STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676105	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interviews and record review, the facility failed to notify the residents physician and representative regarding a change in the resident's condition, for 1 of 2 residents (Resident #1) reviewed for changes in condition. 1. RN C failed to notify Resident #1's family and physician when RN C administered Resident #2's lorazepam to Resident #1 on 11/21/2024. This failure could place residents at risk of not having their family and physicians notified of changes resulting in a delay in decision making for medical interventions. Findings: Resident #1 Record review of Resident #1's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had a medical history of urinary tract infection, obstructive sleep apnea (the most common sleep-related breathing disorder), and muscle weakness. Record review of Resident #1's admission MDS Section- C Cognitive Patterns revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #1's physician orders did not reveal an order for lorazepam 1mg (a sedative that can treat seizure disorders, such as epilepsy. It can also be used before surgery and medical procedures to relieve anxiety). Record review of physician orders did not reveal any new orders regarding the medication error. Record review of Resident #1's medication Error Report revealed: Date/Time Error(s) discovered- 11/21/2024 9:36PM. Errors Discovered by/ Title- RN C. Person Responsible for error- RN C. Date of error(s) 11/21/2024. Time of error(s) 09:30 PM. Medication Ordered- Resident #1 doesn't have order for Ativan Type of Error- Drug Administered without a MD Order, Wrong resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Description of error- Misread , - Wrong Patient Statement of person responsible for error- I had a new patient with 7 new cards and a patient Resident #2 with the wrong first name was in the pile of medications, and I gave the wrong med because I did not read the first name correctly it was another Resident #2 in the pile of new meds. The FM told me to give her, her pain meds as soon as they get here because she was in pain. I tried to accommodate the Resident #1's request as soon as I could. This was a mistake. I tried to hurry up and help a patient and as a result the wrong patients med with the wrong first name was given. Physician notified? -yes. By Whom? -RN C Date/Time- 11/22/2024, 03:35 PM Family notified? - Yes 11/22/2024, 04:01 PM . .Classify errors according to the Medication Error Index as adopted by the National Coordinating Council for Medication Error Reporting and Prevention: Category C An error occurred that reached the patient but did not cause patient harm. Record review of Resident #1's Observation Data sheet revealed vitals signs taken on 11/21/2024 at 9:36pm with reason for observation - follow up incident/fall. BP: 122,65. Heart rate 73, Respiratory rate 18, Temp 97. 5, and Pulse Oximetry 98. Document signed by RN C. Resident #2 Record review of Resident #2's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had a medical history of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), panic disorder with episodic paroxysmal anxiety (a term used to describe the recurrent, severe, and unpredictable panic attacks that are a primary feature of panic disorder), and muscle weakness. Record review of Resident #2's physician orders revealed an order for lorazepam 1mg tablet, give 1 tablet by mouth four times daily. Record review of Resident #2's Controlled Drug Record for Lorazepam 1mg revealed RN C receiving from the pharmacy 48 tablets of Lorazepam and administering 1 lorazepam tablet at 2100 (9pm) on 11/21/2024 with a note written beside stating administered to wrong resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #1's family on 12/03/2024 at 09:30AM, she stated on 11/21/2024 at around 9pm, Resident #1 had been given a tramadol and Ativan (lorazepam) by RN C. She stated RN C clocked out of work around 10pm. She stated nothing was mentioned to her that night regarding a medication error, but the next morning Resident #1 was difficult to arouse from sleep. She stated later in the day on 11/22/2024, RN C did tell her he had made a medication error, but she felt he had treated it like it was nothing. She stated she had talked to Med Aid D about the medication that had made her mother very hard to wake up, and she did not want her taking that medication again. She stated Med Aid D explained that Resident #1 did not have any sleeping medication in her chart. She stated she spoke to the ADM and DON, but she did not know what had been done about RN C. She stated she felt that although mistakes can happen and Resident #1 was okay, she felt that Resident #1's situation was not addressed with importance and a simple apology would have made a difference. She stated RN C knew he had made the error that night on 11/21/2024 and did not notify the physician, the family, or the DON. She stated Med Aid D had notified the DON, but she is not sure why the DON did not address it until the next day instead of that night . During an observation and interview with Resident #1 on 12/03/2024 at 9:30AM, she did not remember any information regarding the incident . Resident appeared clean and comfortable sitting in a wheelchair. Resident was watching television and had finished breakfast. During an interview with LVN A on 12/03/2024 at 11:15AM, she stated she had taken care of Resident #1 on 11/22/24 in the morning. She stated she had not been made aware (that morning) of the medication error that had occurred. She stated if she had, she would have initiated closer observation of Resident #1 even if she had to sit by her door. She stated she received report from LVN B, and the medication error was not reported. LVN A stated she had been trained on medication administration and the five rights of medication administration were right patient, right medication, right dose, right time, and right route. She stated when a medication error occurred, the person who committed the errors needed to notify the physician, the DON, and the family as soon as possible and assess the resident. She stated the possible negative outcomes of medication errors could be harm to the patient. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Med Aid D on 12/03/2024 at 1:02pm, she stated she had been working on 11/21/2024, in medical records. She stated at approximately 9:15pm the pharmacy had dropped off some medications. She stated she was at her medication cart when RN C came up to her to sign off the Ativan in the resident's electronic medical record. She stated when they checked the order on her chart, there was no order for Ativan for Resident #1. She stated she looked at the medication card with the pills and noticed the medication card was for Resident #2. She stated she then asked him please don't tell me you gave this to Resident #1?. She stated he replied, yes I did, I thought it was for Resident #1. She stated RN C went back down hall 300 and she returned to medical records. Med Aid D stated before leaving around 10pm that night she had asked the oncoming night nurse if he had been notified of the medication error on Resident #1. She stated LVN B denied being informed of the medication error. She stated she texted the DON at 10:27pm asking if she had been notified of RN C's medication error. She stated she did not get a response back that night but did get a response saying nope at around 11:25 AM on 11/22/2024. She stated she told the DON she would come talk to her when she got there. She stated the DON asked if the medication error was on a different resident, and she stated it was someone else. The Med Aid stated when she did come in on 11/22/2024, she informed the ADM and the DON of the medication error that RN C had caused. She stated because RN C did not notify anyone, Resident #1 did not have increased monitoring or assessment and the physician had not been notified. She stated the DON did talk to RN C on 11/22/2024 but she did not know about what. The Med Aid stated she had been trained on medication administration and she would report any medication errors to the physician, the family, the DON, and the ADM. She stated the possible negative outcomes of medication errors could be any adverse effect, or an allergic reaction and residents could be harmed. She stated she felt that RN C did not look at the entire name on the medication card and only saw the last name as Resident #1 and Resident #2 had the same last name. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN C on 12/03/2024 at 2:30pm, he stated Resident #1 was a new resident to the facility. He stated on 11/21/2024 he had received about 8 medication cards and all the information had not been put into the computer. He stated all the cards had the same last name. He stated Resident #1's family had requested the resident receive her pain medication as soon as it was delivered. He stated as soon as the medications came in, he popped the tramadol and the lorazepam, and administered the medication to Resident #1. He stated he had made the mistake trying to make the family happy. He stated he had rushed and did not go through the five rights of administration. RN C stated he knew he made the error right away because the Med Aid D had informed him. He stated the Med Aid D had notified the DON. He stated he did notify the FNP. She asked if there had been any adverse reactions, or allergic reactions, and he told her no, and the FNP told him to document the error. He stated at that time, 11/22/2024 the resident was alert but in the morning she had been groggy. He stated he had informed Resident #1 FM of what medication he was giving the resident and the family never said anything about that, they only wanted to know why tramadol and not hydrocodone. RN C stated he notified the FNP on 11/22/2024 at 3:30pm. He stated he did not call the night the mistake was made because he thought Med Aid D would take care of it and notify everyone. He stated the medication error report was usually done on paper and given to the DON. RN C stated he did not follow up with Med Aid D after because he had been busy with other residents. He stated they did not have a charge nurse. RN C stated he had been trained on medication administration, but it had been a while. He stated the five rights of medication administration were right patient, right name, right dose, right time, and right order. He stated the potential negative outcomes of a medication error could be an allergic reaction, loss of balance, and possibly overdose. RN C stated he did not remember mentioning the medication error when he gave report to the night nurse. He stated he did not initiate any increased monitoring or observation on Resident #1. He stated, this often happens when you try to do too much, and mistakes happen. RN C stated he did one set of vital signs but nothing after. He stated, Now that I think about it, I should have initiated more observation. During an interview with the DON on 12/03/2024 at 2:51pm, she stated she was not present at the time of the medication error. She stated she received a text message on 11/22/2024 from Med Aid D asking if RN C had notified her of what had happened the previous night. She stated she was not aware of the events that occurred the previous night and the Med Aid D told her she would talk to her at 2pm. She stated Resident #2's narcotic count appeared off in the computer system due to the medication error. She stated she worked with a med aid to resolve the issue and when RN C arrived at the facility, she had him do the medication error report, notify the physician, and notify the family. She stated the facility did have charge nurses and RN C was the charge nurse on night shift. She stated she did speak to Resident #1's family member on 11/26/2024 after learning the family was very upset about the medication error. The DON stated she was unable to share details of RN C's disciplinary actions but that she had taken the incident seriously. She stated the FNP had a conversation with Resident #1's family and the FNP was willing to send Resident #1 to the ER but at that point the medication was mostly metabolized. She stated, Resident #1 was okay, but if Resident #1's family still wanted her to go to the ER, the FNP would send her. Resident #1 did not go to the ER after that conversation . The DON stated the person who makes the medication errors is to report it to the physician, DON, family and make the medication error report. She stated she was unsure why RN C did not initiate those steps. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B on 12/03/2024 at 4:01pm, he stated he was working that night, 11/21/2024, and remembered someone telling him there had been a medication error with Resident #1. He stated he did not remember who told him that information. He stated he did go and check on her through the night and he did not observe any adverse events or adverse effects. He stated he did not know if the physician had been notified of the medication error. He stated Resident #1 rested through the night. LVN B stated he had been trained on medication administration and medication errors are to be reported immediately to the DON, physician, and family. He stated that the possible negative outcomes could have been an allergic reaction, and abnormal vital signs. During an interview with FNP on 12/04/2024 at 9:26AM, she stated she had not been notified of the medication error with Resident #1 until the following day. She stated she expected to be notified of medication errors when they occurred or within four hours of the medication error. She stated when she was called, Resident #1 was alert and stable and she had no concerns for long lasting negative effects. She stated lorazepam was a medication given for mild sedation or to calm someone down. She stated after the medication was administered, Resident #1 would have experienced some sedation. The FNP stated she talked to Resident #1's family and explained at that time Resident #1 was awake, alert, and stable and did not see a need to send her to the ER. She stated she would expect to be notified sooner of medication errors and implement any needed interventions or orders. Record review of facility policy titled Change of Conditions, last revised on February 13,2023 revealed: The primary goal of identifying Acute Changes of Condition (ACOCs) is to enable staff to evaluate and manage a patient at the community and avoid transfer to a hospital or emergency room (ER). To achieve this goal, the community's staff and practitioners must recognize an ACOC and identify its nature, severity, and cause(s) . Changes in condition of the patient are determined by current and past medical conditions, medical orders, patient safety factors, and/or by assessments . .4 . The nurse notifies the responsible physician or advanced practice nurse (APRN) utilizing appropriate channels and chain of command. 5.Document in the medical record the date, time, and name of each physician notified, actions taken and/or patient's response to treatment. Documentation should also include all nursing assessments and findings, nursing actions, and notification of charge nurse/nurse supervisor. All entries in the EHR will be automatically dated, timed, and signed according to community policy. 6. Patient families, guardians, or other appropriate people are to be contacted when there is a significant change in a patient's condition or health status . Definitions: An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Medication Error: Reporting & Management, last revised on January 10, 2023, revealed: Purpose: To describe the procedure for reporting a medication error and the mechanism for review to allow appropriate follow-up and possible implementation of change to decrease the causes and incidences of medication errors . 4. Administration Error - Wrong: a. Patient . Medication Error Review-Upon discovery of an unusual incident regarding a medication, the staff member should immediately evaluate the patient, notify the physician (or designee), and nurse manager. The staff member will report the incident immediately by completing a Medication Error Report in the EHR. EMR>QAPI>Medication Error Report. The error will be classified according to the Medication Error Index, as adopted by the NCC MERP . Guidelines: 1. The staff member that identifies the error will complete the Medication Error Report 2. Notification to the Director of Nursing

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on interviews and record review the facility failed to ensure that residents were free of significant medication errors for 1 of 3 residents (Resident #1), reviewed for pharmacy services. 1. The facility failed to ensure Resident #1 was free of significant medication errors when a dose of lorazepam 1 mg was administered on 11/21/2024 by RN C. This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician. Findings: Resident #1 Record review of Resident #1's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had a medical history of urinary tract infection, obstructive sleep apnea (the most common sleep-related breathing disorder), and muscle weakness. Record review of Resident #1's admission MDS Section- C Cognitive Patterns revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #1's physician orders did not reveal an order for lorazepam 1mg (a sedative that can treat seizure disorders, such as epilepsy. It can also be used before surgery and medical procedures to relieve anxiety). Record review of physician orders did not reveal any new orders regarding the medication error. Record review of Resident #1's medication Error Report revealed: Date/Time Error(s) discovered- 11/21/2024 9:36PM. Errors Discovered by/ Title- RN C. Person Responsible for error- RN C. Date of error(s) 11/21/2024. Time of error(s) 09:30 PM. Medication Ordered- Resident #1 doesn't have order for Ativan Type of Error- Drug Administered without a MD Order, Wrong resident Description of error- Misread , - Wrong Patient Statement of person responsible for error- I had a new patient with 7 new cards and a patient Resident #2 with the wrong first name was in the pile of medications, and I gave the wrong med because I did not read the first name correctly it was another Resident #2 in the pile of new meds. The daughter told me to give her, her pain meds as soon as they get here because she was in pain. I tried to accommodate the Resident #1's daughters request as soon as I could. This was a mistake. I tried to hurry up and help a patient and as a result the wrong patients med with the wrong first name was given. Physician notified? -yes. By Whom? -RN C Date/Time- 11/22/2024, 03:35 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family notified? - Yes 11/22/2024, 04:01 PM . .Classify errors according to the Medication Error Index as adopted by the National Coordinating Council for Medication Error Reporting and Prevention: Category C An error occurred that reached the patient but did not cause patient harm. Record review of Resident #1's Observation Data sheet revealed vital signs taken on 11/21/2024 at 9:36pm with reason for observation - follow up incident/fall. BP: 122,65. Heart rate 73, Respiratory rate 18, Temp 97. 5, and Pulse Oximetry 98. Document signed by RN C. Vital signs dated 11/22/2024 at 7:54pm revealed a BP of 109/85, and a HR of 65. Vital signs at 9:03 AM 11/22/2024 revealed a respiration rate of 18 and oxygen saturation of 95%. Resident #2 Record review of Resident #2's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had a medical history of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), panic disorder with episodic paroxysmal anxiety (a term used to describe the recurrent, severe, and unpredictable panic attacks that are a primary feature of panic disorder), and muscle weakness. Record review of Resident #2's physician orders revealed an order for lorazepam 1mg tablet, give 1 tablet by mouth four times daily. Record review of Resident #2's Controlled Drug Record for Lorazepam 1mg revealed RN C receiving from the pharmacy 48 tablets of Lorazepam and administering 1 lorazepam tablet at 2100 (9pm) on 11/21/2024 with a note written beside stating administered to wrong resident. During an interview with Resident #1's family on 12/03/2024 at 09:30AM, she stated on 11/21/2024 at around 9pm, Resident #1 had been given a tramadol and Ativan (lorazepam) by RN C. She stated RN C clocked out of work around 10pm. She stated nothing was mentioned to her that night regarding a medication error, but the next morning Resident #1 was difficult to arouse from sleep. She stated later in the day on 11/22/2024, RN C did tell her he had made a medication error, but she felt he had treated it like it was nothing. She stated she had talked to Med Aid D about the medication that had made her mother very hard to wake up, and she did not want her taking that medication again. She stated Med Aid D explained that Resident #1 did not have any sleeping medication in her chart. She stated she spoke to the ADM and DON, but she did not know what had been done about RN C. She stated she felt that although mistakes can happen and Resident #1 was okay, she felt that Resident #1's situation was not addressed with importance and a simple apology would have made a difference. She stated RN C knew he had made the error that night on 11/21/2024 and did not notify the physician, the family, or the DON. She stated Med Aid D had notified the DON, but she is not sure why the DON did not address it until the next day instead of that night . During an observation and interview with Resident #1 on 12/03/2024 at 9:30AM, she did not remember any information regarding the incident . Resident appeared clean and comfortable sitting in a wheelchair. Resident was watching television and had finished breakfast. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Med Aid D on 12/03/2024 at 1:02pm, she stated she had been working on 11/21/2024, in medical records. She stated at approximately 9:15pm the pharmacy had dropped off some medications. She stated she was at her medication cart when RN C came up to her to sign off the Ativan in the resident's electronic medical record. She stated when they checked the order on her chart, there was no order for Ativan for Resident #1. She stated she looked at the medication card with the pills and noticed the medication card was for Resident #2. She stated she then asked him please don't tell me you gave this to Resident #1?. She stated he replied, yes I did, I thought it was for Resident #1. She stated RN C went back down hall 300 and she returned to medical records. Med Aid D stated before leaving around 10pm that night she had asked the oncoming night nurse if he had been notified of the medication error on Resident #1. She stated LVN B denied being informed of the medication error. She stated she texted the DON at 10:27pm asking if she had been notified of RN C's medication error. She stated she did not get a response back that night but did get a response saying nope at around 11:25 AM on 11/22/2024. She stated she told the DON she would come talk to her when she got there. She stated the DON asked if the medication error was on a different resident, and she stated it was someone else. The Med Aid stated when she did come in on 11/22/2024, she informed the ADM and the DON of the medication error that RN C had caused. She stated because RN C did not notify anyone, Resident #1 did not have increased monitoring or assessment and the physician had not been notified. She stated the DON did talk to RN C on 11/22/2024 but she did not know about what. The Med Aid stated she had been trained on medication administration and she would report any medication errors to the physician, the family, the DON, and the ADM. She stated the possible negative outcomes of medication errors could be any adverse effect, or an allergic reaction and residents could be harmed. She stated she felt that RN C did not look at the entire name on the medication card and only saw the last name as Resident #1 and Resident #2 had the same last name. During an interview with RN C on 12/03/2024 at 2:30pm, he stated Resident #1 was a new resident to the facility. He stated on 11/21/2024 he had received about 8 medication cards and all the information had not been put into the computer. He stated all the cards had the same last name. He stated Resident #1's family had requested the resident receive her pain medication as soon as it was delivered. He stated as soon as the medications came in, he popped the tramadol and the lorazepam and administered the medication to Resident #1. He stated he had made the mistake trying to make the family happy. He stated he had rushed and did not go through the five rights of administration. RN C stated he knew he made the error right away because the Med Aid D had informed him. He stated the Med Aid D had notified the DON. He stated he did notify the FNP and she had asked if there had been any adverse reactions, or allergic reactions and he told her no, and the FNP told him to document the error. He stated at that time, 11/22/2024 the resident was alert but in the morning she had been groggy. He stated he had informed Resident #1's FM of what medication he was giving the resident and the family never said anything about that, they only wanted to know why tramadol and not hydrocodone. He stated the medication error report is usually done on paper and given to the DON. RN C stated he had been trained on medication administration, but it had been a while. He stated the five rights of medication administration was right patient, right name, right dose, right time and right order. He stated the potential negative outcomes of a medication error could be an allergic reaction, loss of balance, and possibly overdose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676105	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Lubbock	4910 Emory Lubbock, TX 79416

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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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 12/03/2024 at 2:51pm, she stated she was not present at the time of the medication error. She stated she received a text message on 11/22/2024 from Med Aid D asking if RN C had notified her of what had happened the previous night. She stated she was not aware of the events that occurred the previous night and the Med Aid D told her she would talk to her at 2pm. She stated Resident #2's narcotic count appeared off in the computer system due to the medication error. She stated she worked with a med aid to resolve the issue and when RN C arrived at the facility, she had him do the medication error report, notify the physician, and notify the family. She stated the facility did have charge nurses and RN C was the charge nurse on night shift. She stated she did speak to Resident #1's family member on 11/26/2024 after learning the family was very upset about the medication error. The DON stated she was unable to share details of RN C's disciplinary actions but that she had taken the incident seriously. She stated the FNP had a conversation with Resident #1's family and the FNP was willing to send Resident #1 to the ER but at that point the medication was mostly metabolized. She stated, Resident #1 was okay, but if Resident #1's family still wanted her to go to the ER, the FNP would send her. Resident #1 did not go to the ER after that conversation . The DON stated the person who makes the medication errors is to report it to the physician, DON, family and make the medication error report. She stated she was unsure why RN C did not initiate those steps. During an interview with FNP on 12/04/2024 at 9:26AM, she stated she had not been notified of the medication error with Resident #1 until the following day. She stated she expects to be notified of medication errors when they occur or within four hours of the medication error. She stated after the medication was administered Resident #1 would have experienced some sedation. The FNP stated she talked to Resident #1's family and explained at that time Resident #1 was awake, alert, and stable and did not see a need to send her to the ER. She stated she would expect to be notified sooner of medication errors and implement any needed interventions or orders. Record review of facility policy titled Medication Error: Reporting & Management, last revised on January 10, 2023 revealed: Purpose: To describe the procedure for reporting a medication error and the mechanism for review to allow appropriate follow-up and possible implementation of change to decrease the causes and incidences of medication errors . 4. Administration Error - Wrong: a. Patient . Medication Error Review-Upon discovery of an unusual incident regarding a medication, the staff member should Immediately evaluate the patient, notify the physician (or designee) and nurse manager. The staff member will report the incident immediately by completing a Medication Error Report in the EHR. EMR>QAPI>Medicatlon Error Report. The error will be classified according to the Medication Error Index, as adopted by the NCC MERP . Guidelines: 1. The staff member that identifies the error will complete the Medication Error Report 2. Notification the Director of Nursing