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F 000	INITIAL COMMENTS The survey team entered the facility on 6/20/23 to conduct a complaint investigation survey through 6/21/23. The survey team reentered the facility on 6/27/23 to conduct validation of the immediate jeopardy corrective action plan for F660 and the immediate jeopardy removal plan for F835 and investigate another complaint. Therefore, the survey exit date was changed to 6/27/23. The following intakes were investigated: NC00203953, NC00203942, NC00203656, NC00203085, NC00202337, NC00198899, NC00198758, NC00197388, NC00196818, NC00196903, NC00196096, and NC00194603. 3 of the 36 complaint allegations resulted in deficiency. Intakes NC00203085 and NC00202337 resulted in immediate jeopardy. Immediate jeopardy was identified at: CFR 483.21 tag F660 at a scope and severity (J). CFR 483.70 tag F835 at a scope and severity (K) Non-compliance for F660 began on 4/6/23 and the facility corrected the deficiency on 5/23/23. Immediate Jeopardy for F835 began on 4/17/23 and was removed on 6/23/23.	F 000		
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation	F 660		

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

Electronically Signed | 07/24/2023

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.

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of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received

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F 660	Continued From page 2 from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with resident, family member, pharmacist, physician, and staff the facility failed to implement an effective discharge plan when 2 residents (Resident #2 and Resident #4) were discharged to the community with medications that were prescribed for other residents. On 4/6/23 Nurse #2 provided Resident #4 with medications prescribed for	F 660	Past noncompliance: no plan of correction required.	

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Resident #8 and on 5/16/23 Nurse #1 provided Resident #2 with medications that were prescribed for Resident #6. Resident #4 reported not feeling well and was assessed by Emergency Medical Services in his home with no negative outcome or treatment required. Resident #2 suffered an allergic reaction and was hospitalized for baclofen (a muscle relaxer) toxicity. Discharging residents with medications not prescribed for them had a high likelihood of resulting in serious harm. This deficient practice was identified for 2 of 4 residents reviewed for discharge to the community.

The findings included:

1. Resident #4 was admitted to the facility on 3/24/23 with diagnoses that included diabetes, hypertension, and osteoarthritis.

Review of a nursing admission note dated 3/24/23 revealed Resident #4 was admitted to the facility for diabetic foot infection and short-term rehabilitation therapy.

Resident #4 ' s care plan initiated 3/24/23 had a focus that Resident #4 wished to return home. The goal was for Resident #4 to verbalize/communicate required assistance post discharge and the services required to meet needs before discharge.

The Admission/Medicare 5-day Minimum Data Set Assessment dated 3/29/23 revealed Resident #4 ' s cognition was intact.

The discharge medication list dated 4/6/23 included all the medications prescribed for Resident #4.

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During a telephone interview with Resident #4 on 6/20/23 at 11:58AM, he stated he was discharged on 4/6/23 and Nurse #2 provided him with medications prescribed for another resident in addition to medications prescribed for him. Resident #4 provided Resident #8 ' s name and reported the name of each medication with its dosage.

The medications included:

Meloxicam, (a nonsteroidal anti-inflammatory drug [NSAIDs]), 7.5 milligrams (mg) - 1 tablet by mouth two times a day for pain.

Gabapentin (used with other medications to prevent and control seizures. It is also used to relieve nerve pain) 300 mg- 2 capsules by mouth at bedtime for pain; and

Tizanidine (a skeletal muscle relaxant) 4 mg - Take 2 tablets by mouth at bedtime for pain.

Resident #4 stated he took three medications not prescribed for him for two days. He indicated he didn ' t feel well and was constipated so he called 911.?Resident #4 stated Emergency Medical Services reviewed the cards of medication he reported he had taken. Emergency Medical Services (EMS) instructed Resident #4 not to take those medications as they were not prescribed for him. Resident #4 indicated he had not noticed there was a different name on the medication cards. Resident #4 stated he notified the Administrator at the facility on 4/17/23 that he had been given another resident ' s medication. Resident #4 stated he had asked someone from the facility to come and pick up the medications.

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According to drug information, the starting dose of Meloxicam is 7.5 mg., and the maximum dose is 15 mg. Adverse effects include cardiovascular thrombotic events and gastrointestinal bleeding, ulceration, and perforation. Common side effects for Gabapentin include sleepiness and dizziness. Some common side effects of Tizanidine are drowsiness, dizziness, dry mouth, weakness, and constipation.

During a telephone interview with Nurse #2 on 6/20/23 at 2:08 PM, he stated the nurse caring for the resident was responsible for gathering the resident ' s medication for discharge from the medication cart. Nurse #2 stated he was assigned to Resident #4 at discharge. Nurse #2 stated he was unable to confirm if he had sent another resident ' s medication home with Resident #4. Nurse #2 stated all of Resident #4 ' s medications were removed from the medication cart and placed in a plastic bag. Nurse #2 indicated he had reviewed Resident #4 ' s medication list with him at the time of discharge. Nurse #2 stated he did not compare the medication list with the medications he removed from the cart.

Review of a signed copy of the Post Discharge Plan of Care dated 4/6/23 included an attached list of discharge medications and prescriptions.

During an interview with the Director of Nursing (DON) on 6/21/23 at 10:59 AM, she stated she had spoken with Resident #4 on the telephone on 4/17/23. The DON stated Resident #4 informed her that he had received another resident ' s medication in his discharge medication. The DON

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stated Resident #4 would not disclose the name of the medications or resident whose medication he had. The DON stated Resident #4 told her to come to his home to pick up the medication. The DON stated she did not go to Resident #4 ' s home because she did not feel safe. Further interview with the DON revealed that she spoke with Nurse #2, and he indicated he had not sent any other medications home with Resident #4. The DON stated medications were removed from the medication cart when a resident was discharged. The DON stated the nurse discharging the resident was responsible for removing the medications from the medication cart and compared the discharge medication list with those removed. The DON stated she expected the nurse discharging the resident would review the medication with the resident at the bedside and obtain a signed copy of the discharge recapitulation. The facility did not know which medications Resident #4 took home. He called the facility and told them he had another resident ' s medication mixed in with his but did not give them the name of the resident. The facility did not produce a copy of the medication return sheets for the dates of 4/5, 4/6 and 4/7. The DON stated she was not able to complete a thorough investigation because the resident would not give her the name of the medications nor the resident ' s name.

An interview was conducted with the Medical Director on 6/21/23 at 8:54 AM. The Medical Director indicated he was made aware by the Administrator. Resident #4 had indicated he had gone home with another resident ' s medication. The Medical Director stated given Resident #4 ' s history of pain and osteoarthritis the medications would help with the pain. The Medical Director

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stated he did not feel the resident was in any immediate danger. The Medical Director stated the facility had initiated an investigation based on the reporting of Resident #2 receiving the wrong medication.

An interview was conducted with the Pharmacist on 6/21/23 at 2:10 PM. The Pharmacist stated Meloxicam was a nonsteroidal anti-inflammatory drug (NSAID) and could cause gastrointestinal upset and bleeding with long-term use. She stated that Gabapentin and Tizanidine could both cause sedation. The Pharmacist stated Tizanidine could cause some constipation, but that side effect was highly unlikely with Gabapentin. The pharmacist stated that all pre-discharge medications were to be reconciled with the post discharge medications both prescribed and over the counter.

An interview was conducted with the Administrator on 6/21/23 at 4:18 PM. The Administrator stated she returned a call to Resident #4 on 4/17/23 to discuss the concern with the medication. She stated Resident #4 refused to give her the name of the Resident ' s medication. The Administrator state she completed a grievance detailing Resident #4 ' s concerns.

A Grievance Report dated 4/17/23 revealed Resident #4 had left a voicemail message for the Administrator regarding his concerns after discharge. The Summary Statement of the Grievance revealed Resident #4 was concerned that no one had returned his call from the previous week regarding medication.

Steps taken to investigate the grievance revealed

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the Administrator verified with the DON that Resident #4 had called back to the facility the previous week to discuss medication concerns. The DON stated Resident #4 gave her limited information regarding the medications he reported were sent home. Resident #4 refused to give the DON the name of the resident whose medications he had received in error.

The Administrator determined that the grievance was not confirmed.

2. Resident #2 was admitted to the facility on 4/14/23 with diagnoses that included end stage renal disease with dialysis, Parkinson ' s disease and atrial fibrillation.

Review of a nursing admission note dated 4/14/23 revealed Resident #2 was admitted to the facility with a diagnosis of debility and was admitted for short term rehabilitation therapy.

Resident #2 ' s care plan initiated 4/19/23 had a focus that Resident #2 was to return home with family. The goal was for Resident #2 to verbalize/communicate an understanding of the discharge plan and describe the desired outcome by the review date of 7/25/23.

The Admission/Medicare 5-day Minimum Data Set Assessment dated 3/29/23 revealed Resident #2 ' s cognition was intact.

Review of the Interdisciplinary Discharge Summary for Resident #2 dated 5/16/23 revealed Resident #2 was discharged due to completion of the clinical pathway. She had no sensory impairment and was able to make her needs know. Resident #2 was described as ready for

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discharge home with family. The discharge summary revealed Resident #2 was ambulatory and required a walker and wheelchair for mobility. The discharge summary indicated prescribed medications were given to the family to take home.

A review of Resident #2 ' s medical record did not reveal an order for baclofen.

An interview was conducted with Family Member # 1 on 6/20/23 at 2:08 PM. Family Member # 1 stated she had pulled Resident #2 ' s medication from the bubble packs received from the facility on 5/16/23. Family Member #1 stated the facility did not review Resident #2 ' s medication with her prior to the resident discharging. Family Member # 1 stated she went to administer Resident #2 ' s medications the next day and did not look at the name on the medication cards. Family Member # 1 reported she gathered the medications according to the instructions on the medication card. Family Member # 1 stated she was aware there had been some recent changes to Resident #2 ' s medication so she didn ' t think anything of the baclofen medication. Family Member # 1 stated she had administered the baclofen medication for three doses in two days when Resident #2 had facial, and tongue swelling and became unresponsive. Family Member # 1 stated she called 911 and Resident #2 was admitted to the hospital on 5/19/23.

During an interview with the Director of Nursing on 6/21/23 at 11:04 AM the DON stated she was told Resident #2 was going home with family upon discharge. The DON stated she received a call on 5/20/23 from Resident #2 ' s Family Member # 1 asking if resident was on Baclofen.

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The DON stated she reviewed Resident #2 ' s medication orders and discovered she had not been prescribed Baclofen. The DON stated Resident #2 ' s Caregiver indicated she had given Resident #2 Baclofen and was not paying attention to the medication cards. The DON stated the Caregiver informed her when she reviewed the medication cards, she discovered the Baclofen had another resident ' s name on it. The DON stated Resident #2 ' s family member further stated she had taken Resident #2 to the hospital because she was not acting herself. The DON stated the nurse discharging the resident was responsible for removing the medications from the medication cart. and compared the discharge medication list with those removed. The DON stated she expected the nurse discharging the resident would review the medications with the resident at the bedside and obtain a signed copy of the discharge recapitulation. The DON stated an investigation was launched upon learning about Resident #2 receiving baclofen which was not on her discharge medication list.

Review of Resident #6 ' s medical record revealed Resident #6 was prescribed baclofen 10 mg., one tablet by mouth three times a day for muscle spasticity.

During an interview with Nurse #1 on 6/21/23 at 11:23 AM she stated she was working on Resident #2 ' s discharge when she became distracted. Nurse #1 stated she had reviewed Resident #2 ' s medications with resident the morning of her discharge. Nurse #1 stated she had given Resident #6 her scheduled medication when Resident #2 's family member approached her about discharge. Nurse #1 stated she began

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to remove Resident #2 ' s medication from the medication cart and must have accidentally picked up Resident #6 ' s medication card. Nurse #1 stated she had placed the medications in the room with Resident #2 when she had to step out. Nurse #1 stated she asked Family Member #2 to hold on so she could review the medications with him. Nurse #1 stated Family Member #2 did not wait for her to return so she was unable to compare the medications in the bag with the discharge medication list.

Review of the hospital discharge summary dated 6/12/23 revealed Resident #2 revealed was admitted on 5/19/23 for a primary diagnosis of altered mental status and found to have baclofen toxicity secondary to incorrect prescription. Resident #2 (who was on dialysis) took the Baclofen and had an allergic reaction requiring hospitalization. The anticipatory guidance for the outpatient provider on the hospital discharge summary read: "Please avoid prescribing baclofen in future encounters as she is very prone to baclofen toxicity. Baclofen is listed as an allergy as of this admission." Resident #2 was treated in the hospital for altered mental status, agitation, hypotension (low blood pressure), rigidity (stiffness) and dysphagia (difficulty swallowing). Resident #2 was discharged from the hospital on 6/12/23 with referrals for home health, physical therapy and occupational therapy.

An interview was conducted with the Medical Director on 6/21/23 at 8:54 AM. The Medical Director revealed he had been made aware of that Resident #2 had received Resident #6 ' s medication on 5/20/23. The Medical Director indicated Resident #2 had Baclofen toxicity and

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exhibited hypotension (low blood pressure) and flaccid (hanging loosely) tone. The Medical Director stated he was not sure what medications Resident #2 had taken prior to being admitted to the hospital since there was no medication list to compare what she received. He stated the individual that picked up Resident #2 for discharge was in a rush and did not wait for review of the medications with the nurse.

An interview was conducted with the Pharmacist on 6/21/23 at 2:10 PM. The Pharmacist stated Baclofen was not contraindicated in renal patients. She stated the medication was excreted from the body by the kidneys and the resident would have been prescribed a lower dose given her kidney issues. The Pharmacist stated she had been made aware Resident #2 received Baclofen and recommended that all residents ' medication be reviewed.

An interview was conducted with the Administrator on 6/21/23 at 4:18 PM. The Administrator stated the facility began an investigation once being notified about Resident #2 receiving the baclofen and being hospitalized. The Administrator stated the facility completed a plan of correction and reviewed with the Quality Assurance and Performance Improvement committee.

On 6/21/23 at 1:18 PM, the Administrator was informed of immediate jeopardy.

On 6/22/23 the facility provided the following plan of correction.

Address how corrective action will be accomplished for those residents found to have

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F 660	Continued From page 13 been affected by the deficient practice. PROCESSES THAT LEAD TO THE ALLEGED DEFICIENCY CITED: On 4/17/23, Resident #4 called the facility and spoke with the Director of Nursing (DON) concerning receiving another resident ' s medication when he was discharged on 4/6/23. Resident #4 refused to divulge any information related to the name of the person on the medication card. Administrator was notified and a grievance form was completed to address Resident #4 complaints. The facility investigated the complaint of receiving another resident ' s medication however was unable to validate due to lack of information. The DON interviewed Nurse #2 on 4/17/23. Nurse #2 was unable to confirm that another resident ' s medication was sent with Resident #4. The DON completed an audit of the medication cart for the hall Resident #4 resided on during his stay in the facility. All medications on this medication cart were accounted for. No residents had medication missing. The DON audited the medication room for the hall. No issues were identified. Facility did not audit residents who were recently discharged. On 5/19/2023, DON received a call from Resident #2 ' s daughter who asked if Resident #2 had ever had an order for Baclofen. DON checked previous orders and noted that Resident #2 was never on said medication. Resident #2 ' s family member stated that she was giving medications to Resident #2 and was not paying attention and after medication was given to Resident #2, she noticed that Resident #6 ' s medication (Baclofen) was with the other medications sent home with them.	F 660		

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Resident #2 ' s family member stated she took Resident #2 to the hospital on 5/19/23 because she was more confused and not at her baseline.

Investigation Findings:

On 5/16/2023 Nurse #1 gave medications prescribed for Resident #6 to Resident #2 in error upon discharge. The medications given in error included Baclofen 10 milligrams (mg) that was a scheduled medication for Resident #6. Nurse #1 was preparing medications for Resident #2 for discharge and during the same time also looking for medication for Resident #6. Nurse #1 placed Resident #6 ' s medication card of Baclofen on the top of the medication cart along with Resident #2 ' s medication cards. Nurse #1 grabbed all medication cards for Resident #2 and inadvertently grabbed the medication card of Baclofen for Resident #6.

On 5/19/2023 at 11:00 AM, the DON notified the facility medical provider and the corporate clinical support team (Regional Clinical Director and Corporate Clinical Director).

Upon investigation of this incident by the Director of Nursing, it was determined that Nurse #1 was looking for medication for Resident #6, while pulling medications for Resident #2 for discharge. Nurse #1 pulled medication cards for Resident #2 and inadvertently pulled Resident #6 ' s medication card of Baclofen. Medications were bagged and taken into the room of Resident #2. Nurse #1 realized she did not have the discharge medication paperwork for Resident #2 with her. Nurse #1 asked Grandson to wait until she could retrieve the discharge paperwork folder from the

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Social Worker and review it. Prior to Nurse #1 returning to the room (less than 5 minutes later), Resident #2 and Grandson exited the facility with the medications prior to discharge medication education and paperwork being provided by Nurse #1. Resident #2 ' s medications in addition to Resident #6 ' s Baclofen medication card was within the medications sent home with Resident #2.

Root cause analysis:

Based upon interviews and record review, it is determined that the root cause of this incident is related to the following: Nurse #1 pulled medication for Resident #2 and subsequently got distracted during the retrieval of medications which resulted in failure of Nurse #1 to verify all medications cards which were prepared for resident to take home belonged to Resident #2.

An Ad Hoc (Quality Assurance Performance Improvement) QAPI meeting was conducted on 5/22/23 by the QAPI Committee (Administrator, DON, Social Services Manager, Infection Prevention Control Officer, Minimum Data Set (MDS) Coordinator(s), Therapy Manager, Unit Manager(s), Staff Development Coordinator (SDC), Business Office Manager, Activities Director, Maintenance Director, Dietary Manager and Medical Director) to discuss this event and plan of correction.

Resident #4 was discharged from the facility on 4/6/23.

Resident #2 was discharged on 5/16/23. On 5/19/23, Resident #2 was noted to be in a local

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hospital with "stroke like" symptoms post 3-day discharge from facility.

Resident #6 ' s medication cards were reviewed by the Director of Nursing (DON) on 5/19/23 to ensure all medication cards based upon medication list are accounted for. After review, Resident #6 did not have any further medication cards missing. On 5/20/23, the Pharmacy was contacted by the Director of Nursing related to the facility replacing (at facility cost), one (1) card (30-day supply) of Baclofen 10mg for Resident #6. Per pharmacy, medication is scheduled to arrive at the facility evening of 5/20/23.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

As a precaution on 5/19/23, the DON and Social Worker called discharged residents for the past 14 days to follow up on safety and understanding of medications. No concerns were voiced by any of the residents discharged within this timeframe. An audit was also performed to ensure that discharged residents signed the Discharge Plan of Care. No issues were identified.

On 5/20/23, Nurse #1 was immediately educated by the DON on medication administration, avoiding medication error specifically as it relates to distractions during resident discharge, giving discharge medications and the resident discharge process. A competency test was utilized to ensure competency of education provided.

On 5/21/23, Unit Managers and Director of

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Nursing performed an audit comparing each current residents ' medication administration record (MAR) to the assigned medication cart to ensure discontinued medications were removed from medication cart and returned to pharmacy. Any identified issues were corrected.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Because all residents are at risk when a Licensed Nurse gives medications at discharge and a licensed nurse can become distracted and does not follow the facility medication discharge process, the facility has implemented the following corrective action:

On 5/20/23, the Corporate Clinical Director completed education with the Director of Nursing on ensuring the Interdisciplinary (IDT) Discharge Summary evaluation (which includes recapitulation of resident stay) is completed within the resident medical record for all facility discharges to home and/or another facility.

On 5/22/23, the Administrator was educated by Corporate Clinical Director on the IDT Discharge Summary process to ensure this is completed prior to discharge by the IDT team. This expectation was communicated to the Interdisciplinary Team (IDT) by the Administrator during the daily stand-up meeting on 5/22/23. The following IDT members were present: DON, Unit Manager(s) Social Services Manager, Activity Director, Dietary Manager and Therapy Manager.

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Beginning 5/22/23, Licensed Nurses should not discharge a resident home with medications without obtaining an MD order. Previously, Licensed Nurses sent medications home without ensuring an approved transcribed MD order was within the resident medical record.

Beginning 5/19/23, Licensed Nurses were provided education verbally by the SDC and DON and/or the facility electronic learning system on the following:

"Avoiding Common Medication Errors" which included how to handle (defer) distractions during medication pass, 5 rights of medication administration, discharge processes, discharge medication education when an order to discharge home with medications has been received from the MD.

Discharge Instructions and Med Review: The discharge process includes the Licensed Nurse reviewing the medication discharge instruction form with the resident/family.

The PCC order summary report is to be utilized by the licensed nurse for discharge medication reconciliation.

This medication discharge instruction form should be thoroughly reviewed by the Licensed Nurse with the resident/family, then signed by the resident/family acknowledging understanding of discharge medication instructions.

The Licensed Nurse should sign the form.

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The medication discharge instruction form should be given to the resident/family.

A copy should be retained by the facility and uploaded into the resident medical record.

Prescriptions for medications should be given to the resident. The resident should not take any medications from the facility without an MD order.

If the resident must take medications home at discharge, the Licensed Nurse must verify each medication card to ensure it belongs to the correct resident to be discharged. Additionally, when medication instructions are provided the Licensed Nurse should show each medication card to the resident/family while reviewing the medication discharge instruction form comparing to each for accuracy.

A thorough discharge nurses note utilizing the electronic medical record "Discharge Note" template should be written to detail discharge education provided to the resident/family.

If a medication is discontinued, the Licensed Nurse must remove the medication from the medication cart and return to pharmacy for destruction.

Any Licensed Nurse not educated after 5/21/23 will not be allowed to work until educated. Newly hired Licensed Nurses will be trained by the facility Staff Development Coordinator or designee during their orientation period.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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Beginning 5/23/23, the DON, Unit Manager or Nurse Supervisor will observe the Licensed Nurse discharge to home process with all resident discharges to ensure discharge process is conducted as per education provided. This observation will be conducted with all discharge to home residents for the next 30 days. Thereafter, observations will be conducted by the DON, Unit Manager or Nurse Supervisor twice weekly with (2) Licensed Nurses (as applicable) for 8 weeks or until a pattern of compliance is sustained.

Beginning 5/23/23, education retention questionnaires will be conducted by Nursing Management with (5) Licensed Nurses to ensure retention of education provided in this plan. These questionnaires will be conducted weekly for 12 weeks or until a pattern of compliance is sustained.

Beginning 5/23/23, MAR to Med Cart audits will be conducted by the Unit Managers and/or Director of Nursing weekly to ensure all discontinued medications were removed from cart and returned to pharmacy.

Results of all audits will be reviewed in the facility Quality Assurance and Performance Improvement Committee meeting monthly for three (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the two (3) months.

Effective 5/23/23, the facility Administrator and

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Director of Nursing will be responsible for the implementation of this plan of correction. The Administrator will ensure the facility attains and maintains substantial compliance.

The facility alleged the deficiency was corrected on 5/23/23.

On 6/27/23 the facility ' s corrective action plan with the date of completion of 5/23/2023 was validated onsite and included record review and licensed nursing staff interviews.

Interviews with licensed nursing staff including Nurse #1 was conducted on 6/27/23. Licensed nursing staff revealed they had received recent education regarding medication administration errors. The importance of medication reconciliation, reviewing the discharge instructions with the resident or family and ensuring they understand the instructions and sign as received. A copy of the instructions was given to the resident or family and a copy was retained for the facility. Medications were only sent home with a physician order. Medications were returned to the facility pharmacy and prescriptions were given to the resident or family to be filled at their preferred pharmacy. Discharge notes were completed by the day of discharge.

Documentation review included Nurse #1 ' s education on 5/20/2023, and all other licensed nursing staff education completed by 5/22/2023. Documentation included an Ad Hoc QAPI meeting 5/22/23 sign-in sheet. Review of all resident discharges with locations, follow up calls, and audits noted. Post education staff questionnaires for information retention, and medication cart audits were observed.

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F 660	Continued From page 22 The validation verified the corrective action plan was completed as of 5/23/23.	F 660		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide effective oversight and leadership to correct an identified issue of a resident (Resident #4) being discharged from the facility with another resident ' s medication (Resident #8). This discharge occurred on 4/6/23 and the facility was notified of the error by Resident #4 on 4/17/23. On 5/16/23 the error occurred again when Resident #2 was discharged with medication prescribed for Resident #6. This affected 2 of 4 sampled residents reviewed for discharge and had the high likelihood for serious adverse outcomes for any resident discharged from the facility. Immediate jeopardy began on 4/17/23 when Resident #4 notified the Administrator he had been discharged with another resident ' s medications and the administration did not investigate to ensure effective systems were in place to prevent reoccurence. The immediate jeopardy was removed on 6/23/23 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy	F 835	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to implement an effective discharge plan when 2 residents, Resident #2 and Resident #4 were discharged to the community with medications that were prescribed for other residents. On 4/6/2023, Nurse #2 provided Resident #4 with medications prescribed for	7/25/23

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removal. The facility remains out of compliance at a lower scope and severity level of E, a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy, to ensure monitoring of systems put into place related to the discharge planning process are effective and to complete staff training.

The findings included:

1.Resident #4 was admitted to the facility on 3/24/23 with diagnoses that included diabetes, hypertension, and osteoarthritis.

Review of a nursing admission note dated 3/24/23 revealed Resident #4 was admitted to the facility for diabetic foot infection and short-term rehabilitation therapy.

A telephone interview conducted with Resident #4 on 6/20/23 at 11:58AM, revealed he was discharged on 4/6/23 and Nurse #2 provided him with medications prescribed for another resident in addition to medications prescribed for him. Resident #4 indicated he had taken medications not prescribed for him for 2 days and began to feel bad, so he called Emergency Medical Services (EMS). It was at that time Resident #4 was informed some of the medications were not prescribed for him. Resident #4 called the facility on 4/17/23 and notified the Administrator he had been given another resident ' s medication.

An interview was conducted with the Director of Nursing (DON) on 6/21/23 at 10:59 AM. The DON stated she had spoken with Resident #4 on the telephone on 4/17/23. The DON stated Resident #4 informed her that he had received discharged Resident #8 upon discharge to home for Resident #4. Resident #4 took 3 medications not prescribed for him for 2 days resulting in calling 911 related to not feeling well and being constipated.

Resident #4 called the facility on 4/17/2023 and spoke with the Administrator and Director of Nursing (DON) regarding a concern that he was discharged with another Resident□s medications, however Resident #4 refused to identify the resident or medication that he alleged he was in possession of. Administrator initiated a grievance for Resident #4 concerns.

The facility did not implement a corrective action plan to address the identified issue with Resident #2□s discharge medications when informed on 4/17/23.

On 5/19/2023, the DON received a call from Resident #2□s daughter who asked if Resident #2 had ever had an order for Baclofen. The DON checked previous orders and noted that Resident #2 was never on said medication. Resident #2□s daughter stated that she was giving medications to Resident #2 and was not paying attention and after medication was given to Resident #2, she noticed that Resident #6□s medication (Baclofen) was with the other medications sent home with them.

On 5/16/2023 Nurse #1 gave medications prescribed for Resident #6 to Resident #2 in error upon discharge. The medications

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F 835	Continued From page 24 another resident ' s medication in his discharge medication. The DON stated Resident #4 would not disclose the name of the resident whose medication he had. The DON stated Resident #4 told her to come to his home to pick up the medication. The DON stated she did not go to Resident #4 's home because she did not feel safe. The DON stated she was unable to complete a thorough investigation because Resident #4 would not give her the name of the medications nor the other resident ' s name. An interview was conducted with the Administrator on 6/21/23 at 4:18 PM. The Administrator stated she returned a call to Resident #4 on 4/17/23 to discuss the concern with the medication. She stated Resident #4 refused to give her the name of the Resident ' s medication and a grievance was completed detailing Resident #4 ' s concerns. The Administrator further stated the facility attempted to follow up on the resident ' s concerns but had limited information to complete the investigation. 2. Resident #2 was admitted to the facility on 4/14/23 with diagnoses that included end stage renal disease with dialysis, Parkinson ' s disease and atrial fibrillation. Review of a nursing admission note dated 4/14/23 revealed Resident #2 was admitted to the facility with a diagnosis of debility and was admitted for short term rehabilitation therapy. Review of the Interdisciplinary Discharge Summary for Resident #2 dated 5/16/23 revealed Resident #2 was discharged due to completion of the clinical pathway. She had no sensory	F 835	given in error included Baclofen 10 milligram (mg) that was a scheduled medication for Resident #6. On 5/19/23, Resident #2 was noted to be in hospital with stroke like symptoms post 3-day discharge from facility. Per hospital documentation Resident #2 suffered an allergic reaction to Baclofen. Per hospital documentation Baclofen was added as an allergy for future reference as her tolerance to Baclofen has a low threshold because of her dependence on hemodialysis. All residents have the potential to be affected when the facility administration fails to implement actions to correct identified issues of non-compliance. 2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 6/22/2023, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Vice President of Operations, Corporate Clinical Director and Regional Director of Clinical Services to discuss root cause analysis of the facilities failure to provide effective oversight and leadership. Root cause determined that the Administrator and Director of Nursing failed to implement corrective actions for identified areas of non-compliance.	

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F 835	Continued From page 25 impairment and was able to make her needs know. Resident #2 was described as ready for discharge home with family. The discharge summary revealed Resident #2 was ambulatory and required a walker and wheelchair for mobility. The discharge summary indicated prescribed medications were given to the family to take home. An interview was conducted with Family Member #1 on 6/20/23 at 2:08 PM. Family Member #1 stated she had pulled Resident #2's medication from the bubble packs received from the facility on 5/16/23 and did not look at the name on the medication cards. Family Member #1 stated she had administered baclofen medication for three doses in two days when Resident #2 had facial, and tongue swelling and became unresponsive. Family Member #1 stated she called 911 and Resident #2 was admitted to the hospital on 5/19/23. Review of the hospital discharge summary dated 6/12/23 revealed Resident #2 revealed was admitted for a primary diagnosis of altered mental status and found to have baclofen toxicity secondary to incorrect prescription. Resident #2 (who was on dialysis) took the Baclofen and had an allergic reaction requiring hospitalization. Resident #2 was admitted to the hospital on 5/19/23 where she was treated for altered mental status (change in mental function), agitation (unable to relax), hypotension (low blood pressure), rigidity (stiffness) and dysphagia (difficulty swallowing). Resident #2 was discharged from the hospital on 6/12/23 with referrals for home health, physical therapy and occupational therapy.	F 835	On 6/22/2023, Corporate Clinical Director and Vice President of Operations provided education to the Administrator and Director of Nursing on the QAPI committee role in maintaining compliance with F835. Specifically, as it relates to any identified quality issues. Any identified quality issues should have interventions established to avoid further non-compliance of deficient areas identified. Administrators and Director of Nurses will receive education upon hire during orientation. On 6/22/2023, after the Corporate Clinical Director and Vice President of Operations in-serviced the QAPI Committee, the facility QAPI Committee will continue to identify other areas of quality concern through the quality improvement (QI) review process, for example: Transfer/Discharge process and Pre/Post medication reconciliation. The QAPI was in-serviced on their role as the QAPI committee in identifying concerns and acting upon them. QAPI committee consisted of: Administrator, Director of Nursing, Unit Managers, Social Worker, Dietary Manager, Maintenance Director, Therapy Manager, Activities Director, Business Office Manager, Heath Information Coordinator, MDS Coordinator and Medical Director (by phone). 3) Measures put in place or systemic changes made to ensure that the deficient practice will not recur:	

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	345077	A. BUILDING _____ B. WING _____	C 06/27/2023

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F 835	Continued From page 26 An interview was conducted with the Director of Nursing (DON) on 6/21/23 at 10:59 AM. The DON stated she received a call on 5/20/23 from Resident #2 ' s Family Member #1 asking if resident was on Baclofen. The DON stated she reviewed Resident #2 ' s medication orders and discovered she had not been prescribed Baclofen. The DON stated Resident #2 's Caregiver indicated she had given Resident #2 Baclofen and was not paying attention to the medication cards. The DON stated Family Member #1 informed her when she reviewed the medication cards, she discovered the Baclofen had another resident ' s name on it. The DON stated Resident #2 ' s family member further stated she had taken Resident #2 to the hospital because she was not acting like herself. During the interview the DON was asked to describe the facility ' s process for medication reconciliation at discharge. The DON stated when a resident was discharged the medications were removed from the medication cart by the nurse discharging the resident. This nurse was responsible for removing the medications from the medication cart and compared the discharge medication list with those removed. The DON stated she expected the nurse discharging the resident would review the medications with the resident at the bedside and obtain a signed copy of the discharge recapitulation. The DON stated an investigation was launched upon learning about Resident #2 receiving baclofen which was not on her discharge medication list. An interview was conducted with the Administrator on 6/21/23 at 4:18 PM. The Administrator stated the facility began an investigation once being notified about Resident	F 835	Effective 7/24/2023, Regional Clinical Director and/or Director of Clinical Services will review the Clinical Morning Meeting agenda to ensure corrective actions were implemented for identified areas of non-compliance. The reviews will be conducted weekly x 12 weeks or until pattern of compliance is sustained. Effective 7/24/2023, Vice President of Operations and/or Director of Clinical Services will review weekly grievances to ensure corrective actions were implemented for identified areas of non-compliance. The reviews will be conducted weekly x 12 weeks or until pattern of compliance is sustained. 4) Monitoring process: Results of all audits will be reviewed in the facility Quality Assurance and Performance Improvement Committee meeting monthly for three (3) months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the two (3) months.	

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F 835	Continued From page 27	F 835		

#2 receiving the baclofen and being hospitalized. The Administrator stated the Interdisciplinary Team reviewed the systems in place for discharge medication reconciliation and addressed any identified issues by reeducating staff.

The Administrator was notified of immediate jeopardy on 6/21/23 at 1:20 PM.

The facility provided the following credible allegation of immediate jeopardy removal on 6/22/23.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to implement an effective discharge plan when 2 residents, Resident #2 and Resident #4 were discharged to the community with medications that were prescribed for other residents.

On 4/6/2023, Nurse #2 provided Resident #4 with medications prescribed for discharged Resident #8 upon discharge to home for Resident #4. Resident #4 took 3 medications not prescribed for him for 2 days resulting in calling 911 related to not feeling well and being constipated.

Resident #4 called the facility on 4/17/2023 and spoke with the Administrator and Director of Nursing (DON) regarding a concern that he was discharged with another Resident ' s medications, however Resident #4 refused to identify the resident or medication that he alleged he was in possession of. Administrator initiated a grievance for Resident #4 concerns.

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The facility did not implement a corrective action plan to address the identified issue with Resident #2 ' s discharge medications when informed on 4/17/23.

On 5/19/2023, the DON received a call from Resident #2 ' s daughter who asked if Resident #2 had ever had an order for Baclofen. The DON checked previous orders and noted that Resident #2 was never on said medication. Resident #2 ' s daughter stated that she was giving medications to Resident #2 and was not paying attention and after medication was given to Resident #2, she noticed that Resident #6 ' s medication (Baclofen) was with the other medications sent home with them.

On 5/16/2023 Nurse #1 gave medications prescribed for Resident #6 to Resident #2 in error upon discharge. The medications given in error included Baclofen 10 milligram (mg) that was a scheduled medication for Resident #6. On 5/19/23, Resident #2 was noted to be in hospital with "stroke like" symptoms post 3-day discharge from facility. Per hospital documentation Resident #2 suffered an allergic reaction to Baclofen. Per hospital documentation Baclofen was added as an allergy for future reference as her tolerance to Baclofen has a low threshold because of her dependence on hemodialysis.

All residents have the potential to be affected when the facility administration fails to implement actions to correct identified issues of non-compliance.

Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 6/22/2023, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator, Director of Nursing, Vice President of Operations, Corporate Clinical Director and Regional Director of Clinical Services to discuss root cause analysis of the facilities failure to provide effective oversight and leadership. Root cause determined that the Administrator and Director of Nursing failed to implement corrective actions for identified areas of non-compliance.

On 6/22/2023, Corporate Clinical Director and Vice President of Operations provided education to the Administrator and Director of Nursing on the QAPI committee role in maintaining compliance with F835. Specifically, as it relates to any identified quality issues. Any identified quality issues should have interventions established to avoid further non-compliance of deficient areas identified. Administrators and Director of Nurses will receive education upon hire during orientation.

On 6/22/2023, after the Corporate Clinical Director and Vice President of Operations in-serviced the QAPI Committee, the facility QAPI Committee will continue to identify other areas of quality concern through the quality improvement (QI) review process, for example: Transfer/Discharge process and Pre/Post medication reconciliation. The QAPI was in serviced on their role as the QAPI committee in identifying concerns and acting upon them. QAPI committee consisted of: Administrator, Director

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F 835	Continued From page 30 of Nursing, Unit Managers, Social Worker, Dietary Manager, Maintenance Director, Therapy Manager, Activities Director, Business Office Manager, Heath Information Coordinator, MDS Coordinator and Medical Director (by phone). Effective 6/22/2023, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. The facility alleged removal of immediate jeopardy 6/23/2023. On 6/27/23 the facility ' s immediate jeopardy removal of 6/23/23 was validated onsite and included record review and staff interviews. Interviews with the administrative staff revealed they had received recent education regarding the discharge process, medication reconciliation prior to resident discharges, and bringing to QAPI identified concerns for possible actions. Documentation review included Administrator and Director of Nursing education on 6/21/23 along with education of other members of the Interdisciplinary Team (IDT) on 6/21/23. The education topics included discussing the root cause analysis, discharge policy and procedure review, identifying quality concerns, and the QAPI role in maintaining compliance. The immediate jeopardy was removed on 6/23/2023.	F 835		