essential Primary Hypertension; Atorvastatin Calcium Tablet 80 MG tablet Give one tablet by mouth nightly for Hyperlipidemia; Carvedilol Tablet 12.5 MG Give one tablet two times a day related to Essential (Primary) Hypertension; Escitalopram Oxalate Tablet 10 MG Give one tablet by mouth one time a day related to Adverse Effect of Unspecified Antidepressants; Ferrous Sulfate Tablet Delayed Release 324 MG 65 Fe (iron) Give 1 tablet by mouth two times a day related to Fracture of other parts of pelvis; Glimepiride Tablet 4 MG Give 1 tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Hydralazine HCl Tablet 100 MG Give 1 tablet by mouth three times a day related to Essential (Primary) Hypertension; Insulin NPH(Human) (Isophane)Suspension 100 units/ml (milliliter) Inject 12 unit subcutaneously in the morning related to Type 1 Diabetes Mellitus; Insulin NPH 100 units/ml Inject 6 unit subcutaneously in the evening related to Type 1 Diabetes Mellitus;

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Lisinopril Tablet 20 MG Give one tablet by mouth one time a day related to Essential (Primary) Hypertension; Loperamide HCl Liquid 1 MG/5ML Give 10 ml every 8 hours as needed for Diarrhea; Metformin HCl Tablet 1000 Mg Give one tablet by mouth two times a day related to Type 1 Diabetes Mellitus; Spironolactone Tablet 25 MG Give 1 tablet daily related to Essential (Primary) Hypertension.

Record review of electronic Medication Administration Record for Resident #1 revealed on 12/24/2021 at 6:30 AM, documentation indicated Resident#1 received Glimepiride tablet and refused insulin. The documentation for the 9:00 AM medication pass revealed Resident #1 received: Amlodipine Besylate, Escitalopram Oxalate, Isosorbide Mononitrate, Lisinopril, Spironolactone, Bumetanide, Carvedilol, Ferrous Sulfate, Metformin, Clonidine, Hydralazine HCl.

Record review of the Physician Documentation from the local emergency department dated 12/24/21 at 10:24 AM revealed, HPI History/Physical) ...Presents with complaints of Blood Pressure Problem ... Blood pressure on arrival to the emergency department at 10:24 AM was 76/42 ... EKG and lab work were done in the emergency department. Lab interpretation: Normal except CHLORIDE 111; BUN 30;Creatinine 1.44;Calcium 7.9; Total Protein 5.1; Albumin 2.4. ECG Clinical Impression: Abnormal EKG without significant change ... Intravenous (IV) fluid was started, and resident received 1000 ml of Lactated Ringers via IV. Record revealed the resident received Lomotil 2 tablets for diarrhea ... Glucose level was 71. Diagnosis was hypotension due to drugs and weakness. After treatment, the resident was discharged and

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returned to facility on 12/24/21.

Record review of Medication Error incident report dated 12/24/21 at 9:00 AM revealed Incident Description: Resident was missing Gabapentin ...Resident chart checked for script. None noted ...Admission coordinator was notified of resident needing a hard copy ...She called the hospital to request one ...Discharge med list was provided. List was different from meds on MAR(Medication Administration Record) ...Resident started to feeling light headed and staed that his fingers and hands were feeling numb...MD (Medical Doctor) notified of medication error ...Order was given to send to the ER (emergency room) ...

Record review of Resident #1's Minimum Data Set (MDS) Section C-Cognitive, dated 12/30/2021, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the Resident #1 was cognitively intact.

Immediate Jeopardy Corrective Action Removal Plan February 23, 2022, for F842 and F760

On February 23, 2022, at 6:10 PM the State Agency notified the facility administrator of an Immediate Jeopardy (IJ) related to the facility ' s failure to ensure Resident #1 was free from significant medication errors. On 12/24/21 the facility failed to ensure orders upon admission were accurately entered into the correct resident ' s record resulting in Resident #1 being administered medications prescribed for Resident #2. The medications included eight (8) hypertensive medications, one (1) Antidepressant, and two (2) Diabetic Medications. As a result, Resident #1 was transferred to the

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hospital for treatment and evaluation. The Immediate Jeopardy template was provided to the administrator.

To the best of my knowledge and belief, as an agent of Batesville Health and Rehabilitation Center, the following corrective action removal Plan constitutes a written plan demonstrating actions the center took upon awareness of the deficient practice thus removing the Immediate Jeopardy cited on February 23, 2022.

Immediate Actions for All Residents Potentially Affected:

1. Resident # 1 was evaluated by the Licensed Practical Nurse (LPN) charge nurse on 12/24/2021. The resident voiced not feeling well. The Medical Director, Nurse Practitioner and family were notified. An order was obtained by the nurse, and the patient was sent to Local Medical Center emergency room via ambulance at 10:01 A.M. for a higher level of care, evaluation and monitoring. The resident returned at 9:04 PM with no adverse effects noted from the medication error.

2. Upon return to the center, the physician orders were reviewed by two nurses prior to placing them in Electronic Medical Record. This occurred on 12/24/2021.

3. A root cause analysis of the medication error was initiated immediately by the Director of Nursing. This occurred on 12/24/2021.

4. The employee making the transcription error was provided 1:1 coaching and counseling by the Administrator and the Director of Nursing

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regarding the importance of obtaining signed physician discharge orders prior to admission to the facility. This occurred on 12/24/2021.

5. The nurse that made the error received 1:1 education regarding safe medication administration, including the rights of medication administration on 12/24/2021 by Director of Nursing Services (DNS).

6. The Director of Nursing Services and Assistant Director of Nursing Services began in services on 12/24/2021 for all nurses regarding safe medication administration (including medication transcription, reconciliation, and administration), resident rights, and abuse/neglect. No nurses are allowed to work without completion of this training.

7. The Director of Nursing Service (DNS) and Assistant Director of Nursing Services (ADNS) reviewed previous two week ' s admissions to ensure orders transcribed into the record accurately. There were no additional errors noted. This occurred on 12/28/2021

8. An ad hoc Quality Assurance Process Improvement meeting was initiated post the medication error on 12/24/2021 with the Administrator, The Director of Nursing, the Assistant Director of Nursing (Infection Preventionist), and the Medical Director to discuss the incident and develop a plan to include monitoring of medication transcription and medication administration errors going forward.

9. Beginning 12/24/2021, the facility will assure that each patient has a signed copy of physician discharge orders on admission to the facility.

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10. Beginning 12/28/2022, each new patient ' s orders are reconciled by a minimum of two nurses and reviewed each morning during clinical start up by the Director Nursing Services, Assistant Director of Nursing/ Infection Preventionist, and/or designees to assure the medication regimen and orders are correct.

In summary, upon awareness, the center acted swiftly with the corrective actions, team member in-services, and ensured auditing measures were in place to monitor the plan developed utilizing the QAPI process to address the identified deficient practice immediately and all actions were completed on or before December 28, 2021. The facility alleges the past non-compliance Immediate Jeopardy was removed on December 28, 2021.

State Agency Validation of Immediate Actions for All Residents Potentially Affected:

1. The State Agency (SA) validated through record review of physician orders, progress notes, and hospital emergency room visit records and through interviews with the Director of Nursing, Licensed Practical Nurse #1, Nurse Practitioner, Resident Representative, and Resident #1. Resident # 1 was evaluated by the Licensed Practical Nurse (LPN) charge nurse on 12/24/2021. The resident voiced not feeling well. The Medical Director, Nurse Practitioner and family were notified. An order was obtained by the nurse, and the patient was sent to Local Medical Center emergency room via ambulance at 10:01 A.M. for a higher level of care, evaluation and monitoring. The resident returned at 9:04 PM with no adverse effects noted from the medication

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error.

2. The SA validated through record review of physician orders and electronic medication administration record, and interview with the Director of Nursing. Upon return to the center, the physician orders were reviewed by two nurses prior to placing them in Electronic Medical Record. This occurred on 12/24/2021.

3. The SA validated through record review of the incident report and interview with the Director of Nursing. A root cause analysis of the medication error was initiated immediately by the Director of Nursing. This occurred on 12/24/2021.

4. The SA validated through record review of in-service provided to LPN #2 and through interviews with LPN #2 and the Director of Nursing. The employee making the transcription error was provided 1:1 coaching and counseling by the Administrator and the Director of Nursing regarding the importance of obtaining signed physician discharge orders prior to admission to the facility. This occurred on 12/24/2021.

5. The SA validated through record review of in-service provided to LPN #1 and through interviews with LPN #1 and the Director of Nursing. The nurse that made the error received 1:1 education regarding safe medication administration, including the rights of medication administration on 12/24/2021 by Director of Nursing Services (DNS).

6. The SA validated through record review of in-service sign in sheets and through interviews with the Director of Nurses, LPN #1, LPN #2, LPN #3, and other facility nursing staff. The Director of

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Nursing Services and Assistant Director of Nursing Services began in services on 12/24/2021 for all nurses regarding safe medication administration (including medication transcription, reconciliation, and

administration), resident rights, and abuse/neglect. No nurses are allowed to work without completion of this training.

7. The SA validated through record review of hospital discharge orders, facility orders, and electronic medication administration records for Resident #2, Resident #3, Resident #4, and through interviews with the Director of Nursing, and through interviews with Resident #3 and Resident #4, who are both cognitively intact. The Director of Nursing Service (DNS) and Assistant Director of Nursing Services (ADNS) reviewed previous two week ' s admissions to ensure orders transcribed into the record accurately. There were no additional errors noted. This occurred on 12/28/2021

8. The SA validated through record review of the Quality Assurance meeting sign in sheet and through interviews to confirm contents of meeting with the Director of Nursing, Administrator, and through other staff members that attended the meeting. An ad hoc Quality Assurance Process Improvement meeting was initiated post the medication error on 12/24/2021 with the Administrator, The Director of Nursing, the Assistant Director of Nursing (Infection Preventionist), and the Medical Director to discuss the incident and develop a plan to include monitoring of medication transcription and medication administration errors going forward.

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F 842	Continued From page 49 9. The SA validated through interviews with LPN #1, LPN #2, LPN #3, Director of Nursing, and Admission Coordinator. Beginning 12/24/2021, the facility will assure that each patient has a signed copy of physician discharge orders on admission to the facility. 10. The SA validated through interviews with LPN #1, LPN #2, LPN #3, and Director of Nursing and record review of accuracy of resident ' s orders. Beginning 12/28/2022, each new patient ' s orders are reconciled by a minimum of two nurses and reviewed each morning during clinical start up by the Director Nursing Services, Assistant Director of Nursing/ Infection Preventionist, and/or designees to assure the medication regimen and orders are correct.	F 842		