STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035136	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sierra Vista	2305 East Wilcox Drive Sierra Vista, AZ 85635

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to protect the rights of one resident (#2) from sexual abuse by a visitor. The deficient practice resulted in the resident being sexually abused. Findings include: Resident #2 was admitted on [DATE] with diagnoses of cognitive communication deficit, Parkinson's disease, and anxiety disorder. The care plan with revision date of September 9, 2024 revealed the resident had actual and potential psychosocial well-being problem related to cognitive impairment, family discord and past history of physical and sexual abuse. Interventions included supervised visits with a family member and during visits, resident #2 and the family member had to be either in a public area or must be able to be viewed by staff while in her room. A communication note dated September 23, 2024 included that the resident's family member/POA (power of attorney) asked to get a report of a sexual abuse allegations from September 9; and that, the family member wanted to know what was in the report as he felt that he was being accused of something. Per the documentation, the family member reported that the resident's allegations were done to get attention; and that, the resident was molested when she was 7 and when she was married was abused by her husband. The documentation also included that the family member reported that the day the resident made allegations that she had been raped (September 9) was the day that the family member was not feeling well and only made a short visit. It also included that the short visit did not leave time for a rape and it does for inappropriate touching. The documentation also included that the family member was notified that eyesight visitations will be continued until the facility was told otherwise. The late entry mood note dated September 25, 2024 revealed the resident was more emotional and was crying out more lately. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 035136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Life Care Center of Sierra Vista		STREET ADDRESS, CITY, STATE, ZIP CODE: 2305 East Wilcox Drive Sierra Vista, AZ 85635	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The alert note dated October 1, 2024 included that at approximately 3:30 p.m., the resident reported that she was suicidal as she was crying in the hallway. The facility visitor sign in-sign out sheet for October 14, 2024 revealed that the family member/POA visited and was at the facility from 11:00 a.m. through 12:13 p.m. The clinical record revealed no evidence found that the family/POA was supervised during his visit with resident #2 on October 14, 2024 from 11:00 a.m. through 12:13 p.m. The clinical record also revealed no evidence that the care plan for supervised visits were discontinued for the family member/POA. The alert note dated October 14, 2024 revealed that at approximately 2:00 p.m., two certified nursing assistants (CNAs) reported that resident #2 had abnormal vaginal bleeding that was found during showers; and that both CNAs reported that it was a lot of bleeding. Per the documentation, when the nurse approached the resident in the hall, the resident reported that she did not do anything wrong. It also included that the resident was assessed and external examination showed no bleeding, swelling or bruising and there was no blood in the resident's brief. Further, the documentation included that directions were given to send the resident to the hospital for examination. The alert note dated October 14, 2024 included that at approximately 2:15 p.m., a CNA who was upset reported to the social service director that the CNA was helping other CNAs with showers and was giving resident #2 showers. Per the documentation, the CNA reported that when the CNA was washing the resident's vagina, there was a lot of blood on the wash cloth; and that she grabbed a new wash cloth, washed the area again and there was still significant amount of blood. The documentation included that when the CNA asked the resident if she was ok, the resident yelled out that the family member/POA did not do anything to her. Further, the documentation included that the resident was assessed, EMS (emergency medical services) was called and resident was transferred to the hospital. Another alert note dated October 14, 2024 revealed that at approximately 2:25 p.m., the nurse was informed by a CNA who provided showers to resident #2 that that CNA witnessed a significant amount of vaginal bleeding; and that, the CNA used two rags which were both bloody. The documentation included that when the resident became aware of this, the resident reported that the family member/POA did not do it. The documentation included that a noninvasive assessment was conducted and the resident's brief was examined and there was no apparent blood or visible physical trauma observed. Per the documentation, instruction was given to proceed with hospital transfer and notification of the family member/POA. The transfer to hospital summary note dated October 14, 2024 revealed that at approximately 2:30 p.m., a CNA observed the resident was having vaginal bleeding; and that, the resident was post-menopausal. Per the documentation, both the nurse and the CNA reported that bleeding was initially [NAME]-red with beginning of perineal care whilst in a shower after visit concluded. The documentation also included that when asked about the bleeding, the resident immediately responded that the family member (POA) did not do it. The note included that the resident was sent to the ER (emergency room) with explicit instructions to perform vaginal inspection via speculum. A health status note dated October 14, 2024 included the resident left the facility for evaluation at the hospital ER. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The communication note dated October 14, 2024 included that at approximately 2:45 p.m., the family/POA was notified that the resident was transferred to the hospital for evaluation related to abnormal groin bleeding. Per the documentation, the family/POA responded by asking whether the bleeding was in the resident's private area and then ended the call. The sexual assault medical examination report dated October 14, 2024 revealed that the resident was frail, suffered from Parkinson's disease and had a difficult time communicating. Per the documentation, resident reported that the family member/POA had assaulted her earlier in the day but was not certain of the time. It also included that the resident reported that she and the family member/POA went to the mall and the family member/POA assaulted her in the care. The documentation included that the resident reported that the family member/POA took her shorts off, held her legs, placed his finger into her vagina, put his penis into her vagina and put his mouth and hands on both her breasts. It also included that the resident reported that she was slapped on the left side of the face-neck with the hand; and that, the family member/POA had assaulted her when she was a child. Physical examination included injuries noted in the lower extremities, external genital area and the labia minora. Description of the injuries included 0.5 cm (centimeter) x 1.5 cm red bleeding 1 o'clock to 3 o'clock at the edge of the vaginal orifice and 1 cm linear scratch 12 o'clock approximately 2 cm anterior to the vaginal orifice. Examiner's diagnosis included sexual assault by history and examination. The hospital report dated October 14, 2024 revealed that the resident was seen at 5:00 p.m. for evaluation for sexual assault. Per the documentation, facility reported that there were prior reports of sexual assault that were unsubstantiated. It also included that the resident reported lower abdominal pain, denied vaginal bleeding/discharge; and that, she was allegedly sexually assaulted by a patient from the facility yesterday. The documentation also included that the resident reported there were 3 discrete episodes of sexual assault that included touching and penile penetration. Continued review of the hospital report revealed that the police department informed the hospital that the resident told the police that she had been sexually assaulted 3 times while at the facility. The event note dated October 15, 2024 revealed that the nurse received a report from the hospital ED that the assessment and bruises were consistent with abuse; and that, the resident would need to have additional photos done. The event note dated October 15, 2024 included the resident arrived back to the facility, was agitated, crying and moaning. Per the documentation, the resident stated Why did he do this to me?, Was I bad? How could he hurt me, why did he do this to me? It also included that the resident kept crying and moaning, was given medications, and attention was diverted to watching a movie with the nurse until the resident fell asleep. A communication note dated October 15, 2024 included that the family/POA was informed that he would not be allowed into the building pending investigation. The administration note dated October 15, 2024 revealed that resident was restless and upset. The email correspondence from the facility's executive director (ED/staff #13) addressed to the provider and dated October 15, 2024 included that the resident was sent to the ER for vaginal bleeding; and that, clinical inspection was done at the ER and findings were consistent with sexual abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The administration note dated October 16, 2024 revealed that resident was agitated and was crying. The administration note dated October 17, 2024 included that the resident was crying and was asking the question What did I do wrong? over and over. An interview was conducted on October 17, 2024 at 2:04 PM with CNA (staff #20) who was working the day of October 14, 2024. The CNA stated that she assisted another CNA (staff #10) in getting resident #2 in the shower and then proceeded to the nurses' station. The CNA said that staff #10 came out of the shower and told her that she was washing the resident's vagina and that resident had blood in the area. The CNA said that staff #10 showed her the rag she used and asked her if it was normal for resident #2 to have that much blood. The CNA said that she asked staff #10 if resident #2 had hemorrhoids and staff #10 replied with a no. She stated that she then went with staff #10 back into the showers and had used the flashlight on her phone to check resident #2. The CNA said that she did not see any scratches or hemorrhoids and at that point, she gave resident #2 a towel to dry off and asked the resident if she had gotten hurt. The CNA said that looked at her and replied that family member/POA did not do anything to her vagina. The CNA said that she then reported the incident to the ED (staff #13) and registered nurse (RN/staff #6). Further, the CNA said that earlier in the day of the incident, during lunch, resident #2 appeared to be uncomfortable. An interview was conducted on October 17, 2024 at 3:01 p.m. with another CNA (staff #22) who stated that she was familiar with resident #2 but was not working with her on October 14, 2024. Staff #22 stated that the family member/POA would visit resident #2 often; however, she does not know where these visits take place or if there were any safety precautions in place during these visits. In an interview with a licensed practical nurse (LPN/staff #14) conducted on October 18, 2024 at 9:08 a.m., the LPN stated he was working on October 14, 2024 and was familiar with resident #2. He said that resident #2 had one visitor on October 14, 2024 and it was the family member/POA; however, he said that he was not sure where the visit took place. The LPN stated that at one point, the family member/POA was at the nurses' station for approximately 15 minutes because resident #2 was being changed in her room; but, he lost sight of the family member/POA after that. He stated that during his shift the CNA (staff #10) reported that resident #2 had blood on her washcloth during a shower. The LPN said that he had reported the incident to the Assistant Director of Nursing (ADON/staff #4) and RN (staff #6). An interview was conducted with the CNA (staff #10) on October 18, 2024 at 9:18 a.m. The CNA said that she was scheduled to be on the rehab unit on October 14, 2024 but the long term care unit needed help so she was assisting residents with showers. The CNA said that resident #2 was her first shower of the day since she was up and around; and that, resident #2 does not do her own washing so staff was doing it for her. The CNA said that she was washing the resident's privates with soap and a washcloth when she noticed a good amount of blood and she was not sure where it was coming from. She reported that she was able to get another CNA (staff #20) to assist her in locating the source of the bleeding and both she and staff #20 saw the blood coming out of the resident's vagina. The CNA said that she and staff #200 reported the incident to the RN (staff #6) and the ED (#13). Regarding resident #2, the CNA said that the resident's agitation usually gets worse after her visits with the family member/POA. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/staff #18) conducted on October 17, 2024 at 3:58 p.m. , the DON said that she was somewhat familiar with resident #2 as she had just recently started working at the facility on October 2, 2024; and she was not working on October 14, 2024 which was the day of the incident. The DON said that the visits between resident #2 and the family member/POA were to take place within the staff's line of sight; and that, she only became aware of this on October 14, 2024 when the incident took place. The DON said that the visits of the family member/POA with resident #2 were put on hold pending the outcome of the abuse investigation; and that, if a staff sees the family member/POA on the premises, the staff were to inform her, the ADON or the ED immediately so they could intervene. Further, the DON said that allowing family member/POA to continue to have unsupervised visitation with resident #2 would have the risk of abuse to continue. In an interview conducted with the ED (staff #13) conducted on October 17, 2024 at 4:12 p.m., the ED stated that visits between resident #2 and the family member/POA were to take place either on the front porch, the front lobby, or the sitting area by the ice cream parlor. The ED said that she was working on October 14, 2024 and was approached by the RN (staff #6) and two CNAs (staffs #10 and #20). She said that she was told that the resident was being provided with showers by the CNA and there was blood on the washcloth when the CNA did the peri care. The ED stated that the two CNAs reported that they got on their knees with a flashlight, saw that there were no cuts but the bleeding appeared to be coming from the resident's vagina. The ED said that she instructed the RN (staff #6) and another nurse to do an exam to determine the cause of the bleeding. The ED further stated that the risk to the resident if someone, who was accused of sexually assaulting them continued to have unsupervised visits depended on whether the allegation was substantiated or unsubstantiated. The facility's policy on Abuse - Protection of Resident was last reviewed on July 18, 2023 revealed that the facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. The policy also revealed that to ensure the protection of residents during an investigation included removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents. The facility policy on Visitor Management reviewed on June 17, 2024 included that all associates are responsible for ensuring the safety and well-being of residents, associates and visitors. Reasonable clinical and safety restrictions include a facility's policies, procedures or practices that protect the health and security of all residents and staff; and, these may include, but are not limited to denying access or providing limited and supervised access to an individual if that individual is suspected of abusing, exploiting, coercing a resident until an investigation into the allegation has been completed or has found to be abusing, exploiting or coercing a resident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure abuse policies and procedures were implemented to protect the rights of one resident (#2) from sexual abuse by a visitor. The deficient practice could result in appropriate action not taken and further abuse of the resident. Findings include: Resident #2 was admitted on [DATE] with diagnoses of cognitive communication deficit, Parkinson's disease, and anxiety disorder. The care plan with revision date of September 9, 2024 revealed the resident had actual and potential psychosocial well-being problem related to cognitive impairment, family discord and past history of physical and sexual abuse. Interventions included supervised visits with a family member and during visits, resident #2 and the family member had to be either in a public area or must be able to be viewed by staff while in her room. A communication note dated September 23, 2024 included that the resident's family member/POA (power of attorney) asked to get a report of a sexual abuse allegations from September 9; and that, the family member wanted to know what was in the report as he felt that he was being accused of something. Per the documentation, the family member reported that the resident's allegations were done to get attention; and that, the resident was molested when she was 7 and when she was married was abused by her husband. The documentation also included that the family member reported that the day the resident made allegations that she had been raped (September 9) was the day that the family member was not feeling well and only made a short visit. It also included that the short visit did not leave time for a rape and it does for inappropriate touching. The documentation also included that the family member was notified that eyesight visitations will be continued until the facility was told otherwise. The facility visitor sign-in/sign-out sheet for October 14, 2024 revealed that the family member/POA visited and was at the facility from 11:00 a.m. through 12:13 p.m. The clinical record revealed no evidence found that the family/POA was supervised during his visit with resident #2 on October 14, 2024 from 11:00 a.m. through 12:13 p.m. The clinical record also revealed no evidence that the care plan for supervised visits were discontinued for the family member/POA. There was no evidence found in the clinical record and facility documentation of a reason why the family member/POA was not supervised on October 14, 2024 from 11:00 a.m. through 12:13 p.m. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record review revealed that on October 14, 2024, two certified nursing assistants (CNAs) reported that resident #2 had abnormal vaginal bleeding that was found during showers; and that both CNAs reported that it was a lot of bleeding. Per the documentation, when the nurse approached the resident in the hall, the resident reported that she did not do anything wrong. It also included that the resident was assessed and external examination showed no bleeding, swelling or bruising and there was no blood in the resident's brief. Further, the documentation included that directions were given to send the resident to the hospital for examination. The transfer to hospital summary note dated October 14, 2024 revealed that when asked about the bleeding, the resident immediately responded that the family member (POA) did not do it. The note included that the resident was sent to the ER (emergency room) with explicit instructions to perform vaginal inspection via speculum. The sexual assault medical examination report dated October 14, 2024 revealed that the resident reported that the family member/POA had assaulted her earlier in the day but was not certain of the time; and that, she and the family member/POA went to the mall and the family member/POA assaulted her in the car. Physical examination included injuries noted in the lower extremities, external genital area and the labia minora. Examiner's diagnosis included sexual assault by history and examination. The event note dated October 15, 2024 revealed that the nurse received a report from the hospital ED that the assessment and bruises were consistent with abuse. The email correspondence from the facility's executive director (ED/staff #13) addressed to the provider and dated October 15, 2024 included that the resident was sent to the ER for vaginal bleeding; and that, clinical inspection was done at the ER and findings were consistent with sexual abuse. An interview was conducted on October 17, 2024 at 3:01 p.m. with another CNA (staff #22) who stated that she was familiar with resident #2 but was not working with her on October 14, 2024. Staff #22 stated that the family member/POA would visit resident #2 often; however, she does not know where these visits take place or if there were any safety precautions in place during these visits. In an interview with a licensed practical nurse (LPN/staff #14) conducted on October 18, 2024 at 9:08 a.m., the LPN stated he was working on October 14, 2024 and was familiar with resident #2. He said that resident #2 had one visitor on October 14, 2024 and it was the family member/POA; however, he said that he was not sure where the visit took place. The LPN stated that at one point, the family member/POA was at the nurses' station for approximately 15 minutes because resident #2 was being changed in her room; but, he lost sight of the family member/POA after that. During an interview with the Director of Nursing (DON/staff #18) conducted on October 17, 2024 at 3:58 p.m. , the DON said that the visits between resident #2 and the family member/POA were to take place within the staff's line of sight; and that, she only became aware of this on October 14, 2024 when the incident took place. The DON said that the visits of the family member/POA with resident #2 were put on hold pending the outcome of the abuse investigation; and that, if a staff sees the family member/POA on the premises, the staff were to inform her, the ADON or the ED immediately so they could intervene. Further, the DON said that allowing family member/POA to continue to have unsupervised visitation with resident #2 would have the risk of abuse to continue. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with the ED (staff #13) conducted on October 17, 2024 at 4:12 p.m., the ED stated that visits between resident #2 and the family member/POA were to take place either on the front porch, the front lobby, or the sitting area by the ice cream parlor. The ED said that she was working on October 14, 2024 and was approached by the RN (staff #6) and two CNAs (staffs #10 and #20). She said that she was told that the resident was being provided with showers by the CNA and there was blood on the washcloth when the CNA did the peri care. The ED stated that the two CNAs reported that they got on their knees with a flashlight, saw that there were no cuts but the bleeding appeared to be coming from the resident's vagina. The ED said that she instructed the RN (staff #6) and another nurse to do an exam to determine the cause of the bleeding. The ED further stated that the risk to the resident if someone, who was accused of sexually assaulting them continued to have unsupervised visits depended on whether the allegation was substantiated or unsubstantiated. The facility's policy on Abuse - Protection of Resident was last reviewed on July 18, 2023 revealed that the facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. The policy also revealed that to ensure the protection of residents during an investigation included removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents. The facility policy on Visitor Management reviewed on June 17, 2024 included that all associates are responsible for ensuring the safety and well-being of residents, associates and visitors. Reasonable clinical and safety restrictions include a facility's policies, procedures or practices that protect the health and security of all residents and staff; and, these may include, but are not limited to denying access or providing limited and supervised access to an individual if that individual is suspected of abusing, exploiting, coercing a resident until an investigation into the allegation has been completed or has found to be abusing, exploiting or coercing a resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, facility documentation and policy review, the facility failed to ensure medications were administered as ordered for one resident (#1). The deficient practice could result in resident not receiving treatment for their assessed needs. Findings include: Resident #1 was admitted on [DATE] with diagnoses of encephalopathy, muscle weakness, and a cognitive communication deficit. A review of the admission minimum Data Set (MDS) assessment, dated October 8, 2024, revealed the resident was not able to complete a Brief Interview for Mental Status (BIMS); and that, staff assessment revealed the resident had a severely impaired cognitive skills for daily decision making. The hospital discharge instructions dated October 8, 2024 included an order for Droxidopa (anti-Parkinson agent) 300 mg (milligrams) capsules every 8 hours for 30 days. Problem lists included brain disorder, chronic stroke and coagulopathy. The physician order dated October 4, 2024 included for Droxia (antimetabolite and used to treat certain cancer) oral capsule 300 mg three times a day for hypotension for 30 days. The physician order summary report revealed an order dated October 4, 2024 for Droxia (antimetabolite) oral capsule 300 mg three times a day for hypotension for 30 days. The start date of the order was October 5, 2024 and the end date were November 4, 2024. Continued review of the order summary report revealed that the reason for the discontinuation of the Droxia on October 7, 2024 was documented as entered in error. The order for Droxia was transcribed onto the October 2024 MAR (medication administration record) and had a discontinue date of October 7, 2024. Review of the October 2024 MAR documentation revealed that Droxia was administered to resident #1 six times between October 5, 2024 and October 7, 2024. There was no evidence found that the physician was notified of the error for Droxia. The clinical record revealed no evidence that Droxipoda was administered to resident #1 as ordered by the hospital. There was also no documentation found of why it was not administered; and that, the physician was notified. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN/staff #8) was conducted on October 17, 2024 at 5:16 p.m. The LPN said that the process for entering medication orders involved obtaining the discharge order from the hospital via a computer order system then entering it into the electronic record. The LPN said that a second nurse will double check and reconcile the orders to ensure its accuracy; and, orders can also be entered into the electronic record at any time by any nurse. During the interview, a review of the clinical record was conducted with the LPN who stated that the hospital discharge order did not match orders entered in clinical record. An interview was conducted with the Director of Nursing (DON/staff #18) on October 17, 2024 at 4:25 p.m. The DON said that incoming residents come with discharge orders which goes through the facility's admissions department. The DON said that orders are then given to a nurse who transcribes them orders into the EHR (electronic health record). The DON stated that after the orders were transcribed, a second nurse then verifies the orders as the first nurse reads the discharge orders. A review of the clinical record was conducted with the DON who stated that the hospital order for Droxidopa did not match the order for Droxia in the EHR; and that, resident #1 was administered with Droxia 6 times before the medication was stopped. The DON further stated that this was an order transcription error and this did not meet her expectations. The facility's policy on Administration of Medications was last reviewed on August 24, 2023. The policy defines a medication error as the observed or identified preparation or administration of medications or biologicals which is not in accordance with: 1- The prescriber's order .