STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025018	A. Building B. Wing	10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Transitional Care Center	910 Compassion Circle Anchorage, AK 99504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259 Based on record review and interview, the facility failed to implement pharmaceutical services that included procedures to ensure the accurate dispensing and administration of medications for 2 residents (#s 1 and 2), out of 2 sampled residents. Specifically, the facility failed to ensure the pharmaceutical service processes included the receiving and interpretation of prescriber's original hand-written medication orders to confirm the Five Rights (right patient, right medication, right dose, right route, and right time) were accurately followed during the transcription of the orders into the resident's electronic Medication Administration Record (eMAR). This failed practice resulted in Resident #1 requiring hospitalization for an anemic crisis, did not respond to blood transfusions, and later died , which constituted an immediate jeopardy at, which constituted an immediate jeopardy at CFR 483.45(a) Pharmacy Services. This situation was brought to the attention of the facility's administration on [DATE] at 4:45 PM, at which time the facility was notified of identified immediate jeopardy. The facility submitted an acceptable removal plan on [DATE] at 2:30 PM. The State Survey Agency verified onsite that the immediacy was removed on [DATE] at 2:00 AM. The situation that constituted the immediate jeopardy started on [DATE] at 9:32 AM. Findings: Record review on [DATE] and [DATE] revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included an abscess of the liver, chronic kidney disease, acute cholecystitis (inflammation of the gall bladder), and long term/current use of an anticoagulant (Heparin - a blood thinner medication that decreases the blood's ability to clot). Review of Resident #1's medication orders, dated [DATE], revealed an order for the anticoagulant, Heparin Sodium (Porcine) 5000 Unit/ml solution (1 ml/5000unit) SubQ [injection beneath the skin, but not muscle] every 8 hours ([6:00 AM], [2:00 PM], and [10:00 PM]) x 14 days. This medication was ordered for venous thromboembolism prophylaxis (VTE - a condition that occurs when blood clots form in veins, used as a preventative measure to prevent further clots). Medication Error Synopsis (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed on [DATE], Physician #3 placed a hand-written ordered for LMWH [Low Molecular Weight Heparin: Enoxaparin, also called Lovenox] 80mg subQ BID [twice a day] [DATE]-[DATE] for atrial fibrillation in Resident #2's medical record. Further review revealed Licensed Nurse (LN) #4 signed off this medication order on [DATE], in Resident #2's paper hard chart, however transcribed the order into Resident #1's ECS (Electronic Medication Administration Record [eMAR]) record in error. Review of the ECS system data base, dated [DATE], revealed this transcribed order was electronically sent to the pharmacy on [DATE] at 10:37 PM under Resident #1's name. Review of the pharmacy's PrimeCare system data base, dated [DATE], revealed this transcribed order was reviewed and cleared by the pharmacy at 9:32 AM. Resident #1 was administered seven doses of Lovenox, from [DATE] to [DATE], in addition to Resident #1's regular Heparin therapy, before this error was discovered and discontinued. Effects of Medication Error Resident #1 Lab History Review of Resident #1's lab work, dated [DATE], revealed Resident #1's blood values were at below normal ranges: - [NAME] Blood Cells: 3.36 K/ul (normal value: 4.0 - 11.0 K/ul) - Red Blood Cells: 3.81 M/ul (normal value: 3.9 - 5.0 M/ul) - Hemoglobin (the protein contained in red blood cells, responsible for delivery of oxygen): 9.9 g/dl (normal value: 12.0 - 16.0 g/dl) - Hematocrit (percentage by volume of red blood cells in blood): 32.2 % (normal value: 36.0 - 46.0 %) - Platelets: 75 K/ul (normal value: 140 - 440 K/ul) Review of Resident #1's lab work, dated [DATE], revealed Resident #1's blood values continued to decrease: - [NAME] Blood Cells: 3.00 K/ul - Red Blood Cells: 3.38 M/ul - Hemoglobin: 8.9 g/dl - Hematocrit: 28.4 % - Platelets: 53 K/ul (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's next labs drawn, dated [DATE] (4 days after the start of the medication error, and 1 day after the error was discontinued), revealed Resident #1's blood values were at a critically low level: - [NAME] Blood Cells: 7.37 K/ul (normal level) - Red blood Cells: 2.34 M/ul - Hemoglobin: 6.1 g/dl - Hematocrit: 18.9 % (Critical result: laboratory called the unit for a read back and acknowledgement) - Platelets: 35 K/ul Record review of Resident #1's Progress Note, dated [DATE], revealed: Notified by Nursing supervisor this [morning] of critical hemoglobin of 5.8 . concern for hemolysis [the breakdown of red blood cells] so lab was resent and repeated at 8:50 AM was 6.1 mg/dL. Subsequently also learned that patient has had medication error - was started on Lovenox 80 mg SQ [SubQ] BID ,d+[DATE]-,d+[DATE] in spite of already receiving heparin SQ 5000 units TID [three times a day] when a large volume of orders occurred last week .Today, on chart review noted blood pressure on ,d+[DATE] (below patient baseline) and axial temperature of 94.2 F . On bedside assessment, [he/she] is lethargic and opens eyes to voice but does not answer any questions. [He/she] does spontaneously speak however speech is unintelligible and does not appear to be an attempt to engage in conversation/answer provider questions, which is not patient's baseline. Further review of the Progress Note revealed: . Assessment [and] Plan: . chronic baseline anemia. On follow up ,d+[DATE], noted 3 gm drop in hgb [hemoglobin] following 3 days of administration of supratherapeutic [amounts of a drug that are greater than the therapeutic concentration or maximum dose in a medical treatment] LMWH dosing to patient with baseline CKD [chronic kidney disease]. Hypotension and mental status changes noted on ,d+[DATE] provider exam with hgb 6.1 and PLT [platelets] 35,000 . Received lovenox 80 mg BID SQ ,d+[DATE] - ,d+[DATE] in error was also receiving SQ heparin - discontinue , d+[DATE] (had been resumed ,d+[DATE]) warrants emergent ER [emergency room] evaluation for acute on chronic symptomatic anemia (presume acute blood loss due to supratherapeutic anticoagulation though also concern for hemolysis per prior charting) . Review of Resident #1's Resident Transfer Form Emergency Department revealed Resident #1 left for the Emergency Department (ED) on [DATE]. Review of Resident #1's medical record revealed the resident was transported to Alaska Regional Hospital and admitted on [DATE]. Further review revealed the following course through that hospitalization : [DATE]: admitted through ED, transfused 1 unit of packed red blood cells (prbc), repeated 2 more units. No improvement to blood values. [DATE]: An additional 2 units of prbc's transfused. No improvement to blood values. No further transfusions recommended. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]: Resident #1 unresponsive. No urine output, placed on comfort care. [DATE]: admitted to inpatient hospice. [DATE]: Resident #1 passed away. Resident #2 Record review conducted on [DATE] and [DATE] revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Atrial Fibrillation (A-fib - a quivering or irregular heartbeat that can lead to blood clots, stroke, heart failure, and other complications) and fractures. Review of Resident #2's ECS record revealed he/she had a delay in Lovenox administration, due to the transcription error, and was not started until [DATE]. Facility's Medication Order Processing Procedure During an interview on [DATE] at 2:48 PM, the Director of Nursing (DON) stated the physicians placed orders for medication by handwriting the orders into the residents' paper hard charts. The DON further stated these hand-written orders were reviewed, signed off, and transcribed into the residents' eMAR (called ECS) by the nursing supervisors of the units. Once the order had been transcribed into ECS, the ECS system alerted the pharmacy electronically of the new order. The DON further stated that the original hand-written order remained in the chart and was never sent to the pharmacy. During an interview on [DATE] at 12:00 PM, the Pharmacy Supervisor stated that the pharmacy never received copies of the hand-written medication orders, unless they were a narcotic or a controlled substance. The Pharmacy Supervisor further stated that the pharmacy would be alerted through the ECS system when a nurse transcribed a new order. This transcribed order would then be reviewed by a pharmacist and processed electronically through the pharmacy's separate computer system (called PrimeCare). The Pharmacy Supervisor stated the pharmacy lacked control of orders for new medications and how they were put into ECS to ensure it was done correctly. The Pharmacy Supervisor further stated that the pharmacy could not hold or stop medication orders in the ECS system, they were only able to look in the system at transcribed orders. When asked about the addition of Lovenox to Resident #1's medication regimen, that already included Heparin, the Pharmacy Supervisor stated it was assumed that Lovenox was replacing Heparin, but acknowledged an order to discontinue Heparin was not received. The Pharmacy Supervisor stated that Heparin and Lovenox should not be used together as a risk of increased bleeding could result. The Pharmacy Supervisor further stated the pharmacy did not have control over the facility's medication as all the medications used were stored in a Pyxis Medstation and were not directly dispensed from the pharmacy. Review of the facility's policy Medication Order Processing and Delivery, dated ,d+[DATE], revealed: .The licensed nurse or designee enters new orders into the ECS system. Orders are transmitted electronically to the pharmacy. Orders for controlled substances are printed from ECS and faxed to the Pharmacy . Medications are obtained from the Pyxis Medstation. Bulk items (ointments, inhalers, etc.) are dispensed from the Pharmacy . A pharmacist is responsible for reviewing all medication orders . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review revealed no process for the pharmacist to receive or review the original hand-written medication orders to ensure they were transcribed correctly into the ECS system. Review of the facility's policy Medication Order Initiation and Discontinuation, dated ,d+[DATE], revealed: . The licensed nurse or pharmacist is responsible to receive medication orders . The PCN [primary care nurse] enters the medication order into ECS. When indicated by ECS the order is to be printed from ECS and faxed to the Pharmacy. All other orders should transmit electronically. Pharmacy staff processes the electronic prescriptions from ECS into the pharmacy system . Further review revealed no process for the pharmacist to receive or review the original hand-written medication order to ensure it was transcribed correctly into the ECS system.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40259 Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 2 resident (#s 1 and 2), out of 2 sampled residents. The facility failed to implement and maintain processes and procedures to ensure accurate transcription of physician orders for medications. The facility administered seven doses of an anticoagulant medication (a blood thinning medication that decreases the blood's ability to clot) without a valid physician order which resulted in concurrent administration of two different anticoagulants. This failed practice resulted in Resident #1 requiring hospitalization for an anemic crisis, did not respond to blood transfusions, and later died , which constituted an immediate jeopardy at CFR 483.45(f)(2) Significant Medication Errors. This situation was brought to the attention of the facility's administration on [DATE] at 4:45 PM, at which time the facility was notified of identified immediate jeopardy. The facility submitted an acceptable removal plan on [DATE] at 6:40 PM. The State Survey Agency verified onsite that the immediacy was removed on [DATE] at 7:30 AM. The situation that constituted the immediate jeopardy started on [DATE] at 10:37 PM. Findings: Resident #1 Record review conducted on [DATE] and [DATE] revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included abscess of liver, chronic kidney disease, acute cholecystitis (inflammation of the gall bladder), and long term/current use of an anticoagulant (Heparin - a blood thinner medication that decreases the blood's ability to clot). Review of Resident #1's medication orders, dated [DATE], revealed an order for the anticoagulant, Heparin Sodium (Porcine) 5000 Unit/ml solution (1 ml/5000unit) SubQ [injection beneath the skin, but not muscle] every 8 hours ([6:00 AM], [2:00 PM], and [10:00 PM]) x 14 days. This medication was ordered for venous thromboembolism prophylaxis (VTE - a condition that occurs when blood clots form in veins, used as a preventative measure to prevent further clots). Medication Error Synopsis Record review revealed, on [DATE] at 6:30 PM, Physician #3 placed a hand-written ordered for LMWH [Low Molecular Weight Heparin: Enoxaparin, also called Lovenox] 80mg subQ BID [twice a day] [DATE]-[DATE] for atrial fibrillation in Resident #2's medical record. Further review revealed Licensed Nurse (LN) #4 signed off this medication order on [DATE] at 10:00 PM, in Resident #2's paper hard chart, however transcribed the order into Resident #1's ECS (Electronic Medication Administration Record [eMAR]) record in error. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's Physician Orders form, for the [DATE] order, revealed that the 24-hour chart check was signed off and completed by LN #5 on [DATE] at 6:48 AM. Review of Resident #1' ECS record revealed seven doses of Lovenox was administered, from [DATE] to [DATE], in addition to Resident #1's 13 doses of his/her regular Heparin therapy, before this error was discovered and discontinued. Effects of Medication Error Resident #1 Lab History Review of Resident #1's lab work, dated [DATE], revealed Resident #1's blood values were at below normal ranges: - [NAME] Blood Cells: 3.36 K/ul (normal value: 4.0 - 11.0 K/ul) - Red Blood Cells: 3.81 M/ul (normal value: 3.9 - 5.0 M/ul) - Hemoglobin (the protein contained in red blood cells, responsible for delivery of oxygen): 9.9 g/dl (normal value: 12.0 - 16.0 g/dl) - Hematocrit (percentage by volume of red blood cells in blood): 32.2 % (normal value: 36.0 - 46.0 %) - Platelets: 75 K/ul (normal value: 140 - 440 K/ul) Review of Resident #1's lab work, dated [DATE], revealed Resident #1's blood values continued to decrease: - [NAME] Blood Cells: 3.00 K/ul - Red Blood Cells: 3.38 M/ul - Hemoglobin: 8.9 g/dl - Hematocrit: 28.4 % - Platelets: 53 K/ul Review of Resident #1's next labs drawn, dated [DATE] (results after the additional seven doses of Lovenox were given in error), revealed Resident #1's blood values were at a critically low level: - [NAME] Blood Cells: 7.37 K/ul (normal level) - Red blood Cells: 2.34 M/ul - Hemoglobin: 6.1 g/dl (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Hematocrit: 18.9 % (Critical result: laboratory called the unit for a read back and acknowledgement) - Platelets: 35 K/ul Record review of Resident #1's Progress Note, dated [DATE], revealed: Notified by Nursing supervisor this [morning] of critical hemoglobin of 5.8 . concern for hemolysis [the breakdown of red blood cells] so lab was resent and repeated at 8:50 AM was 6.1 mg/dL. Subsequently also learned that patient has had medication error - was started on Lovenox 80 mg SQ [SubQ] BID ,d+[DATE]-,d+[DATE] in spite of already receiving heparin SQ 5000 units TID [three times a day] when a large volume of orders occurred last week .Today, on chart review noted blood pressure on ,d+[DATE] (below patient baseline) and axial temperature of 94.2 F . On bedside assessment, [he/she] is lethargic and opens eyes to voice but does not answer any questions. [He/she] does spontaneously speak however speech is unintelligible and does not appear to be an attempt to engage in conversation/answer provider questions, which is not patient's baseline. Further review of the Progress Note revealed: . Assessment [and] Plan: . chronic baseline anemia. On follow up ,d+[DATE], noted 3 gm drop in hgb [hemoglobin] following 3 days of administration of supratherapeutic [amounts of a drug that are greater than the therapeutic concentration or maximum dose in a medical treatment] LMWH dosing to patient with baseline CKD [chronic kidney disease]. Hypotension and mental status changes noted on ,d+[DATE] provider exam with hgb 6.1 and PLT [platelets] 35,000 . Received lovenox 80 mg BID SQ ,d+[DATE] - ,d+[DATE] in error was also receiving SQ heparin - discontinue , d+[DATE] (had been resumed ,d+[DATE]) warrants emergent ER [emergency room] evaluation for acute on chronic symptomatic anemia (presume acute blood loss due to supratherapeutic anticoagulation though also concern for hemolysis per prior charting) . Review of Resident #1's Resident Transfer Form Emergency Department revealed Resident #1 left for the Emergency Department (ED) on [DATE]. Review of Resident #1's medical record revealed the resident was transported to Alaska Regional Hospital and admitted on [DATE]. Further review revealed the following course through that hospitalization : [DATE]: admitted through ED, transfused 1 unit of packed red blood cells (prbc), repeated 2 more units. No improvement to blood values. [DATE]: An additional 2 units of prbc's transfused. No improvement to blood values. No further transfusions recommended. [DATE]: Resident #1 unresponsive. No urine output, placed on comfort care. [DATE]: admitted to inpatient hospice. [DATE]: Resident #1 passed away. Resident #2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review conducted on [DATE] and [DATE] revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Atrial Fibrillation (A-fib - a quivering or irregular heartbeat that can lead to blood clots, stroke, heart failure, and other complications) and fractures. Review of Resident #2's ECS record revealed he/she had a delay in Lovenox administration, due to the transcription error, and was not started until [DATE]. Facility's Medication Order Processing Procedure During an interview on [DATE] at 2:48 PM, the Director of Nursing (DON) stated the physicians placed orders for medication by handwriting the orders into the residents' paper hard charts. The DON further stated these hand-written orders were reviewed, signed off, and transcribed into the residents' eMAR (called ECS) by the nursing supervisors of the units. Once the order had been transcribed into ECS, the ECS system alerted the pharmacy electronically of the new order. The DON further stated that the original hand-written order remained in the chart and was never sent to the pharmacy. When asked about the facility's auditing process for medication orders, the DON stated there was a 24-hour chart check that was completed nightly for all new orders written in the hard charts. These written orders were compared to the orders in the ECS system to ensure the orders were transcribed correctly. Facility Training on 24-hour Chart Checks During an interview on [DATE] at 3:05 PM, the Senior Manager of Clinical Education (SMCE) stated the 24-hour chart check was solely looking at the residents' hard paper chart for new orders, and ensuring those orders were transcribed correctly into the ECS system and to ensure proper notifications were completed. The SMCE further stated the 24-hour chart check did not involve reviewing all residents' ECS records to ensure orders transcribed had written orders in the hard paper charts. Facility Investigation of Medication Error During an interview on [DATE] at 3:10 PM, the Quality Director stated an investigation into the medication error occurred. All nurses involved were interviewed and the following was determined: - LN #4 stated when he/she was placing the orders written for Resident #2 when another nurse interrupted the transcription to ask for help in Resident #1's ECS record. LN #4 stopped his/her order entry and opened Resident #1's ECS record to assist the nurse. LN #4 did not switch back into Resident #2's ECS record before completing Resident #2's transcriptions and inadvertently placed Resident #2's Lovenox order into Resident #1's ECS record. - LN #5 stated when he/she performed the 24-hour chart check, he/she found no discrepancies for Resident #1, but did notice Resident #2's Lovenox order was not transcribed onto his/her ECS record. LN #5 spoke with LN #4, who signed off the orders in Resident #2's hard paper chart. LN #5 stated LN #4 wrote down the discrepancy and stated he/she would look at it later. LN #5 signed off Resident #2's chart check as completed, assuming LN #4 would go back and fix the discrepancy. LN #5 admitted that he/she did not follow the 24-hour chart check protocol. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy Order Management, dated ,d+[DATE], revealed: .Every Chart will be checked every night by a licensed nurse to ensure that all orders have been transcribed accurately and no orders have been missed. This is a second check on all orders . Review of the facility's protocol 24-Hour Check of Each Chart, dated ,d+[DATE], revealed: The assigned night shift nurse and/or rover nurse will review all orders and is responsible to ensure that the order is clearly written, transcribed correctly into eMAR and that all communications via fax and email were done (Pharmacy is faxed all controlled substance orders . If an order is found during the 24-hour check that had not been previously processed by nursing, the assigned night shift nurse will ensure that the order is processed . Further review revealed no process to ensure all orders transcribed into the ECS system were audited to ensure it had a written order in the resident's hard chart.