STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345564	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON TOWERS	5100 SHARON ROAD CHARLOTTE, NC 28210

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E 000	Initial Comments An unannounced recertification survey was conducted 11/04/2024 through 11/07/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # PMBS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted 11/04/2024 through 11/7/2024. Event ID# PMBS11	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		11/7/24

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

Electronically Signed | 11/29/2024

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F 625	Continued From page 1 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and Resident Representative (RR) and staff interviews, the facility failed to notify the resident and/or the RR of the facility's bed hold policy when the resident was transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #13). The findings included: Resident #13 was admitted to the facility 7/29/24. The 5-day Minimum Data Set (MDS) dated 8/02/24 indicated Resident #3 had severe cognitive impairment. A review of the nurse's notes revealed Resident #13 was discharged to the hospital 8/19/24 and did not return to the facility. A review of Resident #13's electronic medical record (EMR) revealed there was no documentation that information regarding the bed hold policy was issued when he was transferred to the hospital or that the RR was contacted concerning the bed hold. A telephone interview conducted with the RR on 11/06/24 at 2:06 PM indicated she was notified by the facility on 8/19/24 that Resident #13 was transferred to the hospital but there was no discussion concerning the bed hold policy. The RR stated on 8/25/24 she emailed the Social Service Manager that Resident #13 was being	F 625	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #13 was sent out to the emergency department for an emergency evaluation. Resident #13 received the appropriate care by all healthcare providers and passed away in the hospital under hospice care. Bed hold policy was received and signed by resident representative on 2/8/24 and 8/3/24. Address how the facility will identify other residents having the potential to be affected by the same practice: Any resident could potentially be sent out emergently without a bed hold notice prior to the transfer. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Emergency transfer/discharge packets, which include the bed hold policy, were created 11/7/24 and placed at each nurse□s station. On 11/7/24 all Nurses received training by the staff development coordinator and director of nursing on how	

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F 625	Continued From page 2 discharged from the hospital and would be returning to the facility on 8/26/24 but did not receive a response. She revealed that the Social Service Coordinator emailed her on 8/26/24 that a bed was not available and Resident #13 could not return to the facility. The RR indicated the facility did not send her information on the bed hold policy when Resident #13 was transferred to the hospital, and she was not aware a bed hold was required. A telephone interview conducted with Nurse #4 on 11/07/24 at 8:00 AM revealed she worked 3rd shift (11pm-7am) and was assigned to Resident #13 on 8/19/24. She stated the RR was notified Resident #13 was being transferred to the hospital, but they did not discuss the bed hold policy. She further stated she prepared Resident #13's transfer paperwork which included his face sheet and list of medications. Nurse #4 indicated a bed hold policy was not included in the paperwork and she was not familiar with the form. An interview with the Social Service Coordinator on 11/07/24 at 9:45 AM indicated she did not recall Resident #13 or that she communicated with his RR via email that he could not return to the facility. She stated the Social Service Manager was responsible for discussing the bed hold policy with residents and the RR and coordinating readmissions from the hospital to the facility. An interview conducted with the Social Service Manager on 11/07/24 at 10:00 AM indicated that when a resident was transferred to the hospital, she contacted the resident or the RR the next business day to discuss the bed hold policy. She revealed if the resident or RR wanted to hold the	F 625	to complete the forms and the packet will be sent to the emergency department with the resident at this same time. A resident representative always receives a verbal notification of transfer to include the option for bed hold when a resident is sent out emergently, but a copy of the written notice and bed hold policy will be emailed to the resident representative. If there is no email available, it will be mailed to them. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The administrator and director of nursing will monitor for the completion and timely notification of all emergent transfers/discharges. This will be done on an ongoing basis, indefinitely. A copy of the documentation of sent notification will be kept on file. Audit Results will be reported at the quality assurance committee meeting.	

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F 625	Continued From page 3 bed, she completed a form that was sent to the business office. The Social Service Manager stated she called Resident #13's RR to discuss holding his bed and emailed her the bed hold policy. She further stated the Resident #13's RR declined to hold his bed. The Social Service Manager indicated she was unable to explain why there was no documentation in the EMR that the RR declined to hold the bed, and she did not have a record of the email she sent to the RR with the bed hold policy. An interview with the Administrator on 11/07/24 at 3:09 PM revealed when a resident was admitted to the facility the bed hold policy was reviewed and signed by the resident and/or the RR. The Administrator indicated when a resident was transferred to the hospital the Social Service Manager should contact the resident and/or the RR as soon as practicable to review the bed hold policy and determine if they want to hold the bed.	F 625		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility;	F 626		11/7/24

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F 626	Continued From page 4 and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and Resident Representative (RR), Hospital Case Manager and staff interviews, the facility failed to permit a resident to return to the facility after being discharged to the hospital for evaluation due to a change of condition for 1 of 1 resident reviewed for hospitalization (Resident #13). The findings included: Resident #13 was admitted to the facility 7/29/24. The 5-day Minimum Data Set (MDS) dated 8/02/24 indicated Resident #3 had severe cognitive impairment.	F 626	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #13 was sent out to the emergency department for an emergency evaluation. Resident #13 was offered a long term care bed to return to with his hospice referral. That bed was turned down due to the private pay rate and the family□s preference was to allow him to go to a facility where he would not have admit and then discharge again. The resident passed away in the hospital under hospice care.	

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F 626	Continued From page 5 A review of the nurse's note dated 8/19/24 at 8:05 AM indicated Resident #13 had an unwitnessed fall at 1:40 AM and was being monitored. Resident #13's vital signs were obtained around 5:00 AM and his temperature and heart rate had dropped. The on-call physician and RR were notified, and Resident #13 was transferred to the hospital for further evaluation. The discharge MDS dated 8/19/24 revealed Resident #13 had an unplanned discharge from the facility to the hospital and return to the facility was not anticipated. A review of an email sent from the RR to the Social Service Manager on 8/25/24 indicated that Resident #13 was being discharged from the hospital and the RR requested he return to the facility on 8/26/24. A review of an email sent from the Social Service Coordinator to the RR on 8/26/24 revealed she had communicated with the Hospital Case Manager concerning Resident #13's discharge from the hospital and informed the RR that Resident #13 could not return to the facility because a bed was not available. An interview with the Social Service Coordinator on 11/07/24 at 9:45 AM indicated the Social Service Manager was responsible for all resident admissions/discharges. She did not recall communicating with Resident #13's RR via email concerning his return to the facility. A review of an email sent from the RR to the Social Service Manager on 8/28/24 indicated Resident #13 was still in the hospital and in need of placement for short-term rehab. The RR	F 626	Address how the facility will identify other residents having the potential to be affected by the same practice: Any resident has the potential to be affected by this deficient practice but The Sharon does not refuse to allow any resident to readmit to the facility if sent out and it is appropriate for them to return. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Emergency transfer/discharge packets were created 11/7/24 and placed at each nurse□s station. On 11/7/2024 the director of nursign and staff development coordinator provided all nurses with training on how to complete the forms and the packet will be sent to the emergency department with the patient at this same time. Any resident that is transferred emergently out of the facility will be monitored by the interdisciplinary team in the clinical morning meeting for status on return to the facility. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The administrator and director of nursing will monitor for the completion and timely notification of all emergent transfers/discharges. This will be done on	

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F 626	Continued From page 6 inquired if the facility had a bed available. A review of the facility census record indicated on 8/25/24 the facility census was 15 and there were 5 beds available. The facility census on 8/28/24 was 13 and there were 7 beds available. A review of the hospital discharge plan note dated 8/28/24 revealed Resident #13 was medically ready for discharge however the facility would not accept him back. The Hospital Case Manager provided the RR with a list of skilled nursing facilities, but she was not pleased with the options. The RR was sent an updated list of facilities and discharge planning was ongoing. A telephone interview conducted with the RR on 11/06/24 at 2:06 PM indicated she was notified by Nurse #4 on 8/19/24 that Resident #13 had a fall and was transferred to the hospital for further evaluation. The RR stated on 8/25/24 the Hospital Case Manager contacted her that Resident #13 was ready to be discharged. She stated she emailed the Social Service Manager to inform her he was being discharged from the hospital and asked if he could return to the facility on 8/26/24 but did not receive a response. The RR revealed that the Social Service Coordinator emailed her on 8/26/24 that a bed was not available and Resident #13 could not return to the facility. The hospital physician had discussed hospice care due to Resident #13's frail condition but she was hopeful he was still appropriate for short term rehab, so she emailed the Social Service Manager again on 8/28/24 inquiring if a bed was available but did not receive a response. She stated she was out of town off and on during Resident #13's hospitalization and was communicating by phone and email with the	F 626	an ongoing basis, indefinitely. Emergency transfers not returning to the facility will be reported at the quarterly quality assurance committee meeting.	

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F 626	Continued From page 7	F 626		

physicians and the Hospital Case Manager. The RR revealed on 8/28/24 she agreed to skilled placement with hospice services. She indicated the Hospital Case Manager was assisting her with finding another facility, but she was not pleased with the options. She stated she did not want to move Resident #13 to a facility she was not sure would provide good care and then have to move him again, so Resident #13 remained in the hospital with hospice services and passed away on 9/13/24.

An interview conducted with the Social Service Manager on 11/07/24 at 10:00 AM revealed that when a resident was transferred to the hospital, she contacted the resident and/or RR the next business day to discuss the bed hold policy and determine if they wanted to hold the bed. She revealed that for a resident that declined to hold their bed but requested to return to the facility when discharged from the hospital, they would be permitted to return to the first available bed if they were clinically appropriate. The Social Service Manager stated she did not recall the date, but she emailed the bed hold policy to Resident #13's RR and contacted her to discuss holding the bed which she declined. She further stated although the census indicated beds were available, there was not a bed for Resident #13 because they were being held for residents in independent living that were in the hospital and would require skilled nursing when discharged. She indicated on 8/28/24 there were 11 beds available and if Resident #13 was clinically appropriate he would have been permitted to return. She stated she did not contact Resident #13's RR when a bed was available, nor did she recall receiving an email from the RR on 8/28/24 inquiring if a bed was available.

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F 626	Continued From page 8 A phone interview with the Hospital Case Manager on 11/07/24 at 11:11 AM indicated she was assigned to Resident #13 during his hospitalization 8/19/24 through 9/13/24. The Hospital Case Manager revealed she contacted the facility when Resident #13 was ready for discharge, but they declined for him to return. She further stated she did not recall the date she contacted the facility or the reason why Resident #13 was not able to return. The Hospital Case Manager revealed that she worked with Resident #13's RR on finding alternative placement but due to a decline in his condition he was admitted to hospice and passed away in the hospital on 9/13/24. An interview with the Administrator on 11/07/24 at 3:09 PM indicated that when Resident #13 was discharged to the hospital on 8/19/24 the RR declined to hold his bed. She stated on 8/26/24 when Resident #13 was being discharged from the hospital the facility did not have a bed available. She revealed Resident #13 should have been permitted to return to the first bed available. The Administrator stated a bed was available 8/28/24 but she was not sure why Resident #13 was not permitted to return at that time.	F 626		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		11/27/24

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F 656	Continued From page 9	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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F 656	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop personalized comprehensive care plans in the areas of diuretic (reduce fluid build up in the body) therapy and anticoagulation (blood thinning) therapy for 1 of 5 residents whose comprehensive care plans were reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/30/2024 with diagnoses of atrial fibrillation (A-fib), edema, urinary retention, and congestive heart failure (CHF). A review of Resident #1's medical record revealed a physician order dated 10/1/2024 for Rivaroxaban (an anticoagulant medication) 15 milligram (mg), 1 tablet by mouth in the morning for A-fib (a heart condition that can lead to poor blood flow) and another order dated 10/24/2024 for Furosemide (a diuretic medication) 20 mg, 1 tablet by mouth in the morning every other day for CHF. A review of Resident #1's October and November 2024 Medication Administration Record (MAR) revealed she had been receiving the anticoagulant and diuretic medications as ordered. A review of the most recent Minimum Data Set (MDS) admission assessment dated 10/2/2024 showed Resident #1 received anticoagulant and diuretic medications. Resident #1's care plan last reviewed on	F 656	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 11/6/24 the MDS Nurse updated the care plan of Resident #1 to include goals and interventions for the orders for anticoagulant and diuretic medications. Address how the facility will identify other residents having the potential to be affected by the same practice: On 11/6/24 the MDS Nurse reviewed the medication administration record of all other residents to identify any other high risk medications that should be care planned per policy. One high risk medication was identified (diuretic) and a care plan with appropriate interventions was implemented for this medicaition. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. 1.On 11/22/24 the facility□s Policy for Comprehensive Careplanning was reviewed and revised to include care planning for all high risk medications. 2.All medication administration records will be reviewed following admission to determine if any high risk medications have been ordered and appropriate goals and interventions will be implemented as	

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F 656	Continued From page 11 11/4/2024 revealed there was no care plan in place for anticoagulant medication or diuretic medication. An interview was completed with the MDS Coordinator on 11/5/2024 at 2:50 PM. During the interview the MDS Coordinator revealed she was aware that Resident #1 had orders for anticoagulant and diuretic medications. The MDS Coordinator explained there was no care plan in place for either medication because the interventions that nursing was supposed to monitor were listed in the medication order. The MDS Coordinator went on to say if any medication required lab monitoring then it would be care planned, but she did not believe the medications Resident #1 was receiving needed to be care planned. An interview was conducted on 11/7/2024 at 10:55 AM with the Director of Nursing (DON) where he explained he did believe high risk medications needed to be included in the care plan. The DON also said anticoagulant and diuretic medications were high risk due to the potential side effects and complications related to both medications. On 11/7/2024 at 2:45 PM an interview with the Administrator was completed where she revealed she expected care plans to be complete and accurate to include any high-risk medications in order to provide the best care for the residents.	F 656	needed. 3.On 11/25/24, a 100% inservice of all licensed nurses was initiated by the staff development coordinator and MDS Nurse regarding careplanning for high risk medications. Inservicing will be completed by 11/26/24. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of Nursing will monitor the care plans of all new admissions daily for one week; weekly for four weeks and then monthly for four months. This is to ensure that all ordered high risk medications have been care planned as appropriate. Results of the audit will be reported to the quality assurance Committee	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		11/7/24

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	345564	A. BUILDING _____ B. WING _____	11/07/2024

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F 658	Continued From page 12 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews, the facility failed to ensure the correct medications were administered to the correct resident (Resident #1) on two separate occasions for 1 of 2 residents reviewed for unnecessary medications. The findings included: Resident #1 was admitted to the facility on 9/30/2024 with diagnoses that included Atrial fibrillation (A-fib), cardiac murmur, hyperlipidemia, congestive heart failure (CHF), Hypertension (HTN), edema, and chronic kidney disease. A review of an Admission Minimum Data Set (MDS) assessment dated 10/2/2024 revealed that Resident #1 had some mild cognitive impairment with no mood or behavior issues. The MDS also revealed that Resident #1 required partial assistance with her activities of daily living (ADLs). Review of Resident #1's current physician orders dated October 2024 revealed Resident #1 was ordered the following medications Flomax 0.4 milligrams (mg) times 2 capsules by mouth, Furosemide (to treat increase fluid) 20 mg every other day for CHF, Vitamin D 5000 units daily for vitamin D deficiency, Xarelto (to keep blood thin) 15 mg in the morning for A-fib, Pravastatin Sodium 20 mg daily for high cholesterol, Aspirin 81 mg daily, and Digoxin 125 mg each morning	F 658	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? One resident was affected by the deficient practice. Resident #1 was given the wrong medications two times. The director of nursing and Administrator immediately removed agency nurses involved and they will not be able to return to our building. Initiated double verifications on all meds given to affected resident. No further events have occurred. Address how the facility will identify other residents having the potential to be affected by the same practice: No other residents were affected by the deficient practice; however, any resident could potentially be affected by this deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education on medication safety and administration was given to all nursing staff by the director of nursing and staff development coordinator on 10/25/2024. Education given again on 11/7/24 by the	

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F 658	Continued From page 13 to treat Angina. A.) A review of a medication error report dated 10/24/2024 indicated the incident occurred on 10/23/2024 between 9:00 AM and 10:00 AM read in part, wrong resident (Resident #1) received Vitamin b-12 500 mg and Acetaminophen (APAP) 500 mg x 2 tablets. Medications received were not ordered for Resident #1. The type of error was marked as Wrong Resident and the reason for the error was due to Failure to identify the resident. Corrective actions included Nurse #1 (agency nurse) that administered the medications was not to return to the facility and Nurse education on the 5 rights of medication administration. Measures to prevent recurrence included no agency nurses, staff education, and medication pass audits for Resident #1. Nurse Practitioner (NP) and family members were notified. The report was signed by the Director of Nursing (DON) and Administrator. An interview was conducted via telephone on 11/7/2024 at 9:13 AM with Nurse #1. During the interview Nurse #1 was able to recall the incident that occurred with Resident #1. Nurse #1 explained on 10/23/2024 she picked up a shift through her staffing agency and upon arrival at the facility she was told her assignment but did not receive any type of orientation to the unit. Nurse #1 reported she went to medicate Resident #1, and the resident did not question what she was receiving. Afterwards Nurse #1 was approached by another Nurse (Nurse #3) and was told Resident #1 was assigned to her and she (Nurse #1) had just given Resident #1 the wrong medications and needed to report it. Nurse #1 said she notified the DON of the incident.	F 658	director of nursing with detailed information on education given and forms dated. The new inservice attendance record has been created to capture all information regarding the education as well as dates given. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The director of nursing will complete a medication pass audit weekly x 4 weeks, Every other week x 4 weeks, and then Monthly x 4 months in addition to the monthly medication pass audit conducted by our contracted pharmacy. Pharmacy medication pass audits will continue monthly indefinitely. Monitoring results will be reported to the quarterly quality assurance committee.	

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B.) Review of medication error report dated 10/25/2024 indicated the medication error occurred on 10/24/2024 at 8:00 PM contained the following information, Nurse #2 (agency nurse) administered medication to the wrong resident (Resident #1). The medications included Atorvastatin 10 mg (to treat high cholesterol) and Tramadol 50 mg (to treat pain) were meant for another resident. The DON, MD, and family were notified. The type of error included wrong medication, wrong dose, and wrong resident with the reason being failure to identify resident. Corrective actions taken were Nurse #2 was removed from agency roster for the facility and Nurses were educated on the 5 rights of medication administration. Measures taken to prevent a recurrence included in-services provided to all nurses on medication administration policies and family requesting no agency nurses to take care of Resident #1. Signed by Unit Manager, DON, and Administrator.

Interview was completed on 11/6/2024 at 4:03 PM with Nurse #2 via telephone. Nurse #2 said she was not sure how the error happened on 10/24/2024, Nurse #2 explained Resident #1 was not assigned to her and while she was preparing medication for another resident on the assisted living unit someone came out of Resident #1's room and asked her to come in and check Resident #1's vital signs. Nurse #2 said she told Resident #1 what medications were in the cup before giving them to her and the resident did not try to stop her. Nurse #2 continued by saying she was not sure why she gave Resident #1 the medications, but she had already worked an eight-hour shift and was asked to work an additional 8 hours shift. Nurse #2 also said she did not receive any type of education or

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orientation prior to taking her shift.

Review of Nurse Practitioner note dated 10/25/2024 revealed Resident #1 had received medications that were not prescribed to her on two separate occasions, 10/23/2024 and 10/24/2024. The NP note further revealed the wrong medications that Resident #1 received on 10/23/24 included Vitamin B-12 500 mg and Acetaminophen 500 mg x 2 tablets (to treat pain). The medication received in error on 10/24/2024 included Atorvastatin 10 mg (used to treat high cholesterol) and Tramadol 50 mg (for pain).

Interview was completed on 11/6/2024 at 11:19 AM with Resident #1. During the interview Resident #1 reported she received the wrong medications on 2 separate days. Resident #1 said on the morning of 10/23/2024 she noticed there were a lot of medicines in the medication cup the nurse was giving her. The resident explained she did question what medicines had been given to her and that was when she found out they were the wrong medicines. Resident #1 also said the same thing happened the next evening on 10/24/2024. Resident #1 said after she received the medications, she felt sluggish but could not blame the way she felt entirely on the medicine because she was being treated for pneumonia and urinary retention and was not feeling well at the time. Resident #1 went on to say she has not seen Nurse #1 or Nurse #2 since the incident. Resident #1 went on to say there had not been any other medication incidents since.

An interview was conducted on 11/6/2024 at 11:59 AM via telephone with the NP. During the interview the NP reported she was notified of the

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medication errors involving Resident #1 that occurred on 10/23/2024 and 10/24/2024. The NP reported after being notified of the medication error that occurred on 10/23/2024 she gave orders to increase vital signs monitoring and to hold some of Resident #1's medications. NP explained after being notified of the second mediation error that occurred on 10/24/2024 she gave orders to hold Resident #1's atorvastatin due to risk of lowered blood pressure and draw labs that included a complete blood count (CBC) and a complete metabolic panel (CMP) to monitor for any changes.

On 11/6/2024 at 3:17 PM an interview was completed with the Unit Manager (UM) that was notified of the medication error on 10/24/24. During the interview the UM reported the error was brought to her attention by Nurse #2 who had given the wrong medications to Resident #1. The UM went on to say Nurse #2 was assigned to the long-term care hallway, not the skilled care hallway where Resident #1 resided. The UM explained there was a small medication cart at the end of the skilled care hallway that was for the long-term care hallway and the cart was right beside Resident 1's room. The UM said Nurse #2 reported to her that she was preparing medication for her long-term residents at the medication cart located beside Resident 1's room when she (Nurse #2) was called into the room by the resident's sitter to check her oxygen levels and ended up giving her the medications she had been preparing. Nurse #2 was not assigned to Resident #1.

An interview with the Staff Development Coordinator (SDC) on 11/7/2024 at 11:34 AM revealed there was education provided to agency

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staff nurses by means of a binder located on the medication carts and the nurse would know which cart she was assigned to through shift report. The SDC explained sometimes agency staff nurses would sign the agency checklist along with the employee overview and expectations but was unable to find any competencies or checklists signed by Nurse #1 or Nurse #2. The SDC further explained it would be the responsibility of the Unit Manager to go over any necessary information with agency nurses prior to starting their shift. The SDC also said despite Nurse #1 and Nurse #2 being assigned to the long-term care hallway the checklists and employee overview/expectations should have been discussed and signed.

An interview was conducted on 11/7/2024 at 3:32 PM with the Medical Director (MD). During the interview the MD said she was familiar with Resident #1 and was aware of both medication errors. The MD explained the medications Resident #1 received in error were not considered significant medication errors.

An interview was completed with the DON on 11/7/2024 at 3:50 PM where he explained he expected education related to medication administration to occur on an ongoing basis and nurses from any staffing agency needed to receive education and orientation prior to starting any shift. The DON went on to say he expected the correct medication to always be administered to the correct resident.

On 11/7/2024 at 2:45 PM an interview was conducted with the Administrator. During the interview the Administrator said she expected to see ongoing education and orientation on all staff

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F 658	Continued From page 18 including agency nursing staff with focus on medication administration. The facility provided a corrective action plan with no completion date and did not provide sufficient evidence that the plan had been implemented.	F 658		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		11/29/24

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F 726	Continued From page 19 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Nurse Practitioner, and Medical Director interviews, the facility failed to provide effective orientation and education to 2 of 2 agency nurses (Nurse #1 and Nurse #2) to ensure competency when administering medications to 1 of 1 resident (Resident #1) resulting in Resident #1 receiving the wrong medication on 2 separate occasions. This deficient practice affected 1 of 1 resident reviewed for a medication error. The findings included: This tag is cross referenced to F658 Based on record review, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews, the facility failed to ensure the correct medications were administered to the correct resident (Resident #1) on two separate occasions for 1 of 2 residents reviewed for unnecessary medications. F760 Based on record review, observation, and staff, resident, and facility Nurse Practitioner (NP) and Medical Director interviews the facility failed to prevent a significant medication error when Resident #1 received Metoprolol and Apixaban. The Apixaban was not prescribed to Resident #1, however she had an order for Metoprolol prescribed at a different dose. Nurse #1administered medications prescribed to an Assist Living Resident to Resident #1 on 10/23/2024 which included a different dose of Metoprolol 100 milligram (mg) used to treat hypertension (HTN), Angina (Chest pain) and	F 726	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? One resident was affected by the deficient practice. Resident #1 was given the wrong medications two times. The director of nursing and Administrator immediately removed agency nurses involved and they will not be able to return to our building. Initiated double verifications on all meds given to affected resident. No further events have occurred. Address how the facility will identify other residents having the potential to be affected by the same practice: No other residents were affected by the deficient practice; however, any resident could potentially be affected by this deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education on medication safety and administration was given by the director of nursing and staff development coordinator to all nursing staff on 10/25/2024. Education given again on 11/7/24 by the director of nursing with detailed information on education given and forms	

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F 726	Continued From page 20 Congestive Heart Failure (CHF). (This medication acts by decreasing blood pressure and heart rate which can cause tiredness and shortness of breath). On 10/24/2024 Resident #1 was given medication prescribed to an Assisted Living Resident by Nurse #2 that included Apixaban 2.5 mg (medication used to thin blood). This deficient practice affected 1 of 1 resident reviewed for significant medication error. (Resident #1) A review of education titled Medication Administration was reviewed on 11/7/2024. There was a list of signatures attached, however there were no dates on the education or sign-in sheets to indicate when the education occurred or if it was conducted following the medication errors that occurred on 10/23/2024 and 10/24/2024. An interview with the DON on 11/7/2024 at 10:52 AM revealed the education provided should have had a date on it to show when it occurred and moving forward all in-services would be dated.	F 726	dated. The new in-service attendance record has been created to capture all information regarding the education as well as dates given. A new orientation book and documentation record has been created for all agency staff to include a floor plan of the building in their reference book. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The director of nursing will monitor the documentation of all orientation of agency staff. Monitoring will occur 2x weekly x 4 weeks, Weekly x 4 weeks, and then Monthly x 4 months. Monitoring results will be reported at the quarterly quality assurance committee meeting.	
F 760 SS=D	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, observation, and staff, resident, and facility Nurse Practitioner (NP) and Medical Director interviews the facility failed to prevent a significant medication error when Resident #1 received Metoprolol and Apixaban. The Apixaban was not prescribed to Resident #1, however she had an order for Metoprolol prescribed at a different dose. Nurse #1	F 760	Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? One resident was affected by the deficient practice. Resident #1 was given the wrong medications two times. DON and	11/7/24

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F 760	Continued From page 21 administered medications prescribed to an Assisted Living Resident to Resident #1 on 10/23/2024 which included a different dose of Metoprolol, 100 milligrams (mg) used to treat hypertension (HTN), Angina (Chest pain) and Congestive Heart Failure (CHF). (This medication acts by decreasing blood pressure and heart rate which can cause tiredness and shortness of breath). On 10/24/2024 Resident #1 was given medication prescribed to an Assisted Living Resident by Nurse #2 that included Apixaban 2.5 mg (blood thinner). This deficient practice affected 1 of 1 resident reviewed for significant medication error (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/30/2024 with diagnoses that included Atrial fibrillation (A-fib), Angina, Congestive Heart Failure (CHF), and Right Lower Lobe Pneumonia. Review of Admission Minimum Data Set (MDS) assessment dated 10/20/2024 revealed Resident #1 had moderate cognitive issues with no behaviors. Review of Resident #1's Physician orders dated September 2024 through October 2024 revealed Resident #1 was ordered the following medications: Metoprolol oral tablet, 25 mg to give 0.5 tablet to equal 12.5 mg by mouth at bedtime related to CHF ordered 9/30/2024. This medication helps to lower blood pressure. Rivaroxaban oral tablet, 15 mg to give 1 tablet by mouth in the morning for A-fib ordered 9/30/2024.	F 760	Administrator immediately removed agency nurses involved and they will not be able to return to our building. Initiated double verifications on all meds given to affected resident. No further events have occurred. Address how the facility will identify other residents having the potential to be affected by the same practice: No other residents were affected by the deficient practice; however, any resident could potentially be affected by this deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Education on medication safety and administration was given to all nursing staff by the director of nursing and staff development coordinator on 10/25/2024. Education given again on 11/7/24 by the director of nursing with detailed information on education given and forms dated. The new inservice attendance record has been created to capture all information regarding the education as well as dates given. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of nursing will complete a	

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F 760	Continued From page 22 This medication is used to help keep blood thin. Furosemide, 20 mg every other morning related to CHF ordered 9/30/2024. This medication is used to help remove excess fluid due to heart failure. Digoxin, 125 micrograms (mcg) 1 tablet by mouth in the morning due to Angina ordered 9/30/2024. This medication helps lower heart rate. Review of Resident #1's Medication Administration Record (MAR) for October 2024 revealed the following: Metoprolol oral tablet, 12.5 mg administered 10/1/2024 through 10/25/2024 at bedtime. Further review revealed Rivaroxaban 15 mg was administered every day, in the morning from 10/1/2024 through 10/31/2024. A.) A review of a medication error report dated 10/23/2024 indicated an incident occurred on 10/23/2024 between 9:00 AM and 10:00 AM and read in part, wrong resident (Resident #1) received Metoprolol 100 mg. Director of Nursing (DON) was notified at 12:00 PM on 10/23/2024 of the incident and the facility NP was notified at 12:30 pm on 10/23/2024. The medication was not ordered for Resident #1. The actions that were taken to help prevent negative outcomes included monitoring of vital signs (VS) including blood pressure (BP) and pulse rate every 2 hours and hold Digoxin (used to treat CHF). An additional review of Resident #1's orders revealed the following. An order dated 10/23/2024 at 1:55 PM to hold Digoxin was put into place and continued through 10/24/2024.	F 760	medication pass audit weekly x 4 weeks, every other week x 4 weeks, and then Monthly x 4 months in addition to the monthly medication pass audit conducted by our contracted pharmacy. Pharmacy medication pass audits will continue monthly indefinitely. Monitoring results will be reported to the quarterly quality assurance committee.	

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	345564	A. BUILDING _____ B. WING _____	11/07/2024

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An order for Oxygen (O2) 2 - 4 liters (L) as needed for decreased O2 saturation was started on 10/24/2024.

A review of Resident #1's VS revealed the following: BP reading on 10/23/2024 at 1:25 PM while sitting was 104/66 and on 10/23/2024 at 10:35 pm while lying at 97/56. Furter review of Resident #1's vital signs showed a pulse rate on 10/23/2024 at 1:25 PM to be 55 beats per minute (BMP) and on 10/23/2024 at 10:35 PM the pulse rate was 46 bpm. Further review of Resident #1's VS dated 10/23/2024 through 10/31/2024 revealed fluctuations across all days and all shifts.

An interview was conducted via telephone on 11/7/2024 at 9:13 AM with Nurse #1 (agency). During the interview Nurse #1 was able to recall the incident that occurred with Resident #1. Nurse #1 (agency nurse) explained on 10/23/2024 she picked up a shift through her staffing agency and upon arrival at the facility she was told her assignment but did not receive any type of training or orientation to the unit. Nurse # 1 further explained she was told to go one way and mistakenly went another way because she was not familiar with the hallway or the layout of the facility. She went on to say there was a medication cart right outside of Resident #1's door that was not intended for the resident's on the hallway. Nurse #1 reported she went to medicate Resident #1, and the resident did not question what she was receiving. Afterwards Nurse #1 was approached by another Nurse (Nurse #3) and was told Resident #1 was assigned to her and she (Nurse #1) had just given Resident #1 the wrong medications and

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needed to report it. Nurse #1said she notified the DON of the incident and was told to check Resident #1's VS. Nurse #1 went on to say the VS were within normal limits and she reported them to the DON. Afterwards Nurse #1 said she did not receive any kind of education and left the facility.

An observation of the skilled nursing (SNF) hallway on 11/6/2024 at 11:00 AM revealed two medication carts on the hallway. There was a medication cart sitting directly to the left, outside of Resident #1's room. Resident #1's room was located at the end of the hallway with two rooms across the hall that were Assisted Living (ALF) rooms.

B.) A review of a medication error report dated 10/25/2024 indicated an incident occurred on 10/24/2024 around 8:00 PM that read in part, Nurse #2 (agency nurse) gave the wrong resident (Resident #1) the medication Apixaban (blood thinner) 2.5 mg. The medication received was not ordered for Resident #1. The on-call Physician was notified on 10/24/2024 at 8:10 PM and the DON was notified on 10/24/2024 at 8:15 PM. The Physician ordered lab work that included complete blood count (CBC) and complete metabolic panel (CMP).

A review of Resident #1's orders showed the following order dated 10/25/2024, Normal Saline intravenous (IV)) solution 0.9%. Use 125 milliliters (ml)/hour intravenously every hour for lethargy. Administer 2L of IV fluid and can discontinue IV and fluid orders when complete, ordered 10/25/2024. A review of Resident #1's electronic medication administration report (MAR) showed Normal Saline 0.9%, 125 ml/hour was

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administered 10/25/2024 through 10/26/2024.

Additional review of Resident #1's orders showed an order change on 10/25/2024 for Metoprolol that read; Metoprolol,12.5 mg hold for heart rate less than 60 beats per minute.

Review of labs drawn on 10/25/2024 revealed the following information: Kidney function was 78 with a normal reading being anything above 59. Further review of the lab report indicated Red Blood Cells (RBC) were 3.42 WNL with normal range being 3.72 -5.24. A lab was also drawn to help if determine if blood clotting was normal, the lab is International Normalized Ration Test (INR) The results were 1.2 with normal range being 0.8 - 1.2.

Interview was completed on 11/6/2024 at 4:03 PM with Nurse #2 via telephone. Nurse #2 (agency) said she was not sure how the error happened on 10/24/2024, Nurse #2 explained Resident #1 was not assigned to her and while she was preparing medication for another resident someone came out of Resident #1's room and asked her to come in and check Resident #1's vital signs. Nurse #2 said she told Resident #1 what medications were in the cup before giving them to her and the resident did not try to stop her. Nurse #2 continued by saying she was not sure why she gave the resident the medication, but she had already worked an eight-hour shift and was asked to work an additional 8 hours shift. Nurse #2 also said she did not receive any type of education or orientation prior to taking her shift.

Interview was completed on 11/6/2024 at 11:19 AM with Resident #1. During the interview

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Resident #1 reported she received the wrong medications on 2 separate days. Resident #1 said on the morning of 10/23/2024 she noticed there were a lot of medicines in the medication cup that Nurse #1 was giving to her. The resident explained she did question what medicines had been given to her and that was when she found out they were the wrong medicines. Resident #1 also said the same thing happened the next evening on 10/24/2024. Resident #1 said after she received the medications from Nurse #2, she felt sluggish but could not blame the way she felt entirely on the medicine because she was being treated for pneumonia and urinary retention and was not feeling well at the time. Resident #1 went on to say she has not seen Nurse #1 or Nurse #2 since the incident. Resident #1 also reported there had not been any other medication errors since.

Review of NP note dated 10/25/2024 revealed Resident #1 had received medications that were not prescribed to her on two separate occasions, 10/23/2024 and 10/24/2024. The NP note showed the wrong medications that Resident # 1 received on 10/23/24 was Metoprolol 100 mg and on she received Apixaban 2.5 mg on the evening of 10/24/2024 after receiving her morning dose of Rivaroxaban 15 mg. The NP note also indicated after her evaluation of Resident #1 she did have increased lethargy, however the resident was receiving treatment due to ongoing pneumonia that was diagnosed on 10/21/2024 and had poor oral intake that could be cause for dehydration. The note also revealed Resident #1 was arousable to verbal stimulus Resident #1 did tell the NP that she had no concerns but did admit to having some shortness of breath. Resident #1's O2 saturation was above 93 % on 2L of O2. The

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NP also indicated over the past 24 hours BP systolic number (Top number of the BP to indicate the blood being pumped out of the heart) ranged between 110s and 135, and the diastolic number (the bottom number that measure the pressure in the arteries when the heart rests between beats) ranged between 60s to 82. Her heart rate ranged between 59-67. (Average BP is 120/80 and average heart rate range is between 60 and 100 bpm) Assessment included in the NP note revealed parameters were added to the Metoprolol order.

An interview was conducted on 11/6/2024 at 11:59 AM via telephone with the NP. During the interview the NP reported she was notified of the medication errors involving Resident #1 that occurred on 10/23/2024 and 10/24/2024. The NP reported after being notified of the medication error that occurred on 10/23/2024 she gave orders to increase vital signs monitoring and to hold digoxin (a medication used to treat CHF and slow down heart rate) and Furosemide (a medication used to aid in removing excess fluid) due to the risk of lowered blood pressure and heart rate. The NP further explained after being notified of the second mediation error that occurred on 10/24/2024 she gave orders to draw labs that included an INR level due to an extra dose of anticoagulant medication. In addition to the INR level the NP also ordered a Complete Blood count (CBC) and a Complete Metabolic Panel (CMP). The NP note further explained Resident #1's O2 saturation had remained above 93% on 2L of O2 and blood pressure and heart rate had remained stable over the 24 hours since the medication errors. The NP went on to say she ultimately did not believe there was harm to Resident #1 due to receiving the wrong

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medications and felt like the facility took the appropriate actions and follow-up.

An interview was conducted on 11/7/2024 at 3:32 PM with the Medical Director (MD). During the interview the MD said she was familiar with Resident #1 and was aware of both medication errors that occurred on 10/23/2024 and 10/24/2024. The MD explained the Metoprolol does that Resident #1 received in error would be considered a significant medication errors due to the risk for decreased heart rate and blood pressure. The MD also explained that the one-time administration of Apixaban 2.5 mg in addition to the already ordered Rivaroxaban 15 mg would not necessarily have been a significant error in terms of the effect on the resident. The MD also explained Resident #1 received 2L of IV fluids following the incident related to lethargy that could have been the result of the medication error or a combination of the medication error and the status of Resident #1 at the time that included advanced age, a diagnosis of pneumonia, urinary retention and weakness. She stated Resident #1 made a total turn around after receiving the fluids in regard to lethargy. The MD further explained Resident #1 was also being treated for urinary retention and pneumonia at the time and the combination of all factors could have led to increased weakness and lethargy, however no harm came to the residents as a direct result of the medications.

An interview was completed with the DON on 11/7/2024 at 3:50 PM where he explained he expected the correct medication to always be administered to the correct resident.

On 11/7/2024 at 2:45 PM an interview was

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F 760	Continued From page 29 conducted with the Administrator. During the interview the Administrator said she expected to see all nurses administer the correct medications to the correct residents. The facility provided a corrective action plan with no completion date and did not provide sufficient evidence that the plan had been implemented.	F 760		