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	345236	A. BUILDING _____ B. WING _____	C 11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 000	INITIAL COMMENTS An unannounced on site complaint investigation was completed at the facility from 11/01/22 through 11/03/22 and finished remotely from 11/4 - 11/8/22. Event ID #KIMD11. The following intakes were investigated: NC00191100, NC00192971, NC00193897, NC00194018, NC00192909 NC00193097, NC00192687, NC00192843, NC00193925. 9 of the 24 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		12/12/22

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

Electronically Signed | 12/02/2022

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to eliminate a strong urine odor noted on the 500 and 600 hall section of the facilities long term care section of the building for 2 of 6 halls observed. Finding included: An initial tour of the facility was conducted on 11/01/22 at 10:30 AM. Prior to entering the 500/600 hall which was noted to have two opened doors at the entry way, a very strong odor of urine was detected. Once on the 500 and 600 halls the odor was stronger and more pungent. There was a dirty linen bin and a trash bin noted on each end of the halls. Each bin had a closed lid, and they were not overflowing with dirty linens. An interview with Nurse Aide (NA) #1 on 11/01/22 at 10:30 AM revealed she noticed the urine odor, but it had been like that since she started about a	F 584	F584 Element #1: There were not any specified residents identified affected by a strong odor on the 500/600 hall section. Element #2: All residents have the potential to be affected by a strong odor; no negative resident outcomes identified secondary to a strong odor. Trash Bins on units have been replaced with new trash/linen hampers. Scent deodorizing machines have been mounted on all halls. Element #3: All staff will be educated to document odors that do not go away with routine cleaning or within 30 minutes following a resident care in the Maintenance Logbook on the unit. Maintenance Director or designee, will	

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F 584	Continued From page 2 month ago. An observation of the 500 and 600 hall during the lunch meal on 11/01/22 at 12:30 PM revealed the odor was still strong and pungent prior to entering and while walking through the 500 and 600 halls. The dirty linen bins and the trash bins were not on the units during this observation. An observation of the 500 and 600 halls on 11/01/22 at 4:10 PM revealed the odor remained strong and pungent and unchanged. An interview was conducted with the Wound Treatment Nurse at 4:10 PM on 11/01/22 and she stated the odor had been on the 500 and 600 hall for over a month and she did not know why it was so strong. The Wound Treatment Nurse was not sure if anything was being done about it. An observation of the 500 and 600 hall on 11/02/22 at 9:00 AM revealed the urine odor remained strong and pungent and unchanged. An observation of the Housekeeper on 11/02/22 at 11:15 AM while cleaning rooms on the 500-hall revealed she was sweeping and mopping the rooms. An interview with the Housekeeper on 11/02/22 at 11:40 AM revealed she did not notice the urine odor because of her mask that she was wearing on her face. She stated all she could smell was cleaning supplies. She stated the hall floors were mopped daily on the 500 and 600 halls. The Housekeeper stated she used a room deodorizer in the bathrooms when she was finished with cleaning them. The Housekeeper stated she did not spray the hallways with the deodorizer.	F 584	check logbook daily Monday Friday by 12/12/2022. Element #4: The Administrator, Maintenance Director or designee will interview two residents regarding odors and hallways will be monitored for a strong odor which does not go away within 30 minutes following resident care or following routine cleaning, Monday Friday x 14 days, then weekly x 14 days, then monthly x 60 days. The Administrator or designee will report findings to the Interdisciplinary Team (IDT) during QAPI meetings for three (3) months and will make changes to the plan as necessary. The Administrator and Maintenance Director are responsible for ongoing compliance. Compliance Date: 12/12/2022	

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An interview was conducted with the Maintenance Director on 11/02/22 at 12:17 PM. The Maintenance Director stated he did not notice the smell because he had sinus issues and wore a mask all the time.

An observation of the 500 and 600 hall on 11/03/22 at 1:30 PM revealed the urine odor remained strong and pungent and unchanged.

An interview was conducted with the Maintenance Director on 11/03/22 at 2:10 PM. The Maintenance Director stated the odor was always there no matter what the facility did. He added, the facility recently changed to a new chemical and the housekeeping staff used this chemical when cleaning. The Maintenance Director stated he believed the staff sprayed the halls as well.

An interview was conducted with the Housekeeping Supervisor on 11/03/22 at 2:10 PM. The Housekeeping Supervisor stated the odor had been strong for about a month and they were hoping the new chemical would fix it. The Housekeeping Supervisor stated the housekeepers use the spray whenever they are cleaning the rooms and the halls. The Housekeeping Supervisor was asked to spray the 500 and 600 hall at this time.

A final observation of the 500 and 600 hall was conducted 15 minutes after the Housekeeping Supervisor sprayed the halls on 11/03/22 at 2:30 PM. There was minimal improvement noted in the strong urine odor.

An interview was conducted with the Administrator on 11/03/22 at 4:13 PM. She

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F 584	Continued From page 4 stated the 500 and 600 section of the facility was preparing to go under some new construction with painting and flooring and she hoped that would improve the odor.	F 584		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner, Physician Assistant and Physician interviews, the facility failed to a) accurately administer medications when Resident #1 was administered medications prescribed for Resident #6 to include Potassium Chloride (supplement) 20 milliequivalents (mEq), Aspirin 81 milligrams (mg), Singulair (allergy medication)10 mg, and Gabapentin (medication to treat nerve damage) 300 mg, and b) the facility failed to follow the discharge orders to administer Potassium Chloride 20 mEq twice daily for 5 days which resulted in Resident #1 missing 5 doses for 1 of 2 residents observed for medication errors. Findings included: Resident #1 was admitted to the facility on 05/23/22 with diagnoses to include, in part, adult failure to thrive, weakness, hypokalemia (low	F 684	Address how corrective action will be accomplished for residents affected: Resident #1 was evaluated and treated at the Emergency Department on 9/24/22. The resident was transferred back to the facility on 9/24/22 with a physician□s order for Potassium Chloride 20 mEq twice daily. The Potassium was administered to Resident #1 beginning 9/26/22. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility who have physician□s orders for medications have the potential to be affected. Address what measures will be put into	12/12/22

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F 684	Continued From page 5	F 684		

potassium), severe protein calorie malnutrition, anemia (low red blood cell production), neuropathy (nerve damage) and pain.

The Minimum Data Set quarterly assessment dated 08/31/22 revealed Resident #1 was cognitively intact. Resident #1 was not available for an interview.

a) A nursing progress note written on 09/23/22 at 9:40 PM revealed, in part, on call physician contacted regarding reported medications given to resident. Resident was sent out to hospital for evaluation.

Review of the physician orders from 05/23/22 through 09/23/22 for Resident #1 revealed there were no orders written for Potassium Chloride (a supplement to increase potassium levels) 20 mEq, Aspirin 81 mg, or Singulair 10 mg. A physician's order was written on 07/26/22 for Gabapentin 200 mg three times a day for neuropathy.

Review of Resident #6's physician orders revealed an order for Potassium Chloride 20 mEq one tablet written on 09/15/22, Singulair 10 mg one tablet for allergies written on 9/15/22, Gabapentin 300 mg one capsule four times daily for pain written on 09/15/22 and Aspirin 81 mg one tablet two times daily for blood clot prevention written on 09/16/22. The medications were scheduled to be given at bedtime.

A review of the Medication Administration Record (MAR) revealed Resident #6's bedtime medications including Potassium Chloride 20 mEq, Singulair 10 mg, Aspirin 81 mg, and Gabapentin 300 mg were initialed as given by

place or systemic changes made to ensure that the deficient practice will not recur:

The Staff Development Coordinator and Director of Nursing will in-service all Licensed Nurses and Certified Medication Aides on Medication Administration Pass, with a specific emphasis not to pre-pour medication.
The Staff Development Coordinator and Director of Nursing will provide in-service education on reviewing paperwork from the hospital and outside provider visits for any recommendations and present the recommendations to the attending physician or physician□s extender and input the recommendations / orders in the resident□s electronic medical record, if indicated.
Beginning 12/12/2022 no Licensed Nurse or Medication Aide will be permitted to work without first receiving the mandatory education outlined above. Any newly hired Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care. Any contract Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care.
The Pharmacy Consultant Nurse will perform random observations of medication administration passes during monthly visits for three months.
The Director of Nursing created an audit tool for Nursing Management including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and

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F 684	Continued From page 6 Nurse #3 on 09/23/22. The Emergency Room (ER) report dated 09/24/22 at 12:17 AM revealed, in part, the resident presented for evaluation after she was given multiple medications in error this evening. According to the resident's Family Member, the nurse [Nurse #3] gave her 6 medications that the resident does not take. The medications included Potassium Chloride 20 mEq, Singulair 10 mg, Gabapentin 300 mg, and Aspirin 81 mg. The Family Member noted that her mother was extremely drowsy. The resident denied any headache, nausea, or vomiting. The resident denied any chest discomfort, trouble breathing or abdominal pain. The resident felt tired but otherwise had no complaints. Vital Signs were noted to be blood pressure 96/58 mm/Hg, heartrate 82 beats per minutes (bpm), respiration rate 18 breaths per minutes (bpm). Resident was tired but arousable and in no acute distress with non-labored breathing, normal heart rate and rhythm. Resident was awake and appropriate. The ER course and medical decision making on 09/24/22 revealed, in part, the physician reviewed the residents' labs that were retained upon arrival. The potassium level was low at 2.8 (range 3.5 - 5.5). The potassium she was given will certainly not be a problem as her potassium level this evening was low. New labs were taken and revealed the potassium level remained low at 3.0. The vital signs at 1:30 AM was blood pressure was 97/63 mm/Hg, heartrate 84 bpm, and respiration rate 18 bpm. Final impression was documented as: accidental overdose, anemia, and hypokalemia. Resident #1 returned back to the facility on	F 684	Nurse Supervisor for observations of medication passes to include observations for pre-pouring medication and medications are prepared and immediately administered to resident. Medication Administration passes will be audited by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and Nurse Supervisor five days a week every shift for two weeks, then three times a week on random shifts for two weeks, then weekly for two months. Beginning 12/12/2022 the Director of Nursing will create an audit tool for Nursing Management including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and Nurse Supervisor to audit paperwork from the hospital and outside provider visits to validate any recommendations are approved by the attending physician or physician□s extender and inputted in the resident□s electronic medical record, if indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Unit Managers will present these audits to the Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations as needed to assure compliance is sustained	

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F 684	Continued From page 7 09/24/22 at 10:33 AM via Emergency Medical Services. A phone interview was conducted with Nurse #3 on 11/04/22 at 4:30 PM. Nurse #3 confirmed she had prepared Resident #1 and Resident #6's medications and when she went to give Resident #1 her medication cup she brought in the cup of "pre-poured" medications belonging to Resident #6. Nurse #3 stated she only administered the Metoprolol and nothing else. Nurse #3 stated as she was attempting to administer the Potassium, the resident questioned what the "big pill" was and when she informed Resident #1 and the Family Member it was Potassium, the Family Member stated the resident was not on Potassium. Nurse #3 stated she went back to look at the electronic medication administration record (eMAR) and saw Resident #1 had an order for Potassium and reported that back to the Family Member and the Resident. Nurse #3 reported the Family Member stated "No, that was not right, she was not on Potassium." Nurse #3 stated she went back to look at the eMAR again and saw that she had Resident #6's eMAR up on the screen and not Resident #1 and she realized she made a medication error and reported it to Nurse #2 and the Nursing Supervisor. Nurse #3 stated the Nursing Supervisor had her write a statement of which medications she gave in error to Resident #1. Nurse #3 stated her statement only had Metoprolol on it because that was all she gave. Nurse #3 confirmed she should not have pre poured the medications for more than one resident and added, it would have avoided the medication error. A phone interview was conducted with the Family Member on 11/07/22 at 10:45 AM. The Family	F 684	ongoing. The Director of Nursing or designee is responsible for this plan of correction. Compliance Date: 12/12/2022	

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Member reported on 09/23/22 she recalled Nurse #3 coming in to give Resident #1 her medications. She stated she did not see how many pills were in the cup but there were more than she usually received at bedtime. The Family Member stated Nurse #3 gave all the medications that were in the cup to Resident #1, but it was not until Resident #1 took her Potassium that she began to question Nurse #3 about Resident #1's medications. The Family Member stated Resident #1 inquired as to what the "big pill" was, and Nurse #3 told her it was Potassium and Resident #1 took the medication. The Family Member stated she questioned this because she knew Resident #1 was not on Potassium. The Family Member stated Nurse #3 left the room and when she returned she confirmed to the Resident and the Family Member Resident #1 had an order for the Potassium. The Family Member stated she left the room to find the Nursing Supervisor because she wanted to know about the Potassium and when it was ordered. The Family Member stated it was at this time Nurse #3 told Nurse #2 and Nursing Supervisor there had been a medication error and Resident #1 received all of Resident #6's medication. The Family Member stated the Nursing Supervisor informed her that Resident #1 was going to be getting sent to the ER due to receiving the wrong medications, a low blood pressure and increased sleepiness.

A phone interview was conducted with Nurse #2 on 11/01/22 at 3:10 PM. Nurse #2 reported a Family Member of Resident #1 was visiting and came to her on another hall on the evening of 09/23/22 and asked her about the facility starting Resident #1 on Potassium and questioned when the facility had ordered it. Nurse #2 stated she did not believe the resident was on Potassium.

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Nurse #2 stated at the same time that the Family Member had come to her, Nurse #3 notified her and reported she administered the wrong medications to Resident #1. Nurse #2 explained that Nurse #3 reported to her that when she went in to bring Resident #1 her medications for the evening, the Family Member had questioned Nurse #3 about the Potassium and when it was ordered. Nurse #2 stated Nurse #3 informed the Family Member and the resident she had an order for Potassium and the Family member stated Resident #1 did not have an order. Nurse #2 stated Nurse #3 reported she went back to the eMAR to confirm the order and she realized she was on another residents' (Resident #6) eMAR and had administered the wrong medications to Resident #1. Nurse #2 stated while she was at the medication cart with Nurse #3, she saw a medication cup filled with medications in Nurse #3's medication cart. Nurse #2 stated that Nurse #3 reported she had prefilled the medications for Resident #1 and Resident #6 and had Resident #6's eMAR record open. Nurse #2 stated she and the Nursing Supervisor immediately instructed Nurse #3 to get a set of vital signs and check for any allergies and to write down all the medications that she had given to Resident #1 in error which the statement included Potassium Chloride 20 mEq, Singulair 10 mg, Gabapentin 300 mg, and Aspirin 81 mg.

A phone interview was conducted with the Nursing Supervisor on 11/03/22 at 12:15 PM. The Nursing Supervisor stated Nurse #3 had come to her stating the Family Member was questioning why Resident #1 was receiving Potassium and the Nursing Supervisor added, she was sure the resident was not on Potassium. She questioned Nurse #3 and Nurse #3 stated

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the resident was on Potassium. The Nursing Supervisor stated she and Nurse #2 reviewed the orders and learned Resident #1 was not on Potassium. The Nursing Supervisor stated Nurse #3 admitted she had given the wrong medications to Resident #1 and that she had prepared Resident #1 and Resident #6's medication in medication cups and gave Resident #1 Resident #6's medication cup instead of her own. The Nursing Supervisor stated when she became aware of the medication error she had gone in to see Resident #1 and recalled her blood pressure being 90/58 mm/Hg and she let the on-call physician know what medications were given in error and obtained an order to send her to the ER to be evaluated. The Nursing Supervisor stated Emergency Medical Services (EMS) arrived and she provided them with all the paperwork and a list of the medications that Nurse #3 provided her which indicated which medications were given in error. The Nursing Supervisor reported the list included Potassium Chloride 20 mEq, Singulair 10 mg, Gabapentin 300 mg and Aspirin 81 mg.

A phone follow up interview was conducted with the Nursing Supervisor on 11/07/22 at 9:30 AM. The Nurse Supervisor stated Nurse #3 provided her with a written statement, and it included all the medications she had given to Resident #1 in error including Gabapentin 300 mg, Aspirin 81 mg, Singulair 10 mg, and Potassium 20 mEq. She stated she provided this list to the family and EMS and shortly after the resident was sent out, Nurse #3 provided her with another list which indicated she had only given the Metoprolol and the Potassium. The Nursing Supervisor stated the Family Member reported to her that there were a lot of medications in the cup and the resident usually would only get 2 or 3 medications

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at night and Resident #1 took all the medications that were in the cup that Nurse #3 brought in. The Nursing Supervisor stated Nurse #3 reported to her initially that she gave Resident #1 all the medications that were ordered for Resident #6 to be given at bedtime to Resident #1 and she reminded Nurse #3 about the 5 rights (right resident, right drug, right dose, right route, and right time) of medication administration and stated that nurses were never to prepare other residents medications while preparing to administer medications to another resident.

An interview was conducted with the Nurse Practitioner (NP) on 11/02/22 at 11:22 AM. The NP reported that she was aware the medication error occurred and stated that receiving an extra 100 mg of Gabapentin probably would not have too much effect on the resident nor would the Aspirin or Singulair, and although it was a medication error, receiving the Potassium helped Resident #1 since her Potassium level was low at 2.8.

A phone interview was conducted with the Physician Assistant (PA) on 11/04/22 at 10:38 AM. The PA stated she could not say definitively that the Gabapentin, Aspirin or Singulair caused any harm to the resident and that receiving the Potassium was a medication error, but it was needed for the resident due to her low potassium levels.

A phone interview was conducted with the Physician on 11/04/22 at 10:51 AM. The Physician indicated that receiving the Aspirin, Gabapentin or Singulair did not cause any harm to the resident but and although the resident received the Potassium Chloride and it benefited

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her, it was still a medication error, and it should not have happened.

An interview was conducted with the Director of Nursing (DON) on 11/03/22. The DON reported she had only been at the facility for one week and could not find any written statements regarding the medication error that occurred by Nurse #3 on 09/23/22 for Resident #1. She stated her expectation of the nursing staff was that all nursing staff should complete one residents' medication pass at a time before starting another medication pass on another resident. The DON added, if Nurse #3 had not prepared another residents' medication, this error may not have happened.

b. The After Visit Summary discharge instructions from the hospital for Resident #1 written on 09/24/22 revealed resident's medication had a change and to start taking Potassium Chloride 20 mEq (milliequivalents) twice daily for hypokalemia (low potassium level).

A review of the EMS report revealed Resident #1 arrived back to the facility on 09/24/22 at 10:33 AM and was received by Nurse #8.

A prescription was written by the hospital for Potassium Chloride 20 mEq packet, take 20 mEq by mouth 2 times daily for 5 days with a start date of 09/24/22. It was noted to have only a written note indicating it was faxed to the pharmacy on 09/24/22 at 5:56 PM.

The physician orders for 09/24/22 revealed the order written for Potassium Chloride 20 mEq twice daily was not transcribed into the medical record.

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A physician order was rewritten by the Physician Assistant (PA) on 09/26/22 for Potassium Chloride 20 mEq twice daily.

The Medication Administration Record (MAR) revealed the Potassium Chloride 20 mEq twice daily was on the MAR with a start date of 09/26/22. The MAR revealed Resident #1 received one dose at 5:30 PM on 09/26/22 and one dose at 9:30 AM and 5:30 PM on 09/27/22 of the Potassium Chloride.

A physician order written on 09/27/22 at 12:00 PM revealed obtain stat (immediate) lab for complete blood count and basal metabolic panel one time for anemia and hypokalemia.

A phone interview was conducted with Nurse #8 on 11/02/22 at 4:05 PM. Nurse #8 confirmed she was the nurse on duty on 09/24/22 from 7:00 AM - 7:00 PM, but she did remember anything about Resident #1 or the Potassium order. Nurse #8 stated as the nurse on the unit, if a resident came back from the hospital, she would be responsible for readmitting the resident. Nurse #8 stated she would have been the one to receive any new orders and she would have reviewed the orders with the physician, faxed the orders to pharmacy, and put them in the electronic medical record as an order (eMAR). Nurse #8 added, the second shift nurse would note any new orders that were received. She did not recall receiving the Potassium Chloride prescription for Resident #1 on 09/24/22 or faxing the prescription to the pharmacy.

A phone interview was conducted with the Pharmacist from the Pharmacy Company on

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11/03/22 at 2:09 PM. The Pharmacist reported she received an order for Potassium Chloride 20 mEq packets twice daily for 5 days from the facility on 09/24/22 at 5:56 PM. She added, the medication left the pharmacy on the evening of the 24th and was received from Nurse #8 on 09/25/22 at 7:35 AM.

An interview was conducted with the Unit Manager (UM) on 11/03/22 at 2:48 PM. The UM reviewed the After Visit Discharge Summary and the prescription for the Potassium Chloride for Resident #1. The UM stated the medication should have been put into the eMAR so that Resident #1 could receive the medication as ordered. She stated if the medication was not available from the pharmacy upon admission, the facility has a computerized medication system for back up medications and Potassium Chloride 20 mEq was available. The UM stated she could not explain why Resident #1 did not receive the Potassium starting on 09/24/22 as ordered. The Unit Manager stated any new orders that were written during the shift were noted on the 24-hour report and the oncoming next shift nurse was responsible for verifying any new orders.

A phone interview was conducted with the Physician Assistant (PA) on 11/04/22 at 10:38 AM. The PA stated she became aware that Resident #1 had not received the Potassium Chloride when she had a discussion with the Family Member on 09/26/22. The PA stated she ended up rewriting the order on 09/26/22 because she wanted to make sure Resident #1 received the Potassium. The PA stated she was told by nursing staff they never received the Potassium and she thought maybe something was wrong with the fax machine. The PA was

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F 684	Continued From page 15 informed the Pharmacy received the order via fax from the facility on 09/24/22 and it was delivered and received by Nurse #8 on the morning of 09/25/22. The PA stated she would have expected the nursing staff to implement that Potassium order as prescribed on 09/24/22. The PA reported after receiving the Potassium on 09/26/22 and 09/27/22, Resident #1's potassium level increased on 09/27/22 and was within normal limits at 4.2. A phone interview was conducted with the Physician on 11/04/22 at 10:51 AM. The Physician reported Resident #1 had a low potassium and the medication should have been administered as ordered when she came back from the hospital. An interview was conducted with the Director of Nursing (DON) on 11/04/22 at 12:20 PM. The DON reported she could not explain why the order for the Potassium Chloride was not put into the eMAR resulting in Resident #1 missing 5 doses of Potassium Chloride. The DON stated the prescription was faxed to the pharmacy as it should have been and there was Potassium Chloride available in the back up medications that could have been used until the Potassium Chloride arrived from the pharmacy. She stated she expected her nursing staff to review the discharge summary orders, put the orders into the eMAR upon readmission and a second nurse should be reviewing any new orders and admission paperwork to ensure the orders were put into the eMAR for administration.	F 684		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		12/12/22

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F 760	Continued From page 16 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 review and staff, Nurse Practitioner, Physician Assistant and Physician interviews, the facility failed to accurately administer medications when Resident #1 was administered medications prescribed to Resident #6 to include Metoprolol (a blood pressure medication) 50 milligrams (mg) extended release and Xanax (an antianxiety medication) 1 mg resulting in Resident #1 having increased sleepiness and a decrease in blood pressure which required her to be sent to the Emergency Room for further evaluation for 1 of 2 residents reviewed for medication errors. Findings included: Resident #1 was admitted to the facility on 05/23/22 with admitting diagnoses to include, in part, adult failure to thrive, weakness, hypokalemia (low potassium), severe protein calorie malnutrition, anemia (low red blood cell production), and pain. The Minimum Data Set quarterly assessment dated 08/31/22 revealed Resident #1 was cognitively intact and was noted to not have received any antianxiety medications during this assessment period. Resident #1 was not available for an interview. Review of Resident #1's blood pressures (BP) revealed on 09/20/22 BP was 98/68 mm/Hg and 102/74 mm/Hg, on 09/21/22 BP was 105/74 mm/Hg and 90/56 mm/Hg, on 09/22/22 BP was	F 760	Address how corrective action will be accomplished for residents affected: Resident #1 was evaluated and treated at the Emergency Department on 9/24/22. The resident was transferred back to the facility on 9/24/22 with a physician s order for Potassium Chloride 20 mEq twice daily. The Potassium was administered to Resident #1 beginning 9/26/22. Resident #1 was discharged from facility on 10/10/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility who have physician s orders for medications have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Staff Development Coordinator and Director of Nursing will in-service all Licensed Nurses and Certified Medication Aides on Medication Administration Pass, with a specific emphasis on 5 Rights of Medication Administration and not to pre-pour medication. The Staff Development Coordinator and Director of Nursing will provide in-service education on reviewing paperwork from	

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F 760	Continued From page 17 89/58 mm/Hg, on 09/23/22 BP was 124/66 mm/Hg and 110/64 mm/hg. Review of the physician orders from 05/23/22 through 09/23/22 for Resident #1 revealed there were no orders written for Metoprolol Succinate (blood pressure medication) 50 mg, or Xanax 1 mg. A physician order was prescribed for Gabapentin 200 mg three times daily on 07/26/22. Review of Resident #6's physician orders revealed an order for Metoprolol 50 mg for high blood pressure every 12 hours written on 09/16/22 and Xanax 1 mg one tablet twice daily for anxiety written on 09/21/22. The Medication Administration Record revealed Resident #1's bedtime medications were not initialed as administered on 09/23/22. The Medication Administration Record for Resident #6 revealed six medications prescribed to be given at bedtime which included Metoprolol and Xanax were initialed as given at 9:35 PM by Nurse #3. A nursing progress note written by the Nurse Supervisor on 09/23/22 at 9:40 PM revealed, in part, the on-call physician was contacted regarding reported medications given to resident. Resident was sent out to the hospital for evaluation. A review of the Emergency Medical Services (EMS) transfer form dated 09/23/22 revealed Resident #1's blood pressure was 79/51 mm/Hg (millimeters of mercury). The documentation indicated EMS implemented treatment of	F 760	the hospital and outside provider visits for any recommendations and present the recommendations to the attending physician or physician s extender and input the recommendations / orders in the resident s electronic medical record, if indicated. Beginning 12/12/2022 no Licensed Nurse or Medication Aide will be permitted to work without first receiving the mandatory education outlined above. Any newly hired Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care. Any contract Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care. The Pharmacy Consultant Nurse will perform random observations of medication administration passes during monthly visits for three months. The Director of Nursing created an audit tool for Nursing Management including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and Nurse Supervisor for observations of medication passes to include observations for pre-pouring medication and medications are prepared and immediately administered to resident. Medication Administration passes will be audited by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and Nurse Supervisor five days a week every shift for two weeks, then three times a week on random shifts for two weeks, then weekly for two months.	

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F 760	Continued From page 18 intravenous fluids (IV) 1,000 milliliters and the resident arrived at the hospital at 11:20 PM. Last blood pressure recorded on the EMS report was 89/57 mm/Hg with no time recorded. The Emergency Room (ER) report dated 09/24/22 at 12:17 AM revealed, in part, the resident presented for evaluation after she was given multiple medications in error this evening. According to the resident's Family Member, the nurse [Nurse #3] gave her 6 medications that the resident does not take. The medications included Xanax 1 mg and Metoprolol Succinate Extended Release 50 mg. The Family Member noted that her mother was extremely drowsy. The resident denied any headache, nausea, or vomiting. The resident denied any chest discomfort trouble breathing or abdominal pain. The resident felt tired but otherwise had no complaints. Vital Signs were noted to be blood pressure 96/58 mm/Hg, heartrate 82 beats per minutes (bpm), respiration rate 18 breaths per minutes (bmp). Resident was tired but arousable and in no acute distress with non-labored breathing, normal heart rate and rhythm. Resident was awake and appropriate. The ER course and medical decision making on 09/24/22 revealed, in part, the physician reviewed the residents' labs that were retained upon arrival. The Xanax was likely to provide the most lasting sedation. The resident was given the medications a little over 3 hours ago. The vital signs at 1:30 AM read blood pressure 97/63 mm/Hg, heartrate 84 bpm, and respiration rate 18 bpm. Final impression was documented as: accidental overdose, anemia, and hypokalemia. Resident #1 returned back to the facility on 09/24/22 at 10:33 AM via Emergency Medical	F 760	Beginning 12/12/2022 the Director of Nursing will create an audit tool for Nursing Management including the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Managers and Nurse Supervisor to audit paperwork from the hospital and outside provider visits to validate any recommendations are approved by the attending physician or physician s extender and inputted in the resident s electronic medical record, if indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Unit Managers will present these audits to the Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations as needed to assure compliance is sustained ongoing. The Director of Nursing or designee is responsible for this plan of correction. Compliance Date: 12/12/2022	

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Services.

A phone interview was conducted with Nurse #3 via phone on 11/04/22 at 4:30 PM. Nurse #3 confirmed she had prepared Resident #1 and Resident #6's medications and when she went to give Resident #1 her medication cup she brought in the cup of "pre poured" medications belonging to Resident #6. Nurse #3 stated as she was attempting to administer the Potassium, Resident #1 questioned what the medication was and when she informed the resident and the Family Member it was Potassium, the Family Member stated the resident was not on Potassium. Nurse #3 stated she went back to look at the electronic medical record (eMAR) and saw that there was a Potassium order, so she reported that back to the Family Member and Resident #1. Nurse #3 reported the Family Member stated "No, that was not right, she was not on potassium." Nurse #3 stated she went back to look at the eMAR again and saw that she had Resident #6's eMAR up on the screen and not Resident #1 and she realized she made a medication error and reported it to Nurse #2 and the Nursing Supervisor. Nurse #3 stated the Nurse Supervisor had her write a statement of which medications she gave in error. Nurse #3 stated her statement only had Metoprolol on it because that was all she gave. Nurse #3 denied giving any other medications. Nurse #3 confirmed she should not have pre poured the medications for more than one resident and added, it would have avoided the medication error.

A phone interview was conducted with the Family Member on 11/07/22 at 10:45 AM. The Family Member reported on 09/23/22 she recalled Nurse #3 coming in to give Resident #1 her

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medications. She stated she did not see how many pills were in the cup but there were more than she usually received at bedtime. The Family Member stated Nurse #3 gave all the medications that were in the cup to Resident #1, but it was not until Resident #1 took her Potassium that she began to question Nurse #3 about Resident #1's medications. The Family Member stated Resident #1 inquired as to what the "big pill" was, and Nurse #3 told her it was Potassium and Resident #1 took the medication. The Family Member stated she questioned this because she knew Resident #1 was not on Potassium. The Family Member stated Nurse #3 left the room and when she returned she confirmed to the Resident and the Family Member Resident #1 had an order for the Potassium. The Family Member stated she left the room to find the Nursing Supervisor because she wanted to know about the Potassium and when it was ordered. The Family Member stated it was at this time Nurse #3 told Nurse #2 and Nursing Supervisor there had been a medication error and Resident #1 received all of Resident #6's medication. The Family Member stated the Nursing Supervisor informed her that Resident #1 was going to be getting sent to the ER due to receiving the wrong medications, a low blood pressure and increased sleepiness.

A phone interview was conducted with Nurse #2 on 11/01/22 at 3:10 PM. Nurse #2 reported a Family Member of Resident #1 was visiting and came to her on the evening of 09/23/22 and asked her when the facility started Resident #1 on Potassium. Nurse #2 stated she did not believe the resident was on Potassium. Nurse #2 stated at the same time that the Family Member had come to her, Nurse #3 notified her that she administered the wrong medications to Resident

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#1. Nurse #2 explained that Nurse #3 reported to her that when she went in to bring Resident #1 her medications for the evening, the family had questioned Nurse #3 about the Potassium and when it was ordered. Nurse #2 stated that Nurse #3 informed the family and the resident that the resident had an order for Potassium and the Family Member stated she did not. Nurse #2 stated Nurse #3 reported to her that she went back to the eMAR to confirm the order, and realized she was on another residents' (Resident #6) eMAR. Nurse #2 stated she saw a medication cup filled with medications in Nurse #3's medication cart and stated Nurse #3 reported she had prefilled the medications for Resident #1 and Resident #6 and had Resident #6's eMAR record open. Nurse #2 stated she notified the Nurse Supervisor immediately and instructed Nurse #3 to get a set of vital signs and check for any allergies and to write down all the medications that she had given to Resident #1 in error which included Metoprolol Succinate Extended Release 50 mg and Xanax 1 mg. Nurse #2 reported she assessed Resident #1 and she had begun to have a change in condition including increased sleepiness. Nurse #2 stated Resident #1 was arousable but very sleepy and she had had the medications in her system for about 15 minutes or more and her blood pressure was 88/68 mm/Hg. Nurse #2 stated she did not recall what the blood pressure was when Nurse #3 took it upon discovering the medication error and Nurse #3 did not document it, but when EMS arrived it had lowered to 79/51 mm/Hg. Nurse #2 stated the resident was responsive, she was really sleepy, and her eyes were rolling back.

A phone interview was conducted with the Nurse Supervisor on 11/03/22 at 12:15 PM. She stated

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Nurse #3 had come to her stating the Family Member was questioning why Resident #1 was receiving Potassium and the Nurse Supervisor added, she was sure the resident was not on Potassium. The Nurse Supervisor questioned Nurse #3 and she reported to the Nurse Supervisor that the resident was on Potassium. The Nurse Supervisor stated she and Nurse #2 reviewed the orders and learned Resident #1 was not on Potassium. The Nurse Supervisor stated when she became aware of the medication errors she had gone in to see Resident #1 and the Family Member to make them aware and noted Resident #1 was more tired than usual but arousable. The Nurse Supervisor stated she let the on-call physician know what medications were given in error, the resident's change of condition symptoms, and the most recent blood pressure which she recalled was 90/58 mm/Hg. The Nurse Supervisor stated she was concerned about the residents' blood pressure getting lower once the Metoprolol started to "kick in." She stated EMS arrived and she provided them with all the paperwork and a list of the medications that Nurse #3 provided her which indicated the medications that were given in error which included the Metoprolol Succinate Extended Release 50 mg and the Xanax 1 mg. The Nursing Supervisor reported Resident #6 received all of her ordered medications by Nurse #3.

A follow up phone conversation was conducted with the Nurse Supervisor on 11/07/22 at 9:30 AM. The Nurse Supervisor stated Nurse #3 provided her with a written statement, and it included all the medications she had given to Resident #1 in error including Metoprolol Succinate Extended Release 50 mg, Xanax 1

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F 760	Continued From page 23	F 760		

mg, Gabapentin 300 mg, Aspirin 81 mg, Singulair 10 mg, and Potassium Chloride 20 mEq. She stated she provided this list to the family and EMS and shortly after the resident was sent out, Nurse #3 provided her with another list which indicated she had only given the Metoprolol and the Potassium. The Nurse Supervisor stated the Family Member reported to her that there were a lot of medications in the cup and the resident usually would only get 2 or 3 medications at night and the Family Member stated Resident #1 took all the medications that were in the cup that Nurse #3 brought in. The Nurse Supervisor stated Nurse #3 reported to her initially that she gave Resident #1 all the medications that were ordered for Resident #6 to be given at bed time to Resident #1 and she reminded Nurse #3 about the 5 rights (right resident, right drug, right dose, right route, and right time) of medication administration and stated that nurses are never to prepare other residents medications while preparing to administer medications to another resident.

An interview was conducted with the Nurse Practitioner (NP) on 11/02/22 at 11:22 AM. The NP reported that she was aware the medication error occurred and stated that receiving the Metoprolol Succinate Extended Release caused Resident #1's blood pressure to lower and the Xanax caused the resident increased sleepiness which both resulted in her being sent to the ER.

A phone interview was conducted with the Physician Assistant (PA) on 11/04/22 via phone at 10:38 AM. The PA stated she could not be sure that the Metoprolol Succinate Extended Release contributed to Resident #1's blood pressure being lower with just one dose, but added, her blood

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F 760	Continued From page 24 pressure did run low at times, and it was lower than normal when she was sent out to the ER. The PA also stated she felt the Xanax contributed to her increased lethargy (sleepiness) which also required her to be sent to the ER for further evaluation. A phone interview was conducted with the Physician on 11/04/22 at 10:51 AM. The Physician stated since Resident #1 had received the Metoprolol Succinate Extended Release and the Xanax it had caused hypotension (low B/P) and sedation. He added, although it did not cause any harm, it could have caused harm. He indicated the other medications listed would not have caused any harm. An interview was conducted with the Director of Nursing (DON) on 11/03/22. The DON reported she had only been at the facility for one week and could not find any written statements regarding the medication error that occurred by Nurse #3 on 09/23/22 for Resident #1. She stated her expectation of the nursing staff was that all nursing staff should complete one residents' medication pass at a time before starting another medication pass on another resident. The DON added, if Nurse #3 had not prepared another residents' medication, this error may not have happened.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		12/12/22

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F 761	Continued From page 25 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 2 medication carts observed (500 hall medication cart). Findings included. An observation of an unattended medication cart (500 hall medication cart) was made on 11/02/22 at 1:05 PM. The medication cart was located in a common area near the nurse's station. The lock on the cart was noted to be sticking out instead of pressed in without a staff member present at the cart. During the observation period 4 residents in wheel chairs were observed sitting by the unlocked medication cart. Nurse #5 assigned to	F 761	Address how corrective action will be accomplished for residents affected: No specific residents were identified as having been affected by this deficient practice. The Director of Nursing will perform observation audits and will note if medication carts were locked when unattended by 12/12/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected. Address what measures will be put into place or systemic changes made to	

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F 761	Continued From page 26 the medication cart was located in a room behind the nurse's station eating lunch. An interview was conducted with Nurse #5 on 11/02/22 at 1:05 PM. He stated he was the assigned nurse for the 500 hall and was responsible for the 500-hall medication cart. He acknowledged the medication cart was unlocked when he returned to the cart. He stated he left the medication cart to go eat his lunch and forgot to lock it. He stated it was an oversight on his part and he usually locked the cart before leaving it unattended. An interview was conducted with the Director of Nursing (DON) on 11/03/22 at 4:22 PM. The DON stated the nurse was responsible for keeping the medication cart locked and secured when unattended and Nurse #5 should have made sure the medication cart was locked before leaving it unattended.	F 761	ensure that the deficient practice will not recur: Licensed Nurses and Certified Medication Aides will be in-serviced to keep unattended medications stored in a locked medication cart by the Staff Development Coordinator or Director of Nursing by 12/12/2022. Beginning 12/12/2022 no Licensed Nurse or Medication Aide will be permitted to work without first receiving the mandatory education outlined above. Any newly hired Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care. Any contract Licensed Nurse or Medication Aide will receive the mandatory education outlined above prior to provision of care. A medication cart security audit tool was created to validate unattended medications are stored in a locked medication cart. Each Medication Cart will be observed utilizing this Medication Cart Audit Tool. Observations will be made using the Medication Cart Audit Tool by the Director of Nursing, Staff Development Coordinator, Unit Managers or Nurse Supervisor once a shift for 24 hours, 5 days a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Unit Managers will present audits to the Quality Assurance and Performance	

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F 761	Continued From page 27	F 761	Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations as needed to assure compliance is sustained ongoing. The Director of Nursing or designee is responsible for this plan of correction. Compliance Date: 12/12/2022	
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.	F 885		12/12/22

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F 885	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to inform resident representatives and families by 5:00 PM the next calendar day following the occurrence of confirmed staff COVID-19 infection on 10/06/22 for 1 of 32 staff tested and a confirmed resident COVID-19 infection on 10/08/22 for 1 of 20 residents tested. Findings included: Review of the facility COVID-19 testing log revealed 1 staff tested positive on 10/06/22 and 1 resident tested positive on 10/08/22. An interview was conducted with the Social Worker on 11/02/22 at 10:27 AM. She stated she was aware of the nurse aid testing positive on 10/06/22 but there was no declaration of a COVID-19 outbreak and she was following the new CDC guidelines not the previous recommendations. The Social Worker stated when the resident's result was positive for COVID-19 on 10/08/22, she was instructed by the previous Director of Nursing (DON) to notify the resident's family only. An interview was conducted with the Infection Control Preventivist on 11/02/22 at 2:10 PM. The ICP reported she had been in the role of ICP for a month. She stated a nurse aide came to the facility to get tested on 10/06/22 because she was symptomatic, and the rapid test result was positive. The ICP stated the nurse aide had worked two days prior to this test on 10/06/22 when she was getting weights on residents. The ICP stated the 20 residents she obtained weights on were tested for COVID-19 and the results were negative on 10/06/22. The ICP added,	F 885	F885 Element #1: Resident with positive COVID-19 test results representative/family was notified on date of testing. All facility resident□s representative/family notification was not completed on 10/10/2022. Element #2: All resident representatives/families have the potential to be affected by this deficient practice. All resident representatives/families were notified of COVID outbreak status by 10/10/2022. The administrator reviewed the notification process used for notification. The notification of all resident representatives/families had been assigned to two people, which prevented the notifications from being completed within the regulatory timeframe. Element #3: The Social Service Director and SDC were educated immediately on 483.80(g)(3) to inform residents, their representatives, and families of those residing facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three (3) or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. All Department Managers with notification responsibilities (Director of Nursing; Associate Director of Nursing; Staff Development Coordinator/Infection Control Nurse; Social Services Director;	

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F 885	Continued From page 29 however, on 10/08/22 a resident became symptomatic with signs and symptoms of COVID-19 and tested positive. The ICP reported the residents' family was notified on 10/08/22, but it was not until 10/10/22 that all of the families and residents in the facility were notified for the staff positive result and the resident positive result for COVID-19. The ICP stated she was not aware of the policy to notify all family and residents of a positive COVID-19 test in the facility within 24 hours. An interview with the Administrator on 11/03/22 at 4:13 PM revealed she would expect the staff to follow the CDC guidelines and notify the family within 24 hours of the first positive test. The Administrator stated the process was in place was for the Social Workers to notify the family and representatives of any positive cases and she believed they understood the process, but may have been distracted.	F 885	Social Services Assistant; Business Office Manager; MDS Coordinator LPN/RN; Unit Managers; Activity Director; Medical Records Coordinator) will be educated by the Administrator about 483.80(g)(3) to inform residents, their representatives, and families of those residing facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three (3) or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other by 12/06/2022 Element #4: The Administrator, DON or designee will monitor need to inform residents, their representatives, and families of those residing facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other x 14 days, then weekly x 14 days, then monthly x 60 days. The Administrator or designee will report findings monthly for three (3) months and will make changes to the plan as necessary. The Administrator is responsible for ongoing compliance. Compliance date: 12/12/2022	