STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWELL PARK REHABILITATION AND HEALTHCARE CENTER	1930 WEST SUGAR CREEK ROAD , CHARLOTTE, North Carolina, 28262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An onsite complaint investigation survey was conducted on 07/08/25. Additional information was obtained offsite through 07/15/25. The facility was notified of Immediate Jeopardy on 07/15/25. A validation was completed on 07/18/25. An additional complaint investigation was conducted on 07/24/25. Information was obtained offsite through 07/25/25 therefore, the exit date was changed to 07/25/25. The following intakes were investigated: 753210, 753211, 753209, 753217, 2567587, 2570315 and 2569849. 2 of the 13 allegations resulted in a deficiency. Event ID #8IBI11. Immediate Jeopardy was identified at: CFR 483. 25 at a tag F684 at a scope and severity (J). The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 06/09/25 and was removed on 07/17/25. A partial extended survey was conducted.	F0000		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Family Member #1 and Medical Director interviews, the facility failed to recognize the current treatment plan was not effective and the seriousness of a resident with a diagnosis of hypothyroidism (when the thyroid gland doesn't make enough thyroid hormone) not responding to high doses of levothyroxine (medication used to treat	F0684		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0684 SS = SQC-J	Continued from page 1 hypothyroidism). As of 5/24/25 Resident #1 had an active order for an endocrinology consultation for hypothyroidism. On 06/09/25 lab work was obtained and resulted in a critically high TSH (Thyroid Stimulating Hormone) level of 50.3 (normal range 0.5 to 5.0). The endocrinology consultation order was not faxed by the facility to the consultation office until 06/13/25 and a referral to an endocrinologist for an evaluation was not scheduled. Resident #1's thyroid medication remained at the same dosage for the month of May 2025 and June 2025 at 225 mcg (microgram) by mouth daily. On 06/09/25 Resident #1 had a thyroid stimulating hormone (TSH) level of 50.3 (normal range 0.5 to 5.0). A TSH level of 50 is considered critically high and indicates severe hypothyroidism, which can lead to serious health complications if not addressed. A Nurse Practitioner note dated 06/12/25 revealed Resident #1 was evaluated due to increased confusion and a decrease in appetite. On 06/16/25 Resident #1 was observed in an unresponsive state at the facility. Emergency Medical Service (EMS) was dispatched to the facility and Resident #1's heart rate was 32 beats per minute (bpm) (normal range 60-100 beats per minute) and a transcutaneous pacemaker (temporary external pacing method used to stimulate the heart to contract by delivering electrical impulses through the chest wall) was placed on Resident #1 by EMS. An improvement in heart rate was noted with a reading of 82 bpm (beats per minute). Upon arrival at the Emergency Department (ED), she was unresponsive, pulseless, with a pulse oximetry (measures the percentage of oxygen in the blood) reading of 7% (normal level 95-100%) and cardiopulmonary resuscitation (CPR) was initiated. She required emergent intubation (medical procedure where a tube is inserted into a windpipe to keep the airway open when a person is unable to breathe on their own) and was placed on a ventilator (a machine utilized to support or take over breathing). Hospital records dated 06/16/25 revealed Resident #1 was in a severe hypothyroid state with a diagnosis of myxedema coma (a life-threatening endocrine emergency that occurs when thyroid hormone regulation is disrupted). Resident #1's TSH level was 240. Resident #1 was admitted into the intensive care unit (ICU) with continued intubation and ventilation until 6/20/25. The deficient practice occurred for 1 of 3 residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 06/09/25 when Resident #1 had a thyroid stimulating hormone (TSH) level of 50.3 (normal range 0.5 to 5.0) and the facility failed to initiate effective medical treatment. Immediate jeopardy was removed on 7/17/25 when the facility implemented an acceptable credible allegation of	F0684		

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F0684 SS = SQC-J	Continued from page 2 immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education. The findings included: Resident #1 was admitted to the facility on 06/21/24 with diagnoses which included hypothyroidism, acute kidney failure, obstructive uropathy, muscle weakness, hypertension and anemia. Resident #1's active physician orders as of 5/24/25 included: - Referral for an endocrinology consultation related to a diagnosis of hypothyroidism. - Draw TSH level every 6 weeks related to hypothyroidism. - Levothyroxine 225 mcg 1 tablet by mouth daily for hypothyroidism at 6:00 AM. A review of Resident #1's June 2025 Medication Administration Record revealed the following medications were prescribed and a review of the medications revealed none interfered with the absorption of Levothyroxine. Amlodipine besylate oral tablet daily for hypertension Trazodone HCL tablet (antidepressant) for insomnia Levothyroxine 225 mcg for hypothyroidism Depakote Sprinkles oral capsule (antiepileptic) for dementia with behaviors disturbance. Hydroxyzine HCL oral tablet as needed for anxiety Oxybutynin chloride tablet for overactive bladder. Myrebetriq for overactive bladder. Losartan potassium for hypertension. Cyanocobalamin tablet for vitamin B12 deficiency. Review of the quarterly Minimum Data Set (MDS) assessment dated 06/07/25 revealed Resident #1 was severely cognitively impaired and required extensive	F0684		

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F0684 SS = SQC-J	Continued from page 3 assistance of one staff member with activities of daily living (ADL). Resident #1's lab results dated 06/09/25 revealed a TSH level of 50.3. (Previous labs completed on 04/18/2025 resulted in a TSH level of 29.336.) A Nurse Practitioner note written by Nurse Practitioner (NP) #1 dated 06/10/25 revealed Resident #1 was evaluated on this date. The resident was receiving a dose of (Levothyroxine) thyroid medication at 250 micrograms by mouth daily with a most recent TSH result of greater than 50. The note revealed a referral was initiated for Resident #1 to be evaluated by endocrinology in April 2025. Resident #1 was noted to have no symptoms of hypothyroidism at the time of the evaluation. Review of Resident #1's Medication Administration Record (MAR) dated June 2025 revealed an order initiated on 03/18/25 for levothyroxine 225 mcg 1 tablet by mouth daily for hypothyroidism. The medication was administered daily in the AM except on the dates of 6/7 (resident sleeping) and 6/12 (resident sleeping). Further review of the June 2025 MAR revealed no order for levothyroxine 250 mcg. A nursing progress note written by Nurse #2 dated 06/12/25 at 3:34 PM revealed Resident #1 had eaten 50% or less for 2 or more meals in the day. The note revealed the nursing team had notified the Nurse Practitioner. An interview conducted on 07/08/25 at 3:03 PM with Nurse #2 revealed she was responsible for Resident #1 on 06/12/25, 06/13/25 and 06/15/25 during the 7:00 AM to 3:00 PM shift and Resident #1 had taken her medication without issues. On 06/12/25 Resident #1's blood pressure was 150/60 during the morning medication administration pass. She stated Resident #1 hadn't eaten as much for breakfast and lunch on 06/12/25. However, she was out of bed and sitting in the common area as she normally did. She stated Resident #1 was confused at baseline, but the Nurse Practitioner was notified any time a resident had a decrease in appetite or seemed more lethargic. Nurse #2 stated Resident #1 did not seem to have an increased sense of thirst nor did anything, "stand out". The Nurse Practitioner was in the building, so she saw the resident. She stated she was shocked to learn Resident #1 went to the hospital on 06/16/25 because she didn't remember the resident having any change of condition in the day's prior.	F0684		

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F0684 SS = SQC-J	Continued from page 4 A Nurse Practitioner note written by (NP) #1 dated 06/12/25 at 8:15 PM revealed Resident #1 was evaluated on this date. The note revealed Resident #1 experienced increased confusion from baseline per nursing staff and a loss in appetite over the last 12 to 24 hours. Resident #1 was noted to have not gotten out of bed as much as she usually did. NP #1's note revealed upon assessment Resident #1 appeared at baseline, was easy to awaken and interacted in conversation. Resident #1 was noted with suprapubic tenderness and an order was given to obtain a urinalysis for further evaluation. A faxed letter was sent to the Endocrinology office for a consultation on 06/13/25 by Unit Manager #1 for Resident #1. On 07/08/25 at 1:46 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated the facility had another Unit Manager that was no longer working in the facility who was responsible for sending Resident #1's endocrinology referral in April 2025. Unit Manager #1 indicated she became aware of the referral after a Nurse Practitioner note on 06/10/25 and had seen the physician's order from April was missed. Unit Manager #1 confirmed the first time the referral was sent to the endocrinologist was on 06/13/25. Unit Manager #1 stated she felt like the referral was missed by the previous Unit Manager and the mistake had not been identified by any other facility staff members. She stated the typical process was for a Unit Manager to receive a referral for a consultation and then call the physician's office immediately and set up an appointment. The interview revealed typically NP #1 would place her own orders into the electronic medical record (EMR) and the Unit Managers did not always have time to look over NP #1's progress notes. She stated the nursing staff wouldn't have known to increase Resident #1's thyroid medication unless told by NP #1 or the physicians order was placed into the system. Unit Manager #1 stated she did not recall any orders given by Nurse Practitioner #1 after her evaluation of Resident #1 on 06/12/25. Unit Manager #1 revealed she had seen Resident #1 in the days prior to 06/16/25 and she did not recall any changes in the resident's condition. Resident #1 was confused as she typically was, and Unit Manager #1 had seen her attempting to stand up out of her wheelchair which was normal behavior for her. Staff had to keep a close eye on her at all times. An incident report dated 06/16/25 at 8:30 PM written by Medication Aide (MA) #1 revealed a Nurse Aide (NA #1) reported to MA #1 that Resident #1 had experienced a change of condition. Upon observing Resident #1, MA #1	F0684		

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F0684 SS = SQC-J	Continued from page 5 began to obtain vital signs and told NA #1 to go and notify Nurse #1 of the situation. Nurse #1 applied supplemental oxygen to the resident and called 911 emergency services. On 07/08/25 at 11:40 AM an interview was conducted with Nurse Aide (NA) #1. During the interview she stated she was responsible for Resident #1 on 06/16/25 during the 3:00 PM to 11:00 PM shift. NA #1 stated when she came on shift at 3:00 PM Resident #1 was her normal self, talking and attempting to get up from her wheelchair as she constantly did. She stated the resident was served the supper meal and was able to feed herself with setup assistance provided. NA #1 stated Resident #1 did not appear to have a decrease in appetite on 06/16/25. Around 8:00 PM NA #1 was completing resident charting sitting directly across from Resident #1 approximately 4 feet away. NA #1 stated she looked at Resident #1 and noticed she was mumbling words. She then asked Resident #1 if she was okay and Resident #1 stated, “help me”. NA #1 stated Resident #1 was alert at that time but seemed weak and began slumping down into her chair. She immediately told MA #1 to obtain vital signs, and she went to get Nurse #1. Nurse #1 went to assess Resident #1 and told them to take her to her room and stay with her while she called 911 emergency services. NA #1 stated EMS was in the building within minutes because they were across the street from the facility. She stated, “everyone moved so quickly”. The interview revealed once EMS arrived Resident #1 was transported to the hospital for an evaluation. NA #1 indicated she had taken care of Resident #1 in the days prior to the incident and had not noticed any changes in her behavior. On 07/08/25 at 11:55 AM an interview was conducted with Medication Aide (MA) #1. During the interview she stated she was working on 06/16/25 during the 3:00 PM to 11:00 PM shift on an adjoining hall to Resident #1’s. MA #1 stated she had observed Resident #1 during the shift and saw her eating the supper meal around 5:15 PM with no issues. She stated she was standing at the medication cart in the common area with Resident #1 and NA #1 around 8:00 PM. NA #1 stated to check Resident #1’s vital signs because she had just said, “help me” and went unresponsive. MA #1 then went to the resident and obtained her vital signs while NA #1 went to get Nurse #1. She stated she wrote Resident #1’s vital signs down on a piece of paper and gave it to Nurse #1. MA #1 stated Resident #1 was taken to her room and placed in bed while Nurse #1 called 911 emergency services. EMS were in the building within minutes of the staff placing Resident #1 in her bed. MA #1 stated she heard a “code blue” on the overhead	F0684		

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F0684 SS = SQC-J	Continued from page 6 speaker however EMS was already in the building and had assumed care of the resident. She stated Resident #1 still had a pulse and was breathing with supplemental oxygen in place. MA #1 stated she had worked on the days prior to Resident #1 going to the hospital however she was not directly assigned to the resident. MA #1 indicated she had seen Resident #1 eating her meals and she was able to eat the meals without assistance from staff. She stated she did not recall noticing any changes in the resident's behavior prior to 06/16/25. On 06/16/25 at 9:57 PM (late entry progress note) a nursing progress note written by Nurse #1 revealed Nurse Aide (NA) #1 had notified her that Resident #1 did not look well and needed to be assessed. NA #1 stated Resident #1 was sitting up in her chair and stated, "help me" before going unresponsive. Resident #1 did not respond to verbal or tactile (sense of touch) stimulation. Resident #1 was noted to be a full code, her eyes were open, but she was breathing shallow. The resident's vital signs were the following: temperature 97.1, pulse 67, respirations 8, oxygen saturation 88% on room air with a blood pressure reading of 105/76. A call was placed to 911 emergency services, and the resident was provided with supplemental oxygen at 2 liters per minute via nasal cannula. The 911 dispatcher advised Nurse #1 to prepare for Cardiopulmonary Resuscitation (CPR) and a "code blue" was paged overhead for staff to hear. Emergency Medical Services (EMS) was able to arrive quickly at the facility and already were entering Resident #1's room. EMS decided that CPR was not needed, and Resident #1 was transported to the hospital for further evaluation at 8:30 PM. On 07/08/25 at 3:45 PM an interview was conducted with Nurse #1. Nurse #1 stated she was responsible for Resident #1 on 06/16/25 during the 3:00 PM to 11:00 PM shift. She stated when she came on shift at 3:00 PM she saw Resident #1 sitting in her chair in the common area watching television. Resident #1 was her typical self, talking and attempting to stand up during the shift like she normally did. Nurse #1 stated Resident #1 was served her supper meal around 5:30 PM. Resident #1 was able to feed herself without assistance from staff members. During the gathering of meal trays, Resident #1 was observed to be alert, sitting watching television and interacting with other residents in the common area. Nurse #1 was notified by NA #1 around 7:50/8:00 PM that Resident #1 had experienced a change of condition. She stated the resident looked at NA #1 and said, "help me" before becoming unresponsive. Nurse #1 immediately went to the resident to assess her vital signs. MA #1 and NA #1 assisted Resident #1 to her room	F0684		

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F0684 SS = SQC-J	Continued from page 7 and into bed. Nurse #1 called 911 emergency services, and they advised her to prepare to perform CPR however Resident #1 still had a pulse and was breathing at that time. Nurse #1 stated EMS arrived quickly because they were right across the street. EMS took over the care of Resident #1, stabilized the resident and transported her to the hospital for an evaluation. When she was transported out of the facility, Resident #1 was alert and talking again. Nurse #1 stated she had seen no change in Resident #1's behavior throughout the shift until NA #1 alerted her to a change of condition. She also stated she had cared for Resident #1 in the days prior to the incident and had seen no overall change in the resident's condition. The interview revealed she did not remember Resident #1 having any increased confusion nor had nurse aides notified her the resident had a decrease in appetite. Emergency Medical Service (EMS) records dated 06/16/25 at 8:02 PM revealed Resident #1 was lying on her bed in the facility unresponsive. Staff members from the facility were standing at the doorway stating the resident was "okay" ten minutes prior to calling 911. Resident #1's heart rate was 32 beats per minute (bpm) and a transcutaneous pacemaker (temporary external pacing method used to stimulate the heart to contract by delivering electrical impulses through the chest wall) was placed on Resident #1 by EMS. An improvement in heart rate was noted with a reading of 82 bpm (beats per minute). During transportation to the hospital Resident #1's heart rate began to drop with a reading of 44 bpm. EMS was able to increase the residents heart rate back up to 62 bpm while en route to the hospital. Upon arrival at the hospital Resident #1 was moved from the EMS stretcher to an Emergency Department (ED) bed and hospital staff assumed care for the resident. During the transfer of the beds Resident #1 was noted to decline rapidly without a pulse. The ED initiated CPR and Resident #1 was ultimately intubated in the ED by hospital staff. Emergency Department records dated 06/16/25 at 8:34 PM revealed Resident #1 was found in an unresponsive state at the nursing facility. Resident #1 had arrived at the ED unresponsive with a transcutaneous pacemaker in place. Upon assessment by the ED Physician Resident #1 was noted to have a pulse oximetry (measures the percentage of oxygen in the blood) of 7% (normal level 95-100%). CPR was initiated for a duration of 2 minutes. An emergent intubation was required, and Resident #1 was placed on a ventilator. Resident #1 was noted to be in a severe hypothyroid state with a diagnosis of myxedema coma (a life-threatening endocrine emergency that occurs when thyroid hormone	F0684		

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F0684 SS = SQC-J	Continued from page 8 regulation is disrupted) and a TSH level of 240. The resident received 200 mcg of Levothyroxine intravenously in the ED. Resident #1 was admitted into the hospital intensive care unit with diagnosis of bradycardia (low heart rate), respiratory arrest, myxedema coma and cardiac arrest with profound hypothyroidism contributing to the diagnosis. Hospital records dated 06/16/25 revealed Resident #1 was intubated in the ED and noted to be hypothermic (low body temperature) with a lowest temperature of 91.1 degrees Fahrenheit (normal body temperature 98.6). Resident #1's TSH level was 242.997. She was admitted into the ICU with continued intubation and ventilation. The primary admission diagnosis was myxedema coma followed by bradycardia, unresponsiveness and hypothermia. The hospitalist consulted with endocrinology; Resident #1 received a loading dose of levothyroxine (thyroid medication) 375 mcg intravenous on 06/18/25. It was recommended she continue to receive 100mcg levothyroxine daily. Resident #1 was extubated on 06/20/25 and was still in the hospital setting during the survey period receiving occupational therapy, physical therapy, speech therapy and hospitalist services. On 07/09/25 at 9:11 AM and 3:51 PM an interview was attempted with a Hospitalist. No phone call was returned to the surveyor. On 07/11/25 at 8:49 AM the Director of Nursing (DON) from the Hospital called and stated the surveyor would need to submit a formal request for an interview with the Hospitalist. On 07/11/25 at 10:05 AM a formal request was submitted and faxed by the Department of Health and Human Services Division of Health Service Regulation for an interview with the Hospitalist. No return phone call was received. An interview conducted on 07/08/15 at 9:45 AM with Family Member #1 revealed she was notified on 06/16/25 Resident #1 was found in an unresponsive state and sent to the hospital for an evaluation. She stated Resident #1 was still in the hospital, was drowsy but doing better. Family Member #1 stated she felt the facility was not giving the residents medication correctly for her thyroid level to be so high on the paperwork from the hospital. She stated she had visited in the weeks prior to the incident on 06/16/25 and hadn't noticed a change in Resident #1's behavior but had not visited on 06/16/25. Family Member #1 indicated Resident #1 had not reported that she was not feeling well.	F0684		

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F0684 SS = SQC-J	Continued from page 9 On 07/08/25 at 1:58 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was in the facility on the night of 06/16/25 but did not see Resident #1 until she was being taken out of the front hall by EMS. The interview revealed Resident #1 had a diagnosis of hypothyroidism and was followed by Nurse Practitioner #1 and the Medical Director. The DON indicated Nurse Practitioner #1 had put in an order on 04/23/25 for an endocrinology consult due to the resident's elevated TSH level and the Unit Manager at the time did not complete the referral. This was not identified until 06/13/25 by Unit Manager #1 and Unit Manager #1 then faxed the referral over to the endocrinology office. However, an appointment was never made because when the endocrinology office called the facility back the resident was already at the hospital. She stated the original endocrinology consult should have been completed within a week when it was received back in April 2025. She stated while reviewing paperwork during the survey she realized Nurse Practitioner #1 had put in her progress note dated 05/13/25 to increase Resident #1's thyroid medication to 250 mcg by mouth daily for hypothyroidism. The DON stated NP #1 would typically, 99% of the time put her own orders into the electronic medical record (EMR). She stated NP #1 should have put the physicians' order into the EMR or told a nursing staff member to put the order in so it could have been relayed to the MAR. The DON confirmed Resident #1's thyroid medication had not been increased to 250 mcg during the months of May 2025 and June 2025 prior to her hospitalization. Nurse Practitioner #1 was unable to be interviewed during the survey due to a medical emergency. On 07/08/25 at 12:40 PM an interview was conducted with the Medical Director. The Medical Director stated the resident was admitted into the facility with a diagnosis of hypothyroidism in June 2024. The facility had closely monitored Resident #1's thyroid level and adjusted her medication accordingly. An order for an endocrinology consult was made in April 2025 by Nurse Practitioner #1 being proactive in the resident's care since she had an elevated TSH level. The Medical Director indicated he had seen NP #1's progress note dated 05/13/25 to increase her thyroid medication dosage. The Medical Director stated it was a common error, NP #1 forgot to write the order for the increased medication. The Medical Director stated increasing Resident #1's thyroid medication wouldn't have made a difference in the outcome of her TSH level. The Medical Director stated NP #1 was handling Resident #1's care appropriately and had been monitoring her lab	F0684		

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F0684 SS = SQC-J	Continued from page 10 work closely since admission and adjusted her thyroid medication throughout the past year. He did not recall NP #1 contacting him regarding Resident #1's TSH level of 50.3 on 06/09/25. The Medical Director further stated he felt like the diagnosis of myxedema coma was due to the hospital assuming the resident's thyroid levels were not being monitored or treated, and they had a mistaken impression because the resident was lethargic with a TSH of 240 and jumped to conclusions. On 07/08/25 at 4:00 PM an interview was conducted with the Administrator. He stated the facility should have completed the endocrinology consultation in a timely manner. The Administrator indicated there had been a gap in Unit Managers and the consultation order had just been missed by nursing staff. The Administrator further stated the physician order for the [thyroid] medication increase was missed and should have been in the EMR and Resident #1's medication should have been increased if ordered by the physician. The Administrator was notified of the immediate jeopardy on 07/15/25 at 11:46 AM. The facility provided the following credible allegation of immediate jeopardy removal. 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 provide effective medical evaluation and treatment to Resident #1. Resident #1 had labs completed on 04/18/2025 resulting in a thyroid stimulating hormone (TSH) level of 29.336. The Nurse Practitioner wrote an order for an Endocrinology Consultation on 4/23/2025. Resident #1 did not have an endocrinology appointment scheduled. Resident #1 had labs completed on 5/1/2025 for a T4 lab, with results of 3.8 (normal 4.5-12.0), Free T3 results 1.59 (normal 1.58-3.9. The Nurse Practitioner saw Resident #1 on 5/13/2025 and increased Resident #1's medication from 225 micrograms (mcg) to 250 mcg by mouth daily, which was in the Nurse Practitioner Progress Note, but was not entered into Resident #1's electronic medical record as an order at the time by the Nurse Practitioner, so therefore Resident #1 did not have the recommended increase in the thyroid medication from 225mcg to 250mcg implemented on 5/13/2025 on the Medication Administration Record (MAR). Resident #1 remained on 225mcg of thyroid medication from 5/13/25 to 6/16/25. Resident #1's TSH level on 6/9/2025 was 50.3, which was not addressed at that time. The Nurse Manager faxed the order to schedule the Endocrinology	F0684		

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F0684 SS = SQC-J	Continued from page 11 Consultation on 6/13/2025. On 7/15/2025, the Director of Nursing reviewed the electronic medical record of current residents to determine those on thyroid medications. Based on the list, the Director of Nursing identified 6 other residents receiving thyroid medication. The Director of Nursing reviewed the Nurse Practitioner's most recent progress notes for these 6 residents to ensure their current orders for thyroid medication corresponded to the dose which was indicated in the progress notes and that the medication orders are accurately transcribed to the Medication Administration Record (MAR). Current residents on thyroid medications had their most recent TSH lab results that were completed in the past 120 days reviewed by the Medical Director on 7/15/25 and 7/16/25 to ensure the thyroid medication doses are effective. Current residents' orders for the past 30 days were reviewed by the Director of Nursing (DON) /Assistant Director of Nursing (ADON) on 7/15/2025 to ensure that orders for consultations to include endocrinology have been carried out or are scheduled for a consultation at a future date. Medical Doctor/Nurse Practitioner notes for recommendations for consultations were reviewed for the past 30 days on 7/16/25 by the DON/ADON to ensure any recommendations had been carried out. On 7/15/2025, current residents on thyroid medications and/or upcoming endocrinology appointments, per the electronic medical record order listing report, had a head-to- toe physical assessment by the Assistant Director of Nursing who is a Registered Nurse, as well as a focused based physical examination by the Nurse practitioner, which included vital signs to ensure their vital signs were stable and they were not experiencing a change in condition to include signs and symptoms of hypothyroidism (fatigue, cold sensitivity, constipation, dry skin, and unexplained weight gain) and hyperthyroidism (weight loss, rapid or irregular heartbeat, sweating, and irritability) which would require further medical intervention or a transfer to a higher level of care, and no other residents were identified. On 7/16/2025, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) reviewed the last 90 days of the Pharmacy recommendations to ensure residents receiving thyroid medications did not have any outstanding recommendations that needed to be	F0684		

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F0684 SS = SQC-J	Continued from page 12 implemented. No concerns were identified. On 7/16/2025, the Pharmacist reviewed the 6 residents on thyroid medication to ensure no drug to drug interactions with medications that would be taken at or around the same time of the thyroid medication or that could affect absorption of the medication. The Pharmacist additionally reviewed the 6 residents to ensure the thyroid medication is scheduled to be given at the proper time of 6 am daily. Last, the Pharmacist reviewed the 6 residents to ensure current lab orders are in place to monitor thyroid drug therapy. 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 The Nurse Practitioner was re-educated by the Medical Director on 7/9/2025 on ensuring any medication orders which the Nurse Practitioner orders while making rounds in the facility are entered into each resident's individual electronic medical record by the Nurse Practitioner and should correspond with the Nurse Practitioner progress notes. The DON and ADON were educated on 7/16/2025 by the Regional Clinical Director that a review of Medical Provider progress notes will be done daily by the DON/ADON during morning clinical meeting to ensure the Medical Provider's progress notes that make mention of medication changes correspond to the residents' current medication orders that have been input into the electronic medical record. The Nurse Practitioner was educated on 7/9/2025 by the Medical Director to obtain thyroid panel labs at least every 3-6 months for monitoring of those residents on thyroid medications. Abnormal lab results will be addressed by the Medical Provider including the Medical Director/ Nurse Practitioner to ensure a comprehensive plan for treatment which may include but not be limited to physical assessment of the resident for signs and symptoms of hypothyroidism or hyperthyroidism, further lab monitoring, increases/decreases in medication regimen, consultation with endocrinology specialist, or transfer to a higher level of care. Licensed nursing staff have been educated by the Director of Nursing/Assistant Director of Nursing on 7/15/2025 and 7/16/2025 on the following: - ensuring thyroid medication orders are entered accurately, at the time recommended by the physician	F0684		

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F0684 SS = SQC-J	Continued from page 13 and the pharmacy/ or procedure which is at 6 am on an empty stomach, given with water, and if crushed then it can be given with a small amount of applesauce or pudding - to avoid drinks that could interact with the medication which would be caffeinated drinks such as coffee, tea, fizzy drinks and calcium containing drinks such as milk, fruit juices should not be consumed until 30-60 minutes after receiving thyroid medications - when taking thyroid medication, you must wait 30-60 minutes before eating - medications that have the potential to reduce adsorption for thyroid medication are antacids, Carafate, cholestyramine, colestipol, phosphate binders, and some antibiotics, as well as calcium and iron supplements. - recognizing changes in condition along with notification to the medical provider to include identification of and notification of signs and symptoms of hypothyroidism (fatigue, cold sensitivity, constipation, dry skin, and unexplained weight gain) and hyperthyroidism (weight loss, rapid or irregular heartbeat, sweating, and irritability), this education also included monitoring every shift for signs and symptoms of hypothyroidism and hyperthyroidism and to notify the provider accordingly upon identification of any signs or symptoms - notification of abnormal TSH lab results to ensure notification to the Physician/Nurse Practitioner - the signs and symptoms of hypothyroidism and hyperthyroidism have been added to the Medication Administration Record by the Director of Nursing/Assistant Director of Nursing on 7/15/2025. Any Licensed Nurses not educated by 7/16/2025 will be educated prior to the start of their next scheduled shift. This education will be provided by the Director of Nursing/Assistant Director of Nursing. On 7/15/2025 and 7/16/2025 The Director of Nursing/Assistance Director of Nursing educated all Certified Nursing Assistance (CNAs) on notification to Licensed Nurses on any changes in condition. Any Certified Nursing Assistance (CNAs) that were not educated on 7/16/2025 will be educated prior to the start of their next scheduled shift which will be provided by the Director of Nursing/Assistant Director of Nursing.	F0684		

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F0684 SS = SQC-J	Continued from page 14 The DON/ADON reviewed the facility's process for carrying out consultation orders on 07/16/25. No changes were required. Licensed Nurses/Unit Managers were educated on the process for consultation orders on 7/15/25 and 7/16/25 by the Director of Nursing and Assistant Director of Nursing to include the process for carrying out consultation orders: - At the time that the order is written for consultation in the electronic medical record either by the Medical Provider or by the Licensed Nurse, the licensed nurse who accepts the order will then print a copy of the order to take to the Licensed Nurse Unit Manager. - The Licensed Nurse Unit Manager will then take the order and place it into the Consultation Binder on each unit for scheduling of the appointment within the next 7 days by the Licensed Nurse Unit Managers. - After the appointments are scheduled, the transportation company/van driver is notified by the Licensed Nurse Unit Manager if there is a need for outside transportation to be put on the transportation schedule. - The daily appointment schedule is then set up by the Licensed Nurse Unit Manager and is given to the transportation company/van driver, and is also distributed to the Administrator, DON, ADON, Nurse Managers, Nurses Stations, Receptionist, Transportation Company and Van Drivers the day prior by the Licensed Nurse Unit Manager. - Then once a week, the Consultation Binder will be reviewed by the DON/ADON to ensure orders for consultation appointments were scheduled and placed on the monthly calendar. The DON/ADON will compare the consultation requests to the transportation appointment calendar which will be kept in the South Licensed Nurse Unit Manager's office. The DON/ADON were notified of this responsibility by the Administrator on 7/16/2025. Additionally, the DON/ADON were educated on 7/16/2025 by the Regional Director of Clinical Services regarding reviewing all orders for appointments and reviewing the Physician/Nurse Practitioner Progress Notes of residents which may have the need for a consultation during morning clinical meeting 5 times per week. Any Licensed Nurses not educated by 7/16/2025 will be	F0684		

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F0684 SS = SQC-J	Continued from page 15 educated prior to the start of their next scheduled shift. The Director of Nursing/Assistant Director of Nursing were notified of their responsibility by the Administrator on 7/16/25 and they will be responsible for this education. An Ad-Hoc Quality Assurance Performance Improvement Committee meeting was held on 7/16/25 to review root cause analysis and corrective action plan. The root cause was determined to be when the UM resigned suddenly and failed to communicate that the endocrinology appointment had not been scheduled prior to her departure. This meeting included the Regional Clinical Director, Medical Director (via phone), the Director of Nursing, Assistant Director of Nursing, Administrator, Social Service Director, Activities Director, Rehab Program Manager to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the implementation and completion of the credible allegation. Alleged Immediate Jeopardy Removal Date: 07/17/25 On 07/18/25, the credible allegation of immediate jeopardy removal was validated by onsite verification through facility staff interviews and record review. Verification was completed of the facility's root cause analysis, audits, Nurse Practitioner assessments, lab work and pharmacy recommendations. Interviews revealed all licensed nursing staff had received education on ensuring thyroid medication orders are entered accurately, to avoid drinks that could interact with the medication, taking thyroid medication on an empty stomach and recognizing changes in condition along with notification to the medical provider to include identification of and notification of signs and symptoms of hypothyroidism. In addition, interviews revealed all licensed nursing staff had received education on consultation referrals and the process of consultation orders. The process was the following: at the time that the order is written for consultation in the electronic medical record either by the Medical Provider or by the Licensed Nurse, the licensed nurse who accepts the order will then print a copy of the order to take to the Licensed Nurse Unit Manager. The Licensed Nurse Unit Manager would then take the order and place it into the Consultation Binder on each unit for scheduling of the appointment within the next 7 days by the Licensed Nurse Unit Managers. After the appointments are scheduled, the transportation company/van driver is notified by the Licensed Nurse Unit Manager if there is a need for outside	F0684		

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F0684 SS = SQC-J	Continued from page 16 transportation to be put on the transportation schedule. The daily appointment schedule was reviewed while onsite Current residents receiving thyroid medications had TSH lab work completed and reviewed by the Medical Director who was onsite during the validation. The Medical Director confirmed he had reviewed the lab work and medication. Pharmacy consultations were reviewed for the 6 residents receiving thyroid medication. No drug-to-drug interactions with medications were noted. Interviews conducted with the DON/ADON revealed they had received education on 7/16/2025 from the Regional Director of Clinical Services regarding reviewing all orders for appointments and a review of Medical Provider progress notes will be done daily by the DON/ADON during morning clinical meeting to ensure the Medical Provider's progress notes that make mention of medication changes correspond to the residents' current medication orders that have been input into the electronic medical record. The facility's in-service log and training materials were reviewed. The facility's immediate jeopardy removal date of 07/17/25 was validated.	F0684		