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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 11/06/23 through 11/07/23 and finished remotely through 11/09/23. Additional information was obtained offsite on 11/20/23. Therefore, the exit date was changed to 11/20/23. Event ID #XYLV11. The following intakes were investigated: NC00209392 and NC00200145. Intake #NC00209392 resulted in immediate jeopardy. 1 of the 3 complaint allegations resulted in deficiency. Past non-compliance was identified at: CFR 483.45 at tag F760 at a scope and severity (J) The tag F760 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Physician Assistant, Physician, Emergency Medical Service Responder, Adult Day Care staff nurse, and Pharmacist Consultant interviews, the facility failed to prevent a significant medication error when Medication Aide #1 administered	F 760	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 12/06/2023

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Resident #1 medications prescribed to Resident #3 to include Clonazepam (a medication to treat anxiety classified as benzodiazepine) 1 milligram (mg) and Buprenorphine HCl-Naloxone (a medication to treat opioid addiction) 8mg/2 mg causing Resident #1 to become unresponsive. Resident #1 required 2 doses of Narcan (medication given to reverse opioid overdose) administered by Emergency Medical Services and was sent to the emergency room for further evaluation where it was determined he had a drug overdose as evidenced by the lab results testing positive for benzodiazepine and buprenorphine in Resident #1's blood stream. This deficient practice affected 1 of 4 residents reviewed for significant medication errors.

Findings included:

Resident #1 was admitted to the facility on 04/14/23. Resident #1 did not have a diagnosis of anxiety or opioid addiction.

The Minimum Data Set quarterly assessment dated 10/20/23 revealed Resident #1 was severely cognitively impaired and was not coded as receiving opioid medications or antianxiety medications.

Review of the October 2023 physician orders for Resident #1 revealed there were no orders written for Clonazepam 1 mg or Buprenorphine HCl-Naloxone 8mg/2 mg. Resident #1 had no orders for antianxiety medication or opioids.

Review of the Medication Administration Record (MAR) on 10/05/23 revealed Resident #1 received all of his scheduled medications as ordered and received Lispro insulin for a glucose

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blood sugar of 243 milligrams per deciliter (mg/dL) as evidenced by nursing initials and a checkmark on the MAR.

Resident #3 was admitted to the facility on 04/27/23.

Review of the October 2023 active physician orders (initially written on 04/27/23) for Resident #3 revealed Clonazepam 1 mg three times daily for anxiety and Buprenorphine HCl-Naloxone sublingual (under the tongue) tablet 8mg/2 mg, give one tablet sublingually two times a day.

A review of the Medication Administration Record on 10/05/23 revealed Resident #3 received his scheduled Buprenorphine HCl-Naloxone and Clonazepam as ordered as evidenced by nursing initials and a checkmark on the MAR.

The Medication Monitoring Control Record used to record when controlled medications were given to a resident showed a control record for Resident #3 for Buprenorphine HCl-Naloxone 8mg/2mg one tablet sublingually twice daily. The control record was lined and numbered 1 through 20. It also included a column for date the medication was given, a column for the time it was given, a column for how many were left on hand, how many were administered and how many were remaining. On line number 17 of the control record it was recorded to have Medication Aide (MA) #1's name, the date 10/05/23, the time 9:31 AM with 14 on hand, removing 1 and remaining 13. There was a line drawn through what MA #1 recorded and the word "error" written. On the bottom half of the control record revealed a section labeled "Record of waste and spoilage." The columns included a column for which line

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item number was being wasted, the date, the quantity, description of the waste, signature #1 and signature #2. MA #1 recorded for the item: #17 (to reference line #17), dated 10/05/23, with 1 tablet for the quantity and "dropped in room by pt." under description. Nurse #4 signed under signature #1 and "error" was written under signature #2. There was a line drawn through this written documentation.

The control record revealed on line #18 that MA #1 administered one tablet of Buprenorphine HCl-Naloxone 8mg/2mg at 9:30 AM verifying Resident #3 did receive the ordered medication.

The Medication Monitoring Control Record for Resident #3 for Clonazepam 1mg one tablet three times daily revealed on line number 15 of the control record it was recorded to have Medication Aide #1's name, the date 10/05/23, the time 4:40 PM with 16 on hand, removing 1 and remaining 15. There was a line drawn through line #15 what MA #1 recorded and the word "error" written. On the bottom of the control record under "Record of waste and spoilage" revealed MA #1 recorded for the item column: #15, dated 10/05/23, 1 tablet for the quantity and "dropped in room by pt. at 9:31 AM" under description. Nurse #4 signed under signature #1 and "error" was written under signature #2. There was a line drawn through this written documentation.

The control record revealed on line #14 that MA #1 administered one tablet of Clonazepam 1 mg at 9:30 AM and on line #16 at 4:40 PM verifying Resident #3 did receive the ordered medication.

An interview was conducted with the Nurse Staff

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from the Adult Day Care Program (PACE) via phone on 11/07/23 at 3:17 PM. The PACE nurse discussed an incident with Resident #1 that occurred on 10/05/23. She stated the timeline of what had occurred at the center was as follows:

- Driver from PACE arrived at the facility at 9:00 AM. Resident was alert and oriented and talkative.
- At 10:00 AM the nurse aide assigned to Resident #1 was toileting him and he was very sleepy.
- At 10:30 AM the nurse aide reported to the nurse that Resident #1 was very groggy. Nurse assessed the resident and he reported he was tired and did not sleep well last evening.
- At 12:00 PM Resident #1 was noted to not have eaten his lunch and was lethargic.
- At 12:50 PM nurse aide brought him to the restroom to toilet him and he required the sternum rub to stimulate him to wake up. Nurse was called to assess and vital signs were taken Blood Pressure (BP) was 130/77 millimeters of mercury (mm/Hg), heart rate (HR) 74 beats per minute (bpm), respiration rate (RR) 18 breaths per minute (bpm), temperature 97.8 and blood sugar was 110 milligrams per deciliter (mg/dL). The nursing note stated Resident #1 was able to follow commands with sternum rub (applying stimulus with knuckles of closed fist to the center of chest for a resident who was not alert and does not respond to verbal stimuli) and when asked to go back to his room, he replied "yes, baby."
- At 2:00 PM he appeared to be sleeping and nurse aide assisted the resident on to the van.
- At 3:00 PM Resident #1 arrived at the facility and he was unable to be wakened, but he was breathing.

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The PACE nurse stated during the 11/07/23 phone interview that while at the center, Resident #1 received his ordered 8 units of long acting insulin Lispro and a nebulizer treatment, but he did not receive any other medications and Buprenorphine was not a medication that was dispensed from their pharmacy.

A statement from the Adult Day Care Program dated 10/06/23 revealed "To whom it may concern, Buprenorphine has not been prescribed by any Senior Care provider for the involved participant and there was no record of administration of this medication to this participant by Senior Care staff. This medication is not stocked in the onsite automated dispensing machine pharmacy."

A change in condition summary report written by Nurse #2 on 10/05/23 at 3:10 PM revealed Resident #1 presented with abnormal vital signs to include BP 158/88 (mmHg) and HR 102 bpm. Resident had altered mental status at the time of evaluation. Resident's RR was 14 bpm and his oxygen level was 96% on room air. Resident opened his eyes in response to chest stimuli but did not respond to voice or touch. Resident's right eye pupillary reaction was 0.3 millimeters (mm), and left eye pupillary reaction was 0.1mm (normal pupil size is 2mm-8mm) and they did not respond to light. Provider assessed the Resident and determined he needed to be sent to the emergency room for further evaluation.

A nursing progress note written by Nurse #1 at 3:45 PM revealed this writer was alerted by another staff member that Resident #1 was in the main lobby unresponsive. He had just arrived and was brought inside from the Adult Day

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Program by their transport van driver. This writer immediately went to the lobby and Resident #1 was surrounded by staff including a medication aide, a nurse aide, and a nurse from the day care program visiting the facility. Sternum rubs were being performed by the day care nurse with very little response noted. This writer called the physician who was in the facility to assess resident. A new order was obtained by the physician to send the resident to the hospital. Resident was assisted via wheelchair to an empty room and transferred using a mechanical lift. Emergency Medical Services (EMS) arrived in the room around 3:25 PM. Resident #1 remained unresponsive and EMS noted resident had pinpoint pupils and administered Narcan, but resident did not respond to the Narcan. Staff assisted EMS with transferring Resident onto the gurney and EMS left facility around 3:35PM.

A phone interview was conducted with Nurse #1 on 11/07/22 at 12:46 PM. Nurse #1 reported on 10/05/23 she was the charge nurse for the hall Resident #1 and Resident #3 resided on and was overseeing MA #1. She stated at the beginning of her shift she checked on all of the residents and Resident #1 was his usual alert and oriented self. She stated her responsibility was to oversee the Medication Aides if they needed any assistance, calling the physician if they needed new orders, etc. Nurse #1 stated on the morning of 10/05/23, Resident #1 had gone to the Adult Day Care Program and when he returned a staff member had notified her that he was in the lobby and unresponsive and she immediately went to the lobby and there were two other nurses with him. She stated Resident #1 responded very little to the sternum rub. She stated she notified the provider who was in the facility and the physician

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did a full assessment and gave a verbal order to send him to the ER. Nurse #1 stated EMS arrived and she prepared all the paperwork needed for his transfer to the ER.

The EMS report dated 10/05/23 revealed Resident #1's blood sugar was 77 mg/dL, BP was 163/94 mmHg, Oxygen 98% on room air, Respiration Rate (RR) 16 bmp, and heart rate (HR) 69 bmp.

A phone interview was conducted with the EMS Responder on 11/20/23 at 1:00 PM. The EMS Responder stated when she arrived on scene, Resident #1 was on the mechanical lift. She stated upon assessment she initiated an intravenous (IV) access; he was noted to be non-responsive and had pinpoint pupils. She stated 2 mg of Narcan was administered via IV, his blood glucose level was 77 mg/dL (normal 80 - 120) and added it was low, but not low enough to make unresponsive, his BP was 110/70 mm/Hg manually, HR 58 bpm, oxygen level 99% on room air, skin was normal and temperature was 97.9. The EMS responder stated Resident #1 had a slow response to the 2 mg of Narcan and presented with a response to pain when doing the sternum rub. She stated after the dose of Narcan his pupils remained pinpoint. She stated the hospital was 4 minutes away and she gave a second dose of Narcan 2mg enroute to the hospital with slight improvement.

The Emergency Room (ER) record dated 10/05/23 at 4:01 PM revealed Resident #1 presented to the ER for unresponsiveness. Resident came in from facility and did have some response to Narcan given by EMS. The resident awoke but now was unresponsive again and had

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small pinpoint pupils. A urine drug screen was obtained and results indicated Resident #1 was positive for Benzodiazepines and Buprenorphine. The ER course and medical decision making revealed Resident #1's BP was 110/72 mm/Hg, HR 58 bpm, temperature 98.7, oxygen saturation 97% and blood glucose was 82 mg/dL. Symptoms were improved with Narcan and on reassessment resident was awake and alert. Observed for worsening symptoms and will be discharged to follow up as an outpatient. Final Impression/diagnosis: drug intoxication without complication.
A nursing progress note written by Nurse #3 on 10/06/23 at 7:05 AM revealed Resident #1 returned from hospital with a diagnosis of opioid overdose. Vital signs were within normal limits and resident was stable and resting in bed.

A physician's visit progress note written on 10/06/23 at 5:15 PM by Physician #1 revealed, in part, Resident #1 was being evaluated since he had a decreased level of consciousness on 10/05/23 and was brought to the local emergency room where he was evaluated and discharged back to the nursing home. Buprenorphine HCI-Naloxone (Suboxone) and Benzodiazepine material reportedly were discovered in his urine drug screen. Per nursing staff, he has returned to his baseline mentation/cognition.

A written statement dated 10/06/23 by MA #1 revealed "Passing meds on the hall. At one point, it became overwhelming due to the trays, medications, blood sugars, the traffic on the hall, and residents getting ready for transport to Adult Day Care. I got overwhelmed with questions until I started rushing. I placed medication on cart and then passed it to the nurse [Unit Manager] who

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then took the medications from me to administer to resident. Everything happened so fast. I am not sure what was in the cup. I spilled a cup and I am not sure what happened. I noticed later that I was short [on control record] so I told [Nurse #4] I had to have dropped them somewhere."

An interview with Medication Aide (MA) #1 via phone on 11/06/23 at 2:36 PM revealed she was assigned to the hall that Resident #1 and #3 lived on 10/05/23. She stated she had prepared Resident #1's medications and she was going to bring them into the dayroom where he was sitting but she noted he was no longer in the dayroom. She stated she placed the medication cup in the medication cart and began to prepare Resident #3's medications. She stated the Unit Manager (UM) came by and asked where Resident #1 was because she had to get him to the lobby to be ready to put on the van to go to his adult day care center. MA #1 reported she told the UM that Resident #1 had not received his medications yet and he needed them before he left. MA #1 reported she took Resident #1's medication cup out of the medication cart because the UM was getting ready to take him out of the building. MA #1 reported that when she removed Resident #1's medications from the cart, the drawer to the cart was still opened and at that time Resident #3's medication cup spilled and the medications fell into the cart and around the cart. MA #1 stated she was rushing to get Resident #1 his medications and she quickly picked up the medications that spilled but somehow some of Resident #3's medications must have gotten into Resident #1's cup. She stated she could not remember the details because it was very hectic and she was rushing. MA #1 added she had pre poured medication for more than one resident in

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the past and she pre poured the medications for more than one resident on this day (10/05/23). She stated she pre poured the medications to try and "keep her head above water without asking someone for help." MA #1 stated, unfortunately, Resident #1 received medications that were not ordered for him. She added, Resident #1 also received the medications that were ordered for him. MA #1 reported at around 3:00 PM, Resident #1 came back to the facility and everyone just started running toward the lobby and were concerned Resident #1 had a stroke because he was unresponsive. She stated he was sent to the Emergency Room (ER) and she had learned later that he had an overdose from benzodiazepines and Buprenorphine HCl-Naloxone. MA #1 stated she knew she was not supposed to pre pour medications and received in servicing and training when she was hired back in January 2023.

During a phone interview on 11/07/22 at 12:46 PM Nurse #1 stated the hall MA #1 worked on was a busy hall and it was an especially busy day and she was assisting MA #1 with any requests she had, but MA #1 never informed Nurse #1 that she dropped any medications and had to "waste" them on the control sheet. Nurse #1 stated MA #1 never asked for any assistance or indicated that she was falling behind. Nurse #1 added she had not seen MA #1 prepare more than one resident's medications at a time.

A written statement from the Unit Manager (UM) dated 10/06/23 revealed "I went to [the hall] at approximately 9:10 AM [10/05/23] to get Resident [#1] for his day program. He was usually in the dayroom. I was told he was in his room, so I went to get him to bring him up front to the main

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lobby. As I passed the Medication Aide [MA #1], she asked me to bring him to her so she could give him his medications. I turned him around and wheeled him over to her medication cart, at that time [MA #1] had a cup of medications in her hand and poured them into Resident [#1's] mouth followed by a cup of water. I did not pay attention to what medications were or the color of the medications as they were already poured and in the medication cup."

A written addendum by the Unit Manager dated 10/10/23 to a previous statement related to Resident #1 and MA #1. "I observed a few medication cups with medications in them on her medication cart prior to her giving [Resident #1] his medications."

An interview was conducted with the Unit Manager (UM) on 11/06/23 at 4:40 PM. The UM stated MA #1 had been coached before regarding pre pouring medications and not signing off on her narcotics by the Nurse Educator. The UM stated on the morning of 10/05/23 at around 9:00 AM or so she noticed MA #1 had a couple of medication cups on the medication cart but she (the UM) was rushing and did not say anything to MA #1 at that time. She stated the Adult Day Care van was waiting for the residents who went to the day care and she was running around getting residents gathered up. The UM stated she went to get Resident #1 in the dayroom, but he was not there and had asked MA #1 where he was. She reported in his room. The UM stated Resident #1 was in his room in his wheelchair and she quickly began to bring him to the front lobby when MA #1 had said "hold on, I need to give him his medications." The UM stated MA #1 gave the medication cup to Resident #1 and he

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took them all from the cup and drank his water and the UM wheeled him to the front lobby. The UM stated Resident #1 was his normal self-alert and oriented and he was communicating. The UM stated MA #1 had called her after the UM went home and she was very upset saying the ER reported Resident #1 had overdosed. The UM stated MA #1 stated Resident #1 did not receive any medications that could cause him to overdose. The UM reported she mentioned to MA #1 that perhaps Resident #1 received the wrong medications at the Adult Day Care center. The UM stated, later that night, she received a call from Nurse #4. Nurse #4 reported to her that MA #1 had asked her to sign off on some medications because she dropped them, but MA #1 did not actually have the pills that she said she dropped so Nurse #4 did not want to "waste" them and sign them off on the narcotic control sheet. The UM stated the two medications that she asked Nurse #4 to sign off were Clonazepam and Buprenorphine HCl-Naloxone. The UM stated later when we realized Resident #1 had benzodiazepines and Buprenorphine HCl-Naloxone in his system, MA #1 told Nurse #5 she spilled Resident #3's medication and she believed Resident #1 must have received some of his medications.

An undated written statement by Nurse #4 revealed "on 10/05/23, "I was about to enter the building, [MA #1] approached me outside and asked if I had heard about what happened to [Resident #1]. I said "no, I have not heard anything, what happened?" [MA #1] began telling me that he had been at PACE all day and had come back unresponsive and the facility had to call 911. She stated that EMS had to give him a dose of Narcan. She said they must have given

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him something at PACE. She then said can you please look at my narcotic book [control record] (which she had in her hand) because my count was off. [MA #1] said I need you to sign off a narcotic for me and she opened the book to the page. She pointed to the last one entered on the page. I began to close the book and [MA #1] stated I have 2 sheets I needed you to sign. [MA #1] turned to another page and stated that both pills were in the same cup. I began to write them and noticed the times were different. I asked [MA #1] what happened and why she did not ask her nurse to sign the sheet. She stated the nurse had been disrespectful, rude and on her butt all day. I then asked where the pills were that I had just signed for the Buprenorphine HCl-Naloxone 8mg/2mg and the Clonazepam 1 mg. [MA #1] said that when she was giving the resident the cup of pills they spilled and she could not find them all so she threw the ones that she found in the trash. I then drew a line through my name at the bottom of the narcotic [control] sheet where you make corrections and wrote ERROR beside it cause at that point I was unable to verify the medication or what actually happened to the medication. I later found out the medications she was trying to get me to sign out was the same medications that [Resident #1] tested positive for."

A phone interview was conducted with Nurse #4 on 11/07/23 at 1:00 PM. Nurse #4 reported she worked the night shift from 7:00 PM to 7:00 AM. She stated on 10/05/23 at around 7:00 PM, MA #1 approached her at the door and asked her if she could go over her narcotic (control) book because the count was not right. Nurse #4 reported that when she and MA #1 started going through the count sheet, MA #1 informed Nurse

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#4 she took the medications (Clonazepam and Buprenorphine HCI-Naloxone) out of their packages, but somebody knocked them over. Nurse #4 stated she signed the control sheet with MA #1 to "waste" the medications and then asked where the pills were. Nurse #4 stated MA #1 said she did not have them and she then told MA #1 she could not sign for pills that she did not have so she scratched her name from the "waste portion" and wrote error. Nurse #4 continued and stated later on that night around midnight, Nurse #5 informed her that Resident #1 was found to have benzodiazepines and Buprenorphine HCI-Naloxone in his blood stream and she wanted to let her know that the medications MA #1 was asking her to sign off were the same ones found in Resident #1's blood stream. Nurse #4 stated MA #1 claimed that when she went to give them to Resident #3 they knocked over in his room and she gathered up all the pills she could and threw them in the trash. Nurse #4 asked why she did not ask her Charge Nurse (Nurse #1) to waste the narcotics with her and stated that MA #1 said she did not tell Nurse #1 what had happened. Nurse #4 stated she realized later when the nurse told her at midnight it was the same pills that she asked me sign off for, and at this point it was realized by the nursing staff that Resident #1 received the medications belonging to Resident #3. Nurse #4 stated she immediately called the Director of Nursing and the Unit Manager and was instructed to write a statement.

An interview was conducted with Nurse #5 on 11/06/23 at 4:30 PM. Nurse #5 reported on 10/05/23 MA #1 had come into her office and was trying to find out what was going on with Resident #1. Nurse #5 stated she informed MA #1 she spoke with the charge nurse at the ER and he

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had stated Resident #1 was given Narcan and at this time he was alert and talking and recovering with intravenous fluids. Nurse #5 recalled she was confused as to why Resident #1 would need Narcan because he did not have any narcotics prescribed to him, but the charge nurse stated his urine analysis was positive for Buprenorphine HCI-Naloxone and benzodiazepines which she added, he did not have an order for benzodiazepines either. Nurse #5 stated MA #1 was asked if the resident received any of those medications and MA #1 did not mention anything about medications being spilled, having a hectic day or pre pouring medications, but stated that he may have received those medications at the Adult Day Care Center. Nurse #5 stated it was not until later on that evening when she realized MA #1 was asking Nurse #4 to sign off the Buprenorphine HCI-Naloxone and Clonazepam as "wasted" drugs and learned from Nurse #4 that MA #1 said she dropped the medications but did not have them in her possession to waste.

An interview was conducted with the facility's Physician Assistant (PA) on 11/07/23 at 11:05 AM. The PA revealed given that Resident #1 had pinpoint pupils and responded to the Narcan it was evident that he was overdosing from the Buprenorphine HCI-Naloxone. The PA added his blood sugar was at 77 mg/dL which was low but not low enough for someone to become unresponsive.

An interview was conducted with Physician #2 on 11/07/22 at 1:10 PM. Physician #2 reported he was in the facility and nursing staff notified him stating Resident #1 was unresponsive. He added, the nursing staff stated his blood sugar was checked and he had come to assess

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Resident #1 in the lobby. Physician #2 stated he remained unresponsive and EMS had given him Narcan and the resident was sent to the ER. Physician #2 stated he heard Resident #1 received another dose of Narcan and had labs done at the ER and the blood work was positive for opioids and benzodiazepines but that he had returned to base line and was sent back to the hospital. Physician #2 stated he could not speculate as to what could have happened as a result of the resident receiving those medications (Clonazepam and Buprenorphine HCl-Naloxone) and that it would depend on the patient and their condition. He added, he received Narcan and it worked.

An interview was conducted with the facility's Pharmacist Consultant on 11/07/23 via phone at 3:25 PM. The Pharmacist Consultant revealed that Buprenorphine HCl-Naloxone also known as Suboxone was a combination drug containing 8 mg of Buprenorphine and 2 mg of naloxone. She added what she would be most concerned about with an overdose of Buprenorphine HCl-Naloxone was respiratory depression, but she did not feel that one dose would cause death. A list of Resident #1's additional medications that he received that morning were reviewed with the Pharmacist and she had no concerns regarding mixing the Buprenorphine and Clonazepam with his already prescribed medications.

An interview was conducted with the Nurse Supervisor via phone on 11/08/23 at 11:55 AM. She stated in the past 6 months she had done in services for medication administration for competencies that had to be done. She stated she could not recall if MA #1 had been in serviced regarding pre pouring medications.

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F 760	Continued From page 17 An interview was conducted with the Administrator on 11/07/23 at 3:00 PM. The Administrator revealed there has been a complete change of administration staff to include the Administrator, the Director of Nursing and the Assistant Director of Nursing and he believed the transition of change caused a breakdown in the monitoring that was in place previously for significant medication errors. He stated the process did not continue as it should have in the transition. The facility provided the following corrective action plan: F760 Failure to prevent significant medication errors: 1. The facility identified how correction action will be accomplished for those residents to have been affected by the deficient practice: On 10/5/23, as soon as Resident #1 returned from the Adult Day Program, while in the front lobby, Resident #1 was assessed to have a change of condition to include decrease in cognition and constricted pupils. EMS was notified. Emergency Services administered Resident #1 Narcan prior to transport and one dose in route to the Emergency Department. Resident #1 was transferred to the Emergency Department for further evaluation and treatment. During Resident #1's evaluation and treatment at the Emergency Department, Resident #1 received laboratory tests which were positive for Buprenorphine and Clonazepam. On 10/06/23 the DON interviewed Medication	F 760		

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Aide #1 and Licensed Nurse #1 assigned to Resident #1 regarding medication administration and any new, different, or changes in behavior or change of condition for Resident #1 to determine how the resident could have a change of condition upon returning from the Adult Day Program. Medication Aide #1 and Licensed Nurse #1 did not observe any changes of condition prior to Resident #1 leaving for the Adult Day Program. Resident #1 was noted to have a change of condition when he returned from Adult Day Program while in the front lobby. EMS was notified at that time.

2. The facility identified other residents having the potential to be affected by the same deficient practice:

On 10/06/23, an audit was conducted by the DON, ADON, and Unit Manager to determine residents with physician's orders for Buprenorphine. One resident, Resident #3, was identified with a physician's order for Buprenorphine.

On 10/06/23 a Root Cause Analysis was conducted and determined the Root Cause of the alleged medication error was medication administration was not performed per the facility policy following the rights of medication administration by Certified Medication Aide #1, include not using two resident identifiers, the resident picture on the Medication Administration Record and the resident name, for medication administration as well as preparing resident prescription medication prior to actual resident medication administration. Certified Medication Aide #1 administered Resident #1 and Resident #3 medication on the morning of 10/05/23. Out of

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an abundance of caution, a plan of correction was implemented to include Medication Aides will no longer be permitted to administer Buprenorphine. Beginning 10/07/23, Buprenorphine was currently being administered by the Licensed Nurse.

Residents who have physician's orders for medication, specifically Buprenorphine, have been identified as having the potential to be affected. Since all residents with medications prescribed have the potential to be affected by significant medication errors, beginning 10/06/23 Licensed Nurses and Certified Medication Aides were educated by the SDC, DON, ADON, Unit Manager or Nurse Supervisor on medication administration rights to include right resident, right medication, right dose, right route, right time, right reason, and right documentation, not to hurry during their medication administration pass. Beginning 10/06/23 Licensed Nurses and Certified Medication Aides performed Medication Administration Competencies with the Staff Development Coordinator (SDC), DON, ADON, Unit Manager, or Nurse Supervisor. Each Licensed Nurse and Certified Medication Aides were required to pass with a 100% in order to administer medication.

On 10/06/23 Residents who receive Buprenorphine and Clonazepam medication were identified by the DON, ADON and Unit Manager to determine if any other residents on the same medication assignment as Resident #1 received Buprenorphine and Clonazepam. Resident #3 has physician's orders for both medications. Resident #3 is on the same assignment as Resident #1.

Beginning 10/07/23, Resident #1 and Resident #3

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had their medications administered only by Licensed Nurses.

3. The facility implemented systemic changes to ensure that the deficient practice will not recur:

Beginning 10/06/23 each Licensed Nurse and Medication Aide will have a Medication Administration Pass Competency to include observation of medication administration pass with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator, or Nursing Supervisor completed prior to scheduled shift. A score of 100% is required to be considered as passing the competency. Any Licensed Nurse and Medication Aide who does not pass the Medication Administration Pass Competency will have immediate one to one re-education and will not be permitted to work without direct supervision by the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator, or Nursing Supervisor. The Licensed Nurse or Medication Aide will be given another Medication Administration Pass Competency and must pass the competency in order to work independently. The SDC was tracking the completion of the competency and comparing with the Licensed Nurses and Certified Medication Aides schedule to validate all Licensed Nurses and Certified Medication Aides, in-house or agency, have a competency completed and passed prior to their next scheduled shift. Five of five in-house Medication Aides and twelve of twelve in-house Licensed Nurses have their medication administration pass competencies completed, each with a score of 100%. Five of Five agency Licensed Nurses have their medication administration pass

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competencies completed, each with a score of 100%. Two of two agency Medication Aides have their medication administration pass competencies completed, both scored 100%.

Any newly hired License Nurse and newly hired Certified Medication Aide and any agency Licensed Nurse will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge on following policy for medication administration, controlled medications, that only Licensed Nurses can administer Buprenorphine at our center and have a medication competency performed during their orientation, prior to administering medication independently on the floor.

4. The facility plans to monitor its performance to make sure that solutions are sustained:

Weekly for 90 days, the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe ten residents' medication administration pass to validate competency to include medications were administered per order. During the auditing, if it was noted that that the process was not followed, the Licensed Nurse or Medication Aide will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing, or Staff Development Coordinator. The Licensed Nurse or Medication Aide will not be permitted to provide patient care until they can correctly be observed administering medications properly. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for

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F 760	Continued From page 22 three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing. Alleged Compliance Date: 10/07/23 Validation of the corrective action was completed on 11/07/23. This included staff interviews with nurses and medication aides regarding pre pouring resident's medications in advance, observing all medication carts to ensure there were no prefilled medication cups in the medication carts, and a medication pass observation to ensure medication aides were following the 5 rights of medication administration. The audits were verified and there were no concerns identified. The facility's alleged compliance date of 10/07/23 was validated.	F 760		
F 761 SS=E	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 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	F 761		12/5/23

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F 761	Continued From page 23 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 record an open date on insulin pens, failed to discard an expired insulin pen and inhalers and to refrigerate an unopened insulin, and failed to store medications safely when a medication cup filled with an over the counter stock medication was stored on the top shelf of the medication cart and multiple loose pills were noted in 4 of 4 medications cart observed for medication storage for the 400, 500, 300, and 100/200 hall medications carts. Findings included: a. An observation of the 400 hall medication cart with Nurse #6 on 11/06/23 at 1:18 PM revealed a medication cup filled with 6 clear yellow fluid filled capsules and 2 white tablets were noted to be in the top drawer. Additionally, an Advair inhaling dispenser was noted to be expired. The open date on the inhaler was 10/03/23 with an expiration date of 11/02/23. Further observations of the mediation cart revealed there were several unidentified loose pills on the bottom drawers of the medication carts.	F 761	F761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All medication carts and medication rooms were immediately checked for expired medications, loose pills in cart, pre poured medication cups and non-labeled medications by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Unit Manager on 11/07/23. Any concerns were immediately addressed and corrected by the auditing Nurse Manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who have physician's orders for medication have been identified as having the potential to be affected.	

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F 761	Continued From page 24 An interview with Nurse #6 on 11/06/23 at 1:18 PM revealed she believed nursing staff were to clean out the medication carts on the night shift to check for expired medications, and to be sure the carts were clean to include removing sticky substances and discarding any loose pills. She further stated the medication cup that was filled with the pills were a medication called Biotin. She stated the Biotins was an over the counter stock medication and they were stored in the cup for use and should not have been because not all nursing staff would have known what the medication was. Nurse #6 stated she believed the two white pills in the medication cup were also Biotin. Nurse #6 added, the medications in the cup were not pre poured to be given to a resident, they were just stored in the cup. b. An observation of the 500 hall medication cart with Medication Aide (MA) #2 on 11/06/23 at 1:30 PM revealed an opened Novolog Insulin pen that was not dated and an opened Lispro Insulin pen with an opened date that was illegible. The ink had smeared and the open date was unidentifiable. An interview with MA #2 on 11/06/23 at 1:30 PM revealed that she did not realize there was no open date on the Novolog Insulin pen and that the Lispro Insulin pen open date was not legible. She stated it was the nursing staff's responsibility to ensure the insulin pens were labeled when opened and that the dates were legible so they would know when the insulin pens expired. MA #2 reported that the medication carts should be checked and cleaned every shift by all nursing staff. She stated she checked the cart today, but she must have missed the two insulin pens. MA #2 further added that both residents received the	F 761	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/07/23 the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge initiated education to each Licensed Nurse and Certified Medication Aid on medication storage. Beginning 11/8/23 all Licensed Nurses and Medication aides will need to complete education prior to their scheduled shift. On or before 11/29/23 all Licensed Nurses and Certified Medication Aides received the aforementioned education on medication storage. The Staff Development Coordinator, DON, ADON, Unit Manager, and off shift Nurse Supervisors will provide education on Medication Storage for newly hired Licensed Nurses and Medication Aides during classroom orientation. Prior to working their scheduled shift, any agency License Nurse or agency Certified Medication Aid will receive education on following the policy for storage of medications by the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge. No Licensed Nurse or Certified Medication Aid will be permitted to work after 12/05/23 without first receiving the aforementioned education on medication storage.	

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F 761	Continued From page 25 insulin from these pens today as ordered. c. An observation of the 300 hall medication cart on 11/06/23 at 1:38 PM with Nurse #7 revealed an opened Glargine Insulin pen that was not dated and an opened Novolog Insulin pen with an opened date that was illegible. The ink had smeared and the date was unidentifiable. Additionally, an unopened Glargine Insulin pen indicating "must be refrigerated until opened" was in the medication cart. An interview with Nurse #7 on 11/06/23 at 1:30 PM revealed that she did not realize there was no opened date on the Glargine Insulin pen and that the Novolog Insulin pen open date was not legible. She stated it was the nursing staff's responsibility to ensure the insulin pens were labeled when opened and that the dates were legible so they would know when the insulin pens expired. Nurse #7 added, the Glargine Insulin pen that was unopened should have been refrigerated until it was opened and she did not know how long it was in the medication cart. She stated that the three residents these insulin pens were ordered for did not receive any insulin today. d. An observation of the 100/200 medication cart with MA #3 on 11/06/23 at 1:45 PM revealed a Humalog Insulin pen had expired on 10/23/23. Additionally, an Advair inhaling dispenser was noted to be expired. The open date on the inhaler was 10/03/23 with an expiration date of 11/02/23. Both of these medications were prescribed for the same resident. An interview with Medication Aide #3 on 11/06/23 at 1:50 PM revealed that the medication cart should be checked by all nursing staff at the start	F 761	Out of an abundance of caution, as an additional measure, on 11/21/23 the Quality Assurance and Performance Improvement (QAPI) Committee recommended that online educational classes shall be assigned to the Licensed Nurses and Certified Medication Aides on Medication Storage. The assigned completion date per the QAPI Committee is 12/05/23. No Licensed Nurse or Certified Medication Aid will be permitted to work after 12/05/23 without first receiving the aforementioned online education on medication storage. Out of an abundance of caution, as an additional measure, on 12/05/23 the Quality Assurance and Performance Improvement (QAPI) Committee recommended that the Pharmacy Nurse Consultant provide follow-up education to the Licensed Nurses and Certified Medication Aides on Medication Storage. The education date is set for 12/12/23. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Four times weekly for three months, then twice a week for three additional months the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will audit each medication cart and medication room for proper storage of medications according to the facility policy. The following six months, the Director of Nursing, Assistant	

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F 761	Continued From page 26 of the shift and she must have missed these two items. She further added that the resident did not receive either one of these medications today. An interview was conducted with the Director of Nursing (DON) on 11/07/23 at 4:10 PM. The DON stated she expected her nursing staff to be checking the medication carts thoroughly at the beginning of their shift for any expired medications, checking to be sure there are no unidentified loose pills in the medication cart, and to make sure they date and label whenever they open an insulin pen. The DON further added education would be provided to be sure to use permanent ink pen that will not smear when recording when an insulin pen was opened.	F 761	Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly audit the medication carts and medication rooms for proper storage of medications according to the facility policy. During the auditing, if it is noted that that the process was not followed, the assigned Licensed Nurse or Medication Aid will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or Staff Development Coordinator. The Licensed Nurse or Medication Aid will not be permitted to provide patient care until they are able to state how to store medication per the facility policy and are observed properly storing medications. The audits will be presented by the Director of Nursing or Assistant Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for twelve months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing including providing re-education as staffing changes or if any concerns are observed. Date of Compliance: 12/05/23	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		12/5/23

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policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct

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F 867	Continued From page 29 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a complaint investigation on 11/08/22 and a recertification, follow up, and complaint investigation on 01/20/23. This was for 2 deficiencies that were originally cited in the areas	F 867	F867 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/07/23 the Regional Vice President of Clinical Services educated the Nursing Home Administrator and Director of	

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F 867	Continued From page 30 of significant medication errors and medication storage and were subsequently recited on the current complaint investigation on 11/09/23. The continued failure during 3 surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F760: Based on observations, record review, staff, Physician Assistant, Physician, Emergency Medical Service Responder, Adult Day Care staff nurse, and Pharmacist Consultant interviews, the facility failed to prevent a significant medication error when Medication Aide #1 administered Resident #1 medications prescribed to Resident #3 to include Clonazepam (a medication to treat anxiety classified as benzodiazepine) 1 milligram (mg) and Buprenorphine HCl-Naloxone (a medication to treat opioid addiction) 8mg/2 mg causing Resident #1 to become unresponsive. Resident #1 required 2 doses of Narcan (medication given to reverse opioid overdose) administered by Emergency Medical Services and was sent to the emergency room for further evaluation where it was determined he had a drug overdose as evidenced by the lab results testing positive for benzodiazepine and buprenorphine in Resident #1's blood stream. This deficient practice affected 1 of 4 residents reviewed for significant medication errors. During a complaint survey on 11/08/22 the facility failed to accurately administer medication when Resident #1 was administered medications prescribed for Resident #6 to include Metoprolol (a blood pressure medication) 50 mg and Xanax	F 867	Nursing on developing and maintaining an effective Quality Assurance and Performance Improvement Program. August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 11/07/23 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 11/07/23, under the direction and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI	

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F 867	Continued From page 31 (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. During a recertification, follow up and complaint survey on 01/20/23 the facility failed to administer 14 doses of Valproic Acid Solution (an anti-convulsant medication). F761: Based on observations and staff interviews the facility failed to record an open date on insulin pens, failed to discard an expired insulin pen and inhalers and to refrigerate an unopened insulin, and failed to store medications safely when a medication cup filled with an over the counter stock medication was stored on the top shelf of the medication cart and multiple loose pills were noted in 4 of 4 medications cart observed for medication storage for the 400, 500, 300, and 100/200 hall medications carts. During a complaint survey on 11/08/22 the facility failed to keep unattended medications stored in a locked medication cart. During a recertification, follow up, and complaint survey on 01/20/23 the facility failed to keep unattended medications stored in a locked medication cart. An interview was conducted with the Administrator on 11/07/23 at 3:00 PM. The Administrator revealed there has been a complete change of administration staff to include the Administrator, the Director of Nursing and the Assistant Director of Nursing and he believed the transition of change caused a breakdown in the	F 867	process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. During the QAPI Meeting, the Committee decided to initiate weekly QAPI Meetings to review the status of the plan of correction for F761, Medication Storage, as this is a repeat deficiency. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An Ad Hoc QAPI meeting was held on 11/07/2023 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, Admissions Director, Regional Vice President of Clinical Services and Regional Vice President of Operations. The QAPI Committee will meet weekly for twelve weeks beginning on 11/07/23, then monthly ongoing, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. Corporate oversight will be provided in the center's Quality Assurance Performance Meeting to assist the facility in achieving and maintaining compliance. The QAPI	

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F 867	Continued From page 32 monitoring and audits that were in place previously for significant medication errors and medication storage. He stated the monitoring and audit process did not continue as it should have in the transition. He stated at the monthly QAPI meetings we have a general QAPI agenda and none of those past issues were brought to the meeting.	F 867	Committee determined that the facility is in substantial compliance as of 12/05/23. The Administrator is responsible for ensuring this plan of correction is implemented.	