| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| OAK FOREST HEALTH AND REHABILITATION | 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105 |

| (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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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 11/5/24 through 11/8/24. Event ID# VWXZ11. The following intake was investigated: NC00223689. One (1) of the 3 complaint allegations resulted in deficiency. Intake NC00223689 resulted in immediate jeopardy.<br><br>Past noncompliance was identified at:<br><br>CFR 483.45 at tag F760 at a scope and severity J<br><br>The tag F760 constituted substandard quality of care.<br><br>Noncompliance began on 10/18/24. The facility came back into compliance effective 10/23/24. A partial extended survey was conducted. | F 000 | Past noncompliance: no plan of correction required. | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, and interviews with staff, Nurse Practitioner (NP) and the Medical Director, the facility failed to protect a resident from non-significant medication errors for 1 of 3 residents reviewed for medication administration (Resident #1).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on | F 658 | Past noncompliance: no plan of correction required. | |

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

Electronically Signed | 11/26/2024

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2/19/24, with diagnoses including bipolar disorder, dementia, anxiety disorder, heart failure and chronic kidney disease.

Review of his quarterly Minimum Data Set (MDS) assessment dated 9/2/24 revealed Resident #1 was moderately cognitively impaired.

Review of the of the Medication Administration Record (MAR) for October 2024, revealed that on 10/18/24 at 9:58 AM, Resident #1 received his prescribed medications, including seroquel, 25 mg (milligrams), zoloft, 25 mg, acidophilus 1 tablet, Anoro Ellipta Inhaler (inhaler for asthma/COPD) 1 puff, ferrous sulfate 325mg, magnesium oxide 400 mg, multivitamin 1 tablet, proscar 5 mg, vitamin B12 500 mcg (micrograms), vitamin C 500 mg, and flomax 0.4 mg.

Review of Resident 2's physician's orders for October 2024 revealed medications, including metformin (anti-diabetic medication) 500 mg, aspirin (nonsteroidal anti-inflammatory medication) 81 milligram (mg), Levocarnitine (nutritional supplement) 500 mg, Baclofen, 5 mg (muscle relaxant medication).

The Incident Report, created by Nurse #1 and dated 10/18/24 at 12:40 PM, revealed Nurse #1 went to the common area, where [Resident #1] was seated. She addressed [Resident #1] by the name of [Resident #2], and [Resident #1] replied yes. Nurse #1 gave [Resident 2's] medications to [Resident #1] including metformin 500 mg, aspirin 81 mg, levocarnitine 500 mg, and baclofen 5 mg. Nurse #1 realized the medication administration error, obtained the vital signs, which were within normal limits. Nurse #1 called the Unit Manager,

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the Provider, family member and continued frequent monitoring.

During a phone interview on 11/5/24 at 10:10 AM Nurse #1 indicated she was an agency nurse and 10/18/24 was her second time in the facility. During the medication administration on 10/18/24 between 9:00 AM and 10:00 AM she gave Resident #1 his prescribed morning medications. Nurse #1 continued the morning medication pass and at approximately 11:00 AM she prepared medications for Resident #2. Nurse #1 went to the common area and addressed Resident #1 by Resident #2's name and the resident replied yes, which she felt the response indicated he was Resident #1. Nurse #1 gave Resident 2's medications to Resident #1. When Nurse #1 returned to her medication administration cart to document, she realized she accidently gave the wrong medications to Resident#1. Nurse #1 immediately called the Unit Manager and assessed Resident #1. The resident was not in distress and his vital signs were within normal limits. Nurse #1 notified the Nurse Practitioner (NP #1) and Resident #1's family. NP #1 gave an order to check the resident's vital signs every four hours, monitor for hypotension (low blood pressure), bradycardia (low heart rate), and notify provider of any abnormal results. She reported the medication administration error to Nurse #2 during the shift change report.

The nurses' note dated 10/18/24 at 12:40 PM indicated Nurse #1 reported the medication administration error for Resident #1 to Nurse Practitioner (NP) #1 and NP #1 provided new orders to check vital signs every four hours for the current shift, and continue monitoring.

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On 11/5/24 at 11:30 AM and interview with Nurse #5 (Unit Manager) revealed she received report from Nurse #1 on 10/18/24 at 12:30 PM about accidentally administering Resident #2's medications to Resident #1. Upon assessment together with Nurse #1, the resident was not in distress, seated in bed, and stated he was fine. The resident's vital signs were within normal limits: BP 112/52, pulse 63 beats per minute, and respirations 17 breath per minute. Nurse #1 notified the Nurse Practitioner (NP) and family. NP ordered to check resident's vital signs every four hours and report the abnormalities.

On 11/5/24 at 1:50 PM a phone interview was conducted with Nurse Practitioner (NP) #1. NP #1 indicated on 10/18/24 she was informed of the medication administration error by Nurse #1. At the time of the report Resident #1 was stable, with no distress and NP #1 ordered to check his vital signs every four hours with continued monitoring for hypotension and bradycardia. NP #1 did not expect a long-term systemic (overall) negative effect, or changes in mental status due to the resident having received the wrong medications. NP #1 stated had planned to assess Resident #1 the next day (10/19/24).

On 11/6/24 at 11:20 AM, during the phone interview, the Medical Director indicated that he was notified about the medication administration error that occurred for Resident #1. He did not expect negative outcome from the non-significant medications administered to Resident #1.

The facility implemented the following corrective action plan for identified deficient practice:

All current residents in the facility with orders for

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medication had the potential to be affected by the deficient practice. On 10/18/24 the Director of Nursing (DON) identified residents that were potentially impacted by this practice by completing a 100% (percent) audit on all current alert and oriented residents with brief interviews for mental status (BIMs) of 13 or greater (indicating the resident was interviewable) to ensure there were no issues with medication administration. This was completed on 10/18/24. The results included: 100 of 100 residents with medication orders had no concerns with medication administration.

On 10/18/24 A body audit was completed by the DON, Assistant DON (ADON), and Unit Managers, on all non-verbal, non-alert residents with BIMS of 12 or lower to ensure there were no issues related to medication administration. This audit consisted of signs or symptoms related to change in condition, increased confusion, or mental status changes. The results included: 48 of 48 residents with no signs or symptoms, which were felt may indicate issues related to a possible error in medication administration. On 10/18/24 the DON implemented corrective action for those residents which included: no corrective action needed; no deficient practice identified.

On 10/18/24 The DON, ADON, unit managers, and Staff Development Coordinator (SDC) began interviewing nurses and medication aids during med pass observations on if they had performed medication errors. The results: 46 of 46 Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and med aids denied medication errors including giving medications to the wrong resident.

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On 10/18/24 The DON reviewed all incident reports for the last 14 days to identify any recent medication errors. The results: 0 of 8 incident reports were related to medication errors.
Education: On 10/18/24, the Staff Development Clinician (SDC) began in-servicing all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and medication aides, (including agency) on Preventing Medication Error policy. This training included all current staff including agency. This training included:
Following the 6 rights of medication administration
The right person
The right medication
The right dose
The right time
The right route
The right documentation

The Director of Nursing ensured that any of the above identified staff who did not complete the in-service training by 10/22/24 would not be allowed to work until the training was completed. This education will be ongoing and included in our new hire and agency orientation packet for all RNs, LPNs, and medication aids. The DON, Assistant DON, unit managers, and SDC, will monitor medication administration passes 3 times weekly for 2 weeks and monthly for 3 months for using the Quality Assurance (QA) monitoring tool Med Pass Audit. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, Minimum Data Set Coordinator, Therapy,

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Health Information Management, and the Dietary Manager. On 10/18/24 the decision was made to initiate this into the QA process and to review it in QA.

The completion date of the corrective action plan: 10/23/24

On 11/8/24, the facility's corrective action plan was validated on-site by record review, observations, and interviews. Individual interviews with a sample of residents revealed they received their prescribed medications without concern. A medication administration observation was conducted on 11/8/24. The observation consisted of administration of medications for 3 different residents, by 2 nurses. The nurses and the medication aides were observed implementing the rights of medication administration before administering the medications from start to finish. No concerns were identified. Interviews with nurses and the medication aides revealed they were required to complete in-services for the 5 rights of medication administration and the facility's new process for medication administration.

Review of the in-service documents dated 10/18/24 and 10/23/24 noted the DON completed the in-person in-services for the 6 rights of medication administration and the facility's new process for medication administration with nurses and medication aides. An interview with the DON on 11/8/24 revealed that the in-services were provided to Nurse #1 and all other nurses and medication aides that had not worked since the medication error, as well as to any new nurses and medication aides before they were allowed to

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| F 658 | Continued From page 7<br>administer medications.<br><br>The corrective action plan's completion date of 10/23/24 was validated. | F 658 | | |
| F 760 SS=J | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, interviews with resident, staff, Nurse Practitioner (NP), and Medical Director, the facility failed to protect a resident from a significant medication error when on 10/18/24, Nurse #1, an agency nurse, administered the wrong medications to Resident #1. On 10/18/24, Nurse #1 administered Resident #1's prescribed medications during the morning medication pass and then later in the morning administered medications prescribed for Resident #2 to Resident #1. The wrongly administered medications included olanzapine (antipsychotic medication), lamotrigine (anticonvulsant medication), gabapentin (anticonvulsant medication), paroxetine (antidepressant medication), haloperidol (antipsychotic medication), and clonazepam (antianxiety medication). Nurse #1 identified the medication administration error, reported the medication administration error to Resident 1's family and NP, and interventions were put into place to monitor the resident. On 10/19/24, Resident #1 became lethargic, he was sent to the Emergency Department (ED) for further evaluation. While in the ED, Resident #1 had an elevated blood pressure (145/94), mumbled | F 760 | Past noncompliance: no plan of correction required. | |

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responses, was not following commands, and was unable to provide any information. He was admitted to the hospital with diagnoses which included acute kidney injury, differential diagnoses including medication side effects, dehydration, and required intravenous fluid administration. Resident #1 was discharged from the hospital to another nursing home on 10/24/24 and was documented to be at his baseline upon discharge. This deficient practice was found for 1 of 3 residents reviewed for significant medication errors (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 2/19/24, with diagnoses including bipolar disorder, dementia, anxiety disorder, heart failure and chronic kidney disease.

Review of his quarterly Minimum Data Set (MDS) assessment, dated 9/2/24, revealed Resident #1 was moderately cognitively impaired. The resident received antipsychotic, antidepressant, antianxiety and antibiotic medications during the assessment period.

The plan of care for Resident #1, dated 8/20/24, indicated the risk for adverse side effects of psychotropic and antidepressant medications, with interventions to provide treatment according to physician's orders, monitor behavior, medications side effects, and report the changes to the provider.

The prescribed morning medications per physician's orders for Resident #1 included: quetiapine (antipsychotic) 25 mg and sertraline (antidepressant) 25 mg. The Medication

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Administration Record (MAR) for October 2024 documented on 10/18/24 at 9:58 AM, Resident #1 received his prescribed medications, including quetiapine 25 mg and sertraline 25 mg.

The October 2024 prescribed morning medications per the physician's orders for Resident #2 included the following significant medications: Olanzapine 10 mg (antipsychotic medication), lamotrigine 100 mg (anticonvulsant medication), gabapentin 100 mg (anticonvulsant medication), paroxetine 20 mg (antidepressant medication), haloperidol 0.5 mg (antipsychotic medication), and clonazepam 0.25 mg (antianxiety medication).

The Incident Report, created by Nurse #1 and dated 10/18/24 at 12:40 PM, revealed Nurse #1 went to the common area, where [Resident #1] was seated. She addressed [Resident #1] by the name of [Resident #2], and [Resident #1] replied yes. Nurse #1 gave [Resident 2's] medications to [Resident #1]. Nurse #1 obtained the vital signs, which were within normal limits: blood pressure 112/52 (normal blood pressure range 120/80), pulse 65 beats per minute (normal pulse is 60-100 beats per minute), and respirations were 17 breath per minute (normal respiration range is 12-18 breaths per minute). Nurse #1 called the Unit Manager, the provider, family member, and continued frequent monitoring. The Incident Report included an attached list of wrongly administered medications.

The nurses' note dated 10/18/24 at 12:40 PM indicated Nurse #1 reported the medication administration error for Resident #1 to Nurse Practitioner (NP) #1 and NP #1 provided new orders to check vital signs every four hours for

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the current shift, and continue monitoring.

On 10/18/24 at 3:51 PM, Resident 1's blood pressure (BP) became low. Nurse #1 reported it to NP #1, who ordered one Liter (L) of normal saline (intravenous solution) at the rate of 100 milliliter (ml) per hour for hypotension (low blood pressure).

Review of physician's orders on 10/18/24 at 3:51 PM for Resident #1 revealed one L of normal saline at the rate of 100 ml per hour for hypotension.

The Medication Administration Record (MAR) reflected the order for the normalsSaline solution on 10/18/24 and documented it was completed.

During a phone interview on 11/5/24 at 10:10 AM Nurse #1 indicated she was an agency nurse and 10/18/24 was her second time in the facility. During the medication administration on 10/18/24 between 9:00 AM and 10:00 AM she gave Resident #1 his prescribed morning medications. Nurse #1 continued the morning medication pass and at approximately 11:00 AM she prepared medications for Resident #2. Nurse #1 went to the common area and addressed Resident #1 by Resident #2's name and the resident replied yes, which she felt the response indicated he was Resident #1. Nurse #1 gave Resident 2's medications to Resident #1. When Nurse #1 returned to her medication administration cart to document, she realized she accidently gave the wrong medications to Resident#1. Nurse #1 immediately called the Unit Manager and assessed Resident #1. The resident was not in distress and his vital signs were within normal limits. Nurse #1 notified the Nurse Practitioner

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(NP #1) and Resident #1's family. NP #1 gave an order to check the resident's vital signs every four hours, monitor for hypotension (low blood pressure), bradycardia (low heart rate), and notify provider of any abnormal results. After approximately one hour of monitoring, Resident #1's blood pressure (BP) became low (98/51). Nurse #1 explained she reported the low BP to NP #1 and received the new order for one L of normal saline intravenously, at the rate of 100 ml per hour, for hypotension. Resident #1 was asleep in bed and remained with stable vital signs to the end of Nurse #1's shift at 7:00 PM. She reported the medication administration error to Nurse #2 during the shift change report.

On 11/5/24 at 9:15 AM, during an interview, Nurse Aide #1, who worked on 10/18/24 first shift (7:00 AM to 3:00 PM), indicated Resident #1 was alert, could make his needs known, was walking around facility in the morning, and resting in bed after lunch. Nurse Aide #1 mentioned that Resident #1 often wandered around the facility but at times preferred to have a rest in his bed after lunch. Nurse Aide #1 was aware the resident received wrong medications on 10/18/24, and observed Nurse #1 check his vital signs several times during the shift.

On 11/5/24 at 11:30 AM and interview with Nurse #5 (Unit Manager) revealed she received report from Nurse #1 on 10/18/24 at 12:30 PM about accidentally administering Resident #2's medications to Resident #1. Upon assessment the resident was seated in bed, was not in distress, dnd stated he was fine. The resident's vital signs were within normal limits: BP 112/52, pulse 63 beats per minute, and respirations 17 breath per minute. During the monitoring between

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| OAK FOREST HEALTH AND REHABILITATION | 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105 |

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2:00 PM and 3:00 PM Resident #1's blood pressure became low (98/61). NP #1 was notified by Nurse #1 and the NP ordered intravenous fluids of one liter of normal saline at the rate of 100 ml per hour. Nurse #1 started the intravenous fluids on Resident #1. The resident remained in bed, his vital signs stabilized and overall he appeared to be in stable condition. The Unit Manager observed the resident approximately at 4:00 PM when she found he was in bed, sleepy, and had a BP 120/70.

Review of the nurses' notes, dated 10/19/24, documented at 12:53 AM, revealed Nurse #2 notified NP #2 about Resident 1's changes in condition, including altered level of consciousness. Nurse #2 documented the resident was lying in bed with eyes closed and had limited response to stimulation. NP #2 gave an order to send Resident #1 to the hospital for hospital evaluation.

On 11/5/24 at 10:45 AM, during a phone interview, Nurse #2 indicated on 10/18/24 at 7:00 PM, she received shift change report from Nurse #1, who informed her about the medication administration error for Resident #1. Nurse #2 stated usually, Resident #1 was wandering around and talking. Nurse #2 explained during the monitoring, the resident had normal vital signs, however he was sleepy with limited response to stimulation. On 10/19/24 at approximately 1:00 AM Nurse #2 communicated Resident #1's altered mental status to NP #2, and received an order to send Resident #1 to the Emergency Department (ED) for evaluation. The resident left the nursing home via Emergency Medical Service (EMS).

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Review of the EMS report dated 10/19/24 revealed at 12:56 AM the EMS team arrived at Resident #1 to address the resident's altered mental status after administration of the wrong medications. Nurse #2 informed the EMS team she noticed the changes in Resident #1's behavior: he was ambulatory and more talkative at baseline, but this shift he remained in bed and did not eat or speak much. Upon assessment, Resident #1 was able to answer questions with delayed responses and kept his eyes closed during the conversation. He had the right forearm intravenous catheter in place. The staff stated he just finished an intravenous fluid administration. At 12:56 AM his vital signs were BP 162/104, pulse 88 beats per minute, respirations 14 breath per minute, and oxygen saturation 98% (normal oxygen saturation range is 95-100%) on room air. EMS took the resident to the ED.

Review of the hospital records, dated 10/19/24 at 1:55 AM, revealed Resident #1 arrived at the ED via EMS with chief complaint of altered mental status. Per nursing home staff on 10/18/24 at 9:00 AM, the resident accidently received multiple wrong medications, became less alert/responsive, and more confused. In the ED, the resident presented with "mumble" responses, he was not following commands, had an elevated blood pressure of 145/94 and urinalysis, suggested a Urinary Tract Infection (UTI). Resident #1 was admitted to a general admission unit of the hospital for additional antibiotic therapy, hydration, and differential diagnosis including medication side effects and infection.

On 11/5/24 at 1:50 PM a phone interview was conducted with Nurse Practitioner (NP) #1. NP #1 indicated on 10/18/24 she was informed of the

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medication administration error by Nurse #1. At the time of the report Resident #1 was stable, with no distress and NP #1 ordered to check his vital signs every four hours with continued monitoring for hypotension and bradycardia. NP #1 did not expect a long-term systemic (overall) negative effect, or changes in mental status due to the resident having received the wrong medications. She explained she was more concerned about the possibility of his blood pressure becoming low. At approximatelly 3:00 PM the nursing staff reported low blood pressure (98/61) for Resident #1. NP #1 stated she ordered intravenous fluid administration, monitoring vital signs for hypotension, low heart rate, and planned to assess Resident #1 on 10/19/24.

During a phone interview on 11/6/24 at 11:20 AM the Medical Director indicated he was notified (could not recall the exact date) about the medication administration error for Resident #1. The Medical Director discussed the medication error with the NP #1 (could not recall the exact date), who communicated with the nursing staff at the facility on 10/18/24. The Medical Director agreed with the orders for monitoring, treatment, and hospital evaluation after the wrong medications were adminsitered to Residnet #1. The Medical Director mentioned that considering the single doses of wrongly admininstared medications, he was not worried about a potential negative outcome for Resident #1.

On 11/5/24 at 11:55 AM, during an interview, the Director of Nursing (DON) stated she expected the nurses and medication aides to use the six rights of medication administration (right medication, right dose, right time, right route, and

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the right documentation), and identify the residents prior to medication pass. Nurse #1 was an agency nurse, who recently started to work in the facility, and did not know the residents.

The facility's Administrator was notified of Immediate Jeopardy on 11/5/24 at 3:30 pm.

The facility implemented the following corrective action plan:

All current residents in the facility with orders for medication had the potential to be affected by the deficient practice. On 10/18/24 the Director of Nursing (DON) identified residents that were potentially impacted by this practice by completing a 100% (percent) audit on all current alert and oriented residents with brief interviews for mental status (BIMs) of 13 or greater (indicating the resident was interviewable) to ensure there were no issues with medication administration. This was completed on 10/18/24. The results included: 100 of 100 residents with medication orders had no concerns with medication administration.

On 10/18/24 A body audit was completed by the DON, Assistant DON (ADON), and Unit Managers, on all non-verbal, non-alert residents with BIMS of 12 or lower to ensure there were no issues related to medication administration. This audit consisted of signs or symptoms related to change in condition, increased confusion, or mental status changes. The results included: 48 of 48 residents with no signs or symptoms, which were felt may indicate issues related to a possible error in medication administration. On 10/18/24 the DON implemented corrective action for those residents which included: no corrective action

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| F 760 | Continued From page 16<br>needed; no deficient practice identified.<br><br>On 10/18/24 The DON, ADON, unit managers, and Staff Development Coordinator (SDC) began interviewing nurses and medication aids during med pass observations on if they had performed medication errors. The results: 46 of 46 Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and med aids denied medication errors including giving medications to the wrong resident.<br><br>On 10/18/24 The DON reviewed all incident reports for the last 14 days to identify any recent medication errors. The results: 0 of 8 incident reports were related to medication errors.<br>Education: On 10/18/24, the Staff Development Clinician (SDC) began in-servicing all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and medication aides, (including agency) on Preventing Medication Error policy. This training included all current staff including agency. This training included:<br>Following the 6 rights of medication administration<br>The right person<br>The right medication<br>The right dose<br>The right time<br>The right route<br>The right documentation<br><br>The Director of Nursing ensured that any of the above identified staff who did not complete the in-service training by 10/22/24 would not be allowed to work until the training was completed. This education will be ongoing and included in our new hire and agency orientation packet for all RNs, LPNs, and medication aids. | F 760 | | |

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The DON, Assistant DON, unit managers, and SDC, will monitor medication administration passes 3 times weekly for 2 weeks and monthly for 3 months for using the Quality Assurance (QA) monitoring tool Med Pass Audit. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, Minimum Data Set Coordinator, Therapy, Health Information Management, and the Dietary Manager. On 10/18/24 the decision was made to initiate this into the QA process and to review it in QA.

IJ Removal Date: 10/23/24

On 11/8/24, the facility's corrective action plan was validated on-site by record review, observations, and interviews. Individual interviews with a sample of residents revealed they received their prescribed medications without concern. A medication administration observation was conducted on 11/8/24. The observation consisted of administration of medications for 3 different residents, by 2 nurses. The nurses and the medication aides were observed implementing the rights of medication administration before administering the medications from start to finish. No concerns were identified. Interviews with nurses and the medication aides revealed they were required to complete in-services for the 6 rights of medication administration and the facility's new process for medication administration.

Record review of the in-service documents dated

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| F 760 | Continued From page 18<br>10/18/24, 10/19/24 and 10/22/24 noted the DON completed the in-person in-services for the 6 rights of medication administration and the facility's new process for medication administration with nurses and medication aides. An interview with the DON on 11/8/24 revealed that the in-services were provided to Nurse #1 and all other nurses and medication aides that had not worked since the medication error, as well as to any new nurses and medication aides before they were allowed to administer medications.<br><br>The corrective action plan's completion date of 10/23/24 was validated. | F 760 | | |