STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425063	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Greenwood	437 East Cambridge Street Greenwood, SC 29646

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** 48835 Based on review of facility policy, record review, and interview, the facility failed to ensure Resident (R)1 was free of significant medication error, when R1 received another resident's medications, for 1 of 3 residents reviewed for significant medication error. On 09/11/24 at 5:20 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template, informing the facility IJ existed as of 04/29/24. The IJ was related to 42 CFR 483.45 - Pharmacy Services. On 09/12/24 the facility provided an acceptable IJ Removal Plan. On 09/12/24 the survey team, validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The IJ is considered at Past Non-Compliance as of 04/30/24. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F760, constituting substandard quality of care. Findings include: Review of the facility policy dated 01/01/19, titled, Medication Administration-General Guidelines states, 4) Before administering a medication, the nurse should assure he/she is administering to the correct patient . Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnoses including but not limited to: chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified asthma, uncomplicated, Parkinson's disease with dyskinesia, with fluctuations, cerebral ischemia, depression, anxiety, unspecified fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing, heart failure, CKD, and macular degeneration. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Nurse Practitioner's Observation-Acute and Subsequent Visit Form Medication Error-Acute Episode dated 04/29/24 at 9:50 AM, documented, Pt seen today for np acute visit per nurse request related to medication error that was noted this morning on 1 st shift. Primary nurse reports pt was given another pt 9am medication by another nurse which included lantus 20 units, humalog 8 units, cetirizine, cymbalta, depakote, gabapentin, losartan, and metformin. Primary nurse states that pt vitals, 02 sat and blood sugar, is stable, she remains at baseline and she is not allergic to any of the medications that she was given. Primary nurse also stated that she has reported incident to management. Noted pt out of bed sitting up in chair in room , a&0x1 able to voice wants and need, she remains at baseline and she is not in distress. She remains on 02. Her respirations are even and unlabored, and lung sounds are clear. No signs or symptoms of hyper/hypoglycemia noted. She remains at baseline. She denies weakness, fever, chills, shortness of breath, chest pain or discomfort. She does not have any concerns at this time. This np was in the process of calling to speak with pt daughter about medication error, interventions put into place, and pt status however daughter called another np that was in this office and she informed the np that the nurse had called her and informed her of medication error along with intervention. The above observation of R1 further documented, [R1] was given another residents 9AM medication by another nurse which included Lantus 20 units, Humalog 8 units, Cetirizine, Cymbalta, Depakote, Gabapentin, Losartan, and Metformin. Review of R1's progress notes dated 04/29/24 at 1:10 PM, documented, Observed resident sitting at lunch table holding head back and bobbing her head. This writer assessed pt and vs were obtained. Upon assessment pt c/o dizziness and overall not feeling well. Bp 136/100, p 113, r 20, t 97.3, 02 95% 2l/m. Np was contacted and came to unit to assess pt. Upon her assessment and change in pulse, increased fatigue, and c/o dizziness r/t to medication administration error by another nurse during shift - verbal order obtained to send pt to ER for further evaluation. Emergency contact notified and aware of transfer, in agreeance with plan of care. Ems called; unsuccessful 3 attempts to give report to ecc charge nurse. Awaiting ems arrival. Review of R1's Physician Orders included but was not limited to the following: Aspirin 81 milligram (mg) tablet, Citalopram 10 mg tablet, Breo Ellipta 1 puff daily, Colace 100 mg tablet, Cranberry Extract 250 mg tablet, Levothyroxine 100 mcg tablet, Montelukast 10 mg tablet, Namenda 10 mg tablet and Polythylene Glycol 17 Grams mixed in 6-8 ounces of liquid. Review of R1's Medication Administration Record (MAR) revealed R1 received her scheduled AM medications on 04/29/24. Review of R1's emergency room Visit dated 04/29/24 at 4:59 PM, revealed, Chief Complaint, medication error, given several medications of another resident in error by nurse earlier today. Pulmonary: Slight work of breathing with prolonged expiration and some accessory muscle use. Diminished breath sounds in the bases. No definite wheezing. Patient was noted to become significantly tachycardic upon sitting up. She was given a 300 milliliter bolus of normal saline for possible dehydration. On repeat exam, she does have worsening coarseness of breath sounds on the right base. A chest x-ray (CXR) was completed and revealed pneumonia. Review of a written statement by Licensed Practical Nurse (LPN)1 dated 04/29/2024 revealed, I observed [R1] at the table leaning her head back and another resident calling me to the floor. I obtained another set of VS and BP reading 136/22 manual. I asked pt how she was feeling and she stated, I feel dizzy, I do not feel right. FSBS obtained and was 151, and pulse was 113. I then called the NP to update her on status. NP came and assessed pt and pt was sent out via EMS. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/11/24 at 12:47 PM, Registered Nurse (RN)1 stated, I was in training at the time, a new nurse. I remember giving [R1] the wrong medicine and looking at the picture on the screen, realizing that wasn't the resident I just gave the medication to. I alerted the nurse I was training with, [LPN1]. She called the Nurse Practitioner (NP) and I went to stay with the patient and the NP came just after. We checked her allergies. I checked her vital signs (VS), I was in the room for quite a while. I'm not aware of any adverse outcomes. I did not return later that day, I was off the next day and returned the day after. I was given training on the 5 rights with my Director of Nurses (DON) and Assistant Director of Nurses (ADON) and was able to train more that day. I was very concerned and was checking her blood sugars very often and we were giving her juice to keep her sugar up. She never bottomed out to below normal blood sugars when I was monitoring her. During an interview on 09/11/24 at 10:54 AM, the ADON stated, [R1] was given the incorrect medication from our nurse. We spoke to the NP, followed orders for monitoring. The only thing I noted was some lethargy, where her head was bobbing. She had an elevated pulse rate. She stated she didn't feel good. She was sent to the hospital, but they found after a CXR she had pneumonia. During an interview on 09/11/24 at 11:58 AM, the NP stated, I would monitor vital signs (VS), blood sugar, change in mental status. Her pulse rate was a little bit elevated. I spoke to her daughter just to keep her updated on the status. She requested for her to be sent out. Any medication can have adverse reactions, that is why we were monitoring her. During an interview on 09/11/24 at 1:45 PM, LPN 1 stated, I remember that day, the morning of the med error in April. We were on the cart that morning. Another resident was calling my attention across the breezeway wanting me to check her blood pressure (B/P), I told the nurse to hold on, not to start the med pass. When I returned, she was returning from the room of [R1]. She held 2 insulin pens in her hand. She said she gave these meds to the wrong patient. She was starting to panic. I told her to calm down, we got to monitor the patient. I called the NP. She said to monitor the patient. I also called her daughter and told her. I told her daughter that we have to monitor the blood sugars because of the insulin, that we had to give supplements to keep her sugar up. She may have monitored the resident for the first 3-4 sets of vital signs. She left to lunch, but she didn't come back that day. The NP came over pretty quick. [R1's] blood sugars and VS were stable. I know the Gabapentin could cause dizziness and she did have some drowsiness. The supplements we gave, orange juice, Med Pass Nutritional Supplement, and apple juice because of all the insulin she was given. The daughter requested her to go to the emergency room (ER) because of her drowsiness. On 09/12/24 the facility provided an acceptable IJ Removal Plan which included the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of the medication administration error, RN1 reported to DON and was released for the day. RN1 returned on 5/1/24 and prior to return was reeducated on medication administration to include the 5 rights of medication administration. After the completion of reeducation, RN1 continued training under supervision. RN1 completed a competency check on 4/20/2024 and 4/21/2024 prior to the event and demonstrated competency. On 5/30/2024, RN1 completed another competency check and demonstrated competency. LPN1, the supervising nurse of RN1 was under supervision at all other times. LPN1 was educated on supervision of employees training. Medication administration in-service was conducted on 9/11 and 9/12/24 for all nurses. Any nurse that has not been educated will be educated before clocking in for their shift. All new nurses will be educated on this guideline before working a medication cart. The medication administration policy was reviewed by the Administrator, DON and Regional Nurse and no changes were needed at this time. A QAPI meeting was held with Administrator, DON, Assistant DON, Nurse Managers, and social services on 9/12/2024 to review event and ensure the safety of all residents. A conference with the Medical Director on 9/11/2024 was held for further discussion on the alleged events and to assure the utmost in patient care and safety. A review of the medication administration guideline was conducted. No changes were recommended. An audit of resident records was conducted from date of incident thru 9/11/2024. No other events were noted for medication administration errors. DON or their designee will continue weekly audits or records for 4 weeks and monthly audits for 2 months. Completion by December 12, 2024. Monitoring will be conducted by the DON or their designee with med pass observations occurring at random weekly for 4 weeks. Pharmacy will continue med pass observations monthly thereafter. Overall compliance will be monitored by the Administrator and Director of Nursing and reported to the QAPI meeting monthly and as needed. Compliance Date: 4/29/2024