STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44770 Based on observation, interview, and record review, the facility failed to protect 1 (#1) resident from neglect of medical care by a staff member, when the licensed staff member provided incorrect medications, which was a significant medication error, then failed to properly monitor the resident after the error, and the resident then had a decrease in cognition and change in vital signs. When the decline was identified, the resident had to be given additional medication and was sent to the emergency room and had a hospital stay; the facility also failed to protect two (#s 5 and 7) residents on the memory care unit from having sexual contact without having prior assessment for their ability to consent to sexual contact; and, failed to protect 1 (#10) resident from a resident to resident abuse event which resulted in a resident fall. There were 11 residents in the sample for this investigation. Findings include: 1. During an interview on 8/27/24 at 1:59 p.m., staff member H said she gave resident #1 a 10 mg Vicodin and 60 mg OxyContin (High dose of opioid medications that cause sedation, decreased respirations, and may cause death). This was a significant medication error, as she gave the medication to resident #1, and the resident did not have an order for the medication. Staff member H said she called the provider (physician) on call; and was told to take the resident's (#1) vital signs every 4 hours, and then report to the provider if the resident had any changes. Staff member H said she did not take baseline vital signs on the resident, and she did not put the resident on a continuous oxygen saturation monitor (a monitor to show the effectiveness of respirations) after the error. Staff member H said approximately two hours after she had given the medications to the resident she took resident #1's vital signs and found the resident was hypotensive (low blood pressure), had low oxygen saturation levels, and was not responsive. Staff member H said she gave resident #1 Narcan to reverse the effects of the opioid medication, and then called 911. During a telephone interview on 8/28/24 at 11:06 a.m., staff member I said she received a phone call from staff member H stating she accidentally gave resident #1 the wrong medication. Staff member I said she told staff member H to monitor resident #1 for any changes and to send her (#1) to the Emergency Department if she showed any changes. She said waiting two hours to take vital signs could have been very serious, and a danger for the resident. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of resident #1's electronic medical record, showed resident #1 was given Vicodin 10/325 mg and OxyContin 60 mg ER at 9:38 a.m. Resident #1 was found unable to open her eyes, her blood pressure was 84/54, and her oxygen saturation 80%. There was no time documented for the vital signs, then Narcan 0.4 mg was given at 11:30 a.m. The EMR failed to show documentation of her vital signs, or documentation of her state of consciousness, between 9:38 a.m. and 11:30 a.m., on the morning of 7/27/24. Review of resident #1's ambulance report, dated 7/27/24, showed the ambulance was notified by dispatch of an unresponsive resident who had been given an unintentional overdose of medication at 9:38 a.m. The unit arrived at the facility at 11:36 a.m. The report showed, . Patient is barely conscious but is arousable . Medications had been given approx. 2 hours prior to 911 activation. Patient was found in her room unconscious and initial oxygen saturation of 79%. Staff then administered 0.4 mg naloxone into a vein on the patient's right hand . [sic]. Review of resident #1's hospital EMR, showed resident #1 arrived at the emergency department on 7/27/24 at 11:58 a.m. Resident #1 was treated for opioid overdose including continuous oxygen saturation monitoring, and a continuous intravenous Narcan drip. She had one episode of vomiting while wearing her oxygen mask. She was discharged from the hospital on 7/29/24, with antibiotics and prednisone, for aspiration pneumonia. Review of a facility policy titled, Adverse Consequences and Medication Errors, Revised February 2023, showed: 5. In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare . Review of a facility policy titled, Abuse Prevention Plan-Montana Policy, not dated, showed: Abuse Prohibition 1. All residents have the right to be free of abuse, neglect . .7. Neglect . d. The absence of or likelihood of absence of care or services necessary to maintain the physical and mental health of the resident and which a reasonable person would deem essential to obtain or maintain the Resident's health, safety and comfort . e. Neglect of goods or services may occur when staff are aware, or should be aware, of a resident's care needs . .h. Not providing supervision and/or monitoring of the delivery and implementation of care and/or environment . Further Examples of Abuse .2. Medical Neglect (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	.d. Failure to monitor for adverse drug reactions . 2. During an interview on 8/27/24 at 1:12 p.m., staff member F said he was working on the memory care unit on 8/19/24. He and another staff member noticed residents #5 and #7 were getting pretty close. He said they (staff) were watching them more closely because the residents would go into each other's rooms. He said he became concerned when he noticed resident #5 went into resident #7's room, and they had not been seen for a while. He said he went to check on them, and he found resident #7's door was closed. He said he knocked on the door, opened it, and found resident #5 and resident #7 naked in the bed. Staff member F said it looked like they were having sex. He said he didn't know what to do at first. He said he and another staff member separated the residents, and as he was getting resident #5 dressed, the resident told he would sure like to do that again, and that it made him feel like a man. Staff member F said he did not ask resident #5 what that meant because he felt it was pretty clear. Staff member F said resident #5 seems to be more interested in the female residents since the incident on 8/19/24. Staff member F said he did not know if either resident was assessed for their ability to consent to sexual contact. During an interview on 8/27/24 at 1:28 p.m., staff member B said resident #5 and resident #7 were found naked in resident #7's bed. She said they moved resident #5 out of memory care and onto a different hall because she felt the female residents in that hall have more capability to make a decision. Staff member B said she did not know if anyone had done an assessment on either resident to determine if they were capable of consenting to sexual behavior, but she said it was the responsibility of the Social Service Department to fill those out. During a telephone interview on 8/28/24 at 5:23 p.m., staff member M said she was with staff member F when they found residents #5 and #7 in bed naked together. She said she knew the residents were in the room together, so she had staff member F go with her to check on them. She said after they saw the two residents were naked, and it looked like they were having sex, they shut to door and notified the nurse. She said the nurse called the manager on call, and they were told to separate the residents. She said they went back in, got the two residents out of bed, and separated them. She said she did not ask either resident what was happening or what occurred between them. Staff member M said resident #7 was in memory care because she was an exit seeker. She said resident #7 could carry on a conversation and was confused sometimes, but she did not know if resident #7 was capable of consenting to sexual contact. Staff member M said resident #5 was frequently confused, and he would forget he had difficulty standing, he would forget he was married, and she did not know if he had been assessed for his ability to consent to sexual contact. During an interview on 8/27/24 at 12:59 p.m., staff member L said she heard about resident #5 and #7 being found in bed naked together. She said she did not know if either resident had been assessed for their ability to consent to sexual contact. She said she thought that would be a nursing duty. She said it was possible it was her responsibility, but she had not been instructed to do that type of assessment on resident #5 or resident #7. Staff member L said she did speak with resident #5's significant other, and she was told the significant other did not think resident #5 could have sex. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 8/27/24 at 2:25 p.m., resident #7 was sitting at a table with a male resident. She was telling him about a family with a child, and she was repeating herself frequently. The story she was telling did not seem to follow a timeline, and it was difficult to understand if what she was talking about was something that happened, or if it was fictional. The male resident was looking down and not participating in the conversation. Staff member N said resident #7 was in memory care because she couldn't remember anything and because she would frequently try to escape from the facility. Staff member N said resident #7 would frequently share stories about her past, but she was unsure if what resident #7 was talking about during the observation, was something from resident #7's past. Review of resident #5's EMR, showed resident #5 had a diagnosis of unspecified dementia. He had a BIMS (Brief Interview for Mental Status) on 7/9/24 of 9 reflecting moderate impairment, and a previous BIMS of 4, reflecting severe impairment. Resident #5's care plan showed his wife (who is the POA) aids with all decision-making. A Care Plan note, dated 8/19/24, showed, Resident has now moved from memory care unit to C-hall due to inappropriate sexual conduct with another resident on 8/19/24. However, today after lunch this nurse overheard another resident talk about how this resident was expressing his interest with her in having a sexual relationship. Will continue to monitor resident's location. The EMR lacked an assessment for ability to consent to sexual contact, and lacked documentation in the chart describing the incident of sexual contact,with resident #7, on 8/19/24. Review of resident #7's EMR, showed resident #7 had a diagnosis of Frontotemporal Neurocognitive Disorder, Oppositional Defiant Disorder, and Unspecified Dementia. Resident #7 had a BIMS of 12, reflecting moderate cognitive impairment, on 7/25/24. An admission progress note, dated 8/1/24, showed [Resident Name] has been living with family; however her dementia has progressed to the point where she is a danger to herself and family caregivers. The EMR lacked an assessment for the resident's ability to consent to sexual contact, and lacked documentation in the chart describing the incident of sexual contact with the other resident on 8/19/24. Review of a facility policy, titled, Abuse Prevention Plan-Montana Policy, not dated, showed: Abuse Prohibition 1. All residents have the right to be free of abuse, neglect, involuntary seclusion, exploitation, misappropriation of funds/property and mistreatment/maltreatment. 2. The intent of this policy is to provide a safe living environment to all residents of the facility ad to provide guidelines for investigating and reporting of suspected maltreatment. Definitions 1. Vulnerable Adult a. A vulnerable adult means any resident receiving services from this facility who may be unable to report maltreatment without assistance due to physical or mental impairment . 12. Criminal Sexual Abuse (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. Per Affordable Care Act: Serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is relating to aggravated sexual abuse or any similar offense under State law. . c. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act . 17. Abuse .b. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary obtain or maintain physical, mental and psychosocial well-being . . 2. Sexual Abuse . b. Generally, sexual contact is nonconsensual if the resident either: . i. Appears to want the contact to occur but lacks the cognitive ability to consent . c. Other examples of nonconsensual sexual contact may include, but are not limited to: .vii. Anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will ensure the resident is evaluated/assessed for capacity to consent by the Clinician, legal representative and/or appropriate family members, resident, facility staff, and if needed, a psychologist/psychiatric representative. viii. The review will include an evaluation of the resident's DX, BIMs, observations of past and present behaviors/actions, and fluctuations in lucidity. ix. Results of this evaluation will be kept in the resident's chart. Residents without the capacity to consent to sexual activity may not engage in sexual activity. 3. During an interview on 8/27/24 at 12:55 p.m., staff member K said she was not working the day resident #10 was found in resident #11's room on the floor. Staff member K said the memory care unit was a locked unit, and the staff tried to keep residents that wandered from going into other resident's rooms, but she said it still happened frequently. Staff member K said resident #11 was moved out of the memory care unit because she does not like it when residents wander into her room. During an interview on 8/27/24 at 1:22 p.m., staff member F said he works in the memory care unit, sometimes. He stated resident #10 only speaks Russian, so he uses Google Translate to help him communicate with her. He said she frequently wanders and will go into other resident's rooms. Staff member F said the staff try to keep residents out of other resident's rooms because some of the residents will get upset. He stated it is hard to keep residents out of other rooms when the residents on the memory care unit tend to wander without purpose. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of resident #10's EMR, included an incident note dated 6/29/24, which showed resident #10 was found on the floor in resident #11's room. Resident #11 stated she was trying to get resident #10 out of her room, so she pushed her and resident #10 fell . The EMR showed resident #10 had diagnoses of Repeated Falls, Muscle Weakness, Altered Mental Status, Alzheimer's disease, and Dementia. Review of resident #11's Care Plan, showed on 7/1/24, an intervention was placed reflecting, Please redirect wandering residents away from her personal space. Move off memory care for less interaction with wandering residents. Review of an incident report provided by the facility, showed on 6/29/24, resident #10 wandered into resident #11's room. The Nursing description of the event included, [Resident #11 name] attempted to get resident (#10) out of room causing the other resident (#10) to fall to the floor. The Resident description of the event included, Stated she (#11) was trying to her (#10) out of her (#11) room and pushed her (#10). Review of a facility policy titled, Abuse Prevention Plan-Montana Policy, not dated, showed: Abuse Prohibition 1. All residents have the right to be free of abuse, neglect, involuntary seclusion, exploitation, misappropriation of funds/property and mistreatment/maltreatment. 2. The intent of this policy is to provide a safe living environment to all residents of the facility ad to provide guidelines for investigating and reporting of suspected maltreatment. .6. Abuse .c. Hitting, slapping, kicking, biting, scratching, pushing, pinching or any other corporal punishment .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44770 Based on observation, interview, and record review, the facility failed to identify and report an incident of suspected medical neglect of care by a staff member, for 1 (#1); and failed to identify and report an incident of inappropriate sexual contact, involving 2 (#s 5 and 7) to the State Survey Agency, of 11 sampled residents. Findings include: 1. During a telephone interview on 8/27/24 at 1:59 p.m., staff member H said she accidentally gave resident #1 the wrong medications on 7/27/24. She said she gave resident #1 a 10 mg Vicodin and 60 mg of OxyContin by mistake. She said she called the provider right away. She did not put the resident on a continuous oxygen saturation monitor and did not take vital signs immediately. She said the provider told her to take vital signs every four hours. She said about three hours later, the resident was found unresponsive. She said she gave resident #1 Narcan and called 911. During an interview on 8/28/24 at 11:14 a.m., staff member C said he was the administrator for the facility when the medication error occurred on 7/27/24. He stated, We do a risk management for any incidents that happen in the facility. We do a quick round table. That risk management was done on 8/1/24. We made sure the providers were notified, and we made sure the care plan was updated. Staff member H was terminated for her poor work ethic. I cannot recall if we did anything else . Staff member C did not recognize neglect during his investigation, and he did not report the incident of medical neglect to the State Survey Agency. During an interview and observation on 8/28/24 at 4:58 p.m., staff member B said she did not think a medication error needed to be reported to the State Survey Agency. Staff member B looked in resident #1's EMR, on her computer, and was unable to show documentation by the nurse showing vital signs, or documentation between the time the significant medication error occurred at 9:38 a.m., and when she (#1) was found unable to open her eyes, hypotensive, and hypoxic at 11:30 a.m. Staff member B did not recognize neglect of care during her investigation of the medication error and did not report the incident to the State Survey Agency. Review of resident #1's EMR showed a significant medication error occurred on 7/27/24, resulting in resident #1 requiring Narcan at the facility, and she was transported to the Emergency Department where she was admitted to the hospital requiring a continuous intravenous Narcan drip, continuous oxygen, and hemodynamic monitoring. Refer to F760 - Free of Significant Medication Errors for more information on the medication error. Review of a facility policy titled, Abuse Prevention Plan-Montana Policy, not dated, showed: .7. Neglect . d. The absence of or likelihood of absence of care or services necessary to maintain the physical and mental health of the resident and which a reasonable person would deem essential to obtain or maintain the Resident's health, safety and comfort . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Not providing supervision and/or monitoring of the delivery and implementation of care and/or environment . Further Examples of Abuse .2. Medical Neglect .d. Failure to monitor for adverse drug reactions . The State Survey Agency reporting system failed to show an incident of suspected neglect for resident #1 was reported by the facility on 7/27/24 or 7/28/24. 2. During an interview on 8/27/24 at 1:28 p.m., staff member B said resident #5 and resident #7 were found naked in resident #7's bed together. Staff member B said she did not know if anyone had done an assessment on either resident to determine if they were capable of consenting to sexual behavior. Staff member B stated she did not report the incident to the State Survey Agency because she felt the interaction was consensual. During an interview on 8/27/24 at 12:59 p.m., staff member L said she thought there had been an investigation into the incident involving resident #5 and #7 on 8/19/24. She said she was shocked that it had not been reported to the State Survey Agency. Review of resident #5's EMR showed, resident #5 had a diagnosis of unspecified dementia. The EMR lacked an assessment for ability to consent to sexual contact and lacked documentation in the chart describing the incident of sexual contact with resident #7 on 8/19/24. Review of resident #7's EMR showed, resident #7 had a diagnosis of Frontotemporal Neurocognitive Disorder, Oppositional Defiant Disorder, and Unspecified Dementia. The EMR lacked an assessment to show the resident's ability to consent to sexual contact and lacked documentation in the chart describing the incident of sexual contact with resident #5 on 8/19/24. Review of a facility policy titled, Abuse Prevention Plan-Montana Policy, not dated, showed: Definitions 1. Vulnerable Adult a. A vulnerable adult means any resident receiving services from this facility who may be unable to report maltreatment without assistance due to physical or mental impairment . 12. Criminal Sexual Abuse . c. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act . . 2. Sexual Abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Generally, sexual contact is nonconsensual if the resident either: i. Appears to want the contact to occur but lacks the cognitive ability to consent . c. Other examples of nonconsensual sexual contact may include, but are not limited to: Review of Appendix PP of the State Operations Manual showed, .Required to Report . Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown . [sic] The State Survey Agency reporting system failed to show an incident on 8/19/24 of sexual contact between residents #5 and 7 had been reported by the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on observation, interview, and record review, the facility failed to fully investigate an incident involving a significant medication error when medical neglect occurred after the error, for 1 (#1) resident; failed to fully investigate an incident involving sexual contact between 2 (#s 5 and 7) residents who were not assessed to ensure it was consensual contact, and ensure other residents were protected, which allowed ongoing sexual behaviors to go unaddressed as needed. This negatively affected a resident (#6), who would then not leave her room or go to the dining room due the male's approaches and comments to her, of 4 sampled residents. Findings include: 1. During a telephone interview on 8/27/24 at 2:37 p.m., staff member H said she was administering medications on 7/27/24, and she accidentally gave resident #1 a 10 mg Vicodin and 60 mg OxyContin, neither were ordered for her. Resident #1 was later found later unconscious and hypoxic. Staff member H said she gave resident #1 Narcan to reverse the effects of the opioid medications and called 911. Staff member H said she was fired for the incident. She said she still needed to get her other duties completed, and felt she did not have enough time to follow proper protocol, and other nurses were prepouring medications. During an interview on 8/28/24 at 11:14 a.m., staff member C said he did not remember asking any other nurses if they were pre-pouring medications because he felt that was a method of medication administration the facility did not support. He stated he did not recall if the facility did any education for other nurses after the incident of the significant medication error made by staff member H. Staff member C stated, I personally did not do any training with any of the other nurses after this incident. He stated he did not know if there was a policy directing the nurse to look up the side effects of the medications or monitoring criteria for a resident given the wrong medication. He stated a nurse should know to do those things as part of their nursing degree. He did not know if staff member H had looked up the medications or if she had looked up monitoring criteria for accidental administration of those medications to a resident who does not take those medications regularly. He did not know that taking vital signs every four hours for a resident given such a large dose of opioid medication was not acceptable care. He stated he was responsible for the investigation of the medication error, along with his nurse managers. During a telephone interview on 8/28/24 at 11:06 a.m., staff member I stated contact occurred on 7/27/24 by staff member H and was informed staff member H had given resident #1 the wrong medication. Staff member I was informed resident #1 was given 10 mg Vicodin and 60 mg OxyContin that was for another resident. Staff member I was aware resident #1 did not usually take those medications. She stated she would not have told the nurse to take vital signs every four hours for that type of medication error. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 8/28/24 at 4:58 p.m., staff member B said she could not find any documented vital signs between 9:38 a.m., in #1's EHR, when the medication error was made and 11:33 a.m. , when resident #1 was taken to the hospital by paramedics. Staff member B said she was out of town when this incident happened, and she would normally be the person who would investigate these incidents (medication errors). She said staff member C was available during the incident, and he had been the person responsible to investigate. Staff member B said she released staff member H from employment when she returned to the facility, after her time out of town. Staff member B stated she did not interview other nurses about pre-pouring medications and did not investigate why the provider said to take vital signs every four hours, although the provider denied giving that order to staff member H. Review of a facility provided document, titled Medication Error Scoring Sheet, dated 7/27/24, showed staff member H gave incorrect medications to resident #1. The scoring sheet showed a total error score of 34, reflecting a verbal, written, and signed disciplinary action was required to be placed in the staff member's personnel file for the severity of the medication error. Review of a file provided by the facility, containing the facility's investigation documents for resident #1 receiving the wrong medications on 7/27/24, showed the file lacked QAPI committee information regarding the medication error on 7/27/24, lacked information from the medical director, and lacked information from the consultant pharmacist regarding the medication error on 7/27/24. The file contained information for 7/27/24, and a written corrective action form for the medication error of giving the wrong resident MS ER 60 mg and a Norco 10-325 mg. It showed resident (#1) became hypotensive, had a decreased oxygen level, and shallow respirations. Resident #1 was given Narcan and sent to the hospital, and returned to the facility on [DATE], with a prescription for antibiotics and prednisone. The form showed staff member H was under review for her discharge of employment. Review of facility provided documents, titled Daily Assingments [sic] showed, staff member H worked on 7/27/24, 7/28/24, 7/29/24, and 8/2/24 (specifically assigned AM med pass). Protective measures were not implemented immediately following the medical neglect to ensure safety of other residents. 2. During an interview on 8/27/24 at 12:59 p.m., staff member L stated she found out on 8/23/24 about a complaint from resident #6, showing resident #5 made inappropriate sexual comments to resident #6. Staff member L stated a note in resident #5's EMR, dated 8/22/24, showed a female resident (#6) was isolating in her room and not going to the dining room. Staff member L said resident #5 had a previous sexual encounter with another resident (#7), a few days prior. Resident #5 had been moved out of memory care because of the encounter. Staff member L said on 8/19/24, resident #5 was found naked in bed with resident #7. Staff member L said she just assumed an investigation was done about the incident with resident #5 and #7 on 8/19/24. She did not know if anyone had completed an assessment to determine if residents #5, #6, or #7 could consent to sexual contact. She stated she thought staff member B would be the person who would do the (capacity to consent) assessment, then stated it was possible she was responsible for the assessments, but she did not know for sure. During an interview on 8/27/24 at 1:12 p.m., staff member F said he and another staff member found resident #5 and resident #7 in resident #7's room naked in bed together on 8/19/24. Staff member F said he did not ask resident #5 what was happening when he found the two residents in the room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/28/24 at 5:23 p.m., staff member M stated she was with staff member F, when they found resident #5 and #7 naked in bed together, on 8/19/24. She said she did not ask resident #7 what was happening when they found them together, and they did not do any kind of examination to determine if the residents had sex. During an interview on 8/27/24 at 1:28 p.m., staff member B said resident #5 and resident #7 were found naked in bed together on the memory care unit on 8/19/24. She stated the facility did not investigate the incident because it was felt the sexual contact was consensual. Staff member B said she did not know if an assessment (capacity to consent) had been done for resident #5 or #7 to determine if they were capable of consenting to sexual contact prior to the incident, or afterward. A request was made for the facility's complete investigation into the sexual encounter between the two residents on the memory care unit, residents #5 and #7, on 8/19/24; and a request for the assessments for resident #5 and #7's ability to consent to sexual contact was made on 8/28/24. Neither the investigation of the 8/19/24 incident, nor any capacity to consent assessments completed prior to 8/19/24 were provided, by the end of the survey, on 8/28/24. During an interview on 8/28/24 at 4:47 p.m., staff member B provided sexual consent assessments for resident #5 and #7 that were completed on 8/28/24. She stated there were no capacity to consent assessments completed prior to 8/19/24. Staff member B provided the investigation file for resident #6, accusing resident #5 of inappropriate sexual comments. The file showed she completed it, and included some information for the 8/19/24 incident with resident #7, in that investigation. Review of a facility policy titled, Abuse Prevention Plan-Montana Policy, not dated, showed: Abuse Prohibition . 2. Sexual Abuse b. Generally, sexual contact is nonconsensual if the resident either: i. Appears to want the contact to occur but lacks the cognitive ability to consent . c. Other examples of nonconsensual sexual contact may include, but are not limited to: .vii. Anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will ensure the resident is evaluated/assessed for capacity to consent by the Clinician, legal representative and/or appropriate family members, resident, facility staff, and if needed, a psychologist/psychiatric representative. viii. The review will include an evaluation of the resident's DX, BIMs, observations of past and present behaviors/actions, and fluctuations in lucidity. ix. Results of this evaluation will be kept in the resident's chart. Residents without the capacity to consent to sexual activity may not engage in sexual activity.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interview and record review, the facility failed to protect 2 (#s 9 and 10) residents from accidents and hazards. Resident #9 sustained eight falls within 17 days, she was sent to the hospital for five of the falls, and had significant injuries for two of the falls. Resident #10 was pushed by another resident and fell to the floor, putting her at risk for injury, due to her wandering, of 11 sampled residents. Findings include: 1. Review of resident #9's EMR, showed resident #9 was admitted to the facility on [DATE]. Resident #9's medical record showed: - An alert note documented on 6/23/24 at 12:42 p.m., showed resident #9 was impulsive, forgetful, and was a fall risk. - An Incident note on 6/23/24 at 7:47 p.m., showed resident #9 was found on the floor of her room at 2:00 p. m. - An incident report on 6/23/24 at 7:49 p.m. showed resident #9 was found in her room on the floor, the note showed resident #9 was confused, she was returned to her bed, and given pain medication for low back pain. Resident #9 said she may have hit her head. - An alert note written on 6/26/24 at 7:00 p.m., showed resident #9 was sent to the emergency department for a head laceration after she fell . - An incident note on 6/27/24 at 7:22 a.m. showed resident #9 was found on the floor in her room, bleeding from her head. The note showed resident #9 had a history of falls, was encouraged to call for assistance, and had a sign posted in her room reminding her to call for assistance, at the time of her fall. Resident #9 was transported to the ER. - An event note dated 6/27/24 at 11:01 a.m., showed resident #9 had an unwitnessed fall. The note showed her care plan was updated, and the new intervention included putting resident #9 at the assisted table in the dining room. - An incident note on 7/7/24 at 4:33 a.m. resident #9 was found on the floor in her wheelchair with blood on the ground. She had a laceration on the back of her head. Resident #9 was sent to the hospital. - An event note documented on 7/9/24 at 11:45 a.m., showed resident #9 fell in the dining room. Her table-mates said she was sitting in her wheelchair, she got up and started to walk, and fell on the floor. The note showed her care plan was updated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- An event note written on 7/9/24 at 12:22 p.m. showed resident #9 had an unwitnessed fall in her room. The note showed her care plan was updated and the resident would have a fall mat and seat belt for her wheelchair. Resident #9's care plan showed, The resident is at risk for falls r/t diagnosis of dementia, history of repeated falls, diagnosis of muscle weakness, unsteadiness, confusion, and underlying dementia; initiated on 6/20/24. The interventions were updated on 6/27/24, 7/1/24, 7/9/24, and 7/10/24. Review of #9's emergency department notes showed: - On 7/6/24, resident #9 was seen for a traumatic subarachnoid hemorrhage after she fell . - A CT of resident #9's thoracic spine, dated 7/6/24, showed an acute compression fracture of L1, and a probable acute compression fracture of T9. - An ER note dated 7/9/24 showed her head CT showed a new small subarachnoid hemorrhage, new intraventricular hemorrhage, chronic subdural hematoma from three days prior, and a new frontotemporal scalp hematoma. - The EMR lacked an ER note from 6/26/24, 6/27/24, and 7/7/24. Review of a facility document, titled Read and Sign Education, dated 7/10/24, showed resident #9 was an extreme fall risk. Resident #9 had L1 and T9 compression fractures, and the document included ten interventions to decrease falls for resident #9. The instructions showed staff were to sign the form after reading it. There were no staff signatures on the document. During an interview on 8/27/24 at 1:25 p.m. staff member F said resident #9 . wasn't even supposed to be walking and sometimes she would just stand up and down she would go. You know, people don't want their independence taken away. Staff member F said residents fall when staffing is good, and they fall when staffing is low. Staff member F said he had been a CNA for a long time, so he could just tell when people where a high fall risk, which was by the way they move. Staff member F said staff would get a report when someone is a high fall risk and administration would put notes on the resident's charts, and he said fall risk was put on the report sheets. He said he did not know how to look at the resident's care plan or where to find it. Staff member F said he did not know when there were changes to the care plan, or how fall risk would be communicated unless it was on the report sheets. During an interview on 8/28/24 at 4:47 p.m., staff member B said resident #9's falls where not listed on the fall log provided to surveyor because she only included residents currently in the facility, and resident #9 had been discharged . 2. During an interview on 8/27/24 at 12:55 p.m., staff member K said she was not working the day resident #10 was found in resident #11's room, on the floor. Staff member K said the memory care unit was a locked unit, and the staff try to keep residents that wander from going into other resident's rooms, but she said it still happens frequently. Staff member K said resident #11 was moved out of the memory care unit because she does not like it when residents wander into her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/27/24 at 1:22 p.m., staff member F said he works on the memory care unit sometimes. He stated resident #10 only speaks Russian, so he uses Google Translate to help him communicate with her. He said she frequently wanders and will go into other resident's rooms. Staff member F said the staff try to keep residents out of other resident's rooms because some of the residents will get upset. He stated it is hard to keep residents out of other rooms when the residents on the memory care unit tend to wander without purpose. Review of resident #10's EMR included an incident note, dated 6/29/24, which showed resident #10 was found on the floor in resident #11's room. Resident #11 stated she was trying to get resident #10 out of her room, so she pushed her and resident #10 fell . It was noted resident #10 was wearing fuzzy socks. The EMR showed, resident #10 had diagnoses of Repeated Falls, Muscle Weakness, Altered Mental Status, Alzheimer's disease, and Dementia. Resident #10's care plan showed a focus area for risk of falls related to Alzheimer's, inability to communicate her needs, weakness, decreased mobility, unsteadiness on feet, previous fall history, psychotropic medication use, and history of wandering behaviors, initiated on 5/23/24. Interventions included the resident wearing appropriate footwear, initiated on 6/29/24, and staff to attempt to redirect resident #10 if she wanders into another residents room, was initiated on 7/1/24. Review of resident #11's Care Plan showed, on 7/1/24, an intervention was placed reflecting, Please redirect wandering residents away from her personal space. Move off memory care for less interaction with wandering residents. Review of an incident report provided by the facility, showed on 6/29/24, resident #10 wandered into resident #11's room. The Nursing description of the event included, [Resident #11 name] attempted to get resident (#10) out of room causing the other resident (#10) to fall to the floor. The Resident description of the event included, Stated she (#11) was trying to her (#10) out of her (#11s) room and pushed her (#10).

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on observation, interview, and record review, the facility licensed staff member failed to provide necessary services, medically neglecting a resident's care needs, after a significant medication error occurred due to the staff member failing to follow the facility procedures for medication administration, resulting in an Immediate Jeopardy level significant medication error, for 1 (#1) resident of 3 sampled residents for medication errors. The resident had a significant decline in health, was unresponsive, had to be given Narcan, and was sent to the ER and had a hospital stay due to the failures identified. Findings include: On [DATE] at 12:37 p.m., the facility Regional Director of Operations, Administrator, and Director of Nursing was notified an Immediate Jeopardy situation existed for 1 resident (#1) for F726, Competent Nursing Staff. An acceptable plan for the removal of immediacy was provided on [DATE] at 7:32 p.m. The immediacy was removed on [DATE] at 7:45 p.m. The severity and scope of the Immediate Jeopardy was identified at the J level, immediate jeopardy to resident health and safety. Upon removal of the immediacy, the scope and severity is lowered to the level of G, actual harm that is not immediate jeopardy. 1. During an interview on [DATE] at 1:59 p.m., staff member H said she was passing medications on [DATE]. She said she had two residents left, so she decided to put all their medications into cups, prior to going down the hall to give the medications to the residents. She said this allowed her to save time (prepouring the medications). She was getting ready to give one of the residents his medication when resident #1 came up to her and asked for a Tylenol. She said she retrieved the Tylenol from the cart and placed it in the wrong resident's medication cup, and then handed it to resident #1. Resident #1 swallowed the medications. Staff member H said when she turned to the cart to give the other resident his medications, she realized what she had done. She said she gave resident #1 a 10 mg Vicodin and 60 mg OxyContin (both high dose opioids that cause sedation, decreased respiration, and may cause death). Staff member H said she called the provider on call and was told to take the residents vital signs every four hours and to report to the provider if the resident had any changes. Staff member H said she did not look up the side effects of the medication, she did not take baseline vital signs, and she did not put the resident on a continuous oxygen saturation monitor (a monitor to show the effectiveness of respirations). Staff member H said resident #1 was found approximately two hours after she had taken the medications. She took resident #1's vital signs and found the resident was hypotensive (low blood pressure), had a low oxygen saturation level, and was not responsive. Staff member H said she gave resident #1 Narcan, to reverse the effects of the opioid medication, and called 911. She said the ambulance came and took resident #1 to the hospital. Staff member H did not adhere to the facility medication administration policies and procedures, and used a process for administering medications, which was not an acceptable standard of practice. Staff member H did not implement health monitoring for the resident immediately following the significant medication error, and within two hours, the resident was found to have had a significant decline in health status. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 11:06 a.m., staff member I said she was the provider on call on [DATE]. She said she received a phone call from staff member H stating she accidentally gave resident #1 the wrong medication. Staff member I said she told staff member H to monitor resident #1 for any changes and to send her to the Emergency Department if she showed any changes. Staff member I said she did not tell staff member H to check vital signs every four hours. Staff member I said it would be dangerous not to monitor a resident after being given such a large dose of opioid pain medications. Staff member I said the protocol for monitoring a resident after taking those medications should be vitals every 15 minutes, and she would expect medication action within 30 minutes. She said waiting two hours to take vital signs could have been serious and dangerous for the resident. During an interview and observation on [DATE] at 4:58 p.m., staff member B said she could not find any documented vital signs between 9:38 a.m., when the significant medication error was made, to 11:33 a.m., when resident #1 was taken to the hospital by paramedics. She stated staff member H should have known the resident required continuous monitoring after the significant medication error was made and 4-hour vital signs were not adequate. Staff member B showed a document, titled Nursing Competency Checklist and explained all licensed nursing staff were required to have all of the skills checked off during orientation. She stated staff member B was required to complete the checklist. The checklist showed staff member H was trained that the facility did not allow pre-pouring medications. Review of resident #1's electronic medical record, showed resident #1 was given Vicodin ,d+[DATE] mg and OxyContin 60 mg ER at 9:38 a.m., and resident #1 was found unable to open her eyes, her blood pressure was ,d+[DATE], and her oxygen saturation was 80%. There was no time documented for the resident's vital signs. Narcan 0.4 mg was given at 11:30 a.m. The EMR failed to include documentation of the resident's vital signs, or documentation of her state of consciousness, between 9:38 a.m. and 11:30 a.m., on the morning of [DATE], after the significant medication error occurred. Review of resident #1's ambulance report, dated [DATE], showed the ambulance was notified by dispatch of an unresponsive resident who had been given an unintentional overdose of medication at 9:38 a.m. The unit arrived at the facility at 11:36 a.m. The report showed medications had been given approx. two hours prior to 911 activation . Patient was found in her room unconscious and initial oxygen saturation of 79%. Staff then administered 0.4 mg naloxone into a vein on the patient's right hand . Review of resident #1's hospital EMR, showed resident #1 arrived at the emergency department on [DATE] at 11:58 a.m. Resident #1 was treated for an opioid overdose including continuous oxygen saturation monitoring, and a continuous intravenous Narcan drip. She had one episode of vomiting while wearing her oxygen mask. She was discharged on [DATE] with antibiotics and prednisone for aspiration pneumonia. Review of the OxyContin package insert showed, OxyContin 60 mg, 80 mg, and 160 mg tablets, or single dose greater that 40 mg, ARE FOR USE IN OPIOD-TOLERANT PATIENTS ONLY. A single dose greater than 40 mg, or total daily doses greater than 80 mg, may cause fatal respiratory depression when administered to patients who are not tolerant to the respiratory depressant effects of opioids. Patients should be instructed against use by individuals other than the patient for whom it was prescribed, as such inappropriate use may have severe medical consequences, including death. Review of a file provided by the facility, included documentation for the [DATE] significant medication error, which contained a corrective action form for disciplinary action given to staff member H for giving the wrong resident MS ER 60 mg and Norco ,d+[DATE] mg. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility policy titled Administering Medications, dated [DATE], showed: Policy Interpretation and Implementation .9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . Review of a facility document titled Nursing Competency Checklist, not dated, showed No pre-pouring medications. Review of a facility policy titled, Adverse Consequences and Medication Errors, Revised February 2023, showed, .4. Monitor the resident for medication-related adverse consequences when there is a (an): . f. Medication error, e.g., wrong or expired medication. 5. In the event of a significant medication - related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare .

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interview and record review the facility failed to keep 2 (#s 1 and 3) residents free from significant medication errors, of 3 sampled residents for medication errors. This deficiency resulted in an Immediate Jeopardy level deficiency for 1 (#1) resident, and interventions included medication, emergency medical care, and hospitalization , and the deficiency had the potential to cause life threatening side effects for resident #3. Findings include: On [DATE] at 12:37 p.m., the facility Regional Director of Operations, Administrator, and Director of Nursing was notified an Immediate Jeopardy situation existed for 1 (#1) resident for F726 - Residents Free from Significant Medication Errors. An acceptable plan for the removal of immediacy was provided on [DATE] at 7:32 p.m. The Immediacy was removed on [DATE] at 7:45 p.m. The scope and severity of the Immediate Jeopardy was identified to be at the level of J, Immediate Jeopardy to Health and Safety, and upon removal of the immediacy, the scope and severity was lowered to the level of G, Actual Harm that is not Immediate Jeopardy. 1. During an interview on [DATE] at 1:59 p.m., staff member H said she was passing medications on [DATE]. She said she had two residents left so she decided to put all their medications into cups prior to going down the hall to give the medications to the residents (this was pre-pouring the medications). She said this allowed her to save time. She was getting ready to give one of the residents his medication when resident #1 came up to her and asked for a Tylenol. She said she retrieved the Tylenol from the cart, placed it (unknowingly) in the wrong resident's medication cup, and handed it to resident #1, who then swallowed the medications. Staff member H said when she turned to the cart to give the other resident his medications, she realized what she had done. She said she gave resident #1 a 10 mg Vicodin and 60 mg OxyContin (high dose opioid medications that cause sedation, decreased respiration, and may cause death). Staff member H said she called the provider on call and was told to take the residents vital signs every four hours and to report to the provider if the resident had any changes. Staff member H said she did not look up the side effects of the medication, she did not take baseline vital signs, and she did not put the resident on a continuous oxygen saturation monitor (a monitor to show the effectiveness of respirations). Staff member H said resident #1 was found, approximately two hours after she had taken the medications and took resident #1's vital signs and found the resident was hypotensive (had low blood pressure), had low oxygen saturation levels and was not responsive. Staff member H said she gave resident #1 Narcan to reverse the effects of the opioid medication, and called 911. She said the ambulance came and took resident #1 to the hospital. During a telephone interview on [DATE] at 11:06 a.m., staff member I said she was the provider on call on [DATE]. She said she received a phone call from staff member H stating she accidentally gave resident #1 the wrong medication. Staff member I said she told staff member H to monitor resident #1 for any changes and to send her to the Emergency Department if she showed any changes. Staff member I said she did not tell staff member H to check vital signs every four hours. Staff member I said it would be dangerous not to monitor a resident after being given such a large dose of opioid pain medications. Staff member I said the protocol for monitoring a resident after taking those medications should be to check vitals every 15 minutes. Staff member I said for those medications she would expect medication action within 30 minutes. She said waiting two hours to take vital signs could have been very serious and a danger to the resident. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's electronic medical record, showed resident #1 was given Vicodin ,d+[DATE] mg and OxyContin 60 mg ER at 9:38 a.m. Resident #1 was found unable to open her eyes, her blood pressure was , d+[DATE] and her oxygen saturations were 80%, and there was no time documented for the vital signs taken. Narcan 0.4 mg was given at 11:30 a.m. The EMR failed to show documentation of vital signs, or documentation of her state of consciousness for resident #1, between 9:38 a.m. and 11:30 a.m., on the morning of [DATE]. Review of resident #1's ambulance report from [DATE] showed, the ambulance was notified by dispatch of an unresponsive resident who had been given an unintentional overdose of medication at 9:38 a.m., the unit arrived at the facility at 11:36 a.m. The report showed, on arrival we are met at the door by staff member and directed to the patient's room. Find the patient seated in a wheelchair in the room. Staff members have placed her on oxygen at 15 liter per minute via nasal canula. Patient is barely conscious but is arousable . Medications had been given approx. 2 hours prior to 911 activation. Patient was found in her room unconscious and initial oxygen saturation of 79%. Staff then administered 0.4 mg naloxone into a vein on the patient's right hand . Review of resident #1's hospital EMR, showed resident #1 arrived at the emergency department on [DATE] at 11:58 a.m. Resident #1 was treated for opioid overdose including continuous oxygen saturation monitoring and a continuous intravenous Narcan drip. She had one episode of vomiting while wearing her oxygen mask. She was discharged on [DATE] with antibiotics and prednisone for aspiration pneumonia. Review of the OxyContin package insert showed, OxyContin 60 mg, 80 mg, and 160 mg tablets, or single dose greater that 40 mg, ARE FOR USE IN OPIOD-TOLERANT PATIENTS ONLY. A single dose greater than 40 mg, or total daily doses greater than 80 mg, may cause fatal respiratory depression when administered to patients who are not tolerant to the respiratory depressant effects of opioids. Patients should be instructed against use by individuals other than the patient for whom it was prescribed, as such inappropriate use may have severe medical consequences, including death. Review of a facility policy titled Administering Medications, dated [DATE], showed: Policy Interpretation and Implementation .9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . Review of a facility document titled Nursing Competency Checklist, not dated, showed, No pre-pouring medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility policy titled, Adverse Consequences and Medication Errors, Revised February 2023, showed: . 4. Monitor the resident for medication-related adverse consequences when there is a (an): . f. Medication error, e.g., wrong or expired medication. 5. In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare . 2. Review of resident #3's EMR revealed an Incident Note dated [DATE], which showed, Order dated , d+[DATE] from Urology appt was entered incorrectly and resident received incorrect dose of Trospium. Provider notified, Contact [name] notified, and resident notified. No ill effects noted, and resident denies any side effects. Nurse educated. Review of Resident #3's medication administration record, showed on [DATE], a physician's order was placed for Trospium Chloride 20 mg BID (twice a day), then on [DATE] that order was discontinued, and a new order was placed for Trospium Chloride 20 mg, give 60 mg four times a day. On [DATE], that order was discontinued, and a new order was placed for Trospium Chloride ER 60 mg once daily. Resident #3 was given 80 mg of Trospium Chloride for 7 days, and 80 mg is double the recommended dose for Trospium. During a telephone interview on [DATE] at 3:37 p.m., staff member J said she was aware of a medication error for resident #3. She said two nurses are required for putting orders into the electronic medical record. She said the first nurse puts the order into the electronic medical record, and another nurse is required to double check the order was put in the system correctly. She said staff member O put an order in the EMR for Trospium for resident #3, on [DATE]. Staff member J said she was the nurse who double checked the order in the EMR. She said she was going through a lot of orders that night, and she said she misread the order. She stated, I should have been more careful. She said the order was hard to read, and so she thought QD (every day) was written QID (four times a day). She said that was how it was ordered in the computer, so she completed the order in the system. She said the pharmacy discovered the mistake several days later. Staff member O was not available for interview during the survey. Review of a medication error report for resident #3, dated [DATE], showed, resident #3 was given the wrong dosage of Trospium. The form showed the wrong dosage was entered into the EMR for resident #3, on [DATE]. Review of a Physician Office Visit note for resident #3, dated [DATE], showed, Physician Notes/Orders: Please continue Trospium, will increase to 60 mg QD if not on formulary may use 20 mg BID.