STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145427	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Alton	3523 Wickenhauser Alton, IL 62002

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on record reviews and interviews the facility failed to transcribe medications to Physician Order Sheet, the Medication Administration Record, obtain medications from the pharmacy and administer medications as ordered by the physician for 1 of 3(R3) residents reviewed for providing care according to professional standards. Findings include: R3's Census Report, not dated, documents that R3 was admitted to the facility on [DATE] and discharged from the facility on 4/7/2025 with the following diagnoses: AKI/Acute Kidney Injury on CKD/Chronic Kidney Disease Stage IV non anion gap Metabolic Acidosis Prostatomegaly, Complicated UTI/Urinary Tract Infection bladder stents, Fracture of left Humerus, Pacemaker, Accelerated Hypertension, Ataxia, Coronary Artery Disease status post CABG/Coronary Artery Bypass Graft, Chronic Diastolic Congestive Heart Failure, Anemia of Chronic Disease, Paroxysmal Atrial Fibrillation Mobitz second degree block, Prolonged QTc/corrected QT interval, Non-insulin dependent Diabetes Mellitus/DM, Uncontrolled Diabetes, Hyperglycemia, paraspinal disease, CVA/Cerebrovascular Accident, TIA/Transient Ischemic Attack, PVD/Peripheral Vascular Disease status post Stents, CAD/Coronary Artery Disease status post CABG, Hypertension, Hyperlipidemia, GERD/Gastroesophageal Reflux Disease, Hypotension. R3's Minimum Data Set, dated dated [DATE], documents that R3 is cognitively intact. (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:	(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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Hospital Discharge Orders, dated 4/2/2025 at 9:52 AM, documents the following 1. Isosorbide Dinitrate Oral Tablet 30 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 2. Aspirin Oral Tablet Delayed Release 81 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10) 3. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for supplement. 4. Levothyroxine Sodium Oral Tablet 50 MCG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for thyroid. 5. glipizide Oral Tablet 10 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for DM before meals. 6. Cephalexin Oral Tablet 500 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for infection. 7. hydralazine HCl Oral Tablet 25 MG: 1 tablet by mouth three times a day. Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours. 8. Metoprolol Tartrate Tablet 50 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 9. Simvastatin Oral Tablet 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for cholesterol. 10. Xarelto Oral Tablet 15 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATRIOVENTRICULAR BLOCK, FIRST DEGREE (I44.0) R3's Physician Order Sheet (POS) and Medication Administration Record (MAR), dated April 2025, documents that R3's Hospital discharge orders were transcribed to the POS and the MAR on 4/5/2925. R3's Medication Administration Record (MAR), dated April 2025, documents no orders for 4/2, 4/3, and 4/4. R3's MAR documents orders transcribed 4/5/2025, 4/7/2025 and 4/8/2025. On 5/1/2025 at 12:12 PM V4, Previous Director of Nursing (DON), stated that his last day was 4/3/2025 and he is not familiar with R3. V4 stated that the process for new admission is that the admitting nurse will transcribe the orders in PCC (Point Click Care) so that it can be sent to pharmacy. The orders are sent to the pharmacy through the PCC. There is a triple check system that is in place to assure that the admission is completed correctly. On 5/1/2025 at 12:41 PM, V3, Assistant Director of Nursing (ADON), stated that she was interim Director of Nursing after V4 left. V3 stated that the admission process is completed by the floor nurse regardless of if they work for the facility or agency. V3 stated that she became aware of R3 not receiving his medications on the Sunday prior to his transfer to hospital. V3 stated that the medication should have been transcribed upon admission. V3 stated that it takes 24 hours for an admission to be completed but the medications are to be transcribed within the first couple hours of the admission. V3 stated that she is not sure why the medications were not transcribed. V3 stated that the admitting nurse was from an agency. V3 stated that the agency nurses can and are expected to complete the admission. V3 stated that there is a triple check system that is in place but was not done either. V3 stated that this would have been completed by the following nurses which were agency nurses as well. V3 stated that they only have 4 facility staffed nurses and they are all scheduled on the other side of the building. V3 stated that the nurses that provided care for R3 was agency. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/2025 at 2:33 PM V5, Licensed Practical Nurse (LPN), stated that she was in the facility when R3 was admitted , and V5 sent R3 to the hospital. V5 stated that the night of the admission she worked on the other hall and the nurse had 3 admissions. V5 stated that she took an admission, V8, Registered Nurse (RN), took one and V3, ADON, took one. V5 stated that V3 took R3's hospital records home so she could work on them remotely. V5 stated that the orders did not get transcribed until the 5th. The facility's Physician Order policy, dated 2/2024, documents that GENERAL: Drugs will be administered only upon a clean, complete and signed order of a person lawfully authorized to presc1ibe. Verbal orders will be received only by licensed nurses or pharmacists and confirmed in writing by the physician. Electronic orders transmitted via NCPDP Script 10.6 will be accepted. RESPONSIBLE PARTY: Nursing POLICY: Documentation of the Medication Order: I. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administrative Record (TAR). 2 The following steps are initiated to complete documentation: a. Clarify the order b. Enter the orders with administration schedule in PCC and transmit to pharmacy.

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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 0658 Level of Harm - 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** 42108 Based on record reviews and interviews the facility failed to transcribe medications to Physician Order Sheet, the Medication Administration Record, obtain medications from the pharmacy and administer medications as ordered by the physician according to standards of practice for 1 of 3 (R3) residents reviewed for significant medication errors. This failure resulted in R3 experiencing shortness of breath, heart palpitations, untreated Urinary Tract Infection and R3 feeling like he was going to die. Findings include: 1. R3's Census Report, not dated, documents that R3 was admitted to the facility on [DATE] and discharged from the facility on 4/7/2025 with the following diagnoses: AKI on CKD IV non anion gap metabolic acidosis prostatomegaly, Complicated UTI bladder stents, Fracture of left Humerus, Pacemaker, Accelerated Hypertension, Ataxia, Coronary Artery Disease status post CABG, Chronic diastolic congestive heart failure, Anemia of chronic disease, Paroxysmal Atrial Fibrillation Mobitz second degree block, Prolonged QTc interval, Non-insulin dependent diabetes mellitus, uncontrolled diabetes, Hyperglycemia, paraspinal disease, CVA, TIA, PVD status post Stents, CAD status post CABG, Hypertension, Hyperlipidemia, GERD, Hypotension R3's Minimum Data Set, dated dated [DATE], documents that R3 is cognitively intact. R3's Hospital Discharge Orders, dated 4/2/2025 at 9:52 AM, documents the following 1. Isosorbide Dinitrate Oral Tablet 30 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 2. Aspirin Oral Tablet Delayed Release 81 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10) 3. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for supplement. 4. Levothyroxine Sodium Oral Tablet 50 MCG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for thyroid. 5. glipizide Oral Tablet 10 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for DM before meals. 6. Cephalexin Oral Tablet 500 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for infection. 7. hydralazine HCl Oral Tablet 25 MG: 1 tablet by mouth three times a day. Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours. 8. Metoprolol Tartrate Tablet 50 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 9. Simvastatin Oral Tablet 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for cholesterol. 10. Xarelto Oral Tablet 15 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATRIOVENTRICULAR BLOCK, FIRST DEGREE (I44.0) R3's Physician Order Sheet (POS) and Medication Administration Record (MAR), dated April 2025, documents that R3's Hospital discharge orders were transcribed to the POS and the MAR on 4/5/2925. R3's Medication Administration Record (MAR), dated April 2025, documents no orders for 4/2, 4/3, and 4/4. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	R3's MAR documents orders transcribed 4/5/2025, 4/7/2025 and 4/8/2025. R3's MAR documents that R3 received 1 dose of Glipizide on 5/5/2025. 1 dose of Xarelto, Simvastatin, Cephalexin, glipizide, Cyanocobalamin, Metoprolol, Pantoprazole, Isosorbide on 5/6/2025. R3 did not receive Hydrochlorothiazide, Aspirin, Ascorbic Acid, and hydralazine. On 5/1/2025 at 12:12 PM V4, Previous DON, stated that his last day was 4/3/2025 and he is not familiar with R3. V4 stated that the process for new admission is that the admitting nurse will transcribe the orders in PCC (Point Click Care) so that it can be sent to pharmacy. The orders are sent to the pharmacy through the PCC. There is a triple check system that is in place to assure that the admission is completed correctly. On 5/1/2025 at 12:41 PM, V3, Assistant Director of Nursing (ADON), stated that she was interim Director of Nursing after V4 left. V3 stated that the admission process is completed by the floor nurse regardless of if they work for the facility or agency. V3 stated that this includes medication and assessments. V3 stated that neither were complete timely. V3 stated that she became aware of R3 not receiving his medications on the Sunday prior to his transfer to hospital. V3 stated that the medication should have been transcribed upon admission. V3 stated that it takes 24 hours for an admission to be completed but the medications are to be transcribed within the first couple hours of the admission. V3 stated that she is not sure why the medications were not transcribed. V3 stated that the admitting nurse was from an agency. V3 stated that the agency nurses can and are expected to complete the admission. V3 stated that there is a triple check system that is in place but was not done either. V3 stated that if the triple check would have been completed this would have prevented R3 from missing his medications that he needed, and assessment would have been completed. V3 stated that the floor nurse regardless of if she works for the facility or agency is knowledgeable and capable of completing the admission. V3 stated that the medications are a priority and should have been taken care of. V3 stated that they only have 4 facility staffed nurses and they are all scheduled on the other side of the building. V3 stated that the nurses that provided care for R3 was agency. V3 stated that nurse mangers are audit the admission and make sure it is completed. This includes medications and assessments. On 5/1/2025 at 2:33 PM V5, LPN, stated that she was in the facility when R3 was admitted , and V5 sent R3 to the hospital. V5 stated that the night of the admission she worked on the other hall and the nurse had 3 admissions. V5 stated that she took an admission, V8, RN, took one and V3, ADON, took one. V5 stated that V3 took R3's hospital records home so she could work on them remotely. V5 stated that the orders did not get transcribed until the 5th. On 5/5/2025 at 12:06 PM V10, Pharmacist, stated that R3 not receiving his Cephalexin, Metoprolol, Xarelto, Hydralazine, Glipizide, Imdur was not administered per the physician orders were significant med errors. On 5/5/2025 at 2:00 PM V12, Medical Director, stated that R3 not receiving his Cephalexin as directed was a significant med error with significant results as R3 was hospitalized and treated for a urinary tract infection. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 5/7/2025 at 12:22 PM V8, RN, stated that she was on duty when R3 was admitted . V8 stated that there were 3 admissions that night. V8 stated that she is not sure who did the admission, but she did not. V8 stated that when she returned on 4/5/2025 she went to give R3 his meds a noticed that there were none. V8 stated that she did not have access to the EKit/emergency kit and did not obtain medications from there. V8 stated that she called the pharmacy, and they stated that they would send the medications out. V8 stated that she did not administer any medication to R3. V8 stated that she checked them off in the computer and put in a note that the medications were not there to give. V8 stated that R3 informed hr that he had not received any of his medication since being admitted to the facility. V8 stated that she called the pharmacy multiple times trying to get the medication. The facility's Physician Order policy, dated 2/2024, documents that GENERAL: Drugs will be administered only upon a clean, complete, and signed order of a person lawfully authorized to presc1ibe. Verbal orders will be received only by licensed nurses or pharmacists and confirmed in writing by the physician. Electronic orders transmitted via NCPDP Script 10.6 will be accepted. RESPONSIBLE PARTY: Nursing POLICY: Documentation of the Medication Order: I. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administrative Record (TAR). 2 The following steps are initiated to complete documentation: a. Clarify the order b. Enter the orders with administration schedule in PCC and transmit to pharmacy.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on record reviews and interviews the facility failed to complete the admission process and transcribe medications to Physician Order Sheet, the Medication Administration Record, obtain medications from the pharmacy and administer medications as ordered by the physician for 1 of 3 (R3) residents reviewed for significant medication errors. This failure resulted in R3 experiencing shortness of breath, heart palpitations, elevated blood glucose levels, untreated Urinary Tract Infection (UTI), R3 feeling like he was going to die, hospitalized and received critical care for untreated Urinary Tract Infection. Findings include: R3's Census Report, not dated, documents that R3 was admitted to the facility on [DATE] with the following diagnoses: AKI on CKD IV non anion gap metabolic acidosis prostatomegaly, Complicated UTI bladder stents, Fracture of left Humerus, Pacemaker, Accelerated Hypertension, Ataxia, Coronary Artery Disease status post CABG, Chronic Diastolic Congestive heart failure, Anemia of Chronic Disease, Paroxysmal Atrial Fibrillation Mobitz second degree block, Prolonged QTc interval, Non-insulin dependent Diabetes Mellitus, uncontrolled diabetes, Hyperglycemia, paraspinal disease, CVA, TIA, PVD status post Stents, CAD status post CABG, Hypertension, Hyperlipidemia, GERD, Hypotension. R3's Minimum Data Set, dated dated [DATE], documents that R3 is cognitively intact. R3's Hospital Discharge Orders, dated 4/2/2025 at 9:52 AM, documents the following 1. Isosorbide Dinitrate Oral Tablet 30 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 2. Aspirin Oral Tablet Delayed Release 81 MG: by mouth one time a day. Give 1 tablet by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10) 3. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for supplement. 4. Levothyroxine Sodium Oral Tablet 50 MCG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for thyroid. 5. glipizide Oral Tablet 10 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for DM before meals. 6. Cephalexin Oral Tablet 500 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for infection. 7. hydralazine HCl Oral Tablet 25 MG: 1 tablet by mouth three times a day. Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours. 8. Metoprolol Tartrate Tablet 50 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 9. Simvastatin Oral Tablet 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for cholesterol. 10. Xarelto Oral Tablet 15 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATRIOVENTRICULAR BLOCK, FIRST DEGREE (I44.0) R3's Progress Notes, dated 4/2/2025 at 7:39 PM, documents that Nurses Notes Note Text: Resting in bed color pale skin w/d warm/dry denies pain sling to left arm in place resident states he can't walk unable to get resident up to br (bathroom) or have access to a bsc (bedside commode). R3's Physician Order Sheet(POS) and Medication Administration Record (MAR), dated April 2025, documents that R3's Hospital discharge orders were transcribed to the POS and the MAR on 4/5/2925. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The E-Rc Message Log, not dated, documents that R3's medication orders were received on 4/5/2025 and processed on 4/6/2025. R3's Medication Administration Record (MAR), dated April 2025, documents no orders for 4/2, 4/3, and 4/4. R3's MAR documents orders transcribed 4/5/2025, 4/7/2025 and 4/8/2025. R3's MAR documents that R3 received 1 dose of Glipizide on 5/5/2025. 1 dose of Xarelto, Simvastatin, Cephalexin, Glipizide, Cyanocobalamin, Metoprolol, Pantoprazole, Isosorbide on 5/6/2025. R3 did not receive Hydrochlorothiazide, Aspirin, Ascorbic Acid, and hydralazine. R3's Progress Notes, dated 4/5/2025 at 8:02 PM, documents that eMAR- Medication Administration Note Text: Cephalexin Oral Tablet 500 MG Give 1 tablet by mouth two times a day for infection awaiting from pharmacy R3's Progress Notes, dated 4/5/2025 9:03 PM, documents that eMAR- Medication Administration Note Text: hydralazine HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours awaiting from pharmacy. R3's Progress Notes, dated 4/6/2025 6:04 AM, documents that eMAR- Medication Administration Note Text: hydralazine HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours awaiting from pharmacy. R3's Progress Notes, dated 4/6/2025 6:05 AM, documents that eMAR- Medication Administration Note Text: Levothyroxine Sodium Oral Tablet 50 MCG Give 1 tablet by mouth one time a day for thyroid awaiting from pharmacy. R3's Progress Notes, dated 4/6/2025 1:12 PM, documents that eMAR- Medication Administration Note Text: hydrALAZINE HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours meds not here from pharmacy. R3's Progress Notes, dated 4/6/2025 16:54 eMAR- Medication Administration Note Note Text: glipiZIDE Oral Tablet 10 MG Give 1 tablet by mouth two times a day for DM before meals not available R3's Progress Notes, dated 4/6/2025 10:11 PM, documents eMAR- Medication Administration Note Text: hydrALAZINE HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours to arrive within hour and bp 120/85, hr 58, 93%spo2 room air. no sob. R3's Progress Notes, dated 4/6/2025 10:13 PM, eMAR- Medication Administration Note Text: Cephalexin Oral Tablet 500 MG Give 1 tablet by mouth two times a day for infection not avail/available. take until gone to arrive am, this nurse called pharm x3 no answer. data entry R3's Progress Notes, dated 4/6/2025 11:04 PM, documents that Nurses Notes Note Text: pt bp 120/85, 58 hr. this nurse called pharm x3 to request med pulls. R3's Progress Notes, dated 4/6/2025 at 11:35 PM, documents that Nurses Notes Note Text: pt hr 56, 20/78. pt spso2 92%, ra, 2 Lo2 applied prn for pt. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R3's Progress Notes, dated 4/7/2025 at 1:30 AM, documents that Nurses Notes Note Text: Resident continues to c/o chest discomfort. He called his wife and stated that he felt like he was going to die. This nurse returned a call to his wife, and she was frantic because she is so far away from the resident. This nurse was able to calm her down and talk to her. Previous nurse put the resident on 2 L of 02. Resident stated he hasn't had any meds in 3 days. He wanted to go to the hospital for evaluation. Resident sent to (Local Hospital). Report given to ER (emergency room) nurse. VS stable. HR 66. Resident took his hearing aids. R3's Progress Notes, dated 4/7/2025 5:12 AM, documents that Nurses Notes Note Text: Resident went to (Local Hospital) instead of (Local Hospital) that was mentioned during transfer. Report from ER nurse that resident has a chronic UTI and is possibly being admitted . Waiting for call back . Wife is aware. The Pharmacy Manifest, dated 4/7/2025, documents that R3's ISOSORB DIN TAB 30MG, PANTOPRAZOLE TAB 40MG, SIMVASTATIN TAB 40MG, XARELTO TAB 15MG, glipiZIDE-10MG-TABS, CEPHALEXIN CAP 500MG, HYDRALAZINE TAB 25MG, LEVOTHYROXIN TAB 50MCG, was delivered at 1:12 AM. Signed by V5, LPN. R3's Metoprolol 50mg was delivered at 7:04 PM. Signed by V9, LPN. The (Local Hospital) Progress Notes, dated 4/7/2025, documents that Chief Complaint: Patient presents with Palpitations. Patient is an [AGE] year-old male with history of Coronary Artery Disease, Diabetes, hyperlipidemia, COPD/Chronic Obstructive Pulmonary Disease, Hypertension, for 4 hour disease, chronic kidney disease, atrial fib, and recent fracture of his left humerus who brought to emergency room for evaluation of palpitations. Patient was recently transferred to (Nursing Facility) from Decatur for rehabilitation 4 days ago. Patient states he has not received any of his routine medications presents coming to this facility. Tonight, he began having palpitations of his heart feeling like it was racing. He denies any chest pain or shortness of breath. He denies any nausea vomiting diarrhea or fever. Critical Care: Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Renal failure (Urinary tract Infection secondary to Enterococcus, Atrial Fib). It also documents that Patient reports emergency room from (Nursing Facility) after being transferred there from Decatur. Patient has multiple medical problems and has been without medical treatment for the past 4 days. He was diagnosed with an Enterococcus Faecalis Urinary Tract Infection at Decatur for which he has not been receiving medications for either. Labs came back with a urinalysis showing 51-150 white blood cells per high-power field. Troponin was negative TSH/Thyroid Stimulating Hormone was negative magnesium was normal CMP/Complete Metabolic Panel normal except for 2.02 creatinine. CBC/Complete Blood Count normal except for 8.4 hemoglobin. Chest x-ray was unremarkable. Went over these results with the patient. Also reviewed his hospital record from Decatur. Patient has multiple medical problems for which he is not being treated currently. I felt he would benefit from coming in and receiving IV antibiotics for his Urinary Tract Infection and he agreed. Also documents Pt/patient to ER 3 via EMS/Emergency Medical Service with c/o/complaints of palpitations starting 4 hours PTA/prior to admission. States he is newly at (Nursing Facility) and has not had his medication in 4 days. Pt is a diabetic, cardiac hx/history with a pacemaker. Denies any chest pain. Cardiac protocol initiated. Blood sugar 570 per EMS. It continues at 5: 12 AM V5 from (Nursing Facility) called at this time also requesting an update. Informed her that patient will possibly be admitted for medication management and urinary tract infection. Facility nurse states the reason patient has not received his daily medications in 4 days is because (Nursing facility) does not have a local pharmacy. She states their pharmacy is based in Chicago and they have not received his medications yet. ERP (emergency room physician) notified. (continued on next page)

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	145427	A. Building B. Wing	05/08/2025

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/1/2025 at 12:12 PM V4, Previous DON, stated that his last day was 4/3/2025 and he is not familiar with R3. V4 stated that the process for new admission is that the admitting nurse will transcribe the orders in PCC (Point Click Care) so that it can be sent to pharmacy. The orders are sent to the pharmacy through the PCC (Point Click Care). There is a triple check system that is in place to assure that the admission is completed correctly. On 5/1/2025 at 12:41 PM, V3, Assistant Director of Nursing (ADON), stated that she was the interim Director of Nursing after V4 left. V3 stated that the admission process is completed by the floor nurse regardless of if they work for the facility or agency. V3 stated that this includes medication and assessments. V3 stated that neither were completed timely. V3 stated that she became aware of R3 not receiving his medications on the Sunday prior to his transfer to hospital. V3 stated that the medication should have been transcribed upon admission. V3 stated that it takes 24 hours for an admission to be completed but the medications are to be transcribed within the first couple of hours of the admission. V3 stated that she is not sure why the medications were not transcribed and assessments completed. V3 stated that the admitting nurse was from an agency. V3 stated that the agency nurses can and are expected to complete the admission. V3 stated that there is a triple check system that is in place but was not done either. V3 stated that if the triple check would have been completed this would have prevented R3 from missing his medications that he needed, transfer to hospital and assessment would have been completed. V3 stated that the floor nurse regardless of if she works for the facility or agency is knowledgeable and capable of completing the admission. V3 stated that the medications are a priority and should have been taken care of. V3 stated that they only have 4 facility staffed nurses and they are all scheduled on the other side of the building. V3 stated that the nurses that provided care for R3 was agency. V3 stated that nurse mangers are to audit the admission and make sure it is completed, this was not done either. This includes medications and assessments. On 5/1/2025 at 2:33 PM V5, LPN, stated that she works for an agency and was in the facility when R3 was admitted , and V5 sent R3 to the hospital on 4/7/2025. V5 stated that the night of the admission she worked on the other hall and the nurse had 3 admissions. V5 stated that she took an admission, V8, RN, took one and V3, ADON, took one. V5 stated that V3 took R3's hospital records home so she could work on them remotely. V5 stated that the orders did not get transcribed until the 5th. V5 stated that when she started her shift, she was informed by the previous nurse that R3 wasn't feeling well and O2 had been applied. V5 stated that she went down to the room to check on R3 and perform assessment. V5 stated that R3 complained of not feeling well. O2 was in place at 2 liters. V5 stated that at that time R3 did not appear to be in any distress. V5 stated that R3 voiced concern about not receiving his medication. V5 stated that she went to the cart and R3 had orders but no medication. V5 stated that she did receive a delivery shortly after that. V5 stated that she continued to monitor R3. V5 stated that she received a call from V16, R3's wife, who voiced concern about R3. V5 stated that R3 had called his wife and informed her that he was not feeling well. V5 stated that she went down to R3's room and he complained of feeling pressure in his chest and feeling like he was going to die. V5 stated that she performed her assessment and called to transfer resident to hospital because he was having chest discomfort. V5 stated that she called V16 back and told her that she was sending R3 to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/1/2025 at 2:50 PM V6, LPN, verified that she worked at the facility 4/3/2025 and 4/4/2025. V6 stated that she doesn't remember R3 and not aware of the admission. V6 stated that she is an agency nurse and is responsible for admitting resident to the facility. V6 stated that she gets the hospital documentation, put them (patient) in the system, then verify the orders and transcribe them into the computer. The orders are sent to the pharmacy after transcribed. V6 stated that during the admission process the resident is assessed and oriented to the facility. On 5/1/2025 at 2:42 PM V7, RN, verified that she worked on 4/5/2025. V7 stated that she did not administer medication to R3 and did not access the EKit to obtain medications for R3. On 5/5/2025 at 12:06 PM V10, Pharmacist, stated that R3 not receiving his Cephalexin, Metoprolol, Xarelto, hydralazine, glipizide, Imdur was not administered per the physician orders were significant med errors. On 5/5/2025 at 2:00 PM V12, Medical Director, stated that R3 not receiving his Cephalexin as directed was a significant med error with significant results as R3 was hospitalized and treated for a urinary tract infection. On 5/7/2025 at 12:22 PM V8, RN, stated that she was on duty when R3 was admitted . V8 stated that there were 3 admissions that night. V8 stated that she is not sure who did the admission, but she did not. V8 stated that when she returned on 4/5/2025 she went to give R3 his meds and noticed that there were none. V8 stated that she did not have access to the EKit and did not obtain medications from there. V8 stated that she called the pharmacy, and they stated that they would send the medications out. V8 stated that she did not administer any medication to R3. V8 stated that she checked them off in the computer but had not administered any and put in a note that the medications were not there to give. V8 stated that R3 informed her that he had not received any of his medication since being admitted to the facility. V8 stated that she called the pharmacy multiple times trying to get the medication. On 5/7/2025 at 3:24 PM V9, LPN, stated that she was on vacation when R3 was admitted . V9 stated that when she returned, she worked the floor, 4/5/2025. V9 stated that R3 informed her that he had not received his medication since being at the facility. V9 stated that she noticed that R3 did not have any medications or orders. V9 stated that she went to look through the chart and found the discharge orders in the miscellaneous section of the chart. V9 stated that she entered the medication in the computer and notified the pharmacy. V9 stated that the admission process has many steps. V9 stated that the admitting nurse completes the orders, skin check and oriented to facility. The next nurse will complete the rest. The admission is then reviewed by the managers. This is to prevent this from happening. V9 stated that V3 would have been the one to follow up because she (V9) was on vacation. V9 stated that she asked how this happened. V9 stated that she was concerned because it went for such a long time and through so many people. V9 stated that she asked what happened and received no answer. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/7/2025 at 4:50 PM V13, RN, stated that she worked on 5/6/2025. V13 stated that she worked a 4-hour shift. V13 stated during her shift R3's medications had not come into the facility. V13 stated that she called the pharmacy and was informed that they would be out that night. V13 stated that R3 was complaining of not feeling well. V13 stated that she assessed R3 and noted that his pulse was low. V13 stated that R3 did not complain of shortness of breath but thought she should get a concentrator just in case. V13 stated that the oxygen was applied and R3 seemed stable. V13 stated that she notified the nurse in report. The facility's Admission/Re-Admission policy, dated 4/2024, documents that GENERAL: The facility will ensure that all residents have necessary assessments completed in a timely manner at the point of admission in order to provide the best possible, person-centered care. Responsible Party: All Staff POLICY: I. All new and re-admissions that have been out of the facility for longer than 24 hours should be assessed within 1 hour of arriving to the facility by a licensed nurse to ensure stability and safety of resident. Within 24 hours of admission, the following PCC Forms should be completed: a. NRSG: Admission Observation b. NRSG: Interim Baseline Care Plan c. NRSG: Fall Risk Evaluation d. Braden's Scale for Predicting Pressure Sore Risk e. Comprehensive Pain Evaluation f. Call Light Ability Screen g. All medications should be reconciled with the resident/resident representative and verified with the primary physician or nurse practitioner. h. Physician order sheet should reflect any standing orders specific to the resident as well as medications and treatments that are ordered throughout the stay. 2. All consents that are applicable to the resident, including but not limited to; influenza vaccine. pneumonia vaccine, psychotropic medications, and COVID-19 vaccine and testing should be obtained throughout the admission process. 3. All necessary admission information discussed above will be documented in the resident's clinical record. The facility's Physician Order policy, dated 2/2024, documents that GENERAL: Drugs will be administered only upon a clean, complete, and signed order of a person lawfully authorized to presc1ibe. Verbal orders will be received only by licensed nurses or pharmacists and confirmed in writing by the physician. Electronic orders transmitted via NCPDP Script 10.6 will be accepted. RESPONSIBLE PARTY: Nursing POLICY: Documentation of the Medication Order: I. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administrative Record (TAR). 2 The following steps are initiated to complete documentation: a. Clarify the order b. Enter the orders with administration schedule in PCC and transmit to pharmacy.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on record reviews and interviews the facility failed to transcribe medications to Physician Order Sheet, the Medication Administration Record, obtain medications from the pharmacy and administer medications as ordered by the physician for 1 of 3 (R3) residents reviewed for significant medication errors. This failure resulted in R3 experiencing shortness of breath, heart palpitations, untreated urinary tract infection and R3 feeling like he was going to die. Findings include: 1.x R3's Census Report, not dated, documents that R3 was admitted to the facility on [DATE] and discharged from the facility on 4/7/2025 with the following diagnoses: AKI on CKD IV non anion gap metabolic acidosis prostatomegaly, Complicated UTI bladder stents, Fracture of left Humerus, Pacemaker, Accelerated Hypertension, Ataxia, Coronary Artery Disease status post CABG, Chronic diastolic congestive heart failure, Anemia of chronic disease, Paroxysmal Atrial Fibrillation Mobitz second degree block, Prolonged QTc interval, Non-insulin dependent diabetes mellitus, uncontrolled diabetes, Hyperglycemia, paraspinal disease, CVA, TIA, PVD status post Stents, CAD status post CABG, Hypertension, Hyperlipidemia, GERD, Hypotension. R3's Minimum Data Set, dated dated [DATE], documents that R3 is cognitively intact. R3's Hospital Discharge Orders, dated 4/2/2025 at 9:52 AM, documents the following 1. Isosorbide Dinitrate Oral Tablet 30 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 2. Aspirin Oral Tablet Delayed Release 81 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10) 3. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for supplement. 4. Levothyroxine Sodium Oral Tablet 50 MCG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for thyroid. 5. glipizide Oral Tablet 10 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for DM before meals. 6. Cephalexin Oral Tablet 500 MG: 1 tablet by mouth two times a day. Give 1 tablet by mouth two times a day for infection. 7. hydralazine HCl Oral Tablet 25 MG: 1 tablet by mouth three times a day. Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) every 8 hours. 8. Metoprolol Tartrate Tablet 50 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) 9. Simvastatin Oral Tablet 40 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day for cholesterol. 10. Xarelto Oral Tablet 15 MG: 1 tablet by mouth one time a day. Give 1 tablet by mouth one time a day related to ATRIOVENTRICULAR BLOCK, FIRST DEGREE (I44.0) R3's Physician Order Sheet (POS) and Medication Administration Record (MAR), dated April 2025, documents that R3's Hospital discharge orders were transcribed to the POS and the MAR on 4/5/2925. R3's Medication Administration Record (MAR), dated April 2025, documents no orders for 4/2, 4/3, and 4/4. R3's MAR documents orders transcribed 4/5/2025, 4/7/2025 and 4/8/2025. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R3's MAR documents that R3 received 1 dose of Glipizide on 5/5/2025. 1 dose of Xarelto, Simvastatin, Cephalexin, glipizide, Cyanocobalamin, Metoprolol, Pantoprazole, Isosorbide on 5/6/2025. R3 did not receive Hydrochlorothiazide, Aspirin, Ascorbic Acid, and hydralazine. On 5/1/2025 at 12:12 PM V4, Previous DON, stated that his last day was 4/3/2025 and he is not familiar with R3. V4 stated that the process for new admission is that the admitting nurse will transcribe the orders in PCC (Point Click Care) so that it can be sent to pharmacy. The orders are sent to the pharmacy through the PCC. There is a triple check system that is in place to assure that the admission is completed correctly. On 5/1/2025 at 12:41 PM, V3, Assistant Director of Nursing (ADON), stated that she was interim Director of Nursing after V4 left. V3 stated that the admission process is completed by the floor nurse regardless of if they work for the facility or agency. V3 stated that she became aware of R3 not receiving his medications on the Sunday prior to his transfer to hospital. V3 stated that the medication should have been transcribed upon admission. V3 stated that it takes 24 hours for an admission to be completed but the medications are to be transcribed within the first couple hours of the admission. V3 stated that she is not sure why the medications were not transcribed. V3 stated that the admitting nurse was from an agency. V3 stated that the agency nurses can and are expected to complete the admission. V3 stated that there is a triple check system that is in place but was not done either. V3 stated that this would have been completed by the following nurses which were agency nurses as well. V3 stated that they only have 4 facility staffed nurses and they are all scheduled on the other side of the building. V3 stated that the nurses that provided care for R3 was agency. On 5/1/2025 at 2:33 PM V5, LPN, stated that she was in the facility when R3 was admitted , and V5 sent R3 to the hospital. V5 stated that the night of the admission she worked on the other hall and the nurse had 3 admissions. V5 stated that she took an admission, V8, RN, took one and V3, ADON, took one. V5 stated that V3 took R3's hospital records home so she could work on them remotely. V5 stated that the orders did not get transcribed until the 5th. On 5/5/2025 at 12:06 PM V10, Pharmacist, stated that R3 not receiving his Cephalexin, Metoprolol, Xarelto, Hydralazine, Glipizide, Imdur was not administered per the physician orders were significant med errors. On 5/5/2025 at 2:00 PM V12, Medical Director, stated that R3 not receiving his Cephalexin as directed was a significant med error with significant results as R3 was hospitalized and treated for a urinary tract infection The facility's Physician Order policy, dated 2/2024, documents that GENERAL: Drugs will be administered only upon a clean, complete, and signed order of a person lawfully authorized to presc1ibe. Verbal orders will be received only by licensed nurses or pharmacists and confirmed in writing by the physician. Electronic orders transmitted via NCPDP/National Council for Prescription Drug Programs Script 10.6 will be accepted. RESPONSIBLE PARTY: Nursing POLICY: Documentation of the Medication Order: I. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administrative Record (TAR). 2 The following steps are initiated to complete documentation: a. Clarify the order b. Enter the orders with administration schedule in PCC and transmit to pharmacy.