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F 000	INITIAL COMMENTS A complaint survey was conducted from 4/3/18 through 4/4/18. Past-noncompliance was identified at CFR 483.45 at tag F760 at a scope and severity (G) Non-noncompliance began on 03/19/18. The facility came back in compliance effective 03/25/18.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to prevent a significant medication error for 1 of 3 sampled residents to assure the facility was free of significant medication errors, when a resident (Resident #1) was administered medications ordered for another resident (Resident #6). Findings included: Resident #1 was admitted to the facility on 3/15/18 with diagnoses that included pneumonia, non-Alzheimer's dementia, aortic valve stenosis, chronic obstructive pulmonary disease (COPD), and cancer. Review of the Physician's medication orders for Resident #1 revealed: 3/14/2018 - Levaquin 750 MG Tablet - Give 1 Tablet by mouth daily for 7 days for Pneumonia	F 760	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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(ordered by hospital MD prior to admission to the facility)
3/15/2018 - Medications to be given in pudding type consistency
3/17/2018 - Tylenol Tablet 325 MG - Give 2 tablet by mouth every 4 hours PRN for Pain related to Osteoarthritis

Review of Resident #1's Vital Signs revealed the following baseline blood pressure (BP) and heart rate (HR) readings:

	BP (mmHg)	HR (beats per minute)
3/15/18 at 6:09 PM:	132/65	70
3/16/18 at 1:35 AM:	142/74	90
3/16/18 at 3:27 PM:	132/77	70
3/17/18 at 1:43 AM:	146/77	86
3/17/18 at 6:45 PM:	105/55	90
3/18/18 at 2:55 AM:	157/67	86
3/18/18 at 8:31 PM:	139/59	87
3/19/18 at 2:15 AM:	148/74	88

Review of Incident Report and Verification of Investigation documents dated for 3/19/18 at 7:15 AM stated that Nurse #1 administered medication to the wrong resident (Resident #1). Resident #1's assessment revealed no injury, she was unable to answer, and that she was confused at baseline. Resident #1 was assessed and the Director of Nurses (DON), Physician, Executive Director, and Responsible Party (RP) were notified. The contributing factors to the incident taking place were listed as Resident #1 was new to the facility, she did not have on an armband with her name on it, her resemblance to Resident #6, and her dementia diagnosis. Interventions put into place were listed as the resident was sent to the Emergency Room (ER) for evaluation, an armband audit was completed, and staff

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education was performed.

Review of the Physician's Orders and Medication Administration Record (MAR) for Resident #6 revealed that these ordered medications were ordered to be given on 3/19/18 at 7:30 AM and 9:00 AM:

" Calcium-Vitamin D Tablet 600-400 MG-UNIT - Give 1 tablet by mouth one time a day for Supplementation
" Ergocalciferol Capsule 50000 UNIT - Give 1 capsule by mouth one time a day every Mon for Supplementation
" Lasix Tablet 40 MG - Give 1 tablet by mouth one time a day related to Peripheral Vascular Disease (PAD)
" Metamucil Capsule 0.52 GM - Give 1 capsule by mouth one time a day for Laxatives
" Norvasc Tablet 10 MG - Give 1 tablet by mouth one time a day for Essential Hypertension; Hold if Blood Pressure (BP) less than 110/60
" Vitamin B12 Tablet - Give 1000 mcg by mouth one time a day for Supplementation
" Vitamin C Tablet 500 MG - Give 1 tablet by mouth one time a day for Supplementation
" Zinc Sulfate Tablet 220 MG - Give 1 tablet by mouth one time a day for promote wound healing
" Coreg Tablet 12.5 MG - Give 1 tablet by mouth two times a day related to Essential Hypertension; Hold if Blood Pressure (BP) less than 110/60
" Eliquis Tablet 5 MG - Give 1 tablet by mouth two times a day related to PVD and Coronary Stent
" Klor-Con M10 Tablet Extended Release 10 MEQ - Give 10 mEq by mouth two times a day for Supplementation
" Zofran Tablet 4 MG - Give 1 tablet by mouth

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before meals for nausea 30 mins before each meal
" Carafate Suspension 1 GM/10ML - Give 10 ml by mouth before meals and at bedtime related to Peptic Ulcer
" Reglan Tablet 5 MG - Give 2.5 tablet by mouth before meals and at bedtime related to Peptic Ulcer

Review of Progress Notes revealed a Situation, Background, Assessment, Recommendation Summary (Nurse to Physician Communication Tool) documented by Nurse #3 on 3/19/2018 at 9:43 AM stated that Resident #1's Vital Signs were: BP 100/60, HR 62, Respiration Rate (RR) 18, Temperature (T) 97.8 Rectal, Oxygen Saturation (O2 Sat) 99% with 3 L (liters/minute) of oxygen via nasal cannula. It stated that Resident #1 had a possible drop in blood pressure. Emergency Medical Services (EMS) was notified of emergent transport at 8:32am. EMS arrived at facility at 8:39 AM. Bedside report was given. Family/Health Care Agent Notified at 8:30 AM. Primary Care Clinician Notified at 8:00 AM.

Review of the ER Physician's Notes dated for 3/19/18 at 10:40 AM stated that Resident #1 was evaluated after receiving another resident's medications that morning at the facility. The facility reported that the following medications were given: Reglan, Zinc, Zofran, Norvasc, Lasix, Potassium, Ferrous Sulfate, Eliquis, Coreg, and Carafate. Upon arrival the resident was alert but confused with a BP 99/42, PR 62, and a normal oxygen saturation. Resident #1 had the following orders placed at 9:09 AM:

" 1000 mL of Normal Saline via Intravenous Catheter (IV)

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" Complete Blood Count with Differential (CBC w/ Diff)
" Complete Metabolic Panel (CMP)
" CK-MB & Troponin (cardiac markers used to assist diagnoses of an acute myocardial infarction)
" 12 Lead Electrocardiogram (ECG - recording of the electrical activity of the heart):
" Chest X-Ray
" Head Computerized Tomography (CT) Scan

The ER Physician Note dated for 3/19/18 at 10:40 AM stated "[Resident #1] was apparently given the wrong medication this morning and [the facility] said that she had altered mental status although none of the medications that she was given should've caused that". In relevance to the wrong medications being administered to Resident #1, she had initially presented with some mild hypotension (low blood pressure) that had resolved and the resident was awake, alert, and confused, which was her baseline. The resident was evaluated with laboratory and review of those results from 3/19/18 showed no acute findings. Resident #1 was discharged home from the hospital with family on 3/19/18 at 10:46 AM.

During an interview with the DON on 4/3/18 at 4:00 PM, when asked for the Medication Administration Error Log, the DON had revealed a Plan of Correction (POC) based on the medication error and the following investigation on 3/19/18 for Resident #1. She stated that Resident #1 had mistakenly been given Resident #6's medications by Nurse #1 and Nurse #2 at approximately 7:15 AM. It was Nurse #2's first day of training, and Nurse #1 had pulled Resident #6's medications and had mistakenly pointed out Resident #1 to be given the medications by Nurse

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#2, instead of Resident #6. She stated that Nurse #1 had worked at the facility for approximately 2 years. She stated that when interviewed, Nurse #2 had stated that she had asked Resident #1 if she was [Resident #6], she had stated yes, and had repeated Resident #6's name back to her. Resident #1 had dementia but could answer questions when asked. She stated that the error was discovered when Nurse #3 was seen giving Resident #1 medications on 3/19/18 at approximately 8:30 AM. Nurse #1 and Nurse #2 had reported the error immediately to Charge Nurse #1, and the Physician and the RP were also notified of the medication error. She stated that Resident #1 was sent to the ER for an evaluation as soon as there were any changes observed by staff. A report was requested by the facility to determine if any harm had been done to the resident, and based on the hospital records sent, the DON stated that the resident was not harmed and was sent home with family later that same day. A POC was initiated on 3/19/18 as soon as the medication error was reported, at approximately 8:30 AM. The POC included a 100% audit of all facility residents to ensure that all residents had an armband in place, any missing armbands were replaced immediately. All nursing staff were re-educated on the proper procedure of resident identification prior to administering medications, and the five rights of medication administration. Ambassadors were assigned to check armbands are in place three times per week on rounds. The Staff Development Coordinator (SDC) had completed two random medication pass audits to ensure nurses were checking for armbands, and would continue to do so weekly for twelve weeks (audits were reviewed and verified by the surveyor). The Quality Assurance and Performance

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Improvement (QAPI) committee would discuss all results for the next three months or until no further issues were noted.

During an interview with Nurse #2 on 4/4/18 at 12:38 PM she stated that she was being trained by Nurse #1 and that it was her first day working at the facility. She stated that at approximately 7:15 AM Nurse #1 had pulled Resident #6's medications from the cart and had pointed to Resident #1, who was sitting in the dining room for breakfast, as the resident to receive the medications. She stated that she had walked over to the resident, had asked if she was "[Resident #6]", Resident #1 stated yes and repeated [Resident #6]'s name back to her, so she gave the cup of medications to her and watched her swallow them. She stated that she had administered all of Resident #6's medications ordered for the 7:30 AM and 9:00 AM medication pass times, she had given the pills whole in a medicine cup, and Resident #1 had taken them with water with no straw without difficulty. She stated that at approximately 8:30 AM she and Nurse #1 were walking down the hall and saw Nurse #3 giving Resident #1 medications. They had asked Nurse #3 why she was giving medication to their assigned resident and Nurse #3 had stated that Resident #1 was her assigned resident. She stated that this was when the medication error was discovered. She stated that she and Nurse #1 reviewed Resident #6's MAR, compared it to Resident #1's allergy list (Resident #1 had no known allergies), and immediately reported the error to the Physician and Charge Nurse. She stated that she had received additional training on medication administration and was required to make sure all residents have an armband in place with their name for

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identification prior to administering any medications.

During an interview with Nurse #3 on 4/4/18 at 1:31 PM, she stated that while she was giving Resident #1 her morning medications on 3/19/18, she was approached by Nurse #1 at approximately 8:30 AM, and was asked why she was giving medications to Nurse #1's assigned resident. She stated that she had informed Nurse #1 and Nurse #2 that Resident #1 was her assigned resident and that was when they had notified her of the medication error. She stated that they had immediately reviewed Resident #6's MAR, called the Physician, and had informed Charge Nurse #1. She stated that she was monitoring the resident closely for any changes and that about 30 minutes later she noticed Resident #1 staring off into space and was not responding to her questions. She stated the resident was usually able to respond and answer questions asked by staff. She stated that she had moved the resident to her bed and had informed Charge Nurse #1 and Charge Nurse #2 of the changes observed. She stated that Resident #1 had shown a drop in her blood pressure, but had kept her eyes open, had a pulse, and did not require cardiopulmonary resuscitation (CPR) prior to leaving the facility.

During an interview with the Charge Nurse #1 on 4/4/18 at 3:00 PM, she stated that she was approached by Nurse #1 and was informed that Resident #1 had accidently received Resident #6's morning medications at approximately 8:30 AM and that she had reported the error to the DON, and Resident #1's Responsible Party (RP). She stated that she when she had called the resident's RP to notify her of what was going on

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with the resident, she remembered stating that the resident was unresponsive at that time. When asked by the surveyor to explain what unresponsive meant, she stated that the resident wasn't answering questions and that she was less alert than her baseline. She stated that the Physician had advised staff to closely monitor the resident, and when she had went to assess Resident #1, she was getting her vital signs taken by a Nursing Assistant (NA). She stated that the staff were monitoring her closely for any changes, and that Nurse #3 had reported the resident had started showing level of conscious (LOC) changes about 30 minutes later and had a lower blood pressure than baseline. Resident #1 was moved to her bed at that time and the Charge Nurse had called EMS for immediate transport to the ER for evaluation. She stated that she had her eyes open and had a pulse the whole time, no CPR was performed on Resident #1 while at the facility.

During an interview with Charge Nurse #2 on 4/4/18 at 3:15 PM, she stated that when she had arrived to the facility for her shift the error had already occurred, and she was notified about it when she arrived. She stated that she had assessed the resident and she was in bed at the time. When the resident had shown LOC changes, she had brought the automated external defibrillator (AED) to bedside in case of an emergency. She stated that the resident did not require the use of the AED or CPR at any time while she was at the facility. She stated that once it was determined Resident #1 was going to be sent to the ER, she had notified her RP. She said shortly after the phone call, the RP had come to the facility but the resident was already in route to the hospital. She stated that she had sat down

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with the RP and had given her details of what had happened and had discussed every medication that Resident #1 had accidently received.

An attempt was made to interview the ER Physician on 4/4/18 at 3:26 PM but was unable to conduct an interview.

During an interview with Nurse #1 on 4/4/18 at 3:32 PM, she stated that at approximately 7:15-7:30 AM she had pulled all of Resident #6's medications ordered for the 7:30 AM and 9:00 AM medication pass times. She had thought Resident #1 was Resident #6, and had told Nurse #2 who she was in training, to give the medications to Resident #1 instead of Resident #6. She stated that at approximately 8:30 AM she saw Nurse #3 giving Resident #1 medications. She had asked Nurse #3 why she was giving medication to her assigned resident and Nurse #3 had stated that Resident #1 was her assigned resident. She stated that this was when the medication error was discovered. She stated that she, Nurse #2, and Nurse #3 had printed off and reviewed Resident #6's MAR, compared it to Resident #1's allergy list, and immediately reported the error to the Physician and Charge Nurse. She stated that Nurse #3 was told to closely monitor the resident for changes. Approximately 30-45 minutes, all nursing staff was paged to report to Resident #1's room. She stated the resident was in her bed, that she had a drop in blood pressure, some LOC changes, and that the AED was at the bedside in case of a code situation. She stated that the resident did not require the use of the AED or CPR prior to leaving the facility. She stated that she and Nurse #2 were called to the management's office and were asked to give

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detailed descriptions of what happened that morning. Both Nurse #1 and Nurse #2 were sent home shortly after the resident was sent to the hospital and were required to take a medication administration test. She also stated that the SDC had done one on one education and training on the five rights of medication administration, and was observed passing medications while checking for resident armbands, prior to returning to work.

During an interview with the Administrator on 3/19/18 at 4:05 PM she stated that it was her expectation that staff administered medications based on physician orders, that they verified the resident with the identification armbands, and that the medications were administered by staff based on the facility's policy to ensure quality care to all residents.

Several observations were made throughout the investigation on 4/3/18 through 4/4/18 of medications being administered to residents. All medications were reviewed for accuracy and crosschecked with the correlating physician's order. The facility's medication error rate was zero percent. Staff were observed to follow the facility's policy for identifying the resident by using their armband before medications were given. Observations were made to ensure identification armbands were in place, and all residents observed were noted to have their correct armband in place.