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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 3/28/23 through 3/31/23 and 4/3/23 was conducted 5/23/23 through 5/25/23. The facility was in compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Five complaints were investigated during the survey. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 14 current resident/record reviews, (Residents 101 through 114).	{F 000}		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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

Electronically Signed | 06/08/2023

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F 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interviews, pharmacist interview, clinical record review and facility documentation, the facility's consultant pharmacy failed to ensure two (2) out of 14 residents (Resident #113 and #106) in the survey sample received the correct packaged medication. This deficiency is cited as past non-compliance (PNC.) The findings included: 1. On 04/07/23, a blister card of medications arrived from the facility's pharmacy labeled Rabeprazole (ER) 20 mg for Resident #113 but it contained Verapamil Extended Release (ER) 240 mg tablet. Resident #113 received 24 doses of another resident's high blood pressure medication (Verapamil) and missed 24 doses of her scheduled medication Rabeprazole (treatment of gastroesophageal reflux disease). Resident #113 was admitted to the nursing facility on 04/01/23. The resident was transferred to the local hospital on 05/01/23 and did not return to the facility. Diagnosis for Resident #113 included but are not limited to major depressive disorder, difficulty in walking, muscle weakness, syncope, and collapse. The most recent Minimum Data Set	F 755	Past noncompliance: no plan of correction required.	

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(MDS - an assessment protocol) an admission assessment with an Assessment Reference Date (ARD) of 04/05/23 scored Resident #113, a 99 indicating short-and-long term memory problems with severe cognitive impairment - never/rarely made decisions.

In section "G" (Physical functioning) the MDS coded Resident #113 required total dependence of one with bathing, limited assistance of one with bed mobility, transfer, dressing toilet use, personal hygiene, and eating for Activities of Daily Living (ADL) care.

Resident #113's care plan created on 04/03/23 identified the resident as at risk for cardiac complications secondary to Congestive Heart Failure (CHF), coronary artery disease (CAD), cardiac shunt placement, history of transient ischemic attack (TIA)/cardiovascular accident (CVA) and hypertension (high blood pressure). The goal set for the resident by the staff was to be free from cardiac complications. Some of the interventions/approaches the staff would use to accomplish this goal were to administer medications as ordered, vital signs as needed, and observe for signs of cardiac complications.

A review of Resident #113's Medication Administration Record (MAR) revealed an order dated 04/01/23 to administer Rabeprazole Sodium 20 mg tablet daily before breakfast at 8:00 a.m., for Gastroesophageal reflux disease (GERD.)

An interview was conducted with Resident #113's representative on 05/25/23 at approximately 2:35 p.m. He stated on 05/01/23, Resident #113's medications were reviewed with Resident #113's

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nurse and two other representatives. He stated the medication Rabeprazole 20 mg was not familiar in shape, size, or color so the medication was looked up on Google search. He said after looking up the medication, they were certain that the medication the nursing staff had been giving Resident #113 was not the correct medication (Rabeprazole.)

An interview was conducted with the Pharmacy's Director of Quality on 05/24/23 at 10:16 a.m. She stated the blister card for Resident #113 was labeled Aciphex 20 mg tablet, but the blister pack contained (Verapamil 240 mg tablets) the wrong medication. She said the medication label gave a description of what the pill should look like, giving the color and shape. She stated by giving the description helped to identify the correct medication in the blister pack. She stated the blister pack was packaged and 30 pills were delivered to the nursing facility on 04/07/23.

A phone call was placed to LPN #2 on 05/25/23 at 11:03 a.m. The (LPN) was assigned to administer Resident #113's medication (Aciphex) on the following days in April 2023: 04/19/23 and 04/27/23 at 8:00 a.m. A message was left, but the LPN never returned the call.

A phone interview was conducted with LPN #5 on 05/25/23 at approximately 3:27 p.m. The LPN stated on 05/01/23 (not sure of the exact time) Resident #113's representative requested to review the resident's medications. She stated she removed Resident #113's medication blister cards from the medication cart. She stated after the representative reviewed the residents' medications, he stated the medication (Rabeprazole) did not look familiar, and had the

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wrong shape, size, and color. She said the resident's representative immediately stated the medication given as Rabeprazole was not the correct medication. The LPN stated she immediately reported the resident representative's concern to the Unit Manager.

A review of Resident #113's clinical note revealed during a physical therapy (PT) session on 04/18/23, the resident voiced complaints of dizziness. The resident's BP was taken (sitting position) with a reading of 78/48 (hypotension - low BP), pulse at 105 (tachycardia - increase heart rate) beats per minute (bpm), and the nursing staff were informed of low blood pressure reading.

A review of Resident #113's clinical record revealed the following low BP readings:
-04/15/23, BP = 84/51.
-04/16/23, BP = 93/60.
-04/18/23, BP = 78/48.

A phone interview was conducted with the Nurse Practitioner (NP) on 05/25/23 at 4:06 p.m. She stated she was asked to assess Resident #113 on 04/18/23 after having a hypotensive episode during therapy. She stated because of the resident's extensive cardiac issues, she ordered a low dose of Midodrine. She stated when the Midodrine was ordered, she was not aware at that time Resident #113 had been receiving another resident's blood pressure medication.

A review of Resident #113's Physician Order Summary (POS) revealed the following order: Midodrine 2.5 mg - give 1 tablet by mouth every 24 hours as needed for hypotension (low blood pressure) with a systolic BP less than 100 mmHg

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(millimeters of Mercury) starting on 04/18/23. The resident's BP did not drop below 100 mmHg after the order was written, thus no doses of Midodrine were required.

On 05/01/23, Resident #113 was transferred to the local Emergency Department (ED) for altered mental status (AMS.) A review of the hospital records dated revealed Resident #113 presented to the ED on 05/01/23 at approximately 4:07 p.m., with altered mental status (AMS) and somnolence (sleepiness.) According to the hospital records, Resident #113 received Lactated Ringers 500 ml via Intravenous (IV) on 05/01/23 while in the ED. Resident #113 was discharged from the hospital on 05/12/23.

2. On 4/7/23, for Resident #106, a blister card of medications arrived from the facility's pharmacy labeled Verapamil Extended Release (ER) 240 mg tablet but it contained Rabeprazole (ER) 20 mg. Resident #106 missed 24 doses of her scheduled medication Verapamil and received 24 doses of another resident's medication Rabeprazole.

Resident #106 was originally admitted to the nursing facility on 08/19/21. Diagnosis for Resident #106 included but are not limited to high blood pressure. The most recent Minimum Data Set (MDS - an assessment protocol) quarterly assessment with an Assessment Reference Date (ARD) of 03/02/23 coded the resident with a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

In section "G" (Physical functioning) the MDS

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coded Resident #106 required total dependence on one person with bathing, extensive assistance of one with toilet use and dressing, limited assistance of one with bed mobility, transfer, and personal hygiene, and supervision with eating for Activities of Daily Living (ADL) care.

A review of Resident #106's Medication Administration Record (MAR) revealed an order dated 03/17/23 to administer Verapamil Extended Release (ER) 240 mg tablet by mouth daily at 9:00 a.m., hold for systolic blood pressure less than 120.

A review of Resident #106's MAR for April 2023 included an order written on 04/19/23 to administer Hydralazine HCL 10 mg by mouth every 8 hours as needed for systolic blood pressure greater than 170. Further review of the MAR revealed Hydralazine 10 mg (medication to treat high blood pressure) was administered on the following three (3) days for a systolic BP greater than 170.
-04/20/23, BP = 187/92.
-04/24/23, BP = 182/90.
-04/29/23, BP = 187/100.

A review of the physician progress note dated 05/03/23 at 5:03 4:18 p.m. revealed Resident #106 was supposed to be receiving Verapamil 240 mg; however, she received the medication Aciphex instead due to a pharmacy packaging error. The note revealed a slight increase in the resident's blood pressure. The progress note indicated that the resident was currently receiving the correct medication to monitor her BP.

An interview was conducted with the Pharmacy's Director of Quality on 05/24/23 at 10:16 a.m. She

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stated the label on the blister card for Resident #106 was labeled Verapamil 240 mg, but the blister pack contained Aciphex 20 mg tablet. She said the medication label gave a description of what the pill should look like, giving the color and shape. She stated by giving the description helped to identify the correct medication in the blister pack. She stated the blister pack was packaged and 30 pills were delivered to the nursing facility on 04/07/23. She stated Resident #106 received another resident's medication (Aciphex) and missed her prescribed medication (Verapamil.) The Director of Quality stated a new blister pack card of Verapamil 240 mg ER was packaged and delivered to the nursing facility on 05/01/23.

A phone call was placed to License Practical Nurse (LPN) #2 on 05/25/23 at 11:03 a.m. The (LPN) was assigned to administer Resident #113's medication (Aciphex) on the following days in April 2023: 04/19/23 and 04/27/23 at 8:00 a.m. A message was left, but the LPN never returned the call.

An interview was conducted with LPN #1 on 05/25/23 at approximately 11:26 a.m. The LPN was assigned to administer Resident #106's medication on the following days: 04/07/23, 04/08/23, 04/17/23, 04/18/23, 04/19/23, and 04/24/23. She stated she had to be truthful; she never reviewed the medication label for the description of the medication. She said she only looked at the resident's name and dose of the drug. She stated the facility nurses were educated on the right rights of medication administration (right patient, right dose, right time, right route, and the right frequency.) She stated she was also educated to always check the label

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on the medication card for the description of what the medication looks like (shape, size, and color.) She stated when she administered Resident #106's on the days mentioned, she thought she was administering Resident #106 her scheduled Verapamil for her blood pressure and not Rabeprazole.

An interview was conducted with the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services on 05/25/23 at 12:33 p.m. The Administrator stated a Plan of Correction (POC) was put in place immediately after being notified two (2) residents blister card medications contained the wrong medication. The Administrator presented an Action Plan dated 05/01/23. The Action Plan included the following: Failure to ensure the correct medication and dosage sent to the facility for a resident. Further review of the Action Plan included in-service/education (5 rights of medication administration) started on 05/02/23. The DON stated the blister cards were immediately removed from the medication cart and sent back to the pharmacy. The DON stated there were no further incidents related to packaging errors from the pharmacy or any incidents when the resident (s) did not receive their scheduled medication as ordered by the physician.

On 05/25/23 at 5:45 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Regional Director of Clinical Services Nursing. It was determined that they implemented their Corrective Action Plan, and there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey for the regulatory requirement, F755.

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Facility Action Plan dated 5/1/23:
Step 1a. - Resident #113 was administered another resident antihypertensive medication in error. Resident #106 did not receive the scheduled antihypertensive medication as ordered by the physician. Once the facility was informed of the medication errors, the medication was immediately pulled from the medication cart and returned to the pharmacy. The DON and nursing leadership educated all nursing staff on the 5 rights of Medication Administration and to check the medication label for the description of the medication.

Step 1b. What immediate interventions were for the affected residents? The medication cards were immediately removed from the medication cart and sent back to the pharmacy. The residents were assessed by the physician and the resident's representative was made aware of medication error.

Step 2a. What immediate actions were taken to identify all potential affected? Education for all nurses on using the pill identifier (identifies the shape and color) located on the medication label and the five rights of medication administration; the right patient, the right drug, the right time, the right dose, and the right route) with a return demonstration, completed on 05/10/23.

Step 2b. What continued and immediate interventions were implemented for identified residents or systems? Immediate 100% MAR/Cart audit conducted by the pharmacist. Random MAR/Cart weekly audits are conducted by nursing x 1 month then monthly thereafter x 3 months and monthly audits are conducted by the

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pharmacist.

Step 2c. The results of the audits will be submitted to the QAPI meeting for compliance before the scheduled QA meeting in June 2023. The results were presented to the QA committee on 04/26/23 with 100% compliance. The QA Committee will determine the need for further audits and/or action plans.

The facility's policy titled Medication Error effective 11/01/19. It is the facility's policy for the licensed nurse who discovers a medication error will immediately initiate the appropriate Medication Error Report (s).

The procedure includes but is not limited to:
-The physician is notified of the medication error.
-Any follow-up orders of the physician are carried through.
-RDCS and the Chief Nursing Officer must be notified of significant medication errors.
-The DON will complete an administrative investigation, appropriate follow-up, and form filing.
-The medication error is reported to the Medical Director and the Quality Assurance (QA) committee.
-Significant medication errors that resulted in death/hospitalization will be reported to the appropriate agency.

Definitions
-Verapamil is used to treat high blood pressure and to control angina (chest pain). The immediate-release tablets are also used alone or with other medications to prevent and treat irregular heartbeats (https://medlineplus.gov/druginfo/meds).

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-Midodrine is used to treat orthostatic hypotension (a sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine works by causing blood vessels to tighten, which increases blood pressure (https://medlineplus.gov/druginfo/meds).

-Rabeprazole Sodium is used to treat the symptoms of gastroesophageal reflux disease (GERD), a condition in which the backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube that connects the throat and stomach.) It allows the esophagus to heal and prevents further damage to the esophagus in adults (https://medlineplus.gov/druginfo/meds).

-Hypotension, also known as low blood pressure, is blood pressure under 90/60 mm/Hg. In many people, it has no symptoms. When it does cause symptoms, these are usually unpleasant or disruptive, including dizziness, fainting, and more. In some cases, hypotension is dangerous, so early diagnosis and treatment are important. One way in treating hypotension directly can happen is by increasing blood volume. This method, also known as fluid resuscitation, involves infusing fluids into your blood. Examples of this include intravenous (IV) fluids, plasma, or blood transfusions (https://my.clevelandclinic.org/health/diseases/21156-low-blood-pressure-hypotension).

-Hypertension is a common condition that affects the body's arteries. It's also called hypertension. If you have high blood pressure, the force of the blood pushing against the artery walls is consistently too high. The heart must work harder

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F 755	Continued From page 12 to pump blood (https://www.mayoclinic.org/diseases-conditions).	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: F760 Based on staff interviews, pharmacist interviews, clinical record reviews, and facility documentation, the facility staff failed to ensure one (2) of 14 residents (Resident #113 and 106) in the survey sample were free of significant medication errors. The findings included: 1. Resident #113 was administered 24 doses of another resident's blood pressure (BP) medication Verapamil ER 240 mg and missed 24 doses of her scheduled medication Rabeprazole. On 04/19/23 Resident #113's BP dropped to 78/48 with complaints of feeling dizzy. The resident was assessed by the Nurse Practitioner (NP) with new orders to start Midodrine (used to increase blood pressure.) Resident #113 was admitted to the nursing facility on 04/01/23. The resident was transferred to the local hospital on 05/01/23 and did not return to the facility. Diagnosis for Resident #113 included but are not limited to major depressive disorder, difficulty in walking, muscle weakness, syncope, and collapse. The most recent Minimum Data Set (MDS - an assessment protocol) an admission	F 760	Past noncompliance: no plan of correction required.	

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assessment with an Assessment Reference Date (ARD) of 04/05/23 scored Resident #113, a 99 indicating short-and-long term memory problems with severe cognitive impairment - never/rarely made decisions.

In section "G" (Physical functioning) the MDS coded Resident #113 required total dependence of one with bathing, limited assistance of one with bed mobility, transfer, dressing toilet use, personal hygiene, and eating for Activities of Daily Living (ADL) care.

Resident #113's care plan created on 04/03/23 identified the resident as at risk for cardiac complications secondary to Congestive Heart Failure (CHF), coronary artery disease (CAD), cardiac shunt placement, history of transient ischemic attack (TIA)/cardiovascular accident (CVA) and hypertension (high blood pressure). The goal set for the resident by the staff was to be free from cardiac complications. Some of the interventions/approaches the staff would use to accomplish this goal were to administer medications as ordered, vital signs as needed, and observe for signs of cardiac complications.

A review of Resident #113's Medication Administration Record (MAR) revealed an order dated 04/01/23 to administer Rabeprazole Sodium 20 mg tablet daily before breakfast at 8:00 a.m., for Gastroesophageal reflux disease (GERD.)

An interview was conducted with Resident #113's representative on 05/25/23 at approximately 2:35 p.m. He stated on 05/01/23, Resident #113's medications were reviewed with Resident #113's nurse and two other representatives. He stated

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the medication Rabeprazole 20 mg was not familiar in shape, size, or color so the medication was looked up on Google search. He said after looking up the medication, they were certain that the medication the nursing staff had been giving Resident #113 was not the correct medication (Rabeprazole.)

An interview was conducted with the Pharmacy's Director of Quality on 05/24/23 at 10:16 a.m. She stated the blister card for Resident #113 was labeled Aciphex 20 mg tablet, but the blister pack contained (Verapamil 240 mg tablets) the wrong medication. She said the medication label gave a description of what the pill should look like, giving the color and shape. She stated by giving the description helped to identify the correct medication in the blister pack. She stated the blister pack was packaged and 30 pills were delivered to the nursing facility on 04/07/23.

A phone call was placed to LPN #2 on 05/25/23 at 11:03 a.m. The (LPN) was assigned to administer Resident #113's medication (Aciphex) on the following days in April 2023: 04/19/23 and 04/27/23 at 8:00 a.m. A message was left, but the LPN never returned the call.

A phone interview was conducted with LPN #5 on 05/25/23 at approximately 3:27 p.m. The LPN stated on 05/01/23 (not sure of the exact time) Resident #113's representative requested to review the resident's medications. She stated she removed Resident #113's medication blister cards from the medication cart. She stated after the representative reviewed the residents' medications, he stated the medication (Rabeprazole) did not look familiar, and had the wrong shape, size, and color. She said the

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resident's representative immediately stated the medication given as Rabeprazole was not the correct medication. The LPN stated she immediately reported the resident representative's concern to the Unit Manager.

A review of Resident #113's clinical note revealed during a physical therapy (PT) session on 04/18/23, the resident voiced complaints of dizziness. The resident's BP was taken (sitting position) with a reading of 78/48 (hypotension - low BP), pulse at 105 (tachycardia - increase heart rate) beats per minute (bpm), and the nursing staff were informed of low blood pressure reading.

A review of Resident #113's clinical record revealed the following low BP readings:
-04/15/23, BP = 84/51.
-04/16/23, BP = 93/60.
-04/18/23, BP = 78/48.

A phone interview was conducted with the Nurse Practitioner (NP) on 05/25/23 at 4:06 p.m. She stated she was asked to assess Resident #113 on 04/18/23 after having a hypotensive episode during therapy. She stated because of the resident's extensive cardiac issues, she ordered a low dose of Midodrine. She stated when the Midodrine was ordered, she was not aware at that time Resident #113 had been receiving another resident's blood pressure medication.

A review of Resident #113's Physician Order Summary (POS) revealed the following order: Midodrine 2.5 mg - give 1 tablet by mouth every 24 hours as needed for hypotension (low blood pressure) with a systolic BP less than 100 mmHg (millimeters of Mercury) starting on 04/18/23.

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The resident's BP did not drop below 100 mmHg after the order was written, thus no doses of Midodrine were required.

On 05/01/23, Resident #113 was transferred to the local Emergency Department (ED) for altered mental status (AMS.) A review of the hospital records dated revealed Resident #113 presented to the ED on 05/01/23 at approximately 4:07 p.m., with altered mental status (AMS) and somnolence (sleepiness.) According to the hospital records, Resident #113 received Lactated Ringers 500 ml via Intravenous (IV) on 05/01/23 while in the ED. Resident #113 was discharged from the hospital on 05/12/23.

2. Resident #106 missed 24 doses of Verapamil (medication to treat high blood pressure) and instead received 24 doses of another resident's medication (Rabeprazole to treat gastroesophageal reflux disease). On 04/19/23, Resident #106 received a new order for Hydralazine HCL 10 mg as needed for systolic BP greater than 170. Resident #106 received three (3) doses of Hydralazine for her increased BP.

Resident #106 was originally admitted to the nursing facility on 08/19/21. Diagnosis for Resident #106 included but are not limited to high blood pressure. The most recent Minimum Data Set (MDS - an assessment protocol) quarterly assessment with an Assessment Reference Date (ARD) of 03/02/23 coded the resident with a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.

In section "G" (Physical functioning) the MDS coded Resident #106 required total dependence

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on one person with bathing, extensive assistance of one with toilet use and dressing, limited assistance of one with bed mobility, transfer, and personal hygiene, and supervision with eating for Activities of Daily Living (ADL) care.

A review of Resident #106's Medication Administration Record (MAR) revealed an order dated 03/17/23 to administer Verapamil Extended Release (ER) 240 mg tablet by mouth daily at 9:00 a.m., hold for systolic blood pressure less than 120.

A review of Resident #106's MAR for April 2023 included an order written on 04/19/23 to administer Hydralazine HCL 10 mg by mouth every 8 hours as needed for systolic blood pressure greater than 170. Further review of the MAR revealed Hydralazine 10 mg (medication to treat high blood pressure) was administered on the following three (3) days for a systolic BP greater than 170.
-04/20/23, BP = 187/92.
-04/24/23, BP = 182/90.
-04/29/23, BP = 187/100.

A review of the physician progress note dated 05/03/23 at 5:03 4:18 p.m. revealed Resident #106 was supposed to be receiving Verapamil 240 mg; however, she received the medication Aciphex instead due to a pharmacy packaging error. The note revealed a slight increase in the resident's blood pressure. The progress note indicated that the resident was currently receiving the correct medication to monitor her BP.

An interview was conducted with the Pharmacy's Director of Quality on 05/24/23 at 10:16 a.m. She stated the label on the blister card for Resident

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#106 was labeled Verapamil 240 mg, but the blister pack contained Aciphex 20 mg tablet. She said the medication label gave a description of what the pill should look like, giving the color and shape. She stated by giving the description helped to identify the correct medication in the blister pack. She stated the blister pack was packaged and 30 pills were delivered to the nursing facility on 04/07/23. She stated Resident #106 received another resident's medication (Aciphex) and missed her prescribed medication (Verapamil.) The Director of Quality stated a new blister pack card of Verapamil 240 mg ER was packaged and delivered to the nursing facility on 05/01/23.

A phone call was placed to License Practical Nurse (LPN) #2 on 05/25/23 at 11:03 a.m. The (LPN) was assigned to administer Resident #113's medication (Aciphex) on the following days in April 2023: 04/19/23 and 04/27/23 at 8:00 a.m. A message was left, but the LPN never returned the call.

An interview was conducted with LPN #1 on 05/25/23 at approximately 11:26 a.m. The LPN was assigned to administer Resident #106's medication on the following days: 04/07/23, 04/08/23, 04/17/23, 04/18/23, 04/19/23, and 04/24/23. She stated she had to be truthful; she never reviewed the medication label for the description of the medication. She said she only looked at the resident's name and dose of the drug. She stated the facility nurses were educated on the right rights of medication administration (right patient, right dose, right time, right route, and the right frequency.) She stated she was also educated to always check the label on the medication card for the description of what

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the medication looks like (shape, size, and color.) She stated when she administered Resident #106's on the days mentioned, she thought she was administering Resident #106 her scheduled Verapamil for her blood pressure and not Rabeprazole.

An interview was conducted with the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services on 05/25/23 at 12:33 p.m. The Administrator stated a Plan of Correction (POC) was put in place immediately after being notified two (2) residents blister card medications contained the wrong medication. The Administrator presented an Action Plan dated 05/01/23. The Action Plan included the following: Failure to ensure the correct medication and dosage sent to the facility for a resident. Further review of the Action Plan included in-service/education (5 rights of medication administration) started on 05/02/23. The DON stated the blister cards were immediately removed from the medication cart and sent back to the pharmacy. The DON stated there were no further incidents related to packaging errors from the pharmacy or any incidents when the resident (s) did not receive their scheduled medication as ordered by the physician.

On 05/25/23 at 5:45 p.m., a final interview was conducted with the Administrator, Director of Nursing, and Regional Director of Clinical Services Nursing. It was determined that they implemented their Corrective Action Plan, and there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of the current survey for the regulatory requirement, F760.

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Facility Action Plan dated 5/1/23:
Step 1a. - Resident #113 was administered another resident antihypertensive medication in error. Resident #106 did not receive the scheduled antihypertensive medication as ordered by the physician. Once the facility was informed of the medication errors, the medication was immediately pulled from the medication cart and returned to the pharmacy. The DON and nursing leadership educated all nursing staff on the 5 rights of Medication Administration and to check the medication label for the description of the medication.

Step 1b. What immediate interventions were for the affected residents? The medication cards were immediately removed from the medication cart and sent back to the pharmacy. The residents were assessed by the physician and the resident's representative was made aware of medication error.

Step 2a. What immediate actions were taken to identify all potential affected? Education for all nurses on using the pill identifier (identifies the shape and color) located on the medication label and the five rights of medication administration; the right patient, the right drug, the right time, the right dose, and the right route) with a return demonstration, completed on 05/10/23.

Step 2b. What continued and immediate interventions were implemented for identified residents or systems? Immediate 100% MAR/Cart audit conducted by the pharmacist. Random MAR/Cart weekly audits are conducted by nursing x 1 month then monthly thereafter x 3 months and monthly audits are conducted by the pharmacist.

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Step 2c. The results of the audits will be submitted to the QAPI meeting for compliance before the scheduled QA meeting in June 2023. The results were presented to the QA committee on 04/26/23 with 100% compliance. The QA Committee will determine the need for further audits and/or action plans.

The facility's policy titled Medication Error effective 11/01/19. It is the facility's policy for the licensed nurse who discovers a medication error will immediately initiate the appropriate Medication Error Report (s).

The procedure includes but is not limited to:
-The physician is notified of the medication error.
-Any follow-up orders of the physician are carried through.
-RDCS and the Chief Nursing Officer must be notified of significant medication errors.
-The DON will complete an administrative investigation, appropriate follow-up, and form filing.
-The medication error is reported to the Medical Director and the Quality Assurance (QA) committee.
-Significant medication errors that resulted in death/hospitalization will be reported to the appropriate agency.

Definitions
-Verapamil is used to treat high blood pressure and to control angina (chest pain). The immediate-release tablets are also used alone or with other medications to prevent and treat irregular heartbeats (https://medlineplus.gov/druginfo/meds).

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-Midodrine is used to treat orthostatic hypotension (a sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine works by causing blood vessels to tighten, which increases blood pressure (https://medlineplus.gov/druginfo/meds).

-Rabeprazole Sodium is used to treat the symptoms of gastroesophageal reflux disease (GERD), a condition in which the backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube that connects the throat and stomach.) It allows the esophagus to heal and prevents further damage to the esophagus in adults (https://medlineplus.gov/druginfo/meds).

-Hypotension, also known as low blood pressure, is blood pressure under 90/60 mm/Hg. In many people, it has no symptoms. When it does cause symptoms, these are usually unpleasant or disruptive, including dizziness, fainting, and more. In some cases, hypotension is dangerous, so early diagnosis and treatment are important. One way in treating hypotension directly can happen is by increasing blood volume. This method, also known as fluid resuscitation, involves infusing fluids into your blood. Examples of this include intravenous (IV) fluids, plasma, or blood transfusions (https://my.clevelandclinic.org/health/diseases/21156-low-blood-pressure-hypotension).

-Hypertension is a common condition that affects the body's arteries. It's also called hypertension. If you have high blood pressure, the force of the blood pushing against the artery walls is consistently too high. The heart must work harder to pump blood

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