STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	91 Victoria Road Asheville, NC 28801

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	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with resident, staff and Medical Director, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 which included Risperidone (antipsychotic medication), Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat hypertension), and Amlodipine (a medication used to treat hypertension). Nurse #1 identified the error and Resident #1 was sent to the emergency department (ED) on 2/17/24 for further evaluation due to elevated heart rate and hypotension (low blood pressure). While in the ED, Resident #1 complained of having chest pain and feeling weak. An electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia). Resident #1 was admitted into the hospital for observation due to the prolonged effect of antihypertensives and being hypotensive on presentation. Resident #1 was discharged back to the facility on [DATE] at her baseline with no new orders. This deficient practice affected 1 of 3 residents reviewed for significant medication errors (Resident #1). Immediate jeopardy started on 2/17/24 when Resident #1 was administered medications prescribed for Resident #2. Immediate jeopardy was removed on 2/20/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease. Resident #1 did not have hypertension listed as a diagnosis. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact and did not receive antipsychotic medications. The February 2024 physician orders for Resident #1 indicated the following medications: - Amantadine (anti-dyskinetic medicine) 100 milligrams (mg) 1 tablet by mouth one time a day for Parkinson's disease (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Magnesium oxide (dietary supplement) 400 mg 1 tablet by mouth one time a day for supplement - Melatonin (hormone that plays a role in sleep) 3 mg 1 tablet by mouth one time a day at bedtime for sleep - Spironolactone (diuretic) 25 mg 1 tablet by mouth one time a day for blood pressure, fluid - Carbidopa-Levodopa (dopamine promoter) ER (extended release) 25-100 mg 1.5 tablet by mouth four times a day for Parkinson's disease A review of Resident #1's Medication Administration Record for 2/17/24 indicated she last received a dose of Carbidopa-Levodopa at 6:00 AM but she did not receive any of her scheduled 8:00 AM medications which included Amantadine, and Spironolactone. Resident #2 was admitted to the facility on [DATE]. The February 2024 physician orders for Resident #2 indicated the following medications: - Amlodipine (calcium channel blocker) 10 mg 1 tablet by mouth one time a day for hypertension - Furosemide (diuretic) 40 mg 1 tablet by mouth one time a day for fluid, hypertension - Lisinopril (angiotensin-converting enzyme inhibitor) 20 mg 1 tablet by mouth one time a day for heart/blood pressure - Risperidone (antipsychotic) 2 mg 1 tablet by mouth two times a day for schizophrenia An incident report dated 2/17/24 at 10:00 AM documented by Nurse #1 indicated Nurse #1 went into Resident #1's room to get her name and asked her for her date of birth. Vital signs were taken. When Nurse #1 went back to the medication cart, another resident (Resident #2) approached her with grievances from the previous night and demanded his medications and was unwilling to wait. Then Resident #1 who Nurse #1 was currently with also wanted her medications and was given the wrong medications (which belonged to Resident #2). An on-call physician and Resident #1's family member were notified. The Director of Nursing, Unit Manager, and Administrator were also notified. Vital signs were taken again, and Resident #1 was kept comfortable. EMS (emergency medical services) was called with a detailed report. The incident report did not specify what medications were given to Resident #1. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Nurse #1 on 4/9/24 at 11:44 AM revealed she couldn't remember all the details of how the medication error happened, but she was in the middle of the morning medication pass on 2/17/24. Nurse #1 stated she remembered both Resident #1 and Resident #2 came up to her medication cart at the same time and asked for their medications. Nurse #1 pulled Resident #2's medications and while Resident #1 asked about her medications, Nurse #1 got confused and accidentally gave her Resident #2's medications. Nurse #1 stated it was less than 10 minutes after she had administered the medications and when she started to document the medications in the medication administration record that she realized that she had made a medication error by administering Resident #2's medications to Resident #1. Nurse #1 stated she immediately notified the Unit Manager, the Director of Nursing (DON), and the Administrator. After obtaining Resident #1's vital signs and noting that her heart rate was elevated, Nurse #1 notified an on-call physician who gave her an order to send Resident #1 to the hospital. Nurse #1 stated it took her less than 45 minutes from the time she administered the wrong medications to Resident #1 to the time that she was sent to the ED. A progress note dated 2/17/24 at 10:54 AM by an on-call physician indicated she was contacted by Nurse #1 on 2/17/24 at 9:04 AM about a transfer notification due Resident #1 having received Risperidone 2 mg, Furosemide 40 mg, Lisinopril 20 mg and Amlodipine 10 mg in error and was sent to the emergency room (ER). Vital signs were heart rate 110 beats per minute (normal range 60 to 100), blood pressure 147/95 (normal is less than 120/80), respiratory rate 16 (normal range 12 to 16), temperature 98.1 (normal is around 98.6), and oxygen saturation 95% (normal range between 95% to 100%). This note was electronically signed by the on-call physician on 2/17/24 at 9:30 AM. An interview with Resident #1 on 4/9/24 at 9:48 AM revealed she remembered having received the wrong medications in February. Resident #1 stated it happened during the morning medication pass when the nurse put four pills in a cup, and she gave the cup to her. Resident #1 stated she later found out that three of the pills in the medication cup were blood pressure medications which were supposed to be for another resident. Resident #1 stated she knew something was wrong when the nurse went back after she had swallowed the medications to ask her whether she had already swallowed them, and after she told the nurse that she did, the nurse's face didn't look right. The nurse went down the hall, told someone, called EMS and they sent her to the hospital. Resident #1 further stated she remembered her heart was racing at that time and she stayed at the hospital for observation for two days. At the hospital, they gave her intravenous fluids and put her on a heart monitor. Resident #1 stated at one point while she was at the hospital, her blood pressure got too low, and the hospital doctor told her that one of the pills she accidentally took worked against her Parkinson's disease medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The hospital records dated 2/17/24 indicated Resident #1 arrived at the Emergency Department (ED) at 10:22 AM and was evaluated after a medication mix-up where the resident got someone else's medications. She was hypotensive with systolic blood pressure in the 70s (normal range 110 to 119) and diastolic blood pressure in the 40s (normal range 60 to 90). She was having chest pain and felt weak. She was at her baseline with her Parkinson's. In the ED, electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia) on 2/17/24. Resident #1's laboratory tests indicated her potassium level was 3.7 millimoles per liter (normal value 3.6 to 5.2) and her magnesium level was 1.8 milligrams per deciliter (normal value 1.7 to 2.2). She was referred for admission due to the prolonged nature of antihypertensives and being hypotensive on presentation. It was documented that the hypotension secondary to the medication mix-up could have been an interaction between the agonist of the Risperidone and the antagonist of the Carbidopa-Levodopa. Her blood pressure improved, and Resident #1 was admitted for observation and monitoring after receiving fluids at the ED. Resident #1 was discharged back to the facility on [DATE] at her baseline with no new orders. An interview with the Unit Manager (UM) on 4/9/24 at 2:36 PM revealed she remembered being notified by Nurse #1 that she had accidentally administered Resident #2's medications to Resident #1 on 2/17/24. The UM stated they obtained Resident #1's vital signs which showed an elevated heart rate. Resident #1 also complained to them that she didn't feel right. They notified the on-call physician and received an order to send her out to the hospital. They called 911 and notified the Administrator and the DON. From what Nurse #1 reported to her, both Resident #2 and Resident #1 were at the medication cart at the same time. Resident #2 was upset and demanded for his medications while Resident #1 asked Nurse #1 about her medications as well. The UM stated there was a lot going on at the medication cart and Nurse #1 got turned around and accidentally gave the wrong medications to Resident #1. A phone interview with the Medical Director (MD) on 4/9/24 at 4:04 PM revealed Resident #1 receiving Resident #2's medications was a significant medication error because the medications were not ordered for her, and she did not have indications for them. The MD stated that the hypotension was caused by the antihypertensives that she received. He also stated that he wouldn't be as concerned with the interactions with her Parkinson's medications as much as the hypotension brought on by the antihypertensives. He further stated that this medication error should have been avoided and it was something they did not want to happen again. A phone interview with the former Director of Nursing (DON) on 4/9/24 at 4:29 PM revealed she received a phone call from Nurse #1 on 2/17/24 notifying her about a medication error involving Resident #1. The DON stated Nurse #1 told her that both Resident #1 and Resident #2 were at the medication cart. Resident #2 was becoming aggressive and demanded his medications while Resident #1 also wanted her medications at the same time. While holding the medication cup with Resident #2's medications and walking Resident #1 back to her room, Nurse #1 inadvertently gave the cup of Resident #2's medications to Resident #1. The DON stated that she instructed Nurse #1 to get a set of vital signs on Resident #1 and call 911. The DON stated she immediately started education on the rights of medication administration and on how to handle distractions during medication pass. The DON stated Nurse #1 should have stopped her medication pass with all the distractions at her medication cart at that time. She stated that Nurse #1 unfortunately made the medication error due to her being distracted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Administrator on 4/10/24 at 10:18 AM revealed she was notified about the medication error involving Resident #1, but she couldn't recall a lot of the details because the incident was handled by the former DON. The Administrator was notified of immediate jeopardy (IJ) on 4/17/24 at 12:57 PM. The facility provided the following immediate jeopardy removal plan. Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: On 2/17/24, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 during the morning medication pass which included Risperidone (antipsychotic medication), Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat high blood pressure), and Amlodipine (a medication used to treat high blood pressure). On 2/17/24, the Director of Nursing (DON) received a call from Nurse #1 regarding giving the wrong medications to Resident #1. On-call physician was immediately notified and instructed Nurse #1 to assess vitals and mental status for changes in condition and send to hospital if observed. During the monitoring, Resident #1's heart rate had increased therefore Emergency Medical Services (EMS) was called and Resident #1was transferred to the hospital for evaluation. Resident #1 was sent to the emergency department (ED) for an evaluation. She was referred for admission due to the prolonged nature of antihypertensives and being hypotensive on presentation. It was documented that the hypotension secondary to the medication mix-up could have been an interaction between the agonist of the Risperidone and the antagonist of the Carbidopa-Levodopa. Her blood pressure improved, and Resident #1 was admitted for observation and monitoring after receiving fluids at the ED. Resident #1 returned to the facility on [DATE] with no new orders. Nurse #1 completed a medication error report on 2/17/24 for Resident #1 as appropriate. On 2/17/24, the DON discussed details of incident with Nurse #1 and immediately provided reeducation on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors. All residents are at risk for a medication administration error. On 2/17/24, the DON and facility licensed nurses immediately assessed all current facility residents for changes in vital signs and/or altered mental status and no additional concerns were identified. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/17/24, the Regional Director of Clinical Services (RDCS) completed an audit per the electronic medical record (EMR) of the 1) Medication Administration Audit Report for all current facility resident's medication administration records (MARs) for 2/17/24 first shift (7am-3pm) to ensure medications were administered as ordered without omissions or documented Code 9 (other/see nurses notes) which could indicate an issue such as a medication error or giving a resident the wrong medication. No additional medication errors were identified, including residents being administered the wrong medication. An audit of medication error incident reports from 1/1/2024 - 2/17/2024 were also audited on 2/17/24 by the RDCS per the EMR Risk Management report and no additional incidences of residents being administered the wrong medications were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 2/19/24, the Regional Director of Clinical Services (RDCS) completed an audit of all current resident orders and of medications on the medication on the carts and medication rooms to ensure that medications are available for administration as ordered by the physician. No concerns identified. On 2/17/24, the DON notified the Administrator, Staff Development Coordinator (SDC), Regional Director of Clinical Services (RDCS), [NAME] President of Operations (VPO), [NAME] President of Clinical and Quality (VPCQ) and Medical Director Resident #1's medication error. An ad hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted via telephone to discuss the root cause of facilities failure to prevent a significant medication error. Root cause determined that Nurse #1 failed to effectively redirect another resident during medication administration which led to not confirming the right medications were given to the right resident per the seven (7) rights of medication administration leading to a significant medication error for Resident #1. Immediate corrective actions were discussed and established to ensure no other residents were at risk. Immediate corrective actions to ensure no other current facility residents were at risk for medication errors included full-house assessments for changes in vital signs and/or altered mental status, review of MARs to ensure medications were administered as ordered for all current residents and education to facility and agency licensed nurses and medication aides on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors during medication administration. On 2/18/24, the DON and Staff Development Coordinator (SDC) provided education in person and verbally via telephone to facility and agency licensed nurses and medication aides on the seven rights of medication administration and on strategies to avoid and/or respond to distractions during medication administration to prevent medication errors during medication administration. Facility and agency licensed nurses and medication aides who did not receive education on 2/18/24 will receive education prior to administering medications. The DON and/or SDC will be responsible for monitoring the daily nursing schedule, notifying, and providing education in person or verbally via telephone prior to next shift worked for facility and agency licensed nurses and medication aides who did not receive education on 2/18/24 and for tracking completion of education utilizing the electronic Master Education Log. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Effective 2/18/24, the facility updated the facility and agency orientation packet and checklist to include education on the seven (7) rights of medication administration to prevent medication errors and on redirecting other residents during medication administration to reduce distractions and medication errors. The facility orientation packet will continue to include medication skills competency for licensed nurses and medication aides upon hire, annually and as needed. The DON and/or SDC will be responsible for monitoring the completion of agency and facility education for licensed nurses and medication aides and will utilize the electronic Master Education Log to track compliance. On 2/19/24, the Administrator met with the Interdisciplinary Team (IDT) including but not limited to, the DON, Unit Managers, Social Services Director and Medical Director to discuss the medication error and root cause analysis of the facilities failure to prevent a significant medication error and to discuss any recommended changes to the corrective plan implemented on 2/17/24. No recommended changes were made. Effective 2/19/24, the Administrator will be ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of IJ Removal: 2/20/2024 On 4/10/24 the facility provided a corrective action plan with a completion date of 2/19/24 for the significant medication error that occurred on 2/17/24. This was reviewed and it was determined the corrective action plan did not meet all the criteria for past noncompliance specifically in the area of audits/monitoring. The corrective action plan did not include observations nurses and medication aides during medication pass to ensure residents were administered medications per the 7 rights of medication administration. On 4/10/24, the facility's credible allegation of immediate jeopardy removal was validated on-site by record review, observations, and interviews with nursing staff. A medication administration observation was conducted on 4/9/24. No concerns related to the medication errors were identified. The observation consisted of 26 medications, 3 different residents and 1 nurse and 2 medication aides. The nurse and the medication aides were observed implementing the rights of medication administration, and deferring distractions and interruptions until they completed the medication pass. The medication records of sampled residents were reviewed with a focus on medication errors. No concerns were identified. Interviews with nurses and medication aides revealed they were required to complete an in-service related to medication errors. They confirmed they were educated in person on the 7 rights of medication administration and how to handle distractions and interruptions until the medication pass is completed. A review of the in-service records revealed the DON completed the in person in-services with the nurses and medication aides. All nurses and medication aides who had not worked prior to 2/19/24 or were newly employed were in-serviced before they were allowed to work. The immediate jeopardy removal date of 2/20/24 was validated.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with resident, staff and Medical Director, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigation survey conducted on 3/3/22 and the recertification and complaint investigation survey conducted on 6/1/22. This was for a repeat deficiency in the area of significant medication errors that was originally cited on 3/3/22 during the complaint survey, and subsequently recited during the recertification and complaint investigation survey on 6/1/22 and the complaint survey completed on 4/10/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F760 - Based on record reviews, and interviews with resident, staff and Medical Director, the facility failed to prevent a significant medication error when Nurse #1 administered medications to Resident #1 prescribed for Resident #2 which included Risperidone (antipsychotic medication), Furosemide (a medication used to treat fluid retention and swelling), Lisinopril (a medication used to treat hypertension), and Amlodipine (a medication used to treat hypertension). Nurse #1 identified the error and Resident #1 was sent to the emergency department (ED) on 2/17/24 for further evaluation due to elevated heart rate and hypotension (low blood pressure). While in the ED, Resident #1 complained of having chest pain and feeling weak. An electrocardiogram showed normal sinus rhythm with prolonged QT interval 5-7 seconds (irregular heart rhythm where it takes longer than usual for the heart to recharge between beats). She was given two liters of normal saline bolus and calcium gluconate (medication used to manage hypocalcemia or low calcium levels in the blood, cardiac arrest, and cardiotoxicity due to hyperkalemia or hypermagnesemia). Resident #1 was admitted into the hospital for observation due to the prolonged effect of antihypertensives and being hypotensive on presentation. Resident #1 was discharged back to the facility on [DATE] at her baseline with no new orders. This deficient practice affected 1 of 3 residents reviewed for significant medication errors (Resident #1). During the recertification survey on 6/1/22, the facility failed to prevent significant medication errors whey they failed to acquire and administer Copaxone pre-filled syringes (used to treat multiple sclerosis) and as a result the resident missed 5 doses and when pain medications were not administered as ordered by the physician. During the complaint investigation survey on 3/3/22, the facility failed to prevent significant medication errors when medications were not administered as ordered. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 4/10/24 at 11:46 AM revealed they held monthly QA meetings where each department head reported on certain areas they are were monitoring, and where they reviewed current performance improvement plans that were in place. The Administrator stated one factor for the repeat issue of significant medication errors was the turnover in staffing particularly the nurses and medications aides. She stated that it was hard to keep regular staff and the facility still depended on agency staffing. Another factor was that the facility faced challenges with the resident population being younger compared to other facilities and having increased behaviors in the facility's resident population.