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M 000	Initial Comments 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M. 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 IJ template.	M 000		

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M 000	Continued From page 1 The SQC and IJ existed at: Rule 45.25.1 Medical Records Management (M735). Level IV 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.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse	M 735		3/21/22

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M 735	Continued From page 2 practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level IV 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	M 735	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 RP were interviewed about incident Care Plans for this affected resident were reviewed and updated as deemed necessary.	

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M 735	Continued From page 3 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, 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	M 735	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 of the past 30 days risk events performed and no additional reportables 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 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. 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 Designee on admission and the following day during Clinial 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.	

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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

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

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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 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

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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 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

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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 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

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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 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

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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 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

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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 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

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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 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

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M 735	Continued From page 12 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 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	M 735		

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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 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

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M 735	Continued From page 14 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 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.	M 735		

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M 735	Continued From page 15 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. 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	M 735		

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M 735	Continued From page 16 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. 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	M 735		

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M 735	Continued From page 17 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 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	M 735		

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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 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

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M 735	Continued From page 19 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 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	M 735		

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M 735	Continued From page 20 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 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.	M 735		