STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 1/6/25-1/10/25. Additional information was obtained off-site on 1/15 and 1/16/25, and the exit date was changed to 1/16/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SIH711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 1/6/25 to 1/10/25. Additional information was obtained off-site on 1/15/25 and 1/16/25, therefore the exit date is 1/16/25. The following intakes were investigated NC00212038, NC00215504, NC00211023, NC00224107, NC00224024, NC00220498, NC00213328, NC00219627, NC00225096, NC00222457, NC00216188, NC00217470, NC00225073, NC00216803, and NC00218132. 5 of the 63 complaint allegations resulted in deficiency. Intake NC00222457 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.45 at tag F760 at a scope and severity (J) The tags F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/01/24 and was	F 000		

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

Electronically Signed | 02/07/2025

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F 000	Continued From page 1 removed on 9/27/24 An extended survey was conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		2/4/25

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F 580	Continued From page 2 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and physician and staff interviews, the facility failed to notify the Physician when a prescribed dose of hydrocortisone was not administered for 1 of 1 resident reviewed for notification (Resident #137). The findings included: Resident #137 was admitted to the facility on 8/29/24 with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. Review of Resident #137's medication	F 580	F-580 Notify of Changes Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Physician was notified on 9/15/24 by the Director of Nursing of the missed dose of medication for resident #137. Resident was assessed by the nurse practitioner and no adverse reactions were noted. No other residents were affected by this occurrence. Address how the facility will identify other residents having the potential to be affected by the deficient practice. A quality review was completed by the Director of Nursing on 2/4/25 to ensure that the physician has been notified about any missed medication doses within the past 30 days.	

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F 580	Continued From page 3 administration record (MAR) documented by Nurse #1 that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. There were no nursing notes indicating the physician had been notified Resident #137 had not received the dose of hydrocortisone on 8/29/24. Nurse #1 was interviewed by phone on 1/16/25 at 7:48 AM. Nurse #1 reported she did not specifically recall why the medication was not available for Resident #137 on 8/29/24. Nurse #1 reported if she did not document she had called the physician, she probably had not called him. Nurse #1 reported she should have notified the physician the medication was not administered. Unit Manager #1 was interviewed by phone on 1/16/25 at 10:39 AM. Unit Manager #1 reported she did not recall Nurse #1 reporting the hydrocortisone was not in the facility to administer to Resident #137. Unit Manager #1 reported she did not know if the physician was notified the medication was not administered to Resident #137. An interview was conducted by phone with the Physician on 1/15/25 at 2:48 PM. The Physician reported he had not been notified the hydrocortisone was not administered to Resident #137 on 8/29/24 and he would have expected to be notified of any medication not administered.	F 580	An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Director of Nursing educated the licensed nurses on the importance of notifying the physician when a medication dose is missed. New staff will be educated as hired. Unit Managers or designee will check ACS Pro in clinical meeting to check for missed doses of medications. Notification will be given if needed to the physician. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of medications not administered and report them to the physician. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		2/4/25

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F 583	Continued From page 4 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, and Responsible Party and staff interviews the facility failed to protect the private health information of 1 of 1 resident (Resident #189) when her discharge summary	F 583	F583- Personal Privacy/Confidentiality of Records: Address how corrective action will be	

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F 583	Continued From page 5	F 583		

and medication list was sent home with another resident. A reasonable person would not want their private medical information shared with another resident.

Findings included:

Resident #189 was admitted to the facility on 6/28/2024.

Resident #189's admission Minimum Data Set assessment dated 7/1/2024 indicated she was moderately cognitively impaired.

Resident #189 discharged from the facility to home on 7/26/2024.

A Complaint/Grievance Report form dated 7/31/2024 by Resident #188 indicated she received Resident #189's discharge summary and medication list when she discharged from the facility.

During an interview with Nurse #1 on 1/8/2025 at 12:26 pm she stated there were two residents (Resident #189 and Resident #188) that were scheduled to discharge from the facility on 7/26/2024. She stated Resident #189's records were sent home with Resident #188 by mistake. Resident #188 returned to the facility with the incorrect records, reported the incident and received her own discharge summary and medication list.

Resident #189's Responsible Party was interviewed by phone on 1/8/2025 at 1:02 pm and stated when Resident #189 was discharged from the facility she did not have her Discharge Summary or Medication List in the paperwork that

accomplished for those residents found to have been affectedby the deficient practice.

Resident #189 received the correct discharge summary on 7/31/24 by the Administrator. The Administrator notified Resident #188 of the deficient practice on 1/13/25.

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

A quality review was completed by the Director of Nursing on 2/4/25 to ensure that all discharges with the past 30 days have been sent home with correct discharge summaries. No other residents were affected by this deficient practice. An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to
formulate and approve a plan of correction for the deficient practice.

Address what measures will be put into place or systemic changes that will occur to ensurethe deficient practice will not recur.

The Director of Nursing educated the staff on ensuring confidentiality of resident record and verifying the resident discharge summary for accuracy on 2/4/25. New staff will be educated during orientation. The Social Worker will prepare the discharge summary packets and leave them with the Unit Managers or

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F 583	Continued From page 6 was sent home with her and the Responsible Party returned to the facility on 7/26/2024 to get the discharge summary and the medication list. During an interview with the Director of Nursing on 1/9/2025 at 1:37 pm she did not recall if Resident #189 was notified of the breach of privacy when her Discharge Summary and Medication List was sent home with Resident #188. The DON stated Nurse #1 should have ensured the correct packet was sent with Resident #189 and Resident #188. On 1/9/2025 at 2:10 pm the Administrator was interviewed and stated the staff should have notified Resident #189 or her Responsible of Party of the privacy breach when Resident #189's medical records were sent home with Resident #188. The Administrator stated Resident #189, or her Responsible Party should have been made aware of the potential risk to her personal health information.	F 583	designee. At the time of discharge, two staff members will verify the discharge information with the resident and/or their designee. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of residents that are being discharged. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of swallowing for 1 of 4 residents (Resident #75) reviewed for MDS accuracy. The findings included:	F 641	F641 □ Accuracy of Assessments: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #75□s Minimum Data Set□s	2/4/25

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F 641	Continued From page 7 Resident #75 was admitted to the facility on 06/14/24 with diagnoses that included cerebral infarction and oropharyngeal dysphagia. Review of Resident #75's care plan, last revised on 12/06/24, included a focus area that read Resident #75 had a nutritional problem or potential problem due to mechanically altered diet related to obesity, cerebral infarction and dysphagia. The interventions included for staff to monitor/record/report to physician, as needed, signs and symptoms of malnutrition, emaciation, muscle wasting, significant weight loss. Registered Dietician to evaluate and make diet change recommendations as needed. Resident #75's quarterly Minimum Data Set (MDS) assessment dated 12/17/24 indicated her cognition was moderately impaired. She had no range of motion limitations and required set-up/ clean-up assistance with eating. The area of swallowing for Resident #75 was coded for no swallowing disorders. A phone interview was conducted on 01/08/25 at 11:50 AM with the Registered Dietician. She verified she does complete the nutrition section of the MDS assessment. She explained that Resident #75 did have swallowing problems which resulted in choking and coughing when eating and drinking fluids. She stated it was an oversight that she did not accurately code the quarterly MDS assessment in the area of nutrition. An Interview was conducted on 01/09/25 at 1:15 PM with the Administrator. He stated he expected the MDS assessments to be accurately coded to reflect the residents' conditions, abilities,	F 641	(MDS□) was corrected on 1/13/25 by MDS in the areas of swallowing to accurately reflect the resident□s status dated 12/17/2024. Resident #75 was coded as having no swallowing issues, and no coughing or choking while eating. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; A quality review was completed on the current residents□ MDSs in the areas of swallowing/nutritional status (Section K) to validate the most recent MDS assessment have been coded to accurately to reflect the status of the residents by the Director of Nursing on 2/4/25. An ADHOC Quality Assurance Performance Improvement Committee will be held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing educated the MDS coordinator, Dietitian, and Social Worker on accurately coding when a resident is having swallowing issues (Section K) on 2/4/25. Indicate how the facility plans to monitor	

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F 641	Continued From page 8 concerns, and diagnoses.	F 641	its performance to make sure that solutions are sustained; and The Director of Nursing and/or designee will conduct random quality reviews of 5 resident□s MDS assessments in the areas of swallowing (Section K) to ensure that the MDS is coded correctly 2X a week for 8 weeks, then 1X a week for 4 weeks. The Executive Director will report the results of the quality monitoring to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and updated as indicated.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to transcribe orders for inserting a peripheral intravenous (IV) line, 0.9% normal saline (NS) (water and salt) solution, and flushes (solution that's injected into an IV line to clean it and prevent blockages) for a midline (a type of peripheral IV that is longer than a peripheral IV). This was for 1 of 1 resident (Resident #75) reviewed for IV fluids. The findings included: Resident #75 was admitted to the facility on	F 658	F-658 Services Provided Meet Professional Standards Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #75 was ordered an IV, but an order for IV solution and/or medications was not entered. The resident was subsequently sent to the emergency room for further evaluation of her status. The IV and	2/4/25

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F 658	Continued From page 9 06/14/24 with diagnoses that included cerebral infarction, diabetes mellitus, and diverticulitis of intestines. Resident #75's quarterly Minimum Data Set (MDS) dated 12/17/24 indicated her cognition was moderately impaired. A review of the January 2025 physician orders revealed an order dated 01/01/25 to have a midline IV placed. The orders did not reveal orders for 0.9% NS at 500 milliliters (ml)/hour, a peripheral IV, or midline flushes to maintain patency. A review of the nursing progress notes revealed a note dated 01/02/25 that read Resident #75 had a midline IV placed in the right upper arm. The midline catheter was patent with 0.9% NS flowing per orders. An interview was conducted on 01/07/25 at 12:27 PM with Unit Manager #1. She stated Nurse #3 entered the order for Resident #75 to have a midline IV put in if staff were unable to get a peripheral line inserted. The midline IV was inserted by a healthcare company that specialized in vascular access on 01/02/25. She was aware Nurse #3 did not enter the order for the peripheral IV line, 0.9% NS fluids, or the midline IV flushes. A phone interview was conducted on 01/08/25 at 1:00 PM with Nurse #3. He stated he did not originally obtain the orders for Resident #75 to receive NS fluids and peripheral IV. He was told verbally by Supervisor #1 to try and get a peripheral IV line started on Resident #75 and that if he was unable to get the peripheral IV line	F 658	solution was discontinued at the hospital. Resident #75 IV solutions were discontinued when she readmitted to the facility. Address how the facility will identify other residents having the potential to be affected by the deficient practice. The Director of Nursing and/or Nurse Managers conducted a quality review of residents identified as having an order for IV on 2/4/25 to ensure that orders were transcribed per the Physician orders. An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Director of Nursing educated licensed nurses on the significance of entering orders into the Electronic Medical Record immediately and timely for a resident on 2/4/25. New staff will be educated during orientation. Orders will be audited. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of residents that have a Physician□s order to	

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F 658	Continued From page 10 inserted, they had an order for a midline IV to be placed. He then stated he did not enter the orders because he thought the Supervisor #1 had entered them. An interview was conducted on 01/08/25 at 3:18 PM with Unit Manager #1. She stated she was working on 01/02/25 when the healthcare company that specialized in vascular access inserted the midline IV for Resident #75. She also stated the policy did not include maintenance orders for the midline which included to flush lumen with NS followed by heparin every shift. She explained she forgot to transcribe the flush orders after the midline was inserted. A phone interview was conducted on 01/08/25 at 6:15 PM with Supervisor #1. She stated she did receive orders to attempt to insert a peripheral IV line and to start 0.9% NS at 500ml/hr because Resident #75's eating and drinking had slowed down. Supervisor #1 indicated Resident #75 was alert and verbally responsive and was displaying no signs or symptoms of distress. She explained she communicated with Physician Assistant (PA) #1 through the tele triage in the electronic documentation system. She also stated PA#1 gave orders that if they were unable to insert the peripheral IV line, they could order for a midline IV to be inserted. Supervisor #1 indicated she passed this on to Nurse #3 and asked him if he would transcribe the orders to the electronic medical record. She then explained the orders did not get transcribed due to a miscommunication between her and Nurse #3. A follow-up phone interview was conducted on 01/09/25 at 9:22 AM with Nurse #3 related to the orders not being entered into the electronic	F 658	administer an IV and/or IV solutions in the morning clinical meeting to ensure that all necessary orders are present for IV therapy. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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F 658	Continued From page 11	F 658		

medical record. He stated that when he got an order for peripheral IV line insertion and fluids on a resident that he had attempted to insert the peripheral IV line prior to entering the order. If he was unable to successfully place the peripheral IV line, he would have called to get healthcare company specialized in vascular access to place a midline. He indicated he did not see an order for starting the 0.9% fluids on the electronic medical record although he was aware that was the reason for starting the peripheral IV line to begin with. He explained that he misunderstood Supervisor #1 related to transcribing the orders, he thought she had transcribed them. He also stated Resident #75 was alert and verbally responsive with no signs or symptoms of acute distress.

An interview was conducted on 01/09/25 at 10:58 AM with Nurse Practitioner #3. She stated all orders should be entered into the electronic medical record when they are received. Orders for any
IVs, 0.9% NS fluids, and IV flushes should be entered. Flushes should have been performed per facility policy.

An interview was conducted on 01/08/25 at 2:50 PM with the Director of Nursing (DON). She indicated she was unaware the IV, IV flushes, or 0.9% NS orders for Resident #75 were not entered into the electronic medical record. The DON stated she expected the nurse who received the order to transcribe it when they received it.

An interview was conducted on 01/09/25 at 1:15 PM with the Administrator. He stated he expected all orders to be entered into the electronic medical record as soon as they are received.

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F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Responsible Party interviews, the facility failed to send 2 of 9 residents (Resident # 188 and Resident # 189) with a list of their ordered medications and Discharge Summary when they were discharged from the facility on 7/26/2024. Resident #188 was discharged on 7/26/2024 with	F 661	F- 661 Discharge Summary Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	2/4/25

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F 661	Continued From page 13 Resident #189's Discharge Summary and Medication List. Resident #188 did not receive the correct Discharge Summary and Medication List until 7/29/2024. Resident #189 was discharged without a Discharge Summary and Medication List on 7/26/2024 and the Family Member returned to the facility on 7/26/2024 to obtain the Discharge Summary and Medication List. Findings included: 1. Resident #188 was admitted to the facility on 7/11/2024 with diagnoses of arthritis and fractures. An admission Minimum Data set assessment dated 7/16/2024 indicated Resident #188 was cognitively intact and she planned to discharge home. Resident #188's Care Plan dated 7/11/2024 indicated she planned to discharge back to the community. Resident #188 discharged on 7/26/2024. A complaint/grievance report dated 7/31/2024 indicated Resident #188 was given another resident's (Resident #189's) discharge summary and medication list when she was discharged home from the facility. During an interview with Nurse #2 on 1/8/2025 at 11:09 am she stated she did remember Resident #188 receiving the wrong discharge summary and medication list, but she did not remember being made aware she made the mistake. The Director of Nursing was interviewed on	F 661	The Administrator issued the correct discharge summary for resident #188 and #189 on 7/31/24. No other residents were affected by this occurrence. Address how the facility will identify other residents having the potential to be affected by the deficient practice. On 2/4/25 a quality review was completed by the Director of Nursing of discharges within the past 30 days to ensure that all discharge summaries were given to residents or designees. An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Director of Nursing educated licensed nurses on the importance of ensuring the correct discharge summary is given to the resident or designee when discharging the facility. Two staff members will verify the discharge summary is given to residents or designee when they discharge the building. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee	

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F 661	Continued From page 14 1/9/2025 at 1:37 pm and stated she spoke with Nurse #2 who discharged Resident #188 on 7/26/2024 and Nurse #2 stated she accidentally picked up the wrong packet and sent it home with Resident #188. The Director of Nursing stated Nurse #2 was responsible for placing the Discharge Summary and Medication List in Resident #188's packet and ensuring it was sent with her at discharge. 2. Resident #189 was admitted to the facility on 6/28/2024 with diagnoses of traumatic subdural hematoma and history of fall. An admission Minimum Data Set assessment dated 7/2024 indicated Resident #189 was mildly cognitively impaired and planned to discharge back to the community. Resident #189's Care Plan dated 6/28/2024 indicated she planned to return home with family assistance. During an interview with the Responsible Party on 1/8/2025 at 1:02 pm she stated Resident #189's discharge paperwork that included her medication list was not sent home with her and the family returned to the facility to obtain the medication on the day Resident #189 discharged. Nurse #1 was interviewed on 1/8/2025 at 12:25 pm and stated the Social Worker had mixed up the discharge folder when Resident #189 was discharged home, and she was sent home with Resident #188's Discharge Summary and Medication List. Nurse #1 stated she was Resident #188's nurse on 7/26/2024 but she did not discharge her from the facility and did not remember who had discharged her.	F 661	will conduct a quality review of discharges. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 661	Continued From page 15 The Director of Nursing was interviewed on 1/9/2025 at 1:37 pm and she stated Nurse #1 was responsible for ensuring the discharged resident received the correct packet with a discharge summary and medication list at discharged. She stated Nurse #1 should have ensured Resident #189 had the packet when she was discharged home. On 1/9/2025 at 2:11 pm the Administrator was interviewed and stated Nurse #1 and Nurse #2 should have ensured the correct discharge paperwork was sent home with Resident #188 and Resident #189.	F 661		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and Nurse Practitioner (NP) and staff interviews the facility failed to provide 1 of 1 resident (Resident #190) with a Continuous Positive Airway Pressure (CPAP) machine (a CPAP machine provides constant and steady air pressure to help a resident breath while asleep) reviewed for respiratory services. Findings included:	F 695	F 695 Respiratory / Tracheostomy Care and Suctioning Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #190 was ordered to have a CPAP per his discharge summary from	2/4/25

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F 695	Continued From page 16 A Discharge Summary dated 6/6/2024 from the hospital was reviewed and stated Resident #190 required a CPAP machine when he was sleeping and napping. The Discharge Summary further stated Resident #190 had been noncompliant in the past with his CPAP but had been compliant during his hospitalization. Resident #190 was admitted to the facility on 6/6/2024 with of respiratory disease and obstructive sleep apnea. A review of Resident #190's Physician's Orders revealed no orders for a CPAP were found. Nurse #2, who admitted Resident #190 on 6/6/2024, was interviewed by phone on 1/8/2025 at 1:07 pm and she stated she did not remember Resident #190 and was not able to say whether his hospital Discharge Summary stated he needed a CPAP machine. Resident #190's initial Care Plan dated 6/6/2024 specified he should have 4 liters of oxygen per minute and required a CPAP machine. A 5-day Minimum Data Set assessment dated 6/8/2024 indicated Resident #190 was severely cognitively impaired. Resident #190's Medication Administration Record (MAR) for 6/2024 did not indicate he was provided a CPAP machine. The Respiratory Therapist was interviewed by phone on 1/8/2025 at 2:15 pm and she stated she did not have access to the records at the facility and did not remember Resident #190. The Respiratory Therapist stated when she evaluated	F 695	the hospital. The resident was sent back to the hospital for respiratory intervention on 6/9/2024. Resident #190 no longer resides at the facility. Address how the facility will identify other residents having the potential to be affected by the deficient practice. A quality review was completed on 2/4/25 by the Director of Nursing to identify residents that have a CPAP/BiPAP order. Audits were completed and the presence of the machine was verified. No further discrepancies are noted. An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. Licensed nurses were educated on 2/4/25 by the Director of Nursing about entering orders and ensuring corresponding machinery has been ordered per physician order. Director of Nursing, Assistant Director of Nursing, and Unit Managers will review new admissions in the morning clinical meeting. If a CPAP or BiPAP is indicated they will ensure that it has been ordered by Central Supply, as well as put orders into the system. Indicate how the facility plans to monitor	

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F 695	Continued From page 17 and treated residents at the facility, she did a written note that was scanned and placed in the resident's electronic record. She stated if she saw Resident #190 after he was admitted there would be a note in his electronic record. A hospital Emergency Department Note dated 6/9/2024 at 1:17 pm indicated Resident #190 was seen in the Emergency Department but was not in respiratory distress. The note further indicated a chest x-ray showed pleural effusions and pulmonary edema and re-admission back to the hospital was recommended due to the pulmonary edema and his CPAP not being available. An interview was conducted with the Nurse Practitioner on 1/9/2025 at 1:15 pm and she stated Resident #190 was in very bad shape when he was admitted, and she felt that he should not have been discharged from the hospital. She further stated she saw him the day after he was admitted and did not remember if he had a CPAP or not. The Nurse Practitioner stated she did not know if the CPAP would have made a difference is his outcome since he was already so sick. On 1/9/2025 at 7:52 am the Director of Nursing (DON) was interviewed and stated Resident #190 was admitted to the facility on 6/6/2024 and discharged on 6/9/2024 when his Responsible Party called emergency services to have him sent to the hospital. The DON also stated Resident #190 did not have his CPAP during his stay. She stated he came from the hospital without CPAP supplies or a CPAP machine and usually when a resident is on a CPAP they are sent to the facility with the machine. The DON stated she did not know why the hospital had discharged him	F 695	it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of new admissions and readmissions in clinical meeting to ensure physicians orders are transcribed and that CPAP/BiPAP machines are ordered. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 695	Continued From page 18 without the CPAP. The DON stated she called the Respiratory Therapist on the evening of 6/6/2024 when Resident #190 was admitted and again on the morning of 6/7/2024 but she did not try to reach her again. The DON stated she did not know why the Respiratory Therapist did not come to assess Resident #190 and set up his CPAP. The DON stated the Responsible Party came into the facility on 6/9/2024 and called emergency services because he did not have his CPAP since he was admitted but Resident #190 was not in respiratory distress. The Director of Nursing also stated she was not able to find a progress note written by the Respiratory Therapist in the resident's record. The Administrator was interviewed on 1/9/2025 at 2:08 pm and stated the nursing staff should have ensured Resident #190's CPAP was in place when he was admitted and if they could not get the CPAP on admission, they should have sent him back to the hospital.	F 695		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		2/4/25

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F 732	Continued From page 19 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) hours for 3 of 94 days reviewed for posted nurse staffing (11/23/24, 1/06/25 and 1/07/25). The findings included: A review of the daily posted nurse staffing sheets from October 2024 through January 2025 indicated the staffing sheet dated 11/23/24 had no RN hours documented for any of the 3 shifts. An observation conducted on 1/06/25 at 3:02 PM	F 732	F732 □ Posted Nurse Staffing Information Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The staffing sheet were corrected to reflect daily nursing hours on 11/23/24, 1/6/25, and 1/7/25 by the Director of Nursing on 1/13/25. Address how the facility will identify other	

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F 732	Continued From page 20 revealed the daily posted nurse staffing sheet had no RN hours documented for any of the 3 shifts on 1/06/25. An observation conducted on 1/07/25 at 8:30 AM revealed the daily posted nurse staffing sheet had no RN hours documented for any of the 3 shifts on 1/07/25. An interview with the Staffing Coordinator on 1/09/25 at 8:50 AM indicated she was responsible for completing the daily posted nurse staffing sheets. She revealed there was an RN in the facility at least 8 hours a day but she only documented RN hours on the staffing sheet if they worked on the floor and provided direct resident care. The Staffing Coordinator stated the Weekend Nursing Supervisor was the RN on 1st shift (7am-3pm) 11/23/24 and the MDS Coordinator was the RN on 1st shift 1/06/25 and 1/07/25, but she did not document their hours on the staffing sheet because they were supervisors and not working on the floor. An interview conducted with the Director of Nursing (DON) on 1/09/25 at 9:00 AM revealed the Staffing Coordinator was responsible for completing the daily posted nurse staffing sheets. She indicated there was an RN in the facility at least 8 hours a day and was either a nurse working the floor, the MDS Coordinator, Assistant Director of Nursing or the Weekend Nursing Supervisor. She stated the RN hours on the nurse staffing sheets from 11/23/24, 1/06/25 and 1/07/25 were not accurate. She stated the Weekend Nursing Supervisor worked 1st shift on 11/23/24 and the MDS Coordinator worked 1st shift on 1/06/25 and 1/07/25 and the hours they worked should have been documented on the	F 732	residents having the potential to be affected by the deficient practice. A quality review was completed on 1/13/25 by the staffing scheduler and the Director of Nursing of the last 30 days of staffing sheets and staffing hour to ensure hours of nursing staff worked was accurate. An ADHOC Quality Assurance Performance Improvement Committee meeting was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Executive Director educated the Staffing Scheduler, Nurse Manager, weekend supervisor, and the Director of Nursing as to how to complete and updated the staffing sheet with ongoing census and staffing hours and changes on 2/4/25. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of the previous day□s staffing sheet for accuracy during the clinical meeting. This review will take place 5x a week for four weeks, and 1x a week for eight weeks as a part of ongoing quality oversight. The review will begin on 1/13/25, and will be	

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F 732	Continued From page 21 posted nurse staffing sheet as RN hours.	F 732	completed by 4/5/25. Findings will be reported for review to QAPI committee. Findings will be reviewed by QAPI committee monthly and quality monitoring updated as indicated.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		2/4/25

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F 756	Continued From page 22 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and Consultant Pharmacist, and Director of Nursing interviews the Consultant Pharmacist failed to recognize a medication error when the facility failed to follow admission orders for hydrocortisone used for adrenal insufficiency. This was for 1 of 9 residents reviewed for medication errors (Resident #137). The findings included: Review of the hospital discharge orders for Resident #137 dated 8/28/24 revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.) Resident #137 was admitted to the facility on 8/29/24 with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure.	F 756	F- 756 Drug Regimen Review Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The discharge summary was uploaded on 9/12/24 for a correct drug regimen review. On 9/19/24 acomplete drug regimen review was completed on Resident #137. Medication orders were entered to reflect corrected information received by Nurse Practitioner on 9/18/24. Address how the facility will identify other residents having the potential to be affected by the deficient practice. A quality review was completed by the Director of Nursing on 2/4/25 to ensure that all documents were uploaded for new admissions within the past 30 days to allow for drug regimen reviews to be completed with accuracy and up to date information for the pharmacy. No other residents were affected by this occurrence. An ADHOC Quality Assurance Performance Improvement Committee was held on	

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F 756	Continued From page 23 A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The order concluded on 9/1/24. Review of Resident #137's medication administration record (MAR) documented that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on 8/30/24 and 8/31/24. Review of the medication administration record for September 2024 documented Resident #137 did not receive hydrocortisone 9/1/24 to 9/18/24. A pharmacist note written by Pharmacist #1 and dated 8/30/24 documented "based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities ..." A phone interview was conducted on 1/8/25 at 3:03 PM with Pharmacist #1 and Pharmacist #3, her clinical manager. Pharmacist #1 reported she conducted a remote review of the admission orders for Resident #137 on 8/30/24. Pharmacist #1 reported during the admission review of information for new residents, she reviewed the information that was available in the electronic documentation system, and if the hospital discharge orders were not uploaded into the system, she would have looked at only the orders in the electronic documentation system. Pharmacist #3 explained that the facilities are	F 756	2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, and Unit Managers were educated by the Regional Nurse Consultant on 2/4/25 about the importance of having all documents uploaded for the medication regimen review. Prior to admission, charts will be reviewed to account for all necessary documentation. New admissions will be discussed the next day in morning clinical meeting to ensure that the necessary documents are uploaded. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of residents that are being admitted ensuring all necessary documents are uploaded for an accurate medication regimen review. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit)	

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F 756	Continued From page 24 encouraged to upload all information into the electronic documentation system, so all information is available to the pharmacist, but she did not recall if the hospital discharge orders were available during her review. A follow-up phone interview was conducted on 1/15/25 at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #2 performed a medication review for Resident #137 on 9/19/24 and reported she had not reviewed the hospital discharge orders, only the medication orders available in the electronic documentation system. Pharmacist #3 explained that after the interview on 1/8/25, she had investigated when the hospital discharge orders were available in the electronic documentation system and discovered that the facility had not scanned the orders in for 2 weeks. The Director of Nursing (DON) and Administrator were interviewed by phone on 1/16/25 at 11:09 AM. The DON reported the admission orders for Resident #137 were not uploaded into the electronic documentation system until 9/12/24 and the admission orders were not available for Pharmacist #1 to review on 8/30/24. The Administrator explained that typically the hospital discharge orders were put into the system by the corporate admissions team, but the orders for Resident #137 were emailed to the DON and that caused the delay loading the orders into the electronic documentation system.	F 756	updated as indicated.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		2/4/25

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F 757	Continued From page 25 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and Nurse Practitioner and staff interviews, the facility failed to prevent Resident #27 from receiving an extra dose of Lyrica (a medication used to treat nerve and muscle pain). This was for 1 of 9 residents whose medications were reviewed. The findings included: Resident #27 was admitted to the facility on 1/2/24 with diagnoses that included rheumatoid arthritis. A review of Resident #27's physician orders included an order dated 4/12/24 for Pregabalin (Lyrica) 75 milligrams (mg), give two capsules by mouth every 12 hours for pain.	F 757	F- 757 Drug Regimen is Free of Unnecessary Drugs Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The physician was notified that Resident #27 received an additional dose of Lyrica on 7/25/24. Resident #27 was monitored for adverse reactions by the clinical staff. The medication order was updated in the system to the correct dose of medication on 7/26/24 by the Unit Manager. Address how the facility will identify other residents having the potential to be	

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F 757	Continued From page 26 Review of a facility incident report dated 7/25/24 indicated that Resident #27 had received 300 mg of Lyrica instead of 150 mg. The nurse practitioner (NP) and responsible party were notified. A review of the Controlled Medication Utilization Record indicated the Lyrica was packaged in 150 mg capsules. On 7/25/24 at 9:00 AM Nurse #3 administered two capsules of Lyrica 150 mg instead of one as ordered. On 1/9/25 at 9:20 AM, a phone interview occurred with Nurse #3. He stated it was an oversight to have provided Resident #27 with 300 mg of Lyrica instead of 150 mg and most likely didn't review the narcotic card label that read 150 mg tablets were present. On 1/8/25 at 1:32 PM, an interview occurred with the Unit Manager #2, who completed the incident report dated 7/25/24. She explained that the pharmacy had packaged the Lyrica in 150 mg capsules and the order read to give two 75 mg capsules. During the investigation, Nurse #3 stated he inadvertently provided two capsules without looking at the medication label for the strength. The NP was notified and provided an order to monitor Resident #27. She recalled Resident #27 showed no ill effects from receiving 300 mg of Lyrica instead of 150 mg. An interview was conducted with the Director of Nursing (DON) on 1/9/25 at 9:07 AM, who reviewed the Controlled Medication Utilization Record and physician orders. It was discovered during the investigation, that Nurse #3 didn't review the medication label and inadvertently gave 300 mg instead of 150 mg of Lyrica. She	F 757	affected by thede ficient practice. A quality review was completed by the Unit Managers on 2/4/25 to ensure that all medications were transcribed per physicians order. No discrepancies were noted in chart to MAR reviews. An ADHOC Quality Assurance Performance Improvement Committee was held on 2/4/25 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes that will occur to ensure the deficient practice will not recur. The Director of Nursing educated the licensed nursing staff on verifying and accurately transcribing medication order on 2/4/25. Two members of the nursing staff will check in narcotics when delivered by the pharmacy to ensure that medication doses match orders present in the resident chart. Indicate how the facility plans to monitor it□s performance and to ensure that the solution sustains. The Director of Nursing and/or designee will conduct a quality review of narcotic medications received from the pharmacy. This review will take place 5x a week for four weeks, and then 1x a week for eight weeks. Findings will be reported for review to the QAPI committee. Findings will be reviewed by QAPI committee	

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F 757	Continued From page 27 added that she would expect the right dosage of medication to be given as ordered. A phone interview was completed with NP #2 on 1/9/25 at 9:17 AM and was able to recall Resident #27 receiving 300 mg of Lyrica instead of 150 mg in July 2024. She stated the extra dose of medication would not have caused any serious side effects as Resident #27 had been taking the medication for an extended period and most likely would have only caused drowsiness. She didn't feel this was a significant medication error and recalled ordering the staff to monitor Resident #27. NP #2 stated she would expect the nursing staff to provide the correct dosage of medication.	F 757	monthly and Quality monitoring (audit) updated as indicated.	
F 760 SS=J	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: Based on record reviews, and Nurse Practitioner (NP), Physician, Pharmacist, Endocrinologist, and staff interviews, the facility failed to prevent a significant medication error related to hydrocortisone prescribed for Resident #137 (hydrocortisone tablets are a steroid medication that works by decreasing inflammation, slowing down an overactive immune system or replacing the cortisol hormone that helps the body respond to stress) when Resident #137 missed a dose of hydrocortisone on (8/29/24), received the wrong dose of hydrocortisone for two days (8/30/24 and 8/31/24) and then the medication was abruptly stopped. Abrupt cessation of hydrocortisone for adrenal insufficiency can cause an adrenal crisis,	F 760	Past noncompliance: no plan of correction required.	

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where the body experiences a sudden drop in cortisol levels and can lead to life-threatening complications such as low blood pressure. Resident #137 went 18 days without receiving hydrocortisone. Resident #137 was scheduled to be seen by the Endocrinologist on 9/19/24 for the missed doses of hydrocortisone but she was transferred to the hospital on 9/19/24 at the request of family and admitted for weakness and low blood pressure 99/79 (normal blood pressure is 120/70). This was for 1 of 9 residents reviewed for significant medication errors (Resident #137).

The findings included:

Review of the hospital discharge orders for Resident #137 dated 8/28/24 revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.)

Resident #137 was admitted to the facility on 8/29/24 with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. Additional diagnoses for Resident #137 included diabetes, malnutrition, high blood sodium levels, breast cancer, syncope and collapse (fainting), and abnormal gait.

A physician's order transcribed from the hospital

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discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The stop date for the order was 9/1/24.

A physician order dated 8/30/24 for midodrine (a medication that elevates blood pressure) 10 mg every 8 hours for low blood pressure, do not give fore blood pressure over 130/80.

An NP admission note written by NP #4 dated 8/30/24 was reviewed. NP #4 documented Resident #137 was to take hydrocortisone 10 mg 1.5 tablets every evening with a stop date of 9/2/24.

Review of Resident #137's medication administration record (MAR) documented by Nurse #1 that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on 8/30/24 and 8/31/24.

Review of the medication administration record for September 2024 documented Resident #137 did not receive hydrocortisone from 9/1/24 to 9/18/24.

Review of the blood pressures for Resident #137 revealed the following: (normal blood pressure 120/70)
- 9/1/24 117/78 at 10:00 PM
- 9/3/24 97/64 at 2:00 PM; 109/58 at 10:00 PM
- 9/4/24 106/75 at 2:00 PM; 104/62 at 10:00 PM
- 9/5/24 97/58 at 6:00 AM; 115/56 at 2:00 PM; 96/59 at 10:00 PM
- 9/6/24 93/52 at 6:00 AM; 115/56 at 10:00 PM

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- 9/7/24 81/61 at 6:00 AM; 112/66 at 10:00 PM
- 9/8/24 118/75 at 10:00 PM
- 9/9/24 101/68 at 10:00 PM
- 9/10/24 76/54 at 6:00 AM
- 9/12/24 109/79 at 2:00 PM
- 9/13/24 104/66 at 6:00 AM; 105/76 at 10:00 PM
- 9/14/24 105/72 at 6:00 AM
- 9/15/24 96/56 at 10:00 PM
- 9/16/24 105/68 at 6:00 AM; 102/64 at 2:00 PM; 75/54 at 10:00 PM
- 9/17/24 75/54 at 6:00 AM; 91/48 at 2:00 PM; 112/71 at 10:00 PM
- 9/18/24 95/65 at 6:00 AM; 95/65 at 2:00 PM; 105/55 at 10:00 PM
- 9/19/24 92/61 at 6:00 AM

Unit Manager #1 was interviewed on 1/8/25 at 8:47 AM. Unit Manager #1 reported she transcribed the discharge hospital orders for Resident #137 upon her admission to the facility on 8/28/24. Unit Manager #1 explained she read the hydrocortisone order to be for 3 days only and transcribed the order as she understood it. Unit Manager #1 reported she had not clarified the order with the hospital, and she had not called the Endocrinologist to ask for clarification. Unit Manager #1 reported she was not certain if the NP or the physician had reviewed the orders for Resident #137. Unit Manager #1 reported after she transcribed the hospital discharge orders, she asked Unit Manager #2 to check the orders and Unit Manager #2 did not report any transcription mistakes to her. When asked how she understood the orders for hydrocortisone, Unit Manager #1 explained she thought that the medication was to be given for only 3 days, and it didn't occur to her to call the Endocrinologist for clarification or ask the physician or NP to review the order. Unit Manager #1 reported she was not

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aware Resident #137 did not receive the medication on 8/29/24. Unit Manager #1 reported she was not aware she had not correctly transcribed the order for hydrocortisone.

Unit Manager #2 was interviewed on 1/8/25 at 10:07 AM. Unit Manager #2 reported she reviewed Resident #137's hospital discharge orders and the orders in the electronic documentation system and she did not notice the hydrocortisone was ordered for only 3 days. Unit Manager #2 reported when she reviewed the hospital discharge orders, she thought the medication was supposed to be ordered for 3 days only and she did not notice the dose was not ordered correctly. Unit Manager #2 reported she did not call the physician, NP, or the Endocrinologist for clarification of the hydrocortisone order.

NP #4 was interviewed by phone on 1/8/25 at 12:50 PM. NP #4 reported she saw Resident #137 for her admission assessment on 8/29/24. NP #4 explained she reviewed the hospital discharge orders and the orders in the electronic documentation system, but she did not notice the hydrocortisone was transcribed incorrectly. NP #4 reported hydrocortisone should not have been stopped abruptly because it would cause the body to lose an essential hormone and could cause an adrenal crisis.

A pharmacist note written by Pharmacist #1 and dated 8/30/24 documented "based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities ..."

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A follow-up phone interview was conducted on 1/15/25 at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #3 explained that hydrocortisone was used in adrenocortical insufficiency to replace the hormone cortisol the body made to maintain blood pressure and other functions. Pharmacist #3 reported she was unable to say if Resident #137 was affected adversely by the cessation of the hydrocortisone, as the Endocrinologist would have been responsible for managing the dosage of hydrocortisone.

A physician history and physical note written by the Physician dated 9/3/24 documented hydrocortisone was to continue for adrenal insufficiency. The history and physical note did not document the hydrocortisone dose.

A phone interview was conducted with the Physician on 1/8/25 at 1:03 PM. The Physician reported he had reviewed the hospital discharge orders but had not reviewed the orders transcribed into the electronic documentation system. The Physician reported the hydrocortisone was a significant medication error and the medication should not have been stopped abruptly.

The admission Minimum Data Set assessment dated 9/4/24 assessed Resident #137 to be cognitively intact.

A NP progress note dated 9/18/24 was reviewed. NP #2 documented that on 9/17/24 Resident #137's family member asked about the hydrocortisone and NP #2 documented that the hydrocortisone appeared to not be ordered. NP

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#2 documented she discussed Resident #137's symptoms and labs with the Endocrinologist and "it appears that (Resident #137) is supposed to be on hydrocortisone 15 mg in the morning and 10 mg in the evening, which is not currently ordered. (Resident #137) received 3 days of hydrocortisone since admission to the facility (per medication administration record)." The note documented the Endocrinologist ordered hydrocortisone 20 mg to be given "now" and 10 mg in the evening for 3 days and then 15 mg in the morning and 10 mg in the evening. The note documented the endocrinologist wanted Resident #137 to come to the office to be seen on 9/19/24.

A physician order dated 9/18/24 to administer hydrocortisone 20 mg, give 1 tablet by mouth once per day for 2 days. Administer 10 mg tablet in the evening. Beginning 9/21/24 administer hydrocortisone 15 mg in the morning and 10 mg in the evening.

NP #2 was interviewed on 1/8/25 at 9:40 AM. The NP reported she was not working on 8/28/24 when Resident #137 was admitted to the facility and NP #4 did the admission assessment. NP #2 reported she had reviewed Resident #137's medications (she was uncertain of the exact date) and made a call to the Endocrinologist to clarify the hydrocortisone order. NP #2 reported on 9/17/24 Resident #137's family member inquired about the hydrocortisone and NP #2 was able to talk to the Endocrinologist and received clarification of the order. NP #2 explained Resident #137 should have continued hydrocortisone and it should not have been stopped abruptly because it could cause an adrenal crisis if stopped.

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A follow-up phone interview was conducted with NP #2 on 1/16/25 at 10:50 AM. NP #2 clarified that the Endocrinologist had ordered hydrocortisone to be given immediately, plus gave orders for the medication for the following days.

A follow-up interview was conducted by phone with the Physician on 1/15/25 at 2:48 PM and he reported the hydrocortisone dose would have been determined by the Endocrinologist, and NP #2 did the right thing by contacting the Endocrinologist for orders on 9/17/24. The Physician explained stopping hydrocortisone abruptly could cause an adrenal crisis. The Physician reported he would have expected the Unit Manager to call him, the NP, the hospital or the Endocrinologist for clarification of orders.

A nursing note dated 9/19/24 at 12:15 PM documented Resident #137 was taken to her endocrinology appointment by her family member but returned to the facility without being seen by the Endocrinologist. The family member reported he was running late and was unable to get Resident #137 to the appointment on time, and he requested Resident #137 be sent to the emergency room.
Hospital emergency room records dated 9/19/24 for Resident #137 documented she was admitted to the hospital for weakness and low blood pressure. Blood pressure on admission to the emergency room was 99/79. Resident #137 was a 45-year-old female with a past medical history significant for adrenal insufficiency.

A computed tomography (CT) scan was completed on 9/19/24 and a large volume pneumoperitoneum (a condition where air or gas

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was in the abdominal cavity) was revealed, leading to concerns for a large bowel perforation. The decision was made with Resident #137 and her family member to undergo a laparotomy. Resident #137 was taken urgently to the operating room at 9:00 PM on 9/19/24 for lysis of adhesions, resection of the colon with a colostomy. After the surgery, Resident #137 was transferred to ICU, and she developed worsening low blood pressure. Lab results showed severe acute blood loss anemia. Resident #137 lost pulses and her abdomen was reopened in the ICU where approximately 750 cubic centimeters of blood were discovered. Resident #137 received several rounds of cardiopulmonary resuscitation efforts, and she died at 5:10 AM on 9/20/24.

The Endocrinologist was interviewed by phone on 1/15/25 at 4:49 PM. The Endocrinologist reported she recalled talking to NP #2 and ordered Resident 137 to receive hydrocortisone 20 mg immediately. The Endocrinologist explained that stopping hydrocortisone abruptly would have caused an adrenal crisis and this crisis would have caused Resident #137 difficulties with controlling her blood pressure and caused fatigue, as well as other symptoms. The Endocrinologist explained that the adrenal crisis would not have contributed to the bleeding post-operatively.

The Administrator was notified of immediate jeopardy on 1/9/25 at 10:45 AM.

The facility submitted the following corrective action plan with a compliance date of 9/27/24.

Address how the corrective action will be

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accomplished for those residents found to have been affected by the deficient practice

On 08/29/24 Resident #137 was admitted to the facility. The hospital discharge summary orders for Resident #137 read: hydrocortisone 10mg tablet, (administer) 15mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food, double or triple doses for illness for 3 days as directed. Resident #137 had a diagnosis of adrenal insufficiency and was prescribed hydrocortisone. The Unit Manager transcribed the order on 08/29/24: hydrocortisone 10 milligrams (mg) give 1.5 tablet by mouth in the afternoon for inflammatory for 3 days until 09/01/24. Resident #137's Medication Administration Record (MAR) was reviewed and there was no documentation of any doses of hydrocortisone administered from 09/02/24 - 09/18/24. One 20mg Hydrocortisone was administered the morning of 09/19/24. On 09/19/24, Resident #137 was transferred to the hospital, and she underwent a laparotomy for lysis of adhesions, resections of the sigmoid colon with end colostomy. Post surgery she was transferred to the Intensive Care Unit (ICU) and developed hypotension and was found to have experienced severe acute blood loss anemia and died on 09/20/24.

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

The facility recognizes that all newly admitted and readmitted residents have the potential to be affected from the prior noncompliance with significant medication errors

All newly admitted and readmitted residents

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between 08/26/24 - 09/26/24 medication orders were audited by the Director of Nursing and or Unit Managers to ensure orders were transcribed correctly on 09/26/24. 30 residents were audited with no discrepancies noted.

A quality review was completed on 09/25/24 by the Director of Nursing and or Unit Manager of current residents with a diagnosis of adrenal insufficiency and with hydrocortisone orders to ensure medication is ordered, transcribed correctly, and being given as ordered, no discrepancies noted.
On 09/25/24, a quality review of current residents admitted and readmitted within the past 30 days prior to 09/25/24 was conducted by the Director of Nursing and Unit Manager to ensure all other newly admitted or readmitted patients' medications are administered per physician orders and transcribed correctly on the Medication Admission Record (MAR).

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

On 09/25/24, a Root Cause Analysis was completed by the Director of Clinical Services, and the Executive Director regarding omission of medication administration for resident #137. It was determined through root cause and analysis that the significant medication error was due to the oversight of transcribing the orders incorrectly and there was no verification conducted by a second nurse.

The Director of Nursing and/or the nurse managers provided education on 9/25/24 to current nurses on the importance of transcribing

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all new orders from discharge summaries, verified by 2 nurses to ensure medications are transcribed and administered per physician orders to the residents. Newly hired nurses will be educated on hire during the orientation process. The Executive Director provides oversight for the education of nurses to ensure that 100% of all licensed staff were reeducated on the importance of administrating all ordered medications. Education was completed on 09/25/2024. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing and or Nurse Managers will conduct Quality Improvement Monitoring 5 times per week for 4 weeks, 1 time per week for 3 months and 1 time monthly for 3 months in clinical morning meeting to review the medication administration records of all new residents when admitted or readmitted to ensure all medications are transcribed correctly and medications are administered as ordered per physician starting 9/25/24. Upon receiving hospital discharge summaries medication orders are verified with the provider, 2 nurse verification system; 1 Nurse transcribes all orders, then 1 Nurse verifies/confirms that orders were transcribed correctly. They also review the previous days admissions during the morning meeting and verify during the meeting.

On 9/25/24, when the deficient practice of transcribing orders that resulted in a significant medication error was identified the center Executive Director conducted an ADHOC Quality Assurance Performance Improvement (QAPI) meeting to determine the root cause analysis of the deficient practice. The QAPI committee put a

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plan of action in place to include quality improvement monitoring and the frequency of monitoring beginning on 9/26/24 to ensure medication administration orders were transcribed correctly and medications were administered as ordered. The QAPI committee included the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, a Unit Manager, Wound Care Nurse, and two floor Nurses.

The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for 4 months. Quality Improvement schedule will be modified based on findings of the monitoring.

The Center Executive Director alleges compliance on 9/27/24.

The corrective action plan was validated on 1/9/25. Education for all nurses was reviewed, and interviews were conducted with the Unit Managers and the staff nurses to confirm receipt of the education. Initial audits of new admissions from 8/26/24 to 9/26/24 were reviewed and no significant medication errors were identified. Quality reviews of current residents and new admissions were reviewed, and no issues were identified. Morning meeting and QAPI meeting notes were reviewed with the DON and Administrator. The immediate jeopardy removal date of 9/27/24 and the compliance date of 9/27/24 was validated.