

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2025
NAME OF PROVIDER OR SUPPLIER Stanford Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Harmon Heights Stanford, KY 40484	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>52131</p> <p>Based on observation, interview, and facility policy review, it was determined the facility failed to provide safe medication administration for one of 12 sampled residents.</p> <p>The findings include:</p> <p>Review of the undated facility policy titled Resident Rights revealed the resident had the right to be free from any medication errors and to receive the correct medication.</p> <p>Review of the undated facility policy Medication Administration revealed that the resident had the right to receive the correct medication at the correct time, and the correct dose.</p> <p>Review of the facilities investigative report revealed that Resident (R) 3 and R12 were housed in a room together and on 02/24/2025 they decided that they wanted to switch A bed and B bed positions. The facility switched the two bed positions and did not update the residents bed transfer in the computer system until the next day. On 02/24/2025 at medication pass Registered Nurse (RN)1 gave R3 medications that were supposed to be given to R12 due to failure to properly identify the correct resident. R3 received the following medications that were ordered for R12: 90 units of long-lasting glargine insulin (used to control Diabetes), Xanax 0.25 mg (Used to treat anxiety), Atorvastatin 80 mg (used to reduce cholesterol), Donepezil 10 mg (used to treat Alzheimer's Disease), Duloxetine 60 mg (used to treat Depression/Anxiety Disorders), Eliquis 2.5 mg (a blood thinner), Acetaminophen 500 mg(a pain/fever reducing medication), Ropinirole 0.5 mg (used to treat Parkinson's Disease), Simethicone 80 mg (used to relieve gas), and Trazodone 50 mg (used to treat Depression).</p> <p>In an interview with RN1 at 12:14 PM on 05/14/2025, RN1 stated that it was his first shift working on the floor without a preceptor. RN1 stated that he did not properly identify R3 by her picture, name and date of birth. RN 1 stated that he had been properly trained on how to identify correct residents but only utilized the resident room numbers that night to administer resident medications. RN1 stated he identified the error and reported it to the supervisor and Director of Nursing (DON). RN1 stated the outcome of administering wrong medications to a resident could include, Coma or even death is possible.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 05/15/2025 at 12:34 PM he stated that he had not started working for the company as the DON when the incident happened. He stated that they had an interim DON from regional. When contact information was asked for the regional DON, it was not provided to the surveyor and the surveyor was told that they could not find any contact information for them. According to the DON, coma or even death to a resident could result due administering a wrong medication. The DON stated that he expected that all residents should be properly identified before administering any medication.</p> <p>In an interview with the Administrator on 05/15/2025 at 1:18 PM she stated that she was made aware of the incident on 02/24/2025 around 7:30 PM and that she came to the facility. The Administrator continued to state that RN1 was pulled off the floor immediately and was replaced with another nurse. According to the Administrator, vital signs were obtained for resident #3, the resident was in no distress and the Medical Director/Responsible Party was notified. The Administrator stated that death could be a potential outcome of a resident receiving the wrong medications and her expectations were that everyone will be properly identified each time that a medication was administered.</p> <p>During an interview with the Medical Director on 05/15/2025 at 4:08 PM, he was unable to remember the incident and would have to refer to his notes and continued to state, I am very busy, and it would have to be later in the evening. The surveyor attempted to call back later in the day to contact the Medical Director on 05/15/2025 at 1:48 PM, 2:12 PM, and 2:49 PM. All three attempts received no answer and no call back from the Medical Director.</p>		