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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235599	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage House Nursing and Rehab	2394 Midland Rd Bay City, MI 48706

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 0660

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Plan the resident's discharge to meet the resident's goals and needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38471

This citation pertains to intake number MI00147076

Based on observation, interview and record review the facility failed to maintain professional standards and complete comprehensive and safe discharge for one resident (Residednt #808) reviewed for discharge, resulting in Resident #808 being discharged from the facility with a multitude of another resident's (Resident #807) medications in their possession.

Findings Include:

Resident #808:

On 10/22/2024 at 4:30 PM, Resident #808 was observed watching television in her room. She was in good spirits and when asked about her most recent discharge from the facility she stated the nurse gave her another residents medications. Resident #808 explained she was discharged around 5:30 PM (on 9/20/2024) and provided with a lot of medications which she thought was odd as she was only prescribed 2-3 medications. Resident #808 reported she did take one pill from the blister pack which resembled another one of her medications.

When Resident #808's Home Health Care nurse arrived on Sunday (9/22/2024) was when it was discovered the incorrect medications were discharged with the resident. The nurse observed the name on the blister packs were incorrect. Resident #808 reported she did not have any adverse reactions from ingesting the medications.

On 10/22/2024 at approximately 4:45 PM, a review was completed of Resident #808's medical record. It revealed the resident admitted to the facility on [DATE] with diagnoses that included Rhabdomyolysis, Adult Failure to Thrive, Hyperlipidemia, Peripheral Vascular Disease and Foot Drop. Further review revealed the following:

Progress Notes:

9/20/2024 17:23: Resident discharged home with family, left facility in her wheelchair with all of her belongings. Meds given to family member and reviewed. No belongings left in room. All questions answered. Med rec printed.

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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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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It can be noted while this discharge note was charted, it is not an accurate depiction of what truly occurred during Resident #808's discharge from the facility. On 10/23/2024 at 8:40 AM, an interview was conducted with DON (Director of Nursing) regarding Resident #808's discharge. The DON reported Nurse L contacted her on 9/20/2024 and asked what medications Resident #808 was being discharged with. The DON explained the resident would either have a bag of medications, scripts completed or provide her with medications from the cart. The DON further explained the social worker completes a discharge folder for each resident and the nurse would have to complete the medication reconciliation document, discharge instructions and obtain the resident signature. The DON let Nurse L know if there were any issues to contact the Unit Manager who would further guide her. Nurse L searched the medication room and was not able to locate Resident #808's medications and the discharge folder did not have the scripts. The nurse contacted the Unit Manager who instructed her to pull the meds needed from the medications cart to last until Resident #808's first doctor appointment. The DON reported on Saturday evening she worked the floor, and another nurse was searching for missing medication blister packs that they knew were there yesterday. The nurse had to go in backup to obtain the medications for the resident. The DON stated upon entering the medication room she noticed a bag of medications for Resident #808 atop the counter and questioned Nurse L about it as she was working. The nurses asserted the bag of medications were not in the facility yesterday and someone was playing tricks on her. The DON reviewed the delivery receipt which indicated the medications were delivered Thursday September 19, 2024, and indeed were in the building upon Resident #808' discharge. Nurse L further expressed she enlisted two other nurses to search for the medications which was unsuccessful. The DON interviewed both nurses and one stated Nurse L provided them with a different resident name and the other nurse stated she never assisted in the search. On Sunday morning, Nurse Q alerted the DON that Nurse L discharged Resident #808 with 7 blister packs for another resident (#807). Nurse Q gathered the residents correct medications and delivered them to her. The DON discussed this with Nurse L who admitted to not reviewing the blister pack of medications she pulled from her medication cart, completing a medication reconciliation nor reviewing the specific medications given to resident prior to her leaving. Nurse L's reasoning was they were busy and room changes were completed that day. The medications that the incorrectly sent home with Resident #808 are as follows: -Seroquel 400 MG 1 card -Trintellix 5 mg- 1 card -Atorvastatin 20 mg 1 card -Seroquel 300 MG 1 card -Potassium 20 MeQ- 1 card -Lasix 40mg- 1 card -Prednisone 5 mg 1 card (continued on next page)

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-Gabapentin 600 mg 1 card

-Amitriptyline -25 mg 1 card

On 10/23/2024 at approximately 11:00 AM, a review was completed of medication Packing Slip for Resident #808. It indicated Resident #808's medications were delivered to the facility on [DATE]. The medications delivered were:

40 MG (milligram) Atorvastatin tab

40 MG DR (delayed release) Pantoprazole

On 10/23/2024 at 11:55 AM, an interview was attempted with Nurse L regarding their discharge of Resident #808 on 9/20/2024. Nurse L expressed she was not comfortable answering questions from this writer and would be contacting her attorney.

On 10/23/2024 at 12:10 PM, an interview was conducted with Nurse Q regarding Resident #808's discharge from the facility. Nurse Q explained on Saturday they were not able to find Resident #807's medications and there were only two blister packs in the cart. They pulled what they could from backup but were unable to ascertain where her medications were.

Nurse Q reported on Sunday 9/22/2024 the receptionist informed her Resident #808 was on the phone and stated she received another residents' medications when discharged on Friday. The home health care nurse visited her that morning and discovered the discrepancy. Nurse Q delivered Resident #808's correct medications to her home and picked up Resident #807's medications that had been sent with the resident. Upon arrival at Resident #808's home she told the nurse she took the pink/orange pill as Trintellix (identified by Nurse Q) as she thought it would make her depressed. Nurse Q reported Resident #808 had about 10 blister packs of Resident #807's medications in her possession.

On 10/23/2024 at approximately 12:30 PM, a review was conducted of the facility's investigation into the incident and following was reviewed:

Disciplinary Action for Nurse L dated 9/22/2024:

Nurse sent resident home with incorrect discharge meds, and incorrect/missing discharge instructions. Nurse L was suspended on 9/23/24 and terminated on 9/24/24.

Medication Error Report:

9/20/2024: Nurse (L) sent resident (#808) home with another resident meds (medications). Resident took one Trintellix 5 mg tab that was not ordered for her . Resident remains at her baseline at home . Education mandatory to all nurses. Nurse terminated.

History and Physical from Acute Care Hospital:

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