STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16CO	A. BUILDING: _____ B. WING _____	C 04/19/2022

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M 000	Initial Comments The State Survey Agency (SSA) conducted a Complaint Investigation (CI) at the facility from 04/18/2022 through 04/19/2022 for MS #18430, MS #18442, and MS #18536. During the survey, the SSA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. MS #18536 was substantiated for a medication error and M500 was cited. The SSA did not substantiate MS #18430 and MS #18442 because there is lack of evidence to prove the facility was negligent in preventing pressure sores, workers were made to work when testing positive for COVID-19, and residents not groomed. The facility's census at the time of survey was 143, with a license for 150 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem	M 500		

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M 500	Continued From page 1 rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend	M 500		

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M 500	Continued From page 2 changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the	M 500		

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M 500	Continued From page 3	M 500		

facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and

16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to prevent a significant medication error for one (1) of three (3) sampled residents. Resident #2. Findings include: A record review of the facility's policy "Medication Administration" dated February 12, 2013, revealed "...3. Purpose The purpose of this policy is to describe the process to follow when administering medication to residents ... 4. Procedure: ... 3. Patients are to be identified before the administration of a drug. When in doubt about the identity of a patient, the nurse is to verify identity per protocol of this institution ..." A record review of the facility's "Medication Administration Protocol" (undated) revealed, "When giving medications, be sure to check resident arm bands before giving medications. Be cautious of name alerts on MARs and on room doors. Ask the resident their name prior to administering medications." A record review of Resident #2's "Face Sheet" revealed the facility admitted him on 06/29/2021 with diagnoses including Heart Failure and Hypertension. A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/2022 revealed a Brief Interview for Mental Status (BIMS) score of	M 500		

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M 500	Continued From page 5 4, which indicated he was severely cognitively impaired. On 02/19/2022 at 12:00 PM, during an interview with Registered Nurse (RN) #1, she explained she was the supervisor working the day Resident #2 received Resident #1's medications. The facility has a protocol for medication administration for the nurse to check the arm band, ask the resident's name, and view the picture on the electronic Medication Administration Record (eMAR). She explained that on the day of the incident, Resident #2 was in the big dining room. Licensed Practical Nurse (LPN) #1 was an agency nurse and it was her first day at the facility. She had pulled up Resident #1's medications and asked a Certified Nurse Assistant (CNA) if the resident sitting in the dining room was (Proper last name of Resident #1). The CNA confirmed that it was, however, LPN #1 was not aware there were two residents at the facility with the same last name. LPN #1 administered Resident #1's 9:00 AM medications to Resident #2. When LPN #1 learned of the mistake, she came to the supervisor's office and advised that she had given Resident #1's medications to Resident #2. LPN #1 reported to RN #1 that she only saw the last name of the resident on the identification band and had asked the resident and he had acknowledged that he was Mr. (Proper Last Name of Resident #1)." She explained she notified the nurse practitioner on call and family regarding the medication error. Resident #2 was monitored every 30 minutes for 2 hours and then every 15 minutes. She reported he had no distress after receiving the medications except after two (2) hours, Resident #2's blood pressure began to drop, and he was transferred to a local hospital. He returned to the facility approximately two (2) hours later.	M 500		

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M 500	Continued From page 6 Record review of the facility's "Witness Statement" dated 02/19/2022 and signed by LPN #1 revealed an "Employee Statement" which stated "I checked resident's band and seen (Proper Last Name of both Resident #1 and Resident #2). I asked resident was he Mr. (Proper Last Name of both Resident #1 and Resident #2) he stated yes. I should have read all of the band instead of just the last name." A record review of "Departmental Notes" for Resident #2 dated 02/19/2022 at 11:24 AM revealed, "Resident received wrong medications around 10:20 AM. Notified on call provider (Proper Name of Nurse Practitioner) of medications that were given. He said to monitor vitals closely and if BP (Blood Pressure) starts to drop to send him to (Proper Name of Local Hospital) to be evaluated/monitored ... First set of Vitals are 97.2 (Temperature), 155/64 (Blood Pressure), Pulse 64, O2 (Oxygen) 96%, and RR (Respiratory Rate) 15, blood glucose 110. Monitoring BP and glucose Q (every) 30 minutes until 2 hour mark then monitoring Q 15 minutes ...Spoke with RP ..." A record review of "Departmental Notes" for Resident #2 dated 2/19/22 at 2:43 PM revealed, "After the Q 2 hour mark we have been monitoring BP Q 15 minutes. At 1400 (2:00 PM) BP was 123/72 and 15 minutes later BP dropped to 81/49. Received orders from (Proper Name of Nurse Practitioner) to send him to (Proper Name of Local Hospital) for eval (evaluation) TX (Treatment) ... vitals are: 81/49 (Blood Pressure), pulse 70, O2 95%, RR 14, Temp (Temperature) 98.0 ..." A record review of Resident #1's eMAR for	M 500		

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February 2022 revealed the following medications were administered during the 9:00 AM medication pass on 02/19/2022: Aspirin 81 milligram (mg) tablet take one tablet by mouth (PO) once daily, Valsartan 160 mg tablet- take ½ tablet (80 mg) by PO once daily, Effexor XR 75 mg capsule take 1 capsule PO once daily, MiraLAX 17 gram (gr) powder take 1 dose, 17 gr with 8oz water daily for constipation, multivitamin with minerals PO daily, Flomax 0.4 mg PO daily, Metformin HCL 1,000 mg take one tablet PO twice a day, and Neurontin 600 mg PO three times a day. These medications were administered to Resident #2 instead of Resident #1.

A record review of Resident #2's eMAR for February 2022 revealed he was not administered any of his 9:00 AM medications on 02/19/2022.

A record review of the "Preliminary Report" from the local hospital emergency room for Resident #1 revealed " ...chief complaint a generic problem (Low BP) ... current visit: arrival time 02/19/2022 14:51 ... notes sent from VA for low BP after receiving the wrong meds (medications) ...initial vitals at presentation: 02/19/2022 14:51 BP: 133/73 ...HR: 61 ... "

On 04/18/2022, at 2:20 PM, during an interview, the Administrator confirmed the medication error occurred and the facility did all they could do to prevent any other medication errors. She expects all nurses to follow the facility's protocol of identifying residents and administering medications correctly.

At 3:00 PM on 04/18/2022, during an interview with the Assistance Director of Nursing (ADON), she reported she was aware of the medication error that occurred with Resident #2 receiving

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M 500	Continued From page 8 Resident #1's medication. She confirmed the nurse did not correctly identify the resident prior to administrating medications and Resident #2 did have a low blood pressure reading after receiving the wrong medication.	M 500		