STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205064	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ross Manor	758 Broadway Bangor, ME 04401

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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17282 Based on review of the facility internal investigation, clinical record review, facility Medication Administration Policy and Procedure, and interviews, the facility failed to protect a resident from receiving another residents medications resulting in the resident being transferred to the Acute Care Emergency Department (ED) for evaluation and monitoring of low blood pressure and a drop in hemoglobin and hematocrit for 1 of 1 resident reviewed (Resident #1 [R1]). Finding: On 9/3/24, a review of the facility's internal investigation was completed. The investigation indicated that on 8/27/24, during morning medication pass, Certified Nurse Assistant-Medication (C.N.A.-M) administered the wrong medications (Aspirin 81 milligrams (mg),Cholestyramine 1 packet for high cholesterol, Clopidogrel Bisulfate for atrial fibrillation, Isosorbide 90 mg [Imdur-used to prevent angina], Psyllium Husk Powder for constipation, Metoprolol Tartrate [used to treat high blood pressure/atrial fibrillation], and Tylenol 1000 mg for pain to R1. C.N.A.-M administered Resident #2's (R2's) medications to R1 in error. R1 was not allergic to any of the wrongfully administered medications. R1 was immediately assessed and a physician who was at the facility ordered the resident to be sent to the Emergency Department (ED). R1 was monitored in the ED for low blood pressure and was treated with intravenous fluids (IV) and R1's labs showed a mild drop in hemoglobin and hematocrit. The Skilled Nurse Manager documented in her investigation that C.N.A.-M stated she read the name in the computer system incorrectly, thinking that R1's name was R2's name. The medications were administered. When C.N.A.-M noticed the error, she immediately notified the nurse and R1 was evaluated and sent to the ED. The follow up to this incident was the facility audited the profiles of all residents to ensure pictures were connected to all residents. Audits were continued to monitor that all resident pictures are on their electronic Medication Administration Record (MAR). The Director of Nursing placed the facility's Medication Administration policy and sign sheets on all units to be reviewed by those who pass medications and ensured this was completed by 9/3/24. Documentation in R1's clinical record under the physician orders indicated R1 had an order for Metoprolol Tartrate (used to treat high blood pressure) 25 milligrams (mg) give 0.5 tablet by mouth two times a day for hypertension. Documentation on R1's Minimum Data Set 3.0, dated 8/20/24, was coded to indicate the resident's Brief Interview for Mental Status (BIMS) was a '12'. For this scoring system of 0-15, a score of 8-12 indicates mild cognitive impairment. R1 is alert and confused at times. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 8/27/24 at 9:54 a.m., written by RN1, Laurel Unit Nurse Manager, indicated R1 was given medications that were not prescribed to him/her, one of which contained anti-hypertensives. Resident subsequently started to have low blood pressures for him/her, which was 88/60. Provider notified. Emergency Medical Services (EMS) called for emergent transfer immediately after error was noted. Resident transferred to bed. The Provider stated to put R1 in a Trendelenburg position (position used for hypotension-to help blood return to the heart and restore adequate brain perfusion) while waiting EMS arrival. A nurses note dated 8/27/24 at 10:44 a.m., written by RN2, [NAME] Unit Nurse Manager, indicated R1 was transferred to the ED after a medication pass error. R1 had been given Metoprolol 50 mg and Isosorbide (Imdur-used to prevent angina) 90 mg. Provider notified and resident son notified after call back. Resident transported to ED for evaluation. Documentation in the ED Provider note indicated R1 was inadvertently given the wrong medications. These medications included Imdur, Plavix (antiplatelet medication), aspirin, and a higher dose of Metoprolol. R1 was given IV fluids as her blood pressure was low for a period of time. R1's lab work was overall unremarkable other than a mild drop in hemoglobin and hematocrit (H+H) with no signs of bleeding (this was not a pre-existing problem). Documentation in R1's physician progress note, dated 8/30/24, indicated R1 transferred to ED on 8/27/24 was given wrong meds-Metoprolol 50 mg and Imdur 90 mg. Blood pressure was low and resident feeling lightheaded. H+H low-follow up labs to be done. Facility Medication Administration Policy and Procedure, under #6: The individual administering medications must verify the resident's identity before giving the resident his/her medications which include checking photograph attached to medical record and if necessary, verify resident identification with other facility personnel. Under #7: check the medication label three times for right individual, right medication, right dose . On 9/12/24 at 8:30 a.m., in an interview with the surveyor, R1 stated he/she was given the wrong medications and within a half hour of taking these medications R1 stated he/she felt dizzy/lightheaded. R1 stated he/she did not know who gave the medications, but he/she trusts them to give the correct medications. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 9/12/24 at 12:20 p.m., in an interview with the surveyor, C.N.A.-M confirmed that she gave R1 the wrong medications. She confirmed that she gave R2's medications to R1 on the morning of 8/27/24. C.N.A.-M stated she had come back to work after not working at this facility for about two months. She stated she remembered some residents but not others. It was breakfast time and in the small dining room near the 100/200 rooms, she saw R1 sitting at the table and thought it might be R2. C.N.A.-M stated she thought R2's last name was a females name. C.N.A.-M stated she did not recognize the resident and the name on her computer screen (electronic Medication Administration Record (MAR). R2's name was displayed on the MAR screen. C.N.A.-M stated she asked R1 if his/her name was the last name for R2. C.N.A.-M stated the resident acted as if he/she couldn't hear her, so C.N.A.-M got closer to the resident, spoke a little louder and asked again. C.N.A.-M stated the resident (R1) answered yes and she gave R1 the medications. C.N.A.-M stated she did not know R1 was confused. C.N.A.-M proceeded down the hall to the rooms. She put a room number in the computer and R2's name came up and showed that R2's medications had already been given. C.N.A.-M stated she was confused so she went through all the people she had given medications to and realized she gave R1 the wrong medications. C.N.A.-M stated she gave R2's medications to R1. C.N.A.-M stated she immediately told RN1. As a result of this isolated incident, the following corrective actions were initiated between 8/27/24 and 9/3/24. On 8/27/24, the Skilled Nurse Manager re-educated C.N.A.-M on the medication administration policy and procedure. On 8/27/24, copies of the Medication Administration policy and procedure along with sign sheets was placed at the nurse's stations and all medication technicians and nurses that administer medications were mandated to review the policy and procedure and sign the sheet that they did the review. This was completed by 9/3/24. In addition, the facility recognized that not all residents had a picture attached to their electronic MAR for facial identification. Audits of all the residents MARs was completed to ensure they all had a picture. The Skilled Nurse Manager stated about three residents needed a picture. On-going audits are being done by the director of Nursing and/or the Skilled Nurse Manager weekly for a month to ensure new residents have a picture taken and attached to their MAR.