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	345351	A. BUILDING _____ B. WING _____	C 02/28/2022

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AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 2/22/22 through 2/23/22 with exit from the facility on 2/23/22. Additional information was obtained offsite through 2/28/22; therefore, the exit date was changed to 2/28/22. Event ID# V04811. 2 of the 15 complaint allegations were substantiated. Past-noncompliance was identified at: CFR 483.45 at tag F 760 at a scope and severity J. The tag F760 constituted Substandard Quality of Care. Non-compliance began on 02/09/22. The facility came back in to compliance effective 02/12/22. 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 record review and interviews with staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to administer the correct medications to a resident when Medication Aide (MA) #1 administered medications prescribed for Resident #3 to Resident #1. Resident #1 received 5 medications which included antidepressant, antihistamine, opioid pain medication, muscle relaxant, and antiepileptic. After the incident, the on-call physician ordered to monitor Resident #1's vital signs (VS) every 2 hours and notify her	F 760	Past noncompliance: no plan of correction required.	3/10/22

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

Electronically Signed | 03/10/2022

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if any acute change in condition occurred. Resident #1 became unresponsive approximately 12 hours later. He received 4 doses of Narcan and required initiation of bag valve mask (BVM) ventilation before Emergency Medical Services (EMS) arrived. Narcan is an antidote used to reverse the effects of opioid overdose. BVM is a handheld tool used to deliver positive pressure ventilation to any subject with insufficient or ineffective breaths. Resident #1 was transferred to the Emergency Room (ER) for evaluation of altered mental status (AMS). He returned to the facility the following day on 02/11/2022. This failure occurred for 1 of 3 sampled residents reviewed for significant medication error (Resident #1).

The findings included:

Resident #1 admitted to the facility on 12/28/21 from an acute hospital. His diagnoses included chronic respiratory failure with hypoxia, heart failure, end-stage renal disease, diabetes mellitus, and depression.

The admission Minimum Data Set (MDS) assessment dated 01/04/22 assessed Resident #1 with moderate impairment in cognition. He required extensive assist to total dependent with 1 to 2 or more persons assist in his activities of daily living (ADL) except eating. Resident #1 did not exhibit behavioral symptoms and was receiving insulin, antidepressant, and diuretic daily in this assessment.

Physician's orders for Resident #1 for February 2022 included the following medications:

Insulin Glargine solution, 40 units once daily at

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bedtime (long-acting insulin)
Gabapentin 400 mg 3 times daily (anticonvulsant)

The facility's medication variance report dated 02/10/22 indicated on 02/09/22 at 8:15 PM, MA #1 had completed medicating Resident #2 and began preparing medications for Resident #3 when Resident #2 began talking very loudly to MA #1. Once MA #1 completed preparing the medications, she accidentally went into the wrong resident's room and mistakenly administered medications to Resident #1. MA #1 immediately realized the mistake and immediately notified Nurse #1. Nurse #1 notified the Director of Nursing (DON) immediately and was ordered to call the on-call physician. Orders received from the on-call physician to monitor Resident #1's VS every 2 hours and notify the on-call physician again if any acute change in condition occurred. MA #1 gave Resident #1 the following medications prescribed for Resident #3:

1 capsule of duloxetine 60 mg (antidepressant)
1 tablet of hydroxyzine 50 mg (antihistamine)
1 tablet of Oxycontin extended release (ER) 30 mg (opioid analgesic)
1 tablet of baclofen 20 mg (muscle relaxant)
1 tablet of pregabalin 150 mg (anti-epileptic)
1 capsule of gabapentin 300 mg (anticonvulsant)

Further review of the medication variance report revealed Resident #1's VS were monitored at least once every 2 hours after the incident on 02/09/22 evening through the next morning at 7:00 AM. All the VS were within the normal limits. When the DON assessed Resident #1 on 02/10/22 at 8:15 AM, she noticed Resident #1 responded to voice stimuli when his name was called. The DON remained in the room. At around

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8:30 AM, Resident #1 began to display periods of apnea and sternal rub was conducted and Resident #1 opened his eyes and then became unresponsive. Apnea is a potentially serious sleep disorder in which breathing repeatedly stops and starts. Sternal rub is the application of painful stimuli with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli. The NP was in the facility and was alerted to Resident #1's room. Order for Narcan was received from the NP and instructed to administer with no signs of improvement. After the NP administered another dose of Narcan, reaction to the second dose was noted as Resident #1 responded to voice stimuli. BVM ventilation was initiated by the NP. At around 8:50 AM, EMS was notified to transport Resident #1 to ER. NP remained at bedside providing BVM ventilation. At approximately 9:15 AM, EMS arrived and transported Resident #1 to ER.

During a phone interview with MA #1 on 02/22/22 at 3:05 PM, she stated when she was passing medication on the evening of 02/09/22 around 8:30 PM, she was preparing Resident #3's medications and Resident #2 began yelling loudly. She put the medications in the medication cart drawer because she needed to address Resident #2's needs. MA #1 stated she was distracted when she came out from Resident #2's room about 5-10 minutes later. She thought the medications in the medication cart were for Resident #1 and gave Resident #3's medications to Resident #1. Then, she felt that she was not 100% sure the medications were for Resident #1. When started to check Resident #3's medications, the first medication popped up was the Oxycontin. She immediately realized that she

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had given the medications to the wrong resident. She notified Nurse #1 immediately. Nurse #1 called the DON. The DON wanted Nurse #1 to call the on-call physician. She stated Resident #1 had only received his insulin at 8 PM before receiving Resident #3's medications.

A phone interview was conducted with Nurse #1 on 02/23/22 at 11:03 AM. She stated on 02/09/22 around 8:45 PM, MA#1 told her that she had given medications to the wrong resident. She called the DON immediately and ordered NA#1 to perform VS for Resident #1. The VS were within normal limits. Resident #1 remained alert and was able to talk. She did give Resident #1 insulin at around 8 PM before the incident. She checked his blood glucose (BG) after the incident, and it was 256 milligram/deciliter (mg/dl). The DON wanted her to call the On-call physician and she gave the on-call physician the list of medications that were given in error, allergy status, and list of Resident #1's routine medications. The on-call physician ordered her to monitor Resident #1's VS every 2 hours and to notify her of any acute changes. All other medications for Resident #1 were held after the incident. She focused on respiratory status, level of arousal, and the VS. She recalled she rounded Resident #1 more than once every two hours that night and his VS were within the normal limits. Resident #1 slept deeply as expected but she was able to arouse him on each visit. When she left at 7 AM, Resident #1 was still sleeping.

During an interview with the MD on 02/23/22 at 8:50 AM, he supported the on-call physician's decision to monitor Resident #1's VS every 2 hours, provide supportive measures as needed, and report any acute changes to the on-call

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physician as needed after the incident. He stated had Resident #1 been sent to the hospital, they would have done the same thing. As Resident #1 did not get any cardiac medications, the MD indicated the measures ordered by the on-call physician were sufficient to handle the situation after the incident unless acute change occurred.

An interview was conducted with Nurse #2 on 02/23/22 at 12:02 PM. As the unit manager on 02/10/22 morning, she was alerted by Nurse #3 to assess Resident #1 around 8:30 AM. During her initial assessment, Resident #1 was able to open his eye but unable to say anything. Around 10 minutes later, Resident #1 was unable to open his eyes and kept falling asleep. The NP ordered Resident #1 to be sent to the ER for evaluation and the EMS arrived within 10 minutes. The NP checked Resident #1's VS before EMS arrived. She administered the first dose of intramuscular (IM) Narcan as ordered by the NP and the NP administered the second dose of intranasal Narcan before EMS arrived. Resident #1 did not have any response to the first dose of Narcan but had a weak response to voice stimuli after the second dose. She stated once she entered Resident #1's room, she and the NP stayed with Resident #1 until EMS arrived and took over.

A phone interview was conducted with the on-call physician on 02/23/22 at 12:48 PM. She recalled receiving a call from Nurse #1 on 02/09/22 before 9:00 PM regarding the medication errors related to Resident #1. She asked Nurse #1 the list of medications that were given in error, Resident #1's routine medications, and his allergy status. After she had reviewed all the medications and determined Resident #1 was not allergic to any of the medications in error, she ordered Nurse #1 to

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monitor Resident #1's VS every 2 hours and call her immediately if Resident #1 experienced any acute change.

An interview was conducted with the DON on 02/23/22 at 1:18 PM. She recalled she was not in the facility when the incident occurred 02/09/22. During the interview, she referred to the incident timelines in the medication variance report and stated some of the times in the timelines were approximated to her best knowledge. After Nurse #1 informed her of the medication error on 02/09/22 evening. She directed Nurse #1 to call the on-call physician and follow the directions. The only medication Resident #1 received before the incident in that evening was 40 units of Lantus. She stated Resident #1 was doing okay after the incident until the next morning when he was found unresponsive. When she assessed Resident #1 around 8:15 AM, he was arousable and able to tell his name, but appeared very sleepy. She went ahead to get a set of VS and it was within normal limits. After she stayed in the room for about 15 minutes, Resident #1 became increasingly sleepy and harder to be aroused. She called the NP who was in the facility and Nurse #2 to assess Resident #1. She left the room a few minutes after the NP and Nurse #2 arrived as she needed to prepare Resident #1's paper work for transfer to the ER. The NP and Nurse #2 stayed with Resident #1 until EMS arrived. She stated once the acute change occurred around 8:30 AM, Resident #1 was never left alone in the room until EMS arrived. The NP ordered to send Resident #1 to ER for evaluation. She stated Resident #1 became unresponsive right before sending out with EMS. Resident #1 admitted to the hospital for 1 day and returned to the facility on 02/11/22 evening. Right after the

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incident, she completed in-service that included the 5 Rights and ways to handle distractions during medication administration for all the nurses and MAs on 02/10/22. She started to audit nursing staff for medication pass and the first round completed without any issues on 02/17/22. She completed the medication pass skill checks for all the nurses and MAs on 02/21/22.

During a phone interview conducted with the NP on 02/23/22 at 1:35 PM, she stated she was in the facility on 02/10/22 morning. When she assessed Resident #1, he was unresponsive to voice and painful stimuli and continued to snore. His respirations were shallow, and skin was cold and clammy. She ordered to give 2 rounds of Narcan before the EMS arrived. Resident #1 did not have any response after the first dose of IM Narcan except a small response to painful stimuli. About 5 minutes later, she administered the second dose of intranasal Narcan. Resident #1 had a weak response to voice stimuli. Resident #1 was completely unresponsive before the EMS arrived. She stated the fire department crews who arrived before the EMS gave 2 more doses of intranasal Narcan before the EMS arrived. She added she stayed with Resident #1 since she arrived his room on 02/10/22 morning until the EMS took over.

A phone interview was conducted with Nurse #3 on 02/24/22 at 11:01 AM. As the hall nurse for Resident #1 on 02/10/22 morning, she performed the first assessment for him around 7:20 AM. Resident #1 initially appeared unresponsive but was able to open his eyes with voice and touch stimuli. She recalled Resident #1 took several deep breaths, then returned to sleeping state. She conducted a set of VS, and it was within the

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normal limits. Shortly after the DON arrived, she noted Resident #1 began to have 10-15 seconds of apnea repeatedly. The DON told her to alert Nurse #2 to come over to assist. She was in and out of the room at that time. She stated the DON left Resident #1's room shortly after the NP arrived. The NP and Nurse #2 stayed with Resident #1 until EMS arrived.

EMS report dated 02/10/22 indicated a call was received from the facility at 9:11 AM and the EMS arrived the facility at 9:23 AM. Upon arrival to Resident #1's room at 9:24 AM, Resident #1 was found with altered mental status in the bed with crews from fire department and the NP performing BVM ventilation. Four doses of Narcan had been administered prior to EMS arrival by either the facility staff or the fire department crews. Resident #1's respirations were shallow but remained conscious and responded to voice stimuli. The first set of vital signs was conducted at 9:36 AM with blood pressure (BP) 144/66, pulse (P) 84, respiration rate (RR) 12, and oxygen saturation (O2) 96%. The EMS departed the facility with Resident #1 at 9:48 AM and arrived at the hospital at 10:15 AM.

Review of Hospital Emergency Department Discharge summary dated 02/11/22 revealed Resident #1 was admitted on 02/10/22 at 10:11 AM. Resident #1 presented to the ER with altered mental status and was minimally arousable. He arrived with BVM ventilations due to shallow breathing. His oxygen level was maintained at saturation of 94% on 2 liters nasal cannula. Resident #1's BG was 72 mg/dl, and the Glasgow Coma Scale (GCS) was 7 according to EMS. The GCS is used to objectively describe the extent of impaired consciousness in all types of acute

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medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses. A person's GCS score could range from 3 (unresponsive) to 15 (responsive). The initial VS taken at ER on 02/10/22 at 10:19 AM was BP 135/74, RR 20, P 84, O2 95%. Resident #1 did withdraw from painful stimuli. The second set of VS taken at 10:42 AM was BP 142/56, RR 11, P 68, O2 91%. Resident #1 was assessed with altered consciousness secondary to inadvertent medication administration with Oxycontin, baclofen, hydroxyzine, duloxetine, pregabalin, and docusate. He was admitted to the hospital and monitored closely in progressive level of care. His level of alertness gradually improved and was discharged back to the facility on 02/11/22.

The Administrator was notified of Immediate Jeopardy on 02/24/22 at 5:30 PM.

The facility provided the following corrective action plan with a completion date of 02/12/22.

Resident #1 received medications that were not prescribed for him. Root cause was determined to be distraction during a medication administration.

On the evening of 02/09/22, Resident #1 was administered medications by Medication Aide #1 (MA#1) that were not ordered for him. The on-call provider and the Director of Nursing (DON) were notified of the medication error. The provider gave an order to monitor in place and to assess vital signs (VS) once every 2 hours. On 02/10/22, the Nurse Practitioner (NP) and DON assessed the Resident #1 for a decline in condition. The NP

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gave the order to send to the Emergency Room (ER) for further medical workup. Due to the acute change in condition at around 8:45 AM, the NP and staff remained with Resident #1 all the times until emergency medical service (EMS) arrived and took over care for the resident. Resident #1 was transported to the hospital and admitted on 02/10/22. Resident #1's emergency contact was notified of the error and the transfer to the hospital. The facility pharmacy consultant was also made aware of the medication error, in addition to the facility medical director. MA#1 was removed from the responsibility of medication administrator effective 02/10/22.

All residents have the potential to be affected by this deficient practice. On 02/10/22 the DON completed walking rounds and interviewed alert residents to see if there were concerns with medication errors and to observe non alert residents to determine if there was a decrease in level of alertness that could be indicative of administration of wrong medication. There were no negative findings or concerns. The DON and designee entered *name alert notices in the electronic health record for those residents currently in the facility that have similar names to help deter medication errors related to wrong resident with similar names. The DON monitored and reminded staff to avoid distractions during the medication pass as rounds were completed.

To prevent this from recurring, by 02/10/22, all staff who are responsible for medication administration, will be educated by the DON on the facility medication administration policy including the requirement of facility staff to verify each time a medication is administered that it is the correct medication, at the correct dose, at the

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correct route, at the correct rate, at the correct time, for the correct resident. In addition, the DON will provide education in ways of reducing distractions including stopping and restarting the medication administration process when distracted or unsure, the nurse will not multitask during the medication administration, one resident will be completed before moving on to another resident, no pre-pulling of medications as well as educating staff on not distracting the nurses during the medication administration. On 02/10/22, an ad hoc Quality Assurance (QA) meeting was held to discuss the plan. 10 facility staffs included the Medical Director, Administrator, and DON had participated this meeting. In an abundance of precaution, as an additional educational support in order to strengthen MA #1's skill set, MA #1 was required to complete a course in Relias, which is a comprehensive educational training program that educates and tests staff members proficiency in assigned specific areas, on avoiding medication errors. Starting on 02/11/22 a medication competency assessment was performed on each nurse and medication aide. No issues related to medication error noted after this event. The medication aide also received one on one education with the DON on adhering to the rights of medication pass and limiting distractions during the medication pass. During routine rounds the DON and or designee will observe medication pass to ensure distractions are limited and nurses are completing medication administration to the correct resident. DON or designee will immediately remove distractions if observed and provide education as needed.

To monitor and maintain ongoing compliance, beginning 02/14/22, the DON or clinical manager

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will document observations of medication administration for 5 nurses per week for 8 weeks to ensure the residents remain free from medication errors. In addition, any new nurse hires or agency will be required to complete a medication competency assessment as well as the same education that was provided on 02/10/22 prior to employment. Any negative observations that would require the nurse or medication aide to be stopped, an additional training will be immediately conducted. The affected resident's RP and the MD/NP will be made aware of any negative findings.

Beginning 02/14/22, the results of the audits will be forwarded to the facility Quality Assurance and Performance Improvement (QAPI) committee monthly, for review and recommendations. The committee reserves the right to modify the auditing as they feel appropriate if negative findings are reviewed. The facility DON is responsible for compliance. Date of Compliance is 02/12/22.

The facility's alleged correction date of 02/12/22 was verified by the following:

On 02/28/22, the facility's corrective action plan with correction date of 02/12/22 was validated on-site by record review, observations, and interviews with resident and staff.

A full-scale medication pass was conducted from 02/22/22 through 02/23/22. No concerns related to medication errors were identified. It consisted of 25 medications and involved 7 different residents, 3 different halls, and 4 different nurses. Nurses were seen applying the 5 Rights of medication administration during medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING _____ B. WING _____	C 02/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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passes. They were observed checking resident's picture in the computer, verifying the name plate at the door, and asking alert-oriented residents open-ended question for resident's name before administering medication. For residents who were nonverbal, nurses referred to another nursing staff to confirm residents identify if they remained unsure before administering medication. None of the nurses were seen multitasking or pre-pulling medication during the medication administration observation. Nurses completed medication pass for one resident before moving on to another resident. When they became distracted or unsure during the medication pass, they stopped and restarted the medication pass process.

Interviews with nursing staff for both shifts revealed they had been re-educated per the documentation of in-services provided related to effective identification of the right resident through the 5 Rights, ways to minimize distractions, and handling of distractions during medication administration. Nurses were knowledgeable about the 5 Rights of medication administration and ways to handle distractions during medication pass.

Interviews with alert and oriented residents revealed nursing staff had been asking open-ended questions for their name before administering medication.

The medication records of sample residents were reviewed with focus on medication error. No concerns related to medication errors were identified.

Review of in-service records revealed on 02/10/22, the DON completed the in-person

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F 760	Continued From page 14 in-services that included the 5 Rights of medication administration and ways to handle distractions during medication pass. All other nurses or medication aides not in the facility on 02/10/22 received the in-services via telephonic voice message system. The in-service sign-in sheet indicated all 15 nurses and 4 medication aides had received the re-education on 02/10/22. Review of monitoring tools revealed the management staff had completed audits and monitoring per the audit tools and monitoring documentation provided. This F760 was corrected on 02/12/2022.	F 760		