STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455891	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Park Multi Care Center	4252 Bryant Irvin Rd Fort Worth, TX 76109

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interviews and record review, the facility failed to ensure that an incident of possible neglect was reported to Health and Human Services for one (Resident #1) of seven residents reviewed for abuse and neglect reporting. The facility failed to report a significant medication error, in which MA D administered Resident #2's morning medications to Resident #1, including a narcotic medication, and a psychoactive medication, on [DATE]. This failure could place residents at risk of being neglected and lack of oversight by a state agency. Findings included: Review of Resident #1's face sheet, dated [DATE], reflected he was a [AGE] year-old male, most recently admitted to the facility on [DATE]. He had diagnoses of repeated falls, anxiety disorder, chronic kidney disease, diabetes, and heart disease. Review of Resident #1's admission MDS, dated [DATE], reflected he was usually able to understand others, and was understood by others. He had a BIMS score of 15, indicating intact cognition. He had no behaviors or indicators of psychosis during the assessment period but had a depression indicator score of 13 out of 27, indicating moderate depression. He used a walker and a wheelchair. He required only set-up help for eating, and substantial to maximal assistance (helper does more than half the effort) for toileting, dressing, and hygiene. He required partial to moderate assistance (helper does less than half the effort) for getting in and out of bed, moving himself in bed, and transfers. He did not receive PRN or scheduled pain medication in the past five days and reported no pain in that period. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's face sheet, dated [DATE], reflected he was a [AGE] year-old male, admitted on [DATE]. He had diagnoses of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), acute respiratory failure, type 2 diabetes with chronic foot ulcer, urinary catheter, unspecified psychosis, paraplegia (paralysis of the lower body), hemiplegia and hemiparesis following cerebral infarction (one-sided weakness following a stroke), multiple sclerosis (an autoimmune disorder which attacks nerve cells), chronic kidney disease, neuropathy (nerve pain), heart disease, emphysema (this is a lung diseases that causes air sacs destruction), and chronic obstructive pulmonary disorder (both conditions which make breathing difficult). Review of Resident #2's quarterly MDS, dated [DATE], reflected he was able to be understood by others, and usually understood others. He had a BIMS score of 11, indicating moderate cognitive impairment. He had no indicators of psychosis, or behaviors, during the assessment period, and a depression indicator score of 16 out of 27, indicating moderately severe depression. He had range-of-motion impairment in his upper and lower extremities and used a wheelchair for locomotion. He was dependent on staff for most ADLs and movement in bed. He did not transfer, stand, or walk during the assessment period. He received scheduled and PRN pain medications in the past five days, and had frequent pain, which frequently affected his sleep and interfered with his day-to-day activities. He rated his worst pain in that period as a nine on a one-to-ten scale. Review of nursing progress note by LVN C, dated [DATE] at 5:08 PM, reflected [direct quote] Type: Event Note LATE ENTRY Note Text: The resident was in therapy when this nurse was notified, therefore this nurse immediately ran down to report the incident to the DON. ADON and Administrator. When we arrived back to the floor therapy had just brought him back and reported him being sluggish. Upon getting a assessment and verifying ABC's and he was lethargic and could not answer basic questions. The doctor was notified and orders were given to administer IM injection of Narcan 2mg and check vitals every 15 mins x 1 hour and if no improvement send him to the ER. Review of Resident #2's MAR for [DATE] reflected the following medications/dosages were administered to him on the morning of [DATE]. - Sertraline HCl Tablet 100 MG Give 2 tablet by mouth one time a day for depression - Ascorbic Acid Tablet 1000 MG Give 1000 mg by mouth one time a day for Supplement - Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day for prophylaxis - Bumetanide Tablet 1 MG Give 1 tablet by mouth in the morning for fluid retention - Calcium Oral Tablet 500 MG (Calcium) Give 1 tablet by mouth one time a day for supplement - Cholecalciferol Oral Capsule 125 MCG (5000 UT) (Cholecalciferol) Give 1 capsule by mouth one time a day for supplement - Depakote Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day related to unspecified psychosis not due to a substance or known physiological condition - Famotidine Tablet 20 MG Give 1 tablet by mouth one time a day for acid indigestion (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Flecainide Acetate Tablet 50 MG Give 1 tablet by mouth two times a day for irregular heartbeat - Gabapentin Tablet 600 MG Give 1 tablet by mouth three times a day for Neuropathy - HydrALAZINE HCl Tablet 25 MG Give 3 tablet by mouth three times a day for hypertension - Magnesium Oxide Tablet 400 MG Give 1 tablet by mouth one time a day for supplement - Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day related to essential (primary) hypertension - Multi-Vitamin/Minerals Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for Supplement - Senna Tablet 8.6 MG (Sennosides) Give 2 tablet by mouth one time a day for constipation - OxyCODONE HCl Tablet 15 MG Give 1 tablet by mouth every 12 hours for moderate to severe pain Review of Resident #1's MAR for [DATE] reflected the following morning medications were held on [DATE]: - Clopidogrel Bisulfate (Plavix) Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention -Order Date- [DATE] 2331 [blood thinner/Antiplatelet agent] - Rivaroxaban Oral Tablet 10 MG Give 1 tablet by mouth in the morning for MI-Order Date-[DATE] 2331 [blood thinner/Anticoagulant] -Duloxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth two times a day for depression-Order Date-[DATE] 2331. - Amlodipine Besylate Tablet 5 MG Give 1 tablet by mouth one time a day for HTN -Order Date- [DATE] 2331. -Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth at bedtime for high Cholesterol -Order Date- [DATE] 2331. - Calcium Oral Tablet 500 MG (Calcium) Give 1 tablet by mouth two times a day for Supplement -Order Date- [DATE] 1853 - Carvedilol Tablet 12.5 MG Give 1 tablet by mouth two times a day for Hypertension Hold if SBP less than 100 Order Date- [DATE] 2331 - Cilostazol Tablet 100 MG Give 1 tablet by mouth two times a day for blood thinner -Order Date- [DATE] 2331. - Finasteride Tablet 5 MG. Give 1 tablet by mouth one time a day for bladder Gloves should be worn by person handling or administering this product if they suspect or anticipate pregnancy -Order Date- [DATE] 2331. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG (Isosorbide Mononitrate) Give 1 tablet by mouth in the morning for Angina [chest pain] -Order Date- [DATE] 2331 - Multi-Vitamin/Iron Tablet (Multiple Vitamins-Iron). Give 1 tablet by mouth one time a day for Supplement multivitamin with iron-Ca-FAmin ,d+[DATE].4mg -Order Date- [DATE] 2331. - Pregabalin Oral Capsule 75 MG (Pregabalin). Give 1 capsule by mouth three times a day for Diabetic complication causing injury to some body nerves -Order Date- [DATE] 2331. -Rosuvastatin Calcium Tablet 20 MG Give 1 tablet by mouth one time a day for lipid control -Order Date [DATE] 2331. - Vitamin D (Ergocalciferol) Oral Capsule 50 MCG (2000 UT) (Ergocalciferol). Give 1 capsule by mouth one time a day for supplement -Order Date- [DATE] 1855. - Acetaminophen Tablet 325 MG Give 2 tablets by mouth three times a day for pain -Order Date- [DATE] 1951. Review of Resident #1's MAR for [DATE] reflected the following medications/dosages that were administered to him on of [DATE] at 12:05 PM: - Naloxone HCl Injection Solution 0.4 MG/ML (Naloxone HCl) Inject 1 ml intramuscularly as needed for opioid overdose until [DATE] 10:05 Inject in shoulder or thigh. Repeat after 3 minutes if no or minimal response. Order Date- [DATE] 1205. Also known as Narcan. Review of Resident #1's MAR for [DATE] reflected his 8:00 PM medications were not administered, because he was sleeping. In an interview with Resident #1 on [DATE] at 11:20 AM, Resident #1 was in his room in his bed. He stated he could not recall being given any wrong medications. He stated he cannot remember a lot of things. He stated that he was fine and had no complaints. An interview on [DATE] at 11:29 with CNA A revealed she heard about Resident #1 having to have Narcan [this is a medication that is used to treat narcotic overdose in an emergency] through the grapevine on [DATE]. She heard a med aide gave a resident the wrong medicine. In an interview with MA D on [DATE] at 12:16 PM, MA D stated that on Monday [DATE], she had given Resident #1 medicines that belonged to Resident #2. MA D was visibly distraught when she talked about her error. MA D stated she had a one-on-one in-service after the incident with the DON and that she had done a medication check return demonstration. MA D stated that the medication error was reported to the nurse, the DON, the ADON, and the Administrator the same day it happened. She stated that she worked the rest of her shift after being in-serviced. She stated the risk to Resident #1 getting medicine that did not belong to him was adverse medication reactions and she stated he could have died . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 12:26 PM with LVN C revealed that on [DATE] there had been an incident in which MA D gave all of Resident #2's morning medications to Resident #1, and Resident #1 had a change in condition, becoming lethargic and confused. She said Resident #1's vital signs were stable, and the physician ordered the administration of Narcan because one of the medications was a stronger dose of oxycodone (an opiate) than Resident #1 was used to taking. She was not aware of how the administration handled MA D once they dealt with the immediate concerns about the resident, but MA D did continue to work the rest of her shift after she left the floor for her lunch break. An interview on [DATE] at 2:08 PM with the Administrator stated the medication error in which MA D administered Resident #2's medications to Resident #1 happened because MA D was in the middle of passing Resident #2's medications, and a therapist was waiting to take Resident #1 to therapy. She stated so MA D switched to giving Resident #1 his medications, but got the cups switched. She said they pulled her off the floor and did an inservice with her, and a medication competency, to make sure she knew what she was doing, and that she knew how to identify a resident before she administered medications. She said MA D was borrowed from a sister facility. The Administrator said that she always told their corporate about incidents and took direction from them about whether to report things. They did an incident report, and addressed the issue with their staff, but because they considered this a medication error, they did not consider it as reportable. She said Resident #1 did not suffer any harm from the incident. An interview on [DATE] at 3:15 PM with the Regional RN revealed they did not report it because it was not considered a reportable. She said there was no harm or injury to the resident. She said that having Narcan would not be considered harm, and it would be like if a resident had an allergic reaction to a medication and they were ordered Benadryl. She said that their corporate staff did talk with the Administrators about whether or not to report, but at the end of the day, it was the Administrator's decision. An interview on [DATE] at 4:52 PM with the Administrator and the DON revealed the Administrator had gone ahead and self-reported the medication error to HHSC on [DATE] and would have done so earlier if she had known she needed to. She said they were also doing competencies with all other Medication Aides, in addition to the in-servicing they had already done. The DON said they did not think of what happened as actual harm, because they monitored the resident, his vitals were stable, he did not need to go to the hospital, and he was only affected for a short time. She did not feel like he was at a high risk for harm even if they had not been alerted to the medication error so quickly, because they would have used their nursing judgment, monitored him, and the physician would have sent him out to the hospital if they needed to. She said the physician had seen the resident, the resident was fine, and there were no new orders. She said the risk of a medication error like this one could be the resident potentially getting sick and dying but she felt it was highly unlikely in this case. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Abuse: Identification of Types, issued [DATE], reflected Neglect: Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. a. Neglect includes cases where the facilities indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. b. Neglect of goods or services may occur when staff are aware, or should be aware, of resident care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (e.g. Suctioning, transfers, use of equipment), lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack of knowledge in the needs of the resident. Review of the facility policy for Incident and Reportable Event Management, issued [DATE], reflected Policy: the facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. (.) (.) Federal Regulations: F609: 483.12(c)(1) Reporting of Alleged Violations: 483. 12(c)(1) ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made if the events that caused the allegation evolve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the state survey agency and adult Protective Services where state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures. (.) Definitions: accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction). (.) Event Management includes but is not limited to the following types of events: (.) - Alleged Neglect (.) Medication Discrepancy (.) External Notifications: (.) 3. Refer to state specific guidelines for reporting of events other than injuries of unknown origin, abuse, and Elder Justice Act. 4. The facility should be aware that external reporting may include; (.) Adult Protective Services (.) 48520

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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** 35489 48520 Based on interviews and record review the facility failed to ensure residents were free from significant medication errors for one (Resident #1) of seven residents reviewed for medication errors. The facility failed to ensure Resident #1 got his own medications instead of receiving Resident #2's medications, which included a narcotic medication, on [DATE] by MA D. This failure could place residents at risk of medical complications, and reactions to increased dosages of medications or unfamiliar medications, including potentially death. The noncompliance was identified as PNC. The IJ began on [DATE], and ended on [DATE], as the facility had corrected the non-compliance by in-servicing all Medication Aides prior to the visit. Findings included: Review of Resident #1's face sheet, dated [DATE], reflected he was a [AGE] year-old male, most recently admitted to the facility on [DATE]. He had diagnoses of repeated falls, anxiety disorder, chronic kidney disease, diabetes, and heart disease. Review of Resident #1's admission MDS, dated [DATE], reflected he was usually able to understand others, and was understood by others. He had a BIMS score of 15, indicating intact cognition. He had no behaviors or indicators of psychosis during the assessment period but had a depression indicator score of 13 out of 27, indicating moderate depression. He used a walker and a wheelchair. He required only set-up help for eating, and substantial to maximal assistance (helper does more than half the effort) for toileting, dressing, and hygiene. He required partial to moderate assistance (helper does less than half the effort) for getting in and out of bed, moving himself in bed, and transfers. He did not receive PRN or scheduled pain medication in the past five days and reported no pain in that period. Review of Resident #2's face sheet, dated [DATE], reflected he was a [AGE] year-old male, admitted on [DATE]. He had diagnoses of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), acute respiratory failure, type 2 diabetes with chronic foot ulcer, urinary catheter, unspecified psychosis, paraplegia (paralysis of the lower body), hemiplegia and hemiparesis following cerebral infarction (one-sided weakness following a stroke), multiple sclerosis (an autoimmune disorder which attacks nerve cells), chronic kidney disease, neuropathy (nerve pain), heart disease, emphysema (this is a lung diseases that causes air sacs destruction), and chronic obstructive pulmonary disorder (both conditions which make breathing difficult). (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's quarterly MDS, dated [DATE], reflected he was able to be understood by others, and usually understood others. He had a BIMS score of 11, indicating moderate cognitive impairment. He had no indicators of psychosis, or behaviors, during the assessment period, and a depression indicator score of 16 out of 27, indicating moderately severe depression. He had range-of-motion impairment in his upper and lower extremities and used a wheelchair for locomotion. He was dependent on staff for most ADLs and movement in bed. He did not transfer, stand, or walk during the assessment period. He received scheduled and PRN pain medications in the past five days, and had frequent pain, which frequently affected his sleep and interfered with his day-to-day activities. He rated his worst pain in that period as a nine on a one-to-ten scale. Review of Resident #2's MAR for [DATE] reflected the following medications/dosages were administered to him on the morning of [DATE]. - Sertraline HCl Tablet 100 MG Give 2 tablet by mouth one time a day for depression - Ascorbic Acid Tablet 1000 MG Give 1000 mg by mouth one time a day for Supplement - Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day for prophylaxis - Bumetanide Tablet 1 MG Give 1 tablet by mouth in the morning for fluid retention - Calcium Oral Tablet 500 MG (Calcium) Give 1 tablet by mouth one time a day for supplement - Cholecalciferol Oral Capsule 125 MCG (5000 UT) (Cholecalciferol) Give 1 capsule by mouth one time a day for supplement - Depakote Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day related to unspecified psychosis not due to a substance or known physiological condition - Famotidine Tablet 20 MG Give 1 tablet by mouth one time a day for acid indigestion - Flecainide Acetate Tablet 50 MG Give 1 tablet by mouth two times a day for irregular heartbeat - Gabapentin Tablet 600 MG Give 1 tablet by mouth three times a day for Neuropathy - HydrALAZINE HCl Tablet 25 MG Give 3 tablet by mouth three times a day for hypertension - Magnesium Oxide Tablet 400 MG Give 1 tablet by mouth one time a day for supplement - Metoprolol Succinate ER Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth one time a day related to essential (primary) hypertension - Multi-Vitamin/Minerals Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for Supplement - Senna Tablet 8.6 MG (Sennosides) Give 2 tablet by mouth one time a day for constipation (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- OxyCODONE HCl Tablet 15 MG Give 1 tablet by mouth every 12 hours for moderate to severe pain Review of Resident #1's MAR for [DATE] reflected the following morning medications were held on [DATE]: - Clopidogrel Bisulfate (Plavix) Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention -Order Date- [DATE] 2331 [blood thinner/Antiplatelet agent] - Rivaroxaban Oral Tablet 10 MG Give 1 tablet by mouth in the morning for MI-Order Date-[DATE] 2331 [blood thinner/Anticoagulant] -Duloxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth two times a day for depression-Order Date-[DATE] 2331. - Amlodipine Besylate Tablet 5 MG Give 1 tablet by mouth one time a day for HTN -Order Date- [DATE] 2331. -Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth at bedtime for high Cholesterol -Order Date- [DATE] 2331. - Calcium Oral Tablet 500 MG (Calcium) Give 1 tablet by mouth two times a day for Supplement -Order Date- [DATE] 1853 - Carvedilol Tablet 12.5 MG Give 1 tablet by mouth two times a day for Hypertension Hold if SBP less than 100 Order Date- [DATE] 2331 - Cilostazol Tablet 100 MG Give 1 tablet by mouth two times a day for blood thinner -Order Date- [DATE] 2331. - Finasteride Tablet 5 MG. Give 1 tablet by mouth one time a day for bladder Gloves should be worn by person handling or administering this product if they suspect or anticipate pregnancy -Order Date- [DATE] 2331. - Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG (Isosorbide Mononitrate) Give 1 tablet by mouth in the morning for Angina [chest pain] -Order Date- [DATE] 2331 - Multi-Vitamin/Iron Tablet (Multiple Vitamins-Iron). Give 1 tablet by mouth one time a day for Supplement multivitamin with iron-Ca-FAmin ,d+[DATE].4mg -Order Date- [DATE] 2331. - Pregabalin Oral Capsule 75 MG (Pregabalin). Give 1 capsule by mouth three times a day for Diabetic complication causing injury to some body nerves -Order Date- [DATE] 2331. -Rosuvastatin Calcium Tablet 20 MG Give 1 tablet by mouth one time a day for lipid control -Order Date [DATE] 2331. - Vitamin D (Ergocalciferol) Oral Capsule 50 MCG (2000 UT) (Ergocalciferol). Give 1 capsule by mouth one time a day for supplement -Order Date- [DATE] 1855. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Acetaminophen Tablet 325 MG Give 2 tablets by mouth three times a day for pain -Order Date- [DATE] 1951. Review of Resident #1's MAR for [DATE] reflected the following medications/dosages that were administered to him on of [DATE] at 12:05 PM: - Naloxone HCl Injection Solution 0.4 MG/ML (Naloxone HCl) Inject 1 ml intramuscularly as needed for opioid overdose until [DATE] 10:05 Inject in shoulder or thigh. Repeat after 3 minutes if no or minimal response. Order Date- [DATE] 1205. Also known as Narcan. Review of Resident #1's MAR for [DATE] reflected his 8:00 PM medications were not administered, because he was sleeping. Review of nursing progress note by LVN C, dated [DATE] at 5:08 PM, reflected [direct quotation] Type: Event Note LATE ENTRY Note Text: The resident was in therapy when this nurse was notified, therefore this nurse immediately ran down to report the incident to the DON. ADON and Administrator. When we arrived back to the floor therapy had just brought him back and reported him being sluggish. Upon getting a assessment and verifying ABC's and he was lethargic and could not answer basic questions. The doctor was notified and orders were given to administer IM injection of Narcan 2mg and check vitals every 15 mins x 1 hour and if no improvement send him to the ER. Review of Resident #1's vital signs during the acute assessment reflected the following. Blood pressure, oxygen saturation, and Pulse vital summary: [DATE] at 11:40 AM BP ,d+[DATE], pulse 108, oxygen 98 % by LVN C, [DATE] at 11:55 AM BP ,d+[DATE], pulse 105, oxygen 96 % by LVN C [DATE] at 12:10 PM BP ,d+[DATE], pulse 105, oxygen 97 % by LVN C [DATE] at 12:25 PM BP ,d+[DATE], pulse 105, oxygen 97 % by LVN C [DATE] at 12:40 PM BP ,d+[DATE], pulse 105, oxygen 96 % by LVN C [DATE] at 01:40 PM BP ,d+[DATE], pulse 96, oxygen 97 % by LVN C In an interview with Resident #1 on [DATE] at 11:20 AM, Resident #1 was in his room in his bed. He stated he could not recall being given any wrong medications. He stated he cannot remember a lot of things. He stated that he was fine and had no complaints. (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 on [DATE] at 11:29 with CNA A revealed she heard about Resident #1 having to have Narcan [this is a medication that is used to treat narcotic overdose in an emergency] through the grapevine on [DATE]. She heard a med aide gave a resident the wrong medicine. She said she thought the med aide was working upstairs at the time of this interview, but she was agency or something and she did not know her. She said the nurse on duty when it happened was the same one on duty at the time of this interview. She said she had never heard of anyone getting the wrong medications here before. She said Resident #1 seemed a little sleepy and needed a little more help in the shower on [DATE], but he seemed more like his normal self on the day of this interview. She did not know if he was sent to the hospital, and she thought the CNA on duty that day was CNA B, and she might know more. In an interview with MA D on [DATE] at 12:16 PM, MA D stated that on Monday [DATE], she had given Resident #1 medicine that belonged to Resident #2. She stated that therapy had come to get Resident #1 and at the time she had popped into a medicine cup all morning medicines belonging to Resident #2, but at the time, she thought it belonged to Resident #1. She stated she forgot whose medications they were, but she thought they belonged to Resident #1. She stated after administering the medicine that she had in the cup to Resident #1, he went to therapy. She stated she then took out medications that she thought were for Resident #2 and popped them into another medicine cup and took them to Resident #2 but Resident #2 refused to take them. MA D stated that after Resident #2 refused to take the pills she went to nurse LVN C to let her know that Resident #2 was refusing his medicine saying it was not his. MA D stated that she was confused on which resident was in bed A, and which one was in bed B. She stated that she should have asked someone to verify the bed arrangements so that she could have been sure that bed A was for Resident #1, and it was close to the entry way and bed B belonged to Resident #2 and it was close to the window. She stated she realized that she had given Resident #1 medicine that should have been given to Resident #2. MA D stated that she was confused by trying to rush before therapy took Resident #1, and not being familiar with the residents, the bed numbers, and having only worked at the facility for 4 days. MA D stated she was very upset (observed crying), and she had messed up. MA D stated she had a one-on-one in-service after the incident with the DON and that she had done a medication check return demonstration. MA D stated that the medication error was reported to the nurse, the DON, the ADON, and the Administrator the same day it happened. She stated that she worked the rest of her shift after being in-serviced. She stated that when giving medication it was important to remember the medication rights practice (Right patient, Right medication, Right dose, Right route, Right time). She stated the risk to Resident #1 getting medicine that did not belong to him was adverse medication reactions and she stated he could have died . (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 on [DATE] at 12:26 PM with LVN C revealed that on [DATE] she had been on the opposite end of the hall when MA D came to her and said she could not get a resident to take his medications. She went with her to check, and when she walked in Resident #1's bed was empty, and Resident #2 was in his bed. Resident #2 said those were not his medications, because there were not enough pills in the cup to be his medications. She asked MA D who she was trying to give the meds to, and she and MA D looked at each other and she could see on her face she realized she had given Resident #2's medications to Resident #1. MA D said she had given Resident #1 the other medications before he went downstairs to therapy, and she thought the beds were switched and the A bed was by the window. LVN C went to get the DON Immediately and told her that they needed to go to therapy to check on Resident #1. She, the DON, and the ADON were heading downstairs to therapy room to find Resident #1, at the same time, therapy was bringing Resident #1 back upstairs. She stated she did not know which therapist it was and the DON got the physician on the phone and explained that a med error had occurred while she (LVN C) took Resident #1's vital signs. She said Resident #1 was starting to seem confused and lethargic, but his vital signs were not bad. She said therapy had said he was lethargic, but she felt he was more sleepy than lethargic. The physician ordered two doses of Narcan, 2ml, and for her to check vitals every 15 minutes for one hour. She administered the Narcan, which was 1ml in each of the two bottles, and he became more alert, more easily roused, and less confused. His vital signs remained stable. She said the medication they were most concerned about was oxycodone every 12 hours. She said Resident #1 did occasionally take Tylenol with codeine, but nothing as strong as Resident #2. At first the Administrator asked her to count MA D out (count the medications in the cart so MA D could end her shift.) The DON said MA D was about to go on her lunch, and she did not need to count to go out to lunch. Then she came back and worked the rest of her shift. LVN C said after it happened, she did not know what happened with MA D, in terms of training or disciplinary action. It was her responsibility to oversee her on the floor, but the rest was the administration's responsibility for disciplinary action. She said she thought MA D was from an agency, and [DATE] was the first time she had ever seen her. She said MA D seemed to know what she was doing, and had asked her questions when she had them, but after this incident she was breaking down and crying a lot. She said MA D was very upset, because she knew that her error could have caused the resident to die. Resident #2 understood what happened, and he did receive his medications and did not have any problems with it. An interview on [DATE] at 1:19 with PT E revealed she had worked with Resident #1 on [DATE]. She said he was not as alert as usual, and not able to participate a lot, so they cut the treatment short. His blood pressure was a little low, she thought 91 or 92, over 62. She thought a few minutes of exercise might raise it, so they worked on his legs, and it came up a bit, but went right back down. At that point he said he was not dizzy or anything, but he was seeing blue stars, so she took him to his nurse, who checked his vitals and put him back in bed. She said she saw him on [DATE] working with OT F and he was not able to follow instructions, and was easily roused, but was dozing. She said she was PRN, so she had limited contact with Resident #1, but she had worked with him before. She said he was usually talkative and engaged more. She said it did not happen often that a resident who was normally able to participate showed up not able to. (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 on [DATE] at 1:33 PM with OT F revealed when he worked with Resident #1 on [DATE]. He required maximum assistance to sit on the edge of his bed, and the week before that it took only contact assistance. He said Resident #1's family member had watched him in therapy the previous week, he had a great day, and he barely had to touch him. OT F said that Resident #1 had been experiencing some decline in the week before that day. He said when he went to Resident #1's room to get him, he was sitting on the edge of his bed to taking his medication. He stated after that he took Resident #1 to therapy and for the first 30 minutes, he was OK, but then, in addition to requiring maximum assistance, he started falling asleep and could not follow all of the commands. He said he took his blood pressure, which was fine. He thought maybe the resident was having blood sugar problems, which he did sometimes and, which he could not check. He went to look for a nurse downstairs and did not see one. He took Resident #1 upstairs, and an aide told him that Resident #1 had taken the wrong medications. They put him in bed, and the nurse came, and PT O left the room. He was not sure what happened after that. He heard they might send him out to the hospital, but he did not know if they did. He said on [DATE] Resident #1 did much better in therapy. An interview on [DATE] at 2:08 PM with the Administrator revealed Resident #1 was going to therapy and MA D was in the middle of passing Resident #2 his medications, and because the therapist was waiting, and said they needed to take Resident #1 right then she stopped and dispensed Resident #1's medication and. She stated MA D was going to give Resident #2 his medications afterwards. She accidentally gave Resident #1 the wrong medications. She said it was an honest mistake, and they pulled her off the floor. She stated they did an in-service with her, and a medication competency, to make sure she knew what she was doing, and that she knew how to identify a resident before she administered medications. She said they did an in-service with all the other Medication Aides. She said MA D was borrowed from a sister facility. ADM stated Resident #1 did not suffer any harm from the incident. An interview on [DATE] at 2:18 PM with the DON revealed the medication error happened on Monday [DATE] between 11 AM and 12 PM. She stated the nurse informed her the med aide got two residents medicines mixed up. She stated Resident #1 received Oxycodone and that was the only medication that was concerning at the time. The DON stated she went upstairs to assess Resident #1 while LVN C was on the phone with the doctor. She stated the doctor ordered Narcan to be given to Resident #1 to help reverse the effects of the oxycodone (an opioid medication). She stated vitals were given to the doctor as they were being done and she could not recall the exact numbers. She stated once Resident #1 was stable and easier to arouse the doctor gave orders to monitor Resident #1 for one hour checking his vitals every 15 minutes. The DON stated that they investigated MA D's medication error right away and did training and a competency check with her. They did in-services with the other aides right away, so there was no reason to suspend her. She said the new medication aides normally went through training with another medication aide to make sure they understood what they were doing, their job description, and she and their HR also do their parts of the orientation. She went over the expectations they needed to meet with each new aide. She in-serviced the new staff, and she in-serviced all of her staff a lot. She said when they come in from a sister facility, they did orient them to the floor, but they already have the same training as they would in this facility. She said MA D had not worked in this building in the time she had been here. She said the medication aides just did the med count with the oncoming aide at the end of the shift but did not round like nurses and CNAs did. She said getting the wrong medication could potentially result in death, lethargy, or having a reaction to the medication. (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 on [DATE] at 3:56 PM with MA G revealed he worked in the facility PRN. He said he had not heard about the incident with the wrong medication given, but when he arrived for his shift, the DON did a training and competency with him on medication pass, and she talked about the Five Rights (of medication administration). He said he did not work at the facility often, because he was in nursing school, so they did it right when he came in on this day. He said she went over a lot of things, including how to make sure you erre giving the right resident the medication, giving it the right way, and how to know when to hold it. He said that he would talk to the resident, and ask them, and if they were not able to answer or seemed confused, he would check the picture in the computer, and check with the nurse, or another staff member who would know the resident. He said he would ask the nurse or other staff if he had any questions about anything. An interview on [DATE] at 3:59 PM with MA H revealed that she worked with Resident #1 on Monday after the medication incident. MA H stated that Resident #1 appeared very drowsy, and she asked the night nurse RN M if they could hold his night shift medications that were due on her shift at 8PM. She stated that Resident #1 medicines were not given on nightshift on [DATE]. MA H stated that it was her responsibility to always double and triple check residents' identity before medication administration. She stated that being careful during medication administration was vital. She stated the risk to a resident receiving the wrong medication was reaction a to medicine and other serious medicine effects. An interview on [DATE] at 4:52 PM with the Administrator and the DON revealed the DON had gone over the med pass in-service on [DATE] in-person with MA D, MA H, and MA I, and talked to the other aides, and was still talking to them about it. The DON said she was planning to start having the medication aides round at shift change, but today they were still just doing the count. She said she felt like they did what they could when it happened and did not think of what happened as actual harm. When asked what might have happened if Resident #2 had not been alert and oriented and able to identify that he was being offered the incorrect medications, which alerted them immediately to the error, the DON said that even if Resident #2 had not noticed the medications were wrong, they would have noticed his change in condition and sent him to the hospital. She said after they identified the error LVN C was taking Resident #1's vitals and writing them down and providing them to the physician. She said the physician had come to check on Resident #1 on [DATE], and the resident was doing well, and there were no new orders. The DON said she had checked on him in the middle of the night and they talked about him in their morning meeting. The DON said that the risk to the resident when getting the wrong medications depended on the interventions put in place, and they put the intervention of the Narcan in place. She stated the risk could potentially include actual harm, and that a resident could get sick or die. The Administrator confirmed that she had self-reported the medication error, after the state surveyors started asking about it, and they were doing competency checkoffs with all of the medication aides, as well as the in-servicing they had already done when it happened. (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 on [DATE] at 11:21 AM with Resident #2 revealed MA D was a temp and he had not seen her before. He said they did not really have regular people passing medications like they used to have, and the people often changed. Resident #2 said he knew all of his medications, and he knew the ones she tried to give him on [DATE] were not his. He said his roommate's (Resident #1) medications probably would not have hurt him any if he had taken them, but they probably would not have helped him either, and his medications played havoc with his roommate. He said Resident #1 was normally kind of confused and that he seemed more normal on [DATE] than he had for a couple of days after he got the wrong medications. Resident #1 said he did get his own medicine that morning ([DATE]) and did not have any problems because of what happened. He said that the medication aides did make mistakes on his medications sometimes, and it happened fairly regularly (he was not able to say when it last happened before this, or how often it happened), but he always checked, them so he knew he was getting the right ones. An interview on [DATE] at 12:22 PM with the NP revealed the facility had reached out to the Physician on [DATE] about Resident #1, not her, but she had checked on the resident on [DATE] and [DATE]. She said she did not know what acute monitoring the facility was doing, but they should have been monitoring him routinely for 24 hours. She said that during the acute monitoring the vital signs the facility sent her were good, except for a little bit of tachycardia (fast heartbeat), which was normal for Resident #1. She said even if the staff had not become aware of the medication error, any time they noted a change in condition, like altered mental status, they would have notified the physician, and they would do STAT vitals, ordered STAT labs as appropriate to the situation, and taken any precautions ordered by the physician. She said she did not know exactly what Resident #1's orders were at the current time, but he had been in and out of the hospital, and in the facility before, and had taken narcotic medication, so his body was not naive to narcotics. She said the strength difference could make a difference in how it affected someone, but he would not be as likely to have to have a serious reaction as someone who had not taken any medications of the same type in the past year or so. She said any time they started someone on a medication, especially a geriatric patient, she started them on a low dose , and went slow in working their way up (raising the dosage), so of course they would be concerned about it, and monitor him and act as needed, but she did not feel it was likely to have caused lasting harm to him. (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 on [DATE] at 12:49 PM with the Physician revealed the facility did notify her about the medication error with Resident #1, and she had been made aware of the IJ. She said with narcotics, any negative effect would be relatively immediate. She said when Narcan was given, it's done (the effect is immediate), and it puts a stop to the possibility that a person will stop breathing because of the narcotic. She said she only knew Narcan to work for the opiates, not the other medications, and she listed a long list of possible symptoms. She stated the mixture of those medications could do anything under the sun, and that the combination of the psych meds and opiate could potentially cause a full-on out-of-body experience in some people, and that you never knew how an individual would respond to them. She said with the narcotic 99% of people would just be sleepy, and the next thing they watched for, which would only be .08% would be an allergic reaction. She said when someone got the wrong medication, and they sent them to the hospital, all they do was observe them. The Physician stated that many people got the same combination of medications (narcotic and psych med), and there would be no reason to try to get it out of (by inducing vomiting) someone who got them mistakenly. She said she told them to keep monitoring him, because in the emergency room all they would do would be monitor him for signs of anything besides sleepiness. She felt that even if they had not caught the medication error, she did not feel the resident would have experienced a negative long-term outcome. She said the most likely outcome would be somnolence (sleepiness), and an allergic reaction could have been possible, which was a serious thing, but also only had a very small chance of occurring. She said she was not downplaying the situation, and that this was a serious thing, and they gave him a serious drug (Narcan), but she felt that it was highly unlikely he would have suffered any serious consequences of the error. Review of facility's policy titled Medication-Related Errors, revision date [DATE], reflected . read in part .3.2 Dose Error-dispensing to the resident of a dose that is greater than or less than the amount ordered by physician/prescriber. 3.4. Rate Error-Dispensing the incorrect rate of administration of the medication to a resident other than the amount ordered by physician/prescribe. 3.6. Frequency Error- dispensing to the residents of a medication at an incorrect interval of administration other than that is ordered by physician/prescriber. 3.8. Medication Error-Dispensing to the resident a medication other than that ordered by the physician/prescribe. 3.9. Resident/Facility Error-Dispensing to a resident or facility other than the one intended. 3.12. Monitoring Error-Failure to review a prescription regimen for appropriateness.4. In the event of an administration error, facility staff should follow facility policy relating to medication administration errors . Interviews from [DATE] at 12:00 PM to [DATE] at 10:00 AM with MA D, MA G, MA H, MA I, MA J, and MA K revealed they had all been in-serviced on medication administration topics, including making sure the correct resident received the medications, by the DON, and were able to answer questions about the five rights of medication administration (right patient, right drug, right time, right dose, and right route). They stated they would ask the nurse about any concerns or questions they had about anything, including the identity of a resident, in order to be absolutely sure they were giving the medications to the right person. They all explained how they would go about identifying a resident and knew how to do so if the resident was able to be interviewed reliably, or if they were not. They were all able to explain potential risks of a resident receiving medications which were meant for another resident. Review of an undated staff roster, and an interview on [DATE] at 1:50 PM with the DON and the Administrator reflected MA D, MA G, MA H, MA I, MA J, and MA K were the current medication aides at the facility, and there was one medication aide listed on the roster who was no longer an employee of the facility. (continued on next page)

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