

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Ascension Living Alexian Village Tennessee		STREET ADDRESS, CITY, STATE, ZIP CODE 671 Alexian Way Signal Mountain, TN 37377	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interviews, and corrective action plans, the facility failed to prevent significant medication errors for 1 (Resident #99) resident of 4 residents reviewed for medication administration. Registered Nurse (RN) M administered medications intended for another resident to Resident #99 in error. The medication error caused Resident #99 to develop severe hypotension (low blood pressure) resulting in hospitalization. The facility's failure to administer medications according to physician's orders resulted in HARM to Resident #99. The facility was cited at F-760 as Past Non-Compliance. No further corrective actions are required. Non-Compliance began 9/1/2025 and ended on 11/17/2025. The findings include:Review of the facility policy titled, Administering Medications, dated 12/2024, revealed .Medications shall be administered in accordance with orders .per best practice/regulatory guidelines .The individual administering medications verifies the resident's identity before giving medications . The individual administering the medication must check the label 3 times to verify right resident, right medication, right dosage, right time and right .route of administration .before giving the medication . Review of the medical record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Affecting Right Dominant Side, Atrial Fibrillation, Hypertensive Chronic Kidney Disease, Hypertension, and Anemia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #99 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #99 required supervision by staff with activities of daily living.Review of the facility investigation and witness statements dated 9/1/2025, revealed at approximately 8:25 AM, RN M obtained medications from the medication cart which were prescribed to another resident located next door to Resident #99. RN M failed to check the medication labels for the correct resident, medication, dosage, and time prior to the administration of the medications to Resident #99. RN M failed to identify the medication error that had occurred during the documentation of the medication administration to Resident #99. Resident #99 became symptomatic at approximately 10:25 AM (2 hours after administration of the incorrect medications) when he reported dizziness, and lightheadedness, and questioned the nurse as to what medications he had been given. RN M discovered she had administered medications intended for another resident located in the room next door to Resident #99, in error. Resident #99 received incorrect medications of Isosorbide Mononitrate Extended Release Tablet 120 milligrams (mg) (medication used to treat Coronary Artery Disease and lowers blood pressure), Jardiance 10 mg tablet (medication used to treat Diabetes, Heart Failure and Chronic Kidney Disease which lowers blood pressure and blood sugar levels), Losartan 50 mg tablet (medication used to lower blood pressure), Mucinex 600 mg (a decongestant), Pantoprazole 40mg (a medication used to treat gastric reflux) and Vitamin D3. Continued review of the facility investigation and nursing notes dated 9/1/2025, revealed .[Resident #99] was given wrong packet of medications .not his .but the person in neighboring room .Resident's BP [blood pressure] was 90/60 HR [heart rate] 53, BG [blood glucose] 168 .Nurse realized he was given wrong meds[medications] .contacted MD [medical doctor] .told to push fluids .give salty and sugary snack to counter [counteract medications] and recheck in half hour .When BP continued to drop 59/36 [critical low] MD ordered IV [intravenous fluids].500 ML [milliliter] bolus .Following bolus, BP improved to 76/53 [critical low] and MD ordered second 500 ML bolus .IV was lost [unable to be used] trying to set up second bolus .Resident reported 'seeing black things' and MD ordered him sent out [emergency room]ER)) and skip placing a new IV .911 was called .Resident was sent to [hospital] .Review of the regional hospital emergency department (ED) medical records for Resident #99 dated 9/1/2025, revealed .Chief Complaint . [Resident #99] is an 85 y.o. [year-old] male admitted [to the ED] with .hypotension .Patient [Resident #99] is direct transfer from [satellite hospital] due to medication error at SNF [skilled nursing facility] .Patient was inadvertently administered another patient's medications .received Isosorbide Mononitrate 120mg, Jardiance 10mg, Losartan 50mg .Mucinex 600mg, Pantoprazole 40mg and Vitamin D3 . Continued review revealed .After patient [Resident #99] was mistakenly given wrong medications .about 1.5 hours later he complained about light headedness, his BP rapidly trended down .An IV was started at the SNF .but was quickly sent by EMS to the [satellite hospital] ED where he arrived with a BP of 82/51 [low] He received another 500ml bolus en route to the ED .Received another 1500ML NS [Normal Saline] [bolus] at [satellite hospital] en route to [regional hospital ED] .On arrival.BP was 80/50 [low] and another 500 ML NS bolus was ordered . Continued review revealed .Subsequent RPs have</p>		