STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225474	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49424 Based on a resident group meeting, interviews, and record reviews, the facility failed to ensure concerns from the Resident Council were thoroughly documented to ensure the residents felt their concerns were acted upon timely and included the facility response to the group. Findings include: Review of the facility's policy titled Grievance, revised 3/22, indicated but was not limited to the following: The Resident Council is an additional forum within the facility for voicing complaints/grievances. Complaints/grievances received from this council will be acted upon by this procedure. Review of Resident Council minutes, dated 11/21/24 through 4/30/25, indicated residents voiced concerns with long call bell wait times at five out of six Resident Council meetings held. Review of the Resident Council resolution plan, dated 11/21/24, indicated audits were ongoing with no additional follow-up noted. The facility was unable to provide Resident Council resolution or follow-up for call light concerns identified in the January minutes and February minutes. During an interview on 5/5/25 at 11:14 A.M., the Resident Council President said he/she does not feel the resident group meetings are productive. He/She has said they have served as the president of the council for over a year and the most discussed concern continues to be long call bell wait times. He/She said they were not aware of any follow-up from the concerns raised at the Resident Council meetings. On 5/5/25 at 1:00 P.M., the surveyor held a group meeting with six residents in attendance. The residents shared the following information: -The concern regarding call bell wait times was brought up every month with no resolution, improvement, or follow-up from the staff on what the facility was doing to reduce call bell wait times. (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/5/25 at 1:55 P.M., the Activities Director said if follow up was required after the meetings, she would complete a Resident Council Follow-up form and give it to the department responsible for completing. She said she would expect that the department would follow up with the Residents regarding the response. She said she could not answer any questions about Resident Council group meetings prior to 4/30/25 as she was not working at the facility. During an interview on 5/7/25 at 12:20 P.M., the Director of Operations said he expected the grievance policy to be followed completely and expected staff to follow-up on concerns brought forth at the Resident Council meetings.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49424 Based on interview, observation, and document review, the facility failed to ensure residents had the right to voice and formulate grievances, have those grievances responded to promptly, and be provided a resolution to their grievance. Specifically, the facility failed to: 1. Investigate and address voiced grievances; and 2. Ensure residents had access to grievance/concern forms to submit grievances anonymously, should they choose not to alert a staff member to their concern. Findings include: Review of the facility's policy titled Grievance, last revised 3/2022, indicated but was not limited to: -The resident and/or resident representative will be made aware of the right to voice grievances orally, in writing, and anonymously. -If a resident, and/or health care representative, or another interested family member of a resident has a complaint, a staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the Grievances/Complaint Report form. -Grievances and complaints may be submitted orally or in writing. The resident, and/or health care representative, or the person filing the grievance or complaint on behalf of the resident, should be encouraged to sign written complaints or grievances. If the person filing the grievance is anonymous or wishes to remain anonymous, confidentiality will be maintained, to the extent possible. During a tour of the facility on 5/5/25 at 8:00 A.M., the surveyor was unable to find any information regarding the grievance process posted in resident care areas. The surveyor observed information regarding how to file grievance in the main lobby which was not accessible to all residents. Review of the facility grievance binder on 5/4/25 at 2:30 P.M., indicated the last grievance was resolved on 3/31/25. On 4/7/25 at 1:00 P.M., the surveyor held a resident group meeting with six residents, representing each of the facility's two units, in attendance. The residents said they had not seen any postings about the grievance process and did not know how to file a grievance. The residents said the only way they knew how to submit a grievance was to report the problem to a staff member. One resident said he/she thought they saw grievance forms by the elevator but was not sure and did not know who the grievance officer was. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/5/25 at 4:37 P.M., the Administrator said he had been in the Administrator role for about one month and was unsure about the grievance process prior to his tenure. The Administrator said he expected any staff member responsible for resolving a grievance to follow up with residents about that grievance and to discuss the outcome. The Administrator said the facility's grievance officer and the person responsible for keeping track of the grievance process was the social worker. During an interview on 5/6/25 at 11:09 A.M., the Ombudsman said she reported concerns and grievances to administration, however, she was unsure if reported concerns were being addressed or handled as a grievance. The Ombudsman said the facility had not provided her with any updates or resolutions for the concerns she reported. The Ombudsman said, similarly, the residents she had been communicating with were also not updated on their reported concerns and grievances. During an interview on 5/6/25 at 11:59 A.M., the Social Worker said the Administrator was the grievance officer for the building. The Social Worker said she gave resident concerns and grievance forms to the Administrator. During an interview on 5/5/25 at 1:55 P.M., the Activities Director said she was unsure who the facility grievance officer was, and she was unsure who was responsible for providing residents with grievance updates and resolutions.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 46562 Based on Minimum Data Set (MDS) assessment review and staff interview, the facility failed to ensure staff completed the Quarterly MDS assessment within the required timeframe for five Residents (#49, #63, #1, #4, and #27), out of five residents reviewed for overdue assessments. Findings include: The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment. A Quarterly MDS assessment is considered timely if the Assessment Reference Date (ARD) of the Quarterly MDS is completed within 92 days of the most recent OBRA Assessment reference date (Admission, Annual, Quarterly, or a Significant Change in Status Assessment), and the completion date must be no later than 14 days after the ARD. 1. Resident #49 was admitted to the facility in April 2021. Review of Resident #49's quarterly MDS assessment, dated 3/19/25, indicated it was not completed until 5/1/25, a total of 30 days late. 2. Resident #63 was admitted to the facility in September 2023. Review of Resident #63's quarterly MDS assessment, dated 3/19/25, indicated it was not completed until 5/1/25, a total of 30 days late. 3. Resident #1 was admitted to the facility in January 2023. Review of Resident #1's quarterly MDS assessment, dated 3/26/25, indicated it was not completed until 5/4/25, a total of 26 days late. 4. Resident #4 was admitted to the facility in July 2022. On 5/5/25, the surveyor reviewed Resident #4's quarterly MDS assessment, dated 4/2/25, which indicated the assessment had not been completed. 5. Resident #27 was admitted to the facility in October 2023. On 5/5/25, the surveyor reviewed Resident #27's quarterly MDS assessment, dated 3/26/25, which indicated the assessment had not been completed. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/5/25 at 1:00 P.M., the Regional Nurse reviewed the MDS assessments and said the assessments for Residents #49, #63, #1, #4, and #27 had not been completed within 14 days of the ARD. The Regional MDS Nurse said quarterly MDS assessments should be completed within 14 days of the ARD.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49424 Based on interview and record review, the facility failed to accurately complete a Level I Pre-admission Screening and Resident Review (PASARR) for one Resident (#35), out of a total sample of 18 residents, resulting in Resident #35 being admitted to the facility without the determination of whether he/she screened positive for intellectual disability (ID)/developmental disability (DD) or serious mental illness (SMI) requiring further evaluation. Findings include: Resident #35 was admitted to the facility in February 2025 with diagnoses including post-traumatic stress disorder (PTSD), major depressive disorder, and anxiety disorder. Review of Resident #35's Minimum Data Set (MDS) assessments indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Further review of the assessments listed multiple other mental health diagnoses upon admission to the facility. Review of Resident #35's Level I PASARR indicated: -The Level I PASARR was submitted for review after admitting into the facility. -The Resident subsequently required a Level II PASARR evaluation to be completed. Review of the Resident's record indicated that a Level II PASARR evaluation was completed on 3/4/25 and the Resident met the criteria for SMI and specialized services and/or behavioral health services were required to meet the needs of the Resident while in the nursing facility. During an interview on 5/6/25 at 11:59 A.M., Social Worker #1 said the Level I PASARR should be completed prior to a resident's admission to ensure that the facility is able to meet the needs of the residents. Social Worker #1 said she was not here at the time Resident #35 was admitted and was unable to find documentation the Level I PASARR was submitted prior to Resident #35's admission to the facility. During an interview on 5/6/25 at 3:54 P.M., the Director of Operations said there was no additional information or evidence to provide to indicate the Level I PASARR was completed prior to admission. He said it is the expectation for staff to complete Level I PASARRs for residents before they are admitted into the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49424 Based on observation, interview, and record review, the facility failed to implement the person-centered plan of care for two Residents (#20 and #69), out of 18 sampled residents. Specifically, the facility failed to: 1. Implement the care plan for Resident #20 which indicated that the Resident required two staff for all care; and 2. Follow the plan of care for Resident #69 to wear eyeglasses. Findings include: 1. Resident #20 was admitted to the facility in June 2023 with diagnoses including but not limited to cerebral infarction. Review of Resident #20's care plan indicated but was not limited to: Focus: Behavior problems, sexually inappropriate and accusatory, revised 8/1/23; Goal: Resident will have fewer episodes of accusations and sexually inappropriate statements, revised 5/24/24; Interventions: 2 people always, date initiated 8/1/23. On 5/5/25 at 9:23 A.M., the surveyor observed Resident #20 in their wheelchair being brought out of his/her room by Certified Nursing Assistant (CNA) #3. During an interview with observation on 5/5/25 at 9:23 A.M., CNA #3 said she completed the Resident's care by herself, and that the Resident hadn't had any recent behaviors that she was aware of. She said she had recently provided care to him/her by herself before with no issues. During an interview on 5/6/25 at 8:33 A.M., Unit Manager #1 said Resident #20 still required two people for all care because he/she had a history of accusatory behaviors and could be sexually inappropriate. She said, as an example, the Resident would say staff did something that they didn't do, therefore two people for all care was to protect the Resident and the staff providing care from unfounded accusations. During an interview with on 5/6/25 at 8:38 A.M., CNA #4 said she took care of the Resident last week by herself on the 7 A.M. to 3 P.M. shift and most recently she had cared for the Resident on the 3 P.M. to 11 P.M. shift by herself. She said the Resident was very nice and she had no issues providing care to the Resident by herself with no other staff present. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 12:10 P.M., the Director of Nurses (DON) said CNAs should have access to the information in the electronic health record regarding residents who require two staff members and staff should be following a resident's care plan at all times. The DON said she expected staff to implement Resident #20's care plan requiring two staff members present at all times during Resident care. 36542 2. Resident #69 was admitted to the facility in February 2024. Review of the Minimum Data Set (MDS) assessment, dated 2/21/25, indicated Resident #69 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had a moderate cognitive impairment. Review of the MDS indicated Resident #69 had impaired vision and wore corrective lenses. During an interview on 5/4/25 at 10:15 A.M., Resident #69 said he/she could not see the surveyor because they did not have their glasses and was not sure where they were. Review of a care plan for Resident #69, initiated on 2/17/24, indicated Resident #69 had impaired visual function, with a goal of using appropriate visual devices (glasses) to promote participation in activities of daily living and other activities with a target date of 5/22/25. The care plan indicated the following interventions: ensuring glasses are available to support participation in activities, ensure Resident is wearing glasses which are clean, free from scratches and in good repair and to report any damage to the nurse and family. On 5/5/25 at 11:30 A.M., the surveyor observed Resident #69 in the unit day room, not wearing eyeglasses. During an interview on 5/5/25 at 12:05 P.M., CNA #1 said she was the assigned CNA for the Resident on this day. She said the staff switch assignments every month and had just switched in May and could not recall if Resident #69 wore glasses. During an interview on 5/5/25 at 12:06 P.M., CNA #2 said she was familiar with Resident #69 and could not recall if the Resident wore glasses. During an interview on 5/5/25 at 1:15 P.M., Unit Manager #1 said she had been the Unit Manager on this unit for about a year and a half. Unit Manager #1 said Resident #69 did not wear glasses. When the surveyor inquired about the care plan and the MDS indicating Resident #69 wore glasses, the Unit Manager said the Resident has glasses but does not wear them and the glasses must be in the Resident's room. During an interview on 5/5/25 at 1:40 P.M., Unit Manager #1 said she looked in the Resident's room and was unable to locate the Resident's glasses and would need to call the Resident's son to follow up. She said the staff do not keep eyeglasses in the medication cart and she was not sure where else they could be. The surveyor inquired about plastic drawers on the desk at the nurses' station, one with a drawer labeled glasses. She said those were glasses that were unlabeled so they were not sure who they belonged to. The surveyor opened the drawer labeled scrap paper and found four pairs of glasses, one labeled with a current resident's name. The surveyor opened the drawer labeled glasses and found 7 pairs of glasses, one labeled with a current resident's name. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/5/25 at 5:00 P.M., the Unit Manager said she spoke with the Resident's son who said the Resident's glasses had been missing and he would like assistance in getting the Resident a new pair. The Unit Manager said at care plan meetings the team reviews family concerns or any issues that have occurred throughout the quarter but they do not review each individual care plan. She said she, as the unit manager, will add a new target date to the care plans, but must have missed that Resident #69 had glasses. During an interview on 5/5/25 at 6:55 P.M., the son/Health Care Proxy of Resident #69 said the Resident had been at the facility for a little over a year. He said the Resident was wearing eyeglasses until about 2 months ago when the eyeglasses went missing; he could not be sure of the exact timeframe. He said he had come in one day and the glasses were gone; he had left a note for Unit Manager #1, had asked the staff, had checked with laundry and was unable to locate the glasses. He said he felt the facility was working on finding the glasses or replacing them, but he was not sure what the plan was.

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on record review, interview, and observation, the facility failed to ensure a physician and/or the physician assistant (PA) provided supervision and oversight for the care of one Resident (#40) with a known history of an organ transplant, out of a total sample of 18 residents, who required the daily use of tacrolimus (Prograf, an immunosuppressant medication used to prevent transplanted organ rejection). Specifically, the physician and PA failed to: 1. Identify that tacrolimus was discontinued after a recent hospitalization , resulting in a total of 40 missed doses; and 2. Address and intervene on abnormal tacrolimus level laboratory values, leading to the Resident's emergent hospitalization for organ transplant rejection surveillance and medication management. Findings include: Review of the facility's policy titled Labs and Diagnostics, revised 4/2022, indicated, but was not limited to, the following: -Assessment and Recognition 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. -Physician Responses 1. Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. a. A physician should respond within one hour regarding a lab result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response. b. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. When necessary to help explain clinical decisions, a physician or mid-level practitioner should document the basis for conclusions about how the results were addressed; for example, at the next scheduled or interim visit. Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and heart transplant. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 3/30/25, indicated Resident #40 was cognitively intact, as evidenced by a Brief Interview for Mental Status score of 15 out of 15, was dependent on staff for activities of daily living, and had diagnoses including heart failure and organ transplant. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025. Review of the hospital After Visit Summary, dated 2/27/25, indicated, but was not limited to, the following: -Resident #40 was admitted to the hospital in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. -Resident #40's tacrolimus level laboratory result, obtained via a blood draw from the Resident on 2/26/25, was 6.4 nanograms per milliliter (ng/ml). The Resident's goal tacrolimus level was 4-6 ng/ml -Upon discharge, the Resident should start taking tacrolimus 2 milligrams (mg) each day at 9 A.M. and 3 mg each day at 9 P.M. The dosing was reduced from the Resident's previous dosing (3 mg twice daily) due to elevated tacrolimus levels noted during his/her hospital stay. -A tacrolimus level should be obtained and sent to the hospital's heart failure team on 3/3/25 and the heart failure team would provide recommendations for ongoing dosing of tacrolimus. Review of Resident #40's current Physician's Orders indicated the following: - Fax tacrolimus level results to [fax number redacted] every month between the 7th and the 11th of every month for immunosuppressive therapy (order start date 7/10/24). Further review indicated the fax number was directed to Resident #40's cardiologist's office. -No tacrolimus was prescribed to the Resident from 2/28/25 until 3/19/25. -Review of the current Physician's Orders failed to indicate an order for a tacrolimus level on 3/3/25 as indicated in the Resident's hospital After Visit Summary 2/27/25. Review of Resident #40's laboratory results indicated, but was not limited to, the following: -On 3/6/25, the Resident had a tacrolimus level drawn (three days after the recommended draw date). The tacrolimus level resulted low at 1.2 ng/ml on 3/11/25 at 4:06 P.M. and were marked as reviewed by the PA on 3/13/25 at 12:45 P.M. There was no additional documentation or new orders from the PA entered in the Resident's record at that time. Review of Resident #40's February 2025 and March 2025 Medication Administration Record indicated the Resident missed 40 doses of tacrolimus that he/she should have received in the facility from 2/27/25 through 3/19/25. Review of Resident #40's Progress Notes indicated, but was not limited to, the following: (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 2/27/25, a progress note was entered by the PA. The note indicated that the Resident had a prolonged hospitalization for CHF exacerbation and urinary tract infection and that the Resident's history was significant for organ transplant. The medication list, included in the PA's progress note, indicated the Resident was taking tacrolimus 1 mg two capsules in the morning. The PA's note failed to identify the change in the Resident's tacrolimus regimen to include the additional dose of 3 mg each day at 9 P.M. Additionally, the PA's progress note failed to indicate the follow-up tacrolimus level monitoring to be drawn on 3/3/25, as recommended by the hospital. -On 2/28/25, a progress note was entered by the physician. The physician documented in her note that the Resident was transferred to the hospital on February 22 and returned to the facility on [DATE]. The physician indicated the Resident was hospitalized due to change in mental status, nausea, and tremors and was treated with antibiotics for a urinary tract infection. The physician indicated the Resident was on immunosuppression with prednisone and tacrolimus and was at high risk of complications and infections. The medication list, included in the physician's note, indicated the Resident was taking tacrolimus 1 mg two capsules in the morning. The physician's note failed to identify the change in the Resident's tacrolimus regimen to include the additional dose of 3 mg each day at 9 P.M. Additionally, the physician's progress note failed to indicate the follow-up tacrolimus level monitoring to be drawn on 3/3/25, as recommended by the hospital. -On 3/19/25, a progress note was entered by the physician. The physician's note indicated the nursing notes, vital signs, and medications available in the Resident's electronic health record (EHR), prior external notes, and hospital discharge summary were reviewed. The physician documented that the Resident had received an organ transplant in 2021 and that she was contacted by the Cardiology RN in regard to Resident #40's low tacrolimus level of 1.2 ng/ml. The note indicated the Cardiology RN had discussed the Resident's medication regimen with staff at the facility and it appeared that the Resident had missed his/her tacrolimus since he/she was readmitted to the facility on [DATE] and was supposed to receive tacrolimus twice daily. The physician confirmed with nursing staff that the Resident had not received the tacrolimus and was later informed that the Cardiology RN had called the facility and recommended the Resident be transferred to the hospital for intravenous steroid treatment. Despite the documentation written in the physician's progress note, the medication list included in the progress note again indicated the Resident was taking tacrolimus 1 mg two capsules in the morning and provided no indication of the 9 P.M. tacrolimus dose the Resident should have received but did not. Review of documentation received from Resident #40's consulting cardiology team indicated that on 3/19/25, the Cardiology RN spoke with the Resident's physician at the facility and the physician was unaware of the critical tacrolimus lab value and discontinuation of tacrolimus. During a telephonic interview on 5/7/25 at 1:01 P.M., the physician said the Resident's tacrolimus didn't make it onto his/her medication list at the facility. The physician said the medication was to be used to prevent organ rejection as the Resident had received an organ transplant. The physician said she was made aware of the omission on 3/19/25 when she was informed by the Cardiology RN at the hospital. The physician could not recall being contacted about Resident #40's tacrolimus lab results on 3/11/25, despite being reviewed by the PA. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephonic interview on 5/7/25 at 1:39 P.M., the PA said he was aware of the medication error and had seen Resident #40 in between his/her readmission to the facility on [DATE] and transfer back to the hospital on 3/19/25. The PA said he could not recall when he was made aware of the medication error but if he had been aware of it before the Resident was transferred back to the hospital, he would have restarted the medication at that time. The PA said that he was aware the Resident's tacrolimus level had resulted low on 3/11/25, and said the results should be faxed to cardiologist for review. The PA said he was unaware if the results had been sent to the cardiologist because that is something the nursing staff would do and he did not follow up with nursing to ensure the results were communicated to the Resident's cardiologist. The PA further said he was unaware the Resident had not received the medication at the time the lab value was obtained. During a subsequent interview with record review on 5/8/25 at 1:48 P.M., the PA said he did not recall the date that he became aware of Resident #40's abnormal tacrolimus level in March 2025, but thought it was around the same time the Resident went out to the hospital and the nurses called him for the order to transfer the Resident. The PA said he reviewed the lab but would not make changes to the Resident's tacrolimus regimen despite abnormal tacrolimus levels because the Resident's tacrolimus labs and dosing are managed by the cardiology office. The PA said the results of the Resident's labs drawn at the facility are forwarded to the cardiology office by the facility staff and the cardiologist will review and make any new dosing recommendations, which he or the Resident's attending physician would then review. Further review of Resident #40's medical record failed to indicate that the PA or physician adequately reviewed the hospital discharge/cardiology recommendations or followed up with nursing to ensure the resident's medical care was supervised by the facility's physician services. Refer to F760

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 46562 Based on document review and interview, the facility failed to ensure residents were provided Physician/Nurse Practitioner (NP)/Physician's Assistant (PA) visits every 30 days within the first 90 days of admission and then every 60 days thereafter for two Residents (#65 and #30), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #65, to ensure the Resident was seen by a Physician within 30 days of his/her admission to the facility; and 2. For Resident #30, to ensure required visits alternated between the Physician and NP. Findings include: Review of the facility's policy titled Physician Services and Discipline Recommendations, dated as revised March 2022, indicated but was not limited to the following: Policy Statement: The medical care of each resident is under the supervision of a Licensed Physician; Policy Interpretation and Implementation: -The physician will perform pertinent, timely medical assessments; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage; -Physician visits, frequency of visits, emergency care of residents, etcetera, are provided in accordance with current Omnibus Budget Reconciliation Act (OBRA, a series of laws passed by Congress which set minimum standards of care for nursing homes) regulations and facility policy. 1. Resident #65 was admitted to the facility in June 2024 with diagnoses which included spinal cord injury and paraplegia. Review of Resident #65's physician progress notes and assessments indicated he/she had not been seen by a physician until 11/8/24, five months after his/her admission. On 5/6/25 at 4:49 P.M., the Regional Director of Operations provided the surveyor with Resident #65's provider notes. Review of the provider notes failed to include a physician visit prior to 11/8/24. During an interview on 5/7/25 at 9:05 A.M., the Regional Director of Operations (RDO) said there was no evidence Resident #65 had been seen by a physician prior to 11/8/24 and the facility had no additional documentation to provide. The RDO said new admissions should be seen by a physician within 30 days. 49428 (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #30 was admitted to the facility in November 2020 with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy, dysarthria following cerebral infarct, hemiplegia and hemiparesis, pain, and major depressive disorder. Review of Physician progress notes and assessments indicated Resident #30 had not been seen by a Physician during the timeframe of 6/4/24 through 12/19/24, for a total of 199 days. During an interview on 5/7/25 at 9:00 A.M., the RDO reviewed Resident #30's Physician's notes and said the Physician must see residents every 60 days; visits can alternate between the Physician and NP/PA. The RDO said during the 199-day period from June to December 2024, Resident #30 was not visited by the Physician every 60 days and visits during that time did not alternate between the Physician and the NP/PA. The RDO said the Resident should have been seen more frequently by the Physician.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on observation, record review, and interviews, the facility failed to ensure licensed nursing staff were competent in immunosuppressant drug therapy resulting in: a. failure to identify the adverse discontinuation of a necessary immunosuppressant medication (tacrolimus) for the prevention of organ rejection for one Resident (#40) in a sample of 18 residents; and b. failure to communicate with the practitioner about abnormally low tacrolimus level laboratory results for Resident #40, readmitted to the facility with a known history of heart transplant, resulting in emergent hospitalization in March 2025 for transplanted organ rejection surveillance and medication regimen adjustments. Findings include: Review of the Facility Assessment, updated 4/25/25 and reviewed by the QAPI Committee on 4/28/25, indicated: -Services and Care We Offer Based on our Residents' Needs Medications: Awareness of any limitations of administering medications Administration of medications that residents need Management of medical conditions: Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure -Staff training/education and competencies Once the new staff member has completed the classroom orientation, they are partnered with a member to learn the specifics of their role. The mentor trains and completes a competency check list to assure the staff has received the proper training and can perform the necessary tasks related to their role and according to [Facility Name's] standards. Once competency is evaluated and successfully completed, they can assume their position autonomously. If any deficits are identified, additional training is provided. The staff is then provided with regular in-service opportunities and evaluations at least annually, to identify any additional dementia training, and a corporate compliance review. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled Change in Condition in a Resident Status, effective 3/2017, indicated, but was not limited to, the following: -The Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: *A need to alter the resident's medical treatment significantly *Abnormal laboratory reports *A need to transfer the resident to a hospital/treatment center Review of the facility's policy titled Labs and Diagnostics, revised 4/2022, indicated, but was not limited to, the following: -Review by Nursing Staff 1. A nurse will review all results. -Deciding How Urgently to Contact the Physician 1. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. 2. A nurse will try to determine whether the test was done a. As a routine screen or follow-up; b. To assess a condition change or recent onset of signs and symptoms; or c. To monitor a drug level. -Identifying Situations that Warrant Immediate Notification Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results. 1. The physician has requested to be notified as soon as a result is received. 2. The result is something that should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). -Determining the Reason for Testing 1. If the results do not meet the preceding criteria for immediate notification, then the nursing staff will review why the test was obtained, as well as the resident's current clinical status including the presence of any signs or symptoms. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Options for Physician Notification 1. A physician can be notified by phone, fax, voicemail, e-mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff). a. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. -Physician Responses 1. Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. a. A physician should respond within one hour regarding a lab result requiring immediate notification . and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response b. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and organ transplant. a. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025. Review of the hospital After Visit Summary, dated 2/27/25, indicated, but was not limited to, the following: -Resident #40 was admitted to the hospital in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. -Upon discharge, the Resident should start taking tacrolimus 2 milligrams (mg) each day at 9 A.M. and 3 mg each day at 9 P.M. The dosing was reduced from the Resident's previous dosing (3 mg twice daily) due to elevated tacrolimus levels noted during his/her hospital stay. Review of documentation received from Resident #40's consulting heart failure team indicated at time of discharge from the hospital back to the facility on [DATE], the Resident was prescribed tacrolimus 1 mg - Take 2 mg daily at 9 A.M. and take 3 mg daily at 9 P.M. Review of Resident #40's Medication Reconciliation, dated 2/27/25, indicated the Resident's list of medications from the facility prior to hospitalization (his/her home medication list) and the Discharge Summary were reviewed and indicated that potential clinically significant medication issues were identified. The document failed to indicate what the discrepancies were or the provider's resolutions for the discrepancies. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 2/27/25, an order was obtained from the physician via phone for Tacrolimus 1 mg oral capsule - Give 3 capsule [sic] by mouth at bedtime AND Give 2 capsule by mouth one time a day. The order was transcribed on 2/27/25 at 4:03 P.M. Further review of the Physician's Orders indicated the order was subsequently discontinued on 2/27/25 at 6:05 P.M. Review of Resident #40's Physician's Orders indicated no tacrolimus was prescribed to the Resident from 2/28/25 until 3/19/25. Review of Resident #40's February 2025 and March 2025 Medication Administration Records (MAR) indicated the Resident missed 40 doses of tacrolimus that he/she should have received in the facility from 2/27/25 through 3/19/25. Review of Nurse #1 and Nurse #2's staff education files during the extended survey on 5/8/25 failed to indicate there was previous education completed on immunosuppressant medication. Nurse #2 was working on Resident #40's unit and assigned to Resident #40's care during survey. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said she had been acting as Director of Nursing (DON) at the facility from 12/24/24 until the new DON started at the facility on 3/14/25. Regional Nurse Consultant #1 said that when a resident is admitted /readmitted to the facility, the nurse entering the resident's physician's orders reviews the hospital discharge records and medications and then reviews those medications with the resident's provider at the facility. Regional Nurse Consultant #1 said there is a Medication Reconciliation assessment completed in the electronic health record by the nurse after the medications have been reviewed with the provider. Regional Nurse Consultant #1 said if there is a medication that they recognize a resident is no longer prescribed, they need to make note of it. During an interview on 5/7/25 at 3:22 P.M., Nurse #2, Nurse #3, and Nurse #4, working on the unit where Resident #40 resides, said they could not recall any education pertaining to Resident #40 or his/her immunosuppressant medication regimen. During an interview on 5/8/25 at 11:36 A.M., the surveyor reviewed the facility's education binder with the SDC and she said that records of all in-service training she conducted were in the binder. In-service training records in the education binder failed to include in-service training on immunosuppressant medication use/monitoring prior to 3/18/25. b. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025. Review of the hospital After Visit Summary, dated 2/27/25, indicated, but was not limited to, the following: -Resident #40 was admitted to the hospital in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. -A tacrolimus level should be obtained and sent to the hospital's heart failure team on 3/3/25 and the heart failure team would provide recommendations for ongoing dosing of tacrolimus. Review of documentation received from Resident #40's consulting heart failure team indicated, but was not limited to, the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Resident's tacrolimus level on 2/26/25 was 6.4 ng/ml (goal level was 4-6 ng/ml). A tacrolimus level drawn 2/27/25 remained pending at time of discharge and the facility was to send a tacrolimus level on 3/3/25 to the heart failure team for follow-up and dosing recommendations. Review of Resident #40's Physician's Orders failed to indicate that an order was obtained for a tacrolimus level on 3/3/25 related to abnormal tacrolimus level and tacrolimus dosing adjustments during hospitalization as indicated in the Resident's hospital After Visit Summary 2/27/25. Review of Resident #40's medical record indicated that on 3/6/25, the Resident had a tacrolimus level drawn (three days after the recommended draw date). The tacrolimus level resulted low at 1.2 ng/ml on 3/11/25 at 4:06 P.M. and were marked as reviewed by the Physician Assistant (PA) on 3/13/25 at 12:45 P.M. The medical record failed to indicate the lab values were received by or reviewed with the heart failure team for recommendations for ongoing dosing of tacrolimus prior to 3/18/25. Review of Resident #40's Progress Notes indicated: -On 3/19/25 at 3:05 P.M., the facility nurse documented that the Resident's cardiologist requested the Resident be transferred to the emergency room at the hospital affiliated with the consulting heart failure team due to the Resident not having immunosuppressant drugs for the last two weeks. The Progress Note indicated the Resident was stable at the time of transfer. Review of the facility's education binder on 5/8/25 failed to indicate there was in-service education conducted on provider notification of abnormal lab results or communication with consulting providers. Review of Nurse #1 and Nurse #2's staff education files during the extended survey on 5/8/25 failed to indicate there was previous education completed on laboratory reporting. Nurse #1 and Nurse #2 currently work on Resident #40's unit. On 5/7/25, the surveyor attempted a phone interview with former First Floor Unit Manager #1, the nurse that admitted Resident #40. She has since resigned from the facility and did not return the surveyor's call. During an interview on 5/7/25 at 3:22 P.M., Nurse #2, Nurse #3, and Nurse #4, working on the unit where Resident #40 resides, said they could not recall any education pertaining to Resident #40. During an interview on 5/8/25 at 11:36 A.M., the surveyor reviewed the facility's education binder with the SDC and she said that records of all in-service training she conducted were in the binder. In-service training records in the education binder failed to include in-service training on immunosuppressant medication use/monitoring or laboratory reporting prior to 3/18/25. Refer to F760

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 46562 Based on observation and interview, the facility failed to ensure nurse staffing information which included the current date and actual hours worked per shift for licensed and unlicensed staff including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA) was posted daily as required. Findings include: On 5/4/25 at 7:46 A.M. and 10:23 A.M., the surveyor observed a nurse staffing document posted in the main lobby on top of the receptionist's desk. Review of the Nurse staffing document indicated it was dated 5/2/25. During an interview on 5/7/25 at 3:25 P.M., the Receptionist said the Scheduler leaves the completed nurse staff documents at the desk for the receptionist to change out each morning. The Receptionist said the Nurse staffing document should be updated every morning. During an interview on 5/7/25 at 3:39 P.M., the Scheduler said she was responsible for preparing the nurse staffing document and leaves the completed documents at the receptionist desk. The Scheduler said on Friday evenings she prepares the weekend sheets and leaves them for whoever is working Saturday and Sunday mornings. The Scheduler said the documents should be changed out first thing in the morning.

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on record review and interviews, the facility failed to ensure for one Resident (#40), out of a total sample of 18 residents, an Admission Medication Regimen Review (AMRR) was completed by the Consultant Pharmacist upon readmission to the facility and an irregularity was identified. Specifically, the Consultant Pharmacist failed to identify the discontinuation of Resident #40's immunosuppressant medication and, as a result, Resident #40 (a heart transplant recipient) missed 40 doses of tacrolimus (Prograf, an immunosuppressant medication used to prevent transplanted organ rejection) and required emergent hospitalization and medication adjustments during and after hospitalization . Findings include: Review of the facility's policy titled Reconciliation of Medications on Admission, revised 3/22, indicated, but was not limited to, the following: -Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. -Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. -Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team. -Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (Medication Administration Record) (if applicable), and the admitting orders (sources). -List the dose, route, and frequency for all medications. -Review the list carefully to determine if there are discrepancies/conflicts. Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and heart transplant. Review of the Minimum Data Set (MDS) assessment, dated 3/30/25, indicated Resident #40 was cognitively intact, as evidenced by a Brief Interview for Mental Status score of 15 out of 15, was dependent on staff for activities of daily living, and had diagnoses including heart failure and organ transplant. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025. Review of the hospital After Visit Summary, dated 2/27/25, indicated, but was not limited to, the following: -Resident #40 was admitted to the hospital in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. -Resident #40's tacrolimus level laboratory result, obtained via a blood draw from the Resident on 2/26/25, was 6.4 nanograms per milliliter (ng/ml). The Resident's goal tacrolimus level was 4-6 ng/ml -Upon discharge, the Resident should start taking tacrolimus 2 milligrams (mg) each day at 9 A.M. and 3 mg each day at 9 P.M. The dosing was reduced from the Resident's previous dosing (3 mg twice daily) due to elevated tacrolimus levels noted during his/her hospital stay. -A tacrolimus level should be obtained and sent to the hospital's heart failure team on 3/3/25 and the heart failure team would provide recommendations for ongoing dosing of tacrolimus. Review of Resident #40's Medication Reconciliation, dated 2/27/25 and completed by nursing, indicated the Resident's list of medications from the facility prior to hospitalization (his/her home medication list) and the Discharge Summary were reviewed and indicated that potential clinically significant medication issues were identified. The document failed to indicate what the discrepancies were or the provider's resolutions for the discrepancies. Review of Resident #40's Physician's Orders indicated that on 2/27/25, an order was obtained from the physician via phone for Tacrolimus 1 mg oral capsule - Give 3 capsule [sic] by mouth at bedtime AND Give 2 capsule by mouth one time a day. The order was transcribed on 2/27/25 at 4:03 P.M. Further review of the Physician's Orders indicated an order was entered to discontinue the medication on 2/27/25 at 6:05 P.M. Review of Resident #40's medical record failed to indicate that an AMRR had been completed by a Consultant Pharmacist after the Resident returned to the facility from the hospital on 2/27/25, and there was no indication of a pharmacy review of Resident #40's record from the date of his/her return to the facility until 3/8/25. Review of Resident #40's February 2025 and March 2025 Medication Administration Record indicated the Resident missed 40 doses of tacrolimus that he/she should have received in the facility from 2/27/25 through 3/19/25. Review of Resident #40's Progress Notes indicated: -On 2/27/25, an Order Note entered by nursing indicated an order for Tacrolimus 1 mg - Give 3 capsules by mouth at bedtime and 2 capsules by mouth one time a day was entered and was outside of the recommended dose or frequency (the usually dosing regimen per the note is 3 to 46.5386 capsules two times per day) -On 2/27/25 at 11:48 P.M., the nurse at the facility documented that the Resident had been treated at the hospital for altered mental status and his/her medications were confirmed by the PA. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Progress Notes failed to indicate that the physician's order for tacrolimus was discontinued on 2/27/25 or why the medication was discontinued. -On 3/8/25, the Resident's medication regimen was reviewed by the pharmacy consultant and no irregularities were noted. Review of a Medication Incident and Discrepancy Report Form, dated 3/19/25, indicated that on 2/27/25, Resident #40's tacrolimus had been discontinued in error by a previous employee at the facility. A Performance Improvement Plan (PIP) attached to the Medication Incident and Discrepancy Form indicated medication was not administered for a resident on tacrolimus and the root cause was the medication was entered in the electronic health record incorrectly as it was entered as a one-time order. The Medication Incident and Discrepancy Report Form and PIP failed to indicate that the pharmacy's AMRR had not been completed after Resident #40's readmission to the facility on [DATE] or that the Consultant Pharmacist's monthly MRR did not identify the discontinuation of the Resident's immunosuppressant medication. During an interview on 5/7/25 at 7:58 A.M., Resident #40 said that he/she had been sent to the hospital at the end of March because he/she had missed doses of his/her anti-rejection medication and the transplant doctor wanted him/her to be monitored. Resident #40 said he/she underwent testing at the hospital and everything was okay and he/she returned to the facility. Resident #40 said he/she did not know how much medication was missed or why. During a telephonic interview on 5/7/25 at 11:35 A.M., the Consultant Pharmacist said that a different pharmacist is assigned to review admission/readmission MRRs. The Consultant Pharmacist said that he cannot recall being notified of medication errors at the facility. During an interview on 5/7/25 at 1:08 P.M., the Regional Pharmacy Manager said the AMRRs are not conducted by the Consultant Pharmacist who conducts the routine monthly Medication Regimen Reviews (MRRs) and that there is an additional Consultant Pharmacist who only completes the AMRRs for the facility. The Regional Pharmacy Manager said that he had conducted an audit and concluded that the AMRRs were not completed consistently in February and March 2025. The Regional Pharmacy Manager said that the AMRRs should be completed within 72 hours of a resident's admission/readmission to the facility. The Regional Pharmacy Manager said that Resident #40 had returned to the facility on [DATE], but no AMRR had been completed within 72 hours of his/her readmission. The Regional Pharmacy Manager said that when he reviewed Resident #40's record, a tacrolimus order was in place for only one day and there was a discrepancy between the hospital discharge orders and facility's admission orders for the Resident. The Regional Pharmacy Manager said that had an AMRR been completed, this discrepancy would have been identified at that time. The Regional Pharmacy Manager said that tacrolimus is a medication used to prevent organ rejection and blood levels of the medication are monitored routinely to ensure dosing of the medication is therapeutic. The Regional Pharmacy Manager said Resident #40 had missed 20 days of his/her twice daily tacrolimus doses and that this put the Resident at higher risk for organ rejection. During an interview on 5/7/25 at 4:52 P.M., Regional Nurse Consultant #1 said that she is copied on an email from the pharmacy containing a report of all Medication Regimen Reviews completed for the facility when they are completed. Regional Nurse Consultant #1 said that she was made aware of the inconsistent completion of AMRRs in February and March 2025 by the Regional Pharmacy Manager on 5/7/25. (continued on next page)

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Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a subsequent telephonic interview on 5/08/25 at 9:00 A.M., the Regional Pharmacy Manager said that there are consultant pharmacists who complete the monthly medication regimen reviews (MRRs) and other consultant pharmacists that only complete the AMRRs. The Regional Pharmacy Manager said that when he receives the AMRRs, he reviews a report called the Action Summary from the facility's electronic health record and reviews the residents' date of admission/readmission and the date the AMRR was completed to ensure AMRRs are completed within 72 hours of admission/readmission. The Regional Pharmacy Manager said that when he was doing the audit for the facility at the end of March, he noted that the AMRRs had not been completed as required in February and March 2025. The Regional Pharmacy Manager said that the facility's corporate nursing leadership (Regional Nurse #3) was notified of the issue at the beginning of April 2025. The surveyor attempted to contact Regional Nurse #3, but she was unable to be reached. Refer to F760

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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** 50740 Based on document review and interviews, the facility failed to ensure for one Resident (#40), out of a total sample of 18 residents, to ensure he/she was free from a significant medication error when the Resident's immunosuppressant medication was discontinued in error. As a result, Resident #40 missed 40 doses of tacrolimus (Prograf, an immunosuppressant medication used to prevent transplanted organ rejection) and required emergent hospitalization and medication adjustments during and after hospitalization . Findings include: Review of the facility's policy titled Reconciliation of Medications on Admission, revised 3/22, indicated, but was not limited to, the following: -Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. -Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. -Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team. -Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (Medication Administration Record) (if applicable), and the admitting orders (sources). -List the dose, route, and frequency for all medications. -Review the list carefully to determine if there are discrepancies/conflicts. Review of the facility's policy titled Aftercare of Heart Transplant, effective 4/17, indicated, but was not limited to, the following: -After a heart transplant, a comprehensive aftercare plan is crucial for long-term success and involves ongoing monitoring for rejection, infection, and medication side effects, as well as adherence to lifestyle modifications and regular follow-up appointments. This includes taking immunosuppressant medications, adhering to a prescribed exercise program, and maintaining a healthy diet. -This policy applies to all adult patients who have undergone a heart transplant and are currently more than three years post-transplant. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All heart transplant recipients post-transplant must receive individualized, evidence-based follow-up care focusing on immunosuppressive management, cardiovascular health, infection surveillance, malignancy screening, and psychosocial well-being. -Immunosuppressive Management *Maintain lowest effective dose of maintenance immunosuppression (e.g. tacrolimus, mycophenolate, prednisone) *Monitor for long-term side effects: nephrotoxicity (deterioration in kidney function due to toxic substances), hypertension (high blood pressure), diabetes, dyslipidemia (abnormal levels of fats in the blood) *Evaluate for medication adherence at every visit -Documentation and Communication *All assessments and interventions must be documented in the patient's electronic health record (EHR). *Coordinate care with primary care providers and other specialists. -Quality Assurance *Annual review of resident outcomes (graft survival, complications, hospitalization s) *Compliance audits on follow-up scheduling and lab monitoring Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and heart transplant. Review of the Minimum Data Set (MDS) assessment, dated 3/3/25, indicated Resident #40 was cognitively intact, as evidenced by a Brief Interview for Mental Status score of 15 out of 15, was dependent on staff for activities of daily living, and had diagnoses including heart failure and organ transplant. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025. Review of the hospital After Visit Summary, dated 2/27/25, indicated, but was not limited to, the following: -Resident #40 was admitted to the hospital in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. -Upon discharge, the Resident should start taking tacrolimus 2 milligrams (mg) each day at 9 A.M. and 3 mg each day at 9 P.M. The dosing was reduced from the Resident's previous dosing (3 mg twice daily) due to elevated tacrolimus levels noted during his/her hospital stay. (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 #40's Medication Reconciliation, dated 2/27/25, indicated the Resident's list of medications from the facility prior to hospitalization (his/her home medication list) and the Discharge Summary were reviewed and indicated that potential clinically significant medication issues were identified. The document failed to indicate what the discrepancies were or the provider's resolutions for the discrepancies. Review of Resident #40's Physician's Orders indicated on 2/27/25, an order was obtained from the physician via phone for Tacrolimus 1 mg oral capsule - Give 3 capsule [sic] by mouth at bedtime AND Give 2 capsule by mouth one time a day. The order was transcribed on 2/27/25 at 4:03 P.M. Further review of the Physician's Orders indicated the order was subsequently discontinued on 2/27/25 at 6:05 P.M. No tacrolimus was prescribed to the Resident from 2/28/25 until 3/19/25. Review of Resident #40's February 2025 and March 2025 Medication Administration Record indicated the Resident missed 40 doses of tacrolimus that he/she should have received in the facility from 2/27/25 through 3/19/25. Review of Resident #40's Progress Notes indicated but was not limited to: -On 2/27/25, an Order Note entered by nursing indicated an order for Tacrolimus 1 mg - Give 3 capsules by mouth at bedtime and 2 capsules by mouth one time a day was entered and was outside of the recommended dose or frequency (the usually dosing regimen per the note is 3 to 46.5386 capsules two times per day) -On 2/27/25, a progress note was entered by the physician assist (PA). The medication list, included in the PA's progress note, indicated the Resident was taking tacrolimus 1 mg two capsules in the morning. The PA's note failed to identify the change in the Resident's tacrolimus regimen to include the additional 3 mg each day at 9 P.M. -On 2/27/25 at 11:48 P.M., the nurse at the facility documented that the Resident had been treated at the hospital for altered mental status and his/her medications were confirmed by the PA. -On 2/27/25 at 11:56 P.M., the nurse at the facility indicated the Resident's medication list was faxed to the hospital and receipt was confirmed. -On 2/28/25, a progress note was entered by the physician. The physician documented in her note that the Resident was transferred to the hospital on February 22 and returned to the facility on [DATE]. The physician indicated the Resident was hospitalized due to change in mental status, nausea, and tremors and was treated with antibiotics for a urinary tract infection. The physician indicated the Resident was on immunosuppression with prednisone and tacrolimus and was at high risk of complications and infections. The medication list, included in the physician's note, indicated the Resident was taking tacrolimus 1 mg two capsules in the morning. The physician's note failed to identify the change in the Resident's tacrolimus regimen to include the additional 3 mg each day at 9 P.M. -On 3/8/25, the Resident's medication regimen was reviewed by the pharmacy consultant and no irregularities were noted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/19/25, a progress note was entered by the physician. The physician's note indicated the nursing notes, vital signs, and medications available in the Resident's electronic health record (EHR), prior external notes, and hospital discharge summary were reviewed. The physician documented that the Resident had received an organ transplant in 2021 and that she was contacted by the hospital's Transplant Coordinator in regard to his/her low tacrolimus level of 1.2 ng/ml. The note indicated the Transplant Coordinator had discussed the Resident's medication regimen with staff at the facility and it appeared that the Resident had missed his/her tacrolimus since he/she was readmitted to the facility on [DATE] and was supposed to receive tacrolimus twice daily. The physician confirmed with nursing staff that the Resident had not received the tacrolimus and was later informed that the Transplant Coordinator had called the facility and recommended the Resident be transferred to the hospital for intravenous steroid treatment. Despite the documentation written in the physician's progress note, the medication list again indicated the Resident was only taking tacrolimus 1 mg two capsules in the morning. -On 3/19/25 at 3:05 P.M., the facility nurse documented that the Resident's cardiologist requested the Resident be transferred to the emergency room at the hospital affiliated with the consulting heart failure team due to the Resident not having immunosuppressant drugs for the last two weeks. The Progress Note indicated the Resident was stable at the time of transfer. Further review of Resident #40's Progress Notes failed to indicate that the physician's order for tacrolimus was discontinued on 2/27/25 or why the medication was discontinued. Review of documentation received from Resident #40's consulting heart failure team indicated, but was not limited to, the following: -At time of discharge from the hospital back to the facility on [DATE], the Resident was prescribed tacrolimus 1 mg - Take 2 mg daily at 9 A.M. and take 3 mg daily at 9 P.M. The Resident's tacrolimus level on 2/26/25 was 6.4 ng/ml (goal level was 4-6 ng/ml). A tacrolimus level drawn 2/27/25 remained pending at time of discharge and the facility was to send a tacrolimus level on 3/3/25 to the heart failure team follow-up and dosing recommendations. -On 2/27/25, 3/4/25, 3/5/25, and 3/18/25 the Cardiology Registered Nurse (RN) documented that she called the facility to request the Resident's medication list and lab results be faxed to the cardiology office. The Cardiology RN indicated that she had difficulty reaching a nurse or provider at the facility -On 3/19/25, the Cardiology RN documented that the Resident's labs and medication list were faxed on 3/18/25. The Cardiology RN noted that the labs were drawn on 3/6/25 and the tacrolimus level was 1.2 ng/ml after the dose had been decreased to 2 mg in the A.M. and 3 mg in the P.M. The Cardiology RN reviewed the medication list and no tacrolimus was noted. -On 3/19/25, the Cardiology RN documented that she contacted the Resident's physician at the facility and the physician was unaware of the critical value and discontinuation of tacrolimus and would call back with confirmation. (continued on next page)

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Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/19/25 the consulting cardiologist requested to coordinate a hospital admission for the Resident for further testing (transthoracic echocardiogram - a non-invasive test that uses ultrasound to create images of the heart, and possible biopsy - a procedure that involves taking a sample of tissue to examine it more closely). Review of Resident #40's hospital Discharge Summary, dated 3/26/25, indicated, but was not limited to, the following: -The Resident presented to the hospital from the facility with recent history of missed immunosuppression doses and was admitted for rejection surveillance. -The Resident was found to have tacrolimus trough (the lowest level of the drug in the body) of 1.5 ng/ml. TTE and blood work for rejection was reassuring and the heart failure team deferred inpatient heart biopsy. -The Resident was discharged with his/her tacrolimus dosing increased to achieve tacrolimus trough to goal level of 4-6 ng/ml, recommendations for weekly labs including tacrolimus level every Friday for two weeks, prednisone taper for empiric transplant rejection therapy, and changes to his/her insulin regimen due to high blood sugar levels while on prednisone. Review of a Medication Incident and Discrepancy Report Form, dated 3/19/25, indicated that on 2/27/25, Resident #40's tacrolimus had been discontinued in error by a previous employee at the facility. The Form indicated that the Resident's transplant clinic had noted the medication was missing from the Resident's medication list. In the section of the Form titled Outcome of Investigation, it is noted that the medication was not administered and was entered as a one-time administration. During an interview on 5/7/25 at 7:58 A.M., Resident #40 said that he/she had been sent to the hospital at the end of March because he/she had missed doses of his/her anti-rejection medication and the transplant doctor wanted him/her to be monitored. Resident #40 said he/she underwent testing at the hospital and everything was okay and he/she returned to the facility. Resident #40 said he/she did not know how much medication was missed or why. During an interview on 5/7/25 at 12:24 P.M., the Staff Development Coordinator (SDC) said that on 3/19/25, former First Floor Unit Manager #2 approached her and informed her that the hospital had called asking about the Resident's tacrolimus regimen and that he/she was supposed to be on tacrolimus two times daily because he/she had received an organ transplant. The SDC said she was not familiar with the Resident's medication regimen at the time but reviewed his/her record and confirmed that the order for tacrolimus was initially entered but then was discontinued. The SDC said the hospital instructed the facility to monitor the Resident's tacrolimus level and ensure the Resident received his/her medications. The SDC said she did not have further involvement in the situation and that former First Floor Unit Manager #2 handled all further communication with the hospital and the Resident's providers. The SDC said former First Floor Unit Manager #2 was new to the position at the time and no longer worked at the facility. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephonic interview on 5/7/25 at 1:01 P.M., the Physician said the Resident's tacrolimus didn't make it onto his/her medication list at the facility. The Physician said the medication was to be used to prevent organ rejection as the Resident had received an organ transplant. The Physician said she was made aware of the omission on 3/19/25 when she was informed by the Cardiology RN at the hospital. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said she had been acting as Director of Nursing at the facility from 12/24/24 until the new Director of Nursing started at the facility on 3/14/25. Regional Nurse Consultant #1 said that when a resident is admitted /readmitted to the facility, the nurse entering the resident's physician's orders reviews the hospital discharge records and reviews the medications and then reviews those medications with the resident's provider at the facility. Regional Nurse Consultant #1 said there is a Medication Reconciliation assessment completed in the electronic health record by the nurse after the medications have been reviewed with the provider. Regional Nurse Consultant #1 said the pharmacy also completes a medication review when a resident is admitted /readmitted to the facility. Regional Nurse Consultant #1 said that when a medication error is identified, an incident report is completed and a root cause analysis is done. Regional Nurse Consultant #1 said that in regard to this specific medication error, former First Floor Unit Manager #2 was notified of the error first and then she notified Regional Nurse Consultant #1. Regional Nurse Consultant #1 said she spoke with the Cardiology RN who reported that a medication list had been sent to her and that tacrolimus was not on the Resident's medication list. Regional Nurse Consultant #1 said the Cardiology RN requested to know when the Resident had last received the medication and that his/her tacrolimus level was below goal range. Regional Nurse Consultant #1 said she had reviewed Resident #40's record and identified that the order entered on 2/27/25 was entered as a one-time dose, maybe due to a glitch, and he/she had not received the medication since then. Regional Nurse Consultant #1 said that staff at the facility had not identified the medication error prior to being notified by the Cardiology RN on 3/19/25. Regional Nurse Consultant #1 said that the Cardiology RN notified the facility that the Resident should be transferred to the hospital for admission for rejection surveillance. Regional Nurse Consultant #1 said as a result of the medication error, staff at the facility were reeducated on the process for medication reconciliation and that if there is a medication that they recognize a resident is no longer prescribed, they need to make note of it. During a telephonic interview on 5/7/25 at 1:39 P.M., the Physician Assistant (PA) said he was aware of the medication error and had seen Resident #40 in between his/her readmission to the facility on [DATE] and transfer back to the hospital on 3/19/25. The PA said he could not recall when he was made aware of the medication error but if he had been aware of it before the Resident was transferred back to the hospital, he would have restarted the medication at that time. The PA said he did not recall giving an order to discontinue the Resident's tacrolimus on 2/27/25. The PA said he was unaware if the results had been sent to the cardiologist because that is something the nursing staff would do and he did not follow up with nursing to ensure the results were communicated to the Resident's cardiologist. The PA further said he was unaware the Resident had not received the medication at the time the lab value was obtained. The PA said that he was aware the Resident's tacrolimus level had resulted low on 3/11/25, but was not aware the Resident had not received the medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/7/25 at 1:59 P.M., the Regional Director of Operations said that when a medication error is discovered, the Director of Nursing at the facility would oversee the investigation, education, follow-up, and any disciplinary action that may occur as a result. The Regional Director of Operations said that when there is no Director of Nursing at the facility, a Regional Nurse Consultant would be assigned to the position until a new Director of Nursing is hired. The Regional Director of Operations said that he was not aware of the medication error before being informed by the survey team on 5/7/25. During a telephonic interview on 5/7/25 at 2:03 P.M., the Cardiology RN said that Resident #40 has been followed by the cardiology team at the hospital since receiving an organ transplant years prior. She said that Resident #40 is seen every three to six months for routine clinic visits and the cardiology team communicates with the facility to obtain an updated medication list periodically, such as when the Resident returns to the facility after a hospitalization . The Cardiology RN said that after Resident #40 was discharged from the hospital on 2/27/25, she reached out to the facility that day to request an updated medication list and labs. The Cardiology RN said she ran into extensive hurdles when trying to contact a nurse or provider at the facility and attempted calls on 3/4/25, 3/5/25, and 3/18/25. The Cardiology RN said she had reviewed the medication list and tacrolimus level on 3/19/25 and noted that the Resident's tacrolimus level was virtually undetectable at 1.2 ng/ml and that the lab had been drawn on 3/6/25 and resulted on 3/11/25, but she had not been notified of the abnormal result prior. The Cardiology RN said she placed a call to the facility on [DATE] and spoke with a nurse who reported the medication had been discontinued on 2/27/25. The Cardiology RN said the Resident had gone a significant amount of time without the anti-rejection medication before she was able to speak with someone at the facility. The Cardiology RN said there was no follow-through by the facility staff and she encountered many barriers when trying to get an updated medication list from the facility. The Cardiology RN said the reason a medication list is requested is so the cardiology team can ensure the Resident is taking the anti-rejection medication and that the medication error would have been caught sooner and avoided a hospital admission if the information had been sent to her sooner. The Cardiology RN said that the medication error could have caused organ transplant rejection, which can be irreversible and could have resulted in a severe outcome. The Cardiology RN said that as a result of the medication error, the Resident required a weeklong hospital admission, testing, and intravenous steroid infusions. The surveyor attempted to contact former First Floor Unit Manager #2, but she was unable to be reached and was no longer employed at the facility.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41065 Based on records reviewed and interviews, the facility failed to ensure it provided appropriate administrative oversight specific to clinical management when a Resident (#40) did not receive his/her tacrolimus (Prograf, an immunosuppressant medication used to prevent transplanted organ rejection) after readmission from the hospital in February 2025, resulting in abnormally low laboratory results and the Resident required emergent hospitalization and medication adjustments during and after hospitalization . Specifically, the facility administration failed to: 1. Ensure the use of laboratory services and pharmacy services, which provide ongoing support and oversight to the facility was addressed in the Facility Assessment; 2. Ensure effective systems were in place for education, and training for licensed staff to ensure competent, safe, and effective resident care related to medication reconciliation, laboratory result reporting and communication with consulting providers; 3. Ensure an Admission Medication Regimen Review (AMRR) was completed for Resident #40 upon return to the facility after a hospitalization , resulting in Resident #40 missing a total of 40 doses of tacrolimus; and 4. Ensure a medication error was fully investigated and brought all components of the error, including missed laboratory values and AMRR, to the Quality Assurance Performance Improvement Committee. Findings include: 1. Review of the Facility Assessment, most recently updated on 4/25/25 and reviewed with the QAPI committee on 2/28/25 and 4/28/25, indicated the following: -[The facility] has established a clinical grid that outlines what our clinical capabilities are. Our admission and field liaisons staff use this grid to determine if we can meet a resident's continuing needs. The clinical team along with the corporate office are responsible for validating a competency before a new clinical competency is added to the Grid. -[The facility] accepts and cares for patients that its staff is competent to care for. The facility must be able to meet the medical, nursing, therapy and equipment needs to meet the requirements of the patients admitted . The DNS updates the Clinical Service Level of Care grid quarterly and as clinical capabilities are added under the direction of the clinical team and of the corporate office. Reviews are done throughout the year regarding whether a clinical capability needs to be added to ensure the staff is prepared. -The staff is provided with regular in-servicing opportunities and evaluations -The Staff Development Coordinator tracks required in-service to monitor compliance with requirements. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Facility Assessment indicated the facility offers services and care related to medications including awareness of any limitations of administering medications and the administration of medications that residents need. The Facility Assessment failed to indicate the use of Laboratory Services or Pharmacy Services, including how discrepancies and concerns are brought to the Administration. 2. Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and heart transplant. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. A tacrolimus level should be obtained and sent to the hospital's heart failure team on 3/3/25 and the heart failure team would provide recommendations for ongoing dosing of tacrolimus. Further review of the medical record for Resident #40 indicated the following: -Resident #40's Medication Reconciliation, dated 2/27/25, indicated potential clinically significant medication issues were identified. The document failed to indicate what the issues were or the provider's resolutions for the issues. -Review of Resident #40's February 2025 and March 2025 MAR indicated the Resident missed 40 doses of tacrolimus that he/she should have received in the facility from 2/27/25 through 3/19/25. -Resident #40's laboratory results indicated that on 3/6/25 (3 days after the recommended lab draw date), the Resident had a tacrolimus level drawn. The tacrolimus level resulted low at 1.2 ng/ml (nanograms per milliliter) on 3/11/25 at 4:06 P.M. The results were reviewed by the cardiology office on 3/19/25, 8 days after the results were reported to the facility. -Review of Resident #40's medical record failed to indicate an AMRR had been completed by a Consultant Pharmacist after the Resident returned to the facility from the hospital on 2/27/25. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said she had been acting as Director of Nursing at the facility from 12/24/24 until the new Director of Nursing started at the facility on 3/14/25. Regional Nurse Consultant #1 said when a resident is admitted /readmitted to the facility, the nurse entering the resident's physician's orders reviews the hospital discharge records and medications and then reviews those medications with the resident's provider at the facility. Regional Nurse Consultant #1 said there is a Medication Reconciliation assessment completed in the electronic health record by the nurse after the medications have been reviewed with the provider. Regional Nurse Consultant #1 said nursing staff are supposed to call and report labs to the Attending Physician or their designee and that specifically for Resident #40, the labs are also reported to the cardiology office. Review of the facility's education binder on 5/8/25 failed to indicate there was in-service education conducted on medication reconciliation, provider notification of abnormal lab results or communication with consulting providers before 3/18/25. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/08/25 at 11:36 A.M., the surveyor reviewed the facility's education binder with the Staff Development Coordinator (SDC). The SDC said that medication reconciliation in-servicing was conducted on 3/20/25 after discovery of a medication error but failed to provide evidence of medication reconciliation training conducted prior. 3. Review of Resident #40's medical record indicated that Resident #40 was hospitalized in February 2025 for heart failure exacerbation and some of his/her medications had changed, including tacrolimus. During a telephonic interview on 5/08/25 at 9:00 A.M., the Regional Pharmacy Manager said when he was doing an audit for the facility at the end of March, he noted that the AMRRs had not been completed as required in February and March 2025. The Regional Pharmacy Manager said the facility's Corporate nursing leadership (Regional Nurse #3) was notified of the issue at the beginning of April 2025 by his supervisor. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said she was unaware of any MRR or AMRR discrepancies or concerns back in March or April, despite her being in the acting role of Director of Nurses. During an interview on 5/7/25 at 11:35 A.M., the Consultant Pharmacist said communication with the facility had been challenging lately because there has been a lot of turnover in management. The Consultant Pharmacist said he usually includes Regional Nurse Consultant #1 on the email that includes his report and recommendations because he is not sure who is covering. The Consultant Pharmacist said the facility's responsiveness to recommendations fluctuates from month to month. The Consultant Pharmacist said that readmissions are reviewed by another pharmacist who completes the AMRR. The Consultant Pharmacist said he could not say that he had been notified of medication errors at the facility. The surveyor attempted to contact the Regional Nurse #3, but she was unable to be reached. 4. Review of a Medication Incident and Discrepancy Report Form, dated 3/19/25, indicated on 2/27/25, Resident #40's tacrolimus had been discontinued in error by a previous employee at the facility. A Performance Improvement Plan (PIP) was attached to the Medication Incident and Discrepancy Form and indicated medication was not administered for a resident on tacrolimus and the root cause was the medication was entered in the electronic health record incorrectly as it was entered as a one-time order. Recommendation/Action Steps on the PIP indicated all other residents on medication were reviewed to ensure that no medications were entered incorrectly, the physician and patient were aware, the transplant clinic was aware, education was provided to nursing staff, an interdisciplinary team (IDT) meeting was held to review new admission medications vs. discharge summary or new orders to ensure medications were not missed, the Resident was sent to the emergency room for evaluation, and medication errors would be tracked. The PIP failed to identify that an Admission Medication Regimen Review had not been completed by the pharmacy after the Resident returned from the hospital on 2/27/25 or that the facility staff failed to ensure the Resident's cardiology office was aware of the abnormal tacrolimus level results prior to the Cardiology RN's request for information on 3/18/25. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/25 at 1:08 P.M., the Regional Pharmacy Manager said he had conducted an audit and concluded that the AMRRs were not being completed consistently in February and March 2025. The Regional Pharmacy Manager said that the AMRRs should be completed within 72 hours of a resident's admission/readmission to the facility. The Regional Pharmacy Manager said Resident #40 had returned to the facility on [DATE], but no AMRR had been completed within 72 hours of his/her readmission. The Regional Pharmacy Manager said that had an AMRR been completed, this discrepancy would have been identified at that time. The Regional Pharmacy Manager said Resident #40 had missed 20 days of his/her twice daily tacrolimus doses and that this put the Resident at higher risk for organ rejection. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said after the medication error had been identified, she had reviewed Resident #40's record and identified that the order entered on 2/27/25 was entered as a one-time dose, maybe due to a glitch. Regional Nurse Consultant #1 further said the pharmacy should complete a medication review when a resident is admitted /readmitted to the facility. Regional Nurse Consultant #1 said staff at the facility had not identified the medication error prior to being notified by the Cardiology RN on 3/19/25. Regional Nurse Consultant #1 said nursing staff are supposed to call and report labs to the Attending Physician or their designee, and that specifically for Resident #40, the labs are also reported to his/her cardiology office. During an interview on 5/7/25 at 1:59 P.M., the Regional Director of Operations said when a medication error is discovered, the Director of Nursing at the facility would oversee the investigation, education, follow-up, and any disciplinary action that may occur as a result. The Regional Director of Operations said when there is no Director of Nursing at the facility, a Regional Nurse Consultant would be assigned to the position until a new Director of Nursing is hired. The Regional Director of Operations said he was not aware of the medication error before being informed by the survey team on 5/7/25. During a subsequent interview on 5/8/25 at 1:29 P.M., Regional Nurse Consultant #1 said that she did not report Resident #40's medication error to the governing body because she had handled the situation as a part of the governing body. Refer to F867 50740

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on document review and interview, the facility failed to ensure that the Quality Assurance Committee developed and implemented an effective Performance Improvement Plan (PIP), including a corrective action plan with effective monitoring for delayed laboratory result reporting, readmission medication reconciliation, and pharmacy Admission Medication Regimen Review (AMRR) after admission/readmission. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement, revised 4/2022, indicated, but was not limited to, the following: -The facility has a Quality Assurance/Performance Improvement (QAPI) Program which systematically monitors, analyzes, and improves its performance to improve resident outcomes. -The QAPI committee will consist of the Administrator, Director of Nursing Services, a physician designated by the center and at least three other members of the facility staff. These additional members may include representation from nursing, dietary, housekeeping, laundry, maintenance, health information management, activities, and staff education. -Our QAPI plan addresses: *Clinical Care monitor existing QI/Q (Quality Improvement/Quality) results, intention monitors for falls, medication errors, pressure ulcers, incident reports, infection reports. Center Leadership, including, but not limited to Administrator and Director of Nursing meets at least quarterly with Medical Director and others to address care concerns. -Review of State/National and past facility measures will be used to benchmark for improvement in all areas. These benchmarks will be reviewed at least quarterly, and reported to the QAPI Committee on a quarterly basis. -The Administrator is responsible and accountable for developing, leading, and closely monitoring a QAPI program. *Input is obtained from facility staff on a quarterly basis through members of the QAPI Committee through ongoing dialogue with employees. Department heads are responsible for talking to their employees before reporting into QAPI. Residents and families have input through resident and family committee or queries. *The input given is acted upon and brings QAPI to life in the facility. Concerns are brought up when a certain department or task is not hitting benchmark. The concern is discussed and an action plan is developed. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The information gathered is analyzed and compared to benchmarks and/or targets established by the facility. Resident #40 was admitted to the facility in January 2024 with diagnoses including stroke, heart failure, and organ transplant. Review of Resident #40's Physician's Orders indicated, but was not limited to, the following: -Fax Tacrolimus, CBC w/ diff (Complete Blood Count, a blood test that measures various components of your blood, helping to diagnose and monitor numerous health conditions), and CMP (Comprehensive Metabolic Panel, a blood test that measures 14 different substances in your blood, providing important information about your body's metabolism and the functioning of various organs, particularly the liver and kidneys), results to [fax number redacted] every shift starting on the 7th and ending on the 11th of every month for immunosuppressive therapy (order start date 7/10/24) -On 2/27/25, an order was obtained from the physician via phone for Tacrolimus 1 mg oral capsule - Give 3 capsule [sic] by mouth at bedtime AND Give 2 capsule by mouth one time a day. The order was transcribed on 2/27/25 at 4:03 P.M. Further review of the Physician's Orders indicated a phone order was obtained from the Physician Assistant (PA) to discontinue the medication on 2/27/25 at 6:05 P.M. -No tacrolimus was prescribed to the Resident from 2/28/25 until 3/19/25. -The Physician's Orders failed to indicate an order was obtained for a tacrolimus level on 3/3/25 related to abnormal tacrolimus level and tacrolimus dosing adjustments during hospitalization as indicated in the Resident's hospital After Visit Summary 2/27/25. Further review of Resident #40's medical record indicated that on 3/6/25, the Resident had a tacrolimus level drawn (3 days after the recommended draw date). The tacrolimus level resulted low at 1.2 ng/ml on 3/11/25 at 4:06 P.M. and were marked as reviewed by the Physician Assistant (PA) on 3/13/25 at 12:45 P.M. The medical record failed to indicate the lab values were faxed to the heart failure team for recommendations for ongoing dosing of tacrolimus. Review of Resident #40's Progress Notes indicated that on 3/19/25, a Progress Note was entered by the physician. The medication list in the physician's note indicated the Resident was taking tacrolimus 1 mg two capsules in the morning. The physician's note indicated the nursing notes, vital signs, and medications available in the Resident's electronic health record (EHR), prior external notes, and hospital discharge summary were reviewed. The physician documented that the Resident had received an organ transplant in 2021 and she was contacted by the hospital's Transplant Coordinator in regards to his/her low tacrolimus level of 1.2 ng/ml. The note indicated the Transplant Coordinator had discussed the Resident's medication regimen with staff at the facility and it appeared the Resident had missed his/her tacrolimus since he/she was readmitted to the facility on [DATE] and was supposed to receive tacrolimus twice daily. The physician confirmed with nursing staff the Resident had not received tacrolimus and was later informed that the Transplant Coordinator had called the facility and recommended the Resident be transferred to the hospital for intravenous steroid treatment. Review of Resident #40's medical record failed to indicate that an Admission Medication Regimen Review (AMRR) had been completed by a Consultant Pharmacist after the Resident returned to the facility from the hospital on 2/27/25. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Medication Incident and Discrepancy Report Form, dated 3/19/25, indicated on 2/27/25, Resident #40's tacrolimus had been discontinued in error by a previous employee at the facility. The Form indicated that the Resident's transplant clinic had noted the medication was missing from the Resident's medication list. In the section of the Form titled Outcome of Investigation, it is noted the medication was not administered and was entered as a one-time administration. A Performance Improvement Plan (PIP) attached to the Medication Incident and Discrepancy Form indicated medication was not administered for a resident on tacrolimus and the root cause was the medication was entered in the electronic health record incorrectly as it was entered as a one-time order. Recommendation/Action Steps on the PIP indicated all other residents on medication were reviewed to ensure that no medications were entered incorrectly, the physician and patient were aware, the transplant clinic was aware, education was provided to nursing staff, an interdisciplinary team (IDT) meeting was held to review new admission medications vs. discharge summary or new orders to ensure medications were not missed, the Resident was sent to the emergency room for evaluation, and medication errors would be tracked. An Education Sheet included with the Medication Incident and Discrepancy Form indicated education was provided on going through medications with patient and family member/HCP (health care proxy) on 3/20/25. During an interview on 5/7/25 at 1:25 P.M., Regional Nurse Consultant #1 said she had been acting as Director of Nursing at the facility from 12/24/24 until the new Director of Nursing started at the facility on 3/14/25. Regional Nurse Consultant #1 said after the medication error had been identified, she had reviewed Resident #40's record and identified that the order entered on 2/27/25 was entered as a one-time dose, maybe due to a glitch. Regional Nurse Consultant #1 said as a result of the medication error, staff at the facility were reeducated on the process for medication reconciliation and if there is a medication they recognize a resident is no longer prescribed, they need to make note of it. During a telephonic interview on 5/7/25 at 2:03 P.M., the Cardiology RN said that Resident #40 has been followed by the cardiology team at the hospital since receiving an organ transplant years prior. She said that Resident #40 is seen every three to six months for routine clinic visits and the cardiology team communicates with the facility to obtain labs and an updated medication list periodically, such as when the Resident returns to the facility after a hospitalization . The Cardiology RN said that after Resident #40 was discharged from the hospital on 2/27/25, she reached out to the facility that day to request an updated medication list and labs. The Cardiology RN said she ran into extensive hurdles when trying to make contact with a nurse or provider at the facility. The Cardiology RN said she had received the medication list and tacrolimus level on 3/19/25 and noted that the Resident's tacrolimus level was virtually undetectable at 1.2 ng/ml and that the lab had been drawn on 3/6/25 and resulted on 3/11/25, but she had not been notified of the abnormal result prior. The Cardiology RN said the Resident had gone a significant amount of time without the anti-rejection medication before she was able to speak with someone at the facility. The Cardiology RN said there was no follow-through by the facility staff and she encountered many barriers when trying to get an updated medication list and lab results from the facility. The Cardiology RN said that the medication error could have caused organ transplant rejection, which can be irreversible and could have resulted in a severe outcome. The Cardiology RN said that as a result of the medication error, the Resident required a weeklong hospital admission, testing, and intravenous steroid infusions. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 3:22 P.M., the surveyor reviewed the 3/20/25 Education Sheet included with the Medication Incident and Discrepancy Form with nurses on the First Floor unit. Nurse #4 reviewed the Education Sheet confirmed her signature was on it. Nurse #4 said she thought the education was related to explaining the medication regimen to a resident at time of discharge from the facility and it was a general education, not specific to a certain resident. Nurse #4 said if the education was specific to a resident, the resident's initials would be on the Education Sheet and there were no initials on the 3/20/25 Education Sheet. Nurse #2 said he did not recall any education or in-servicing specifically related to Resident #40 and his/her medications. On 5/7/25 at 3:30 P.M., the surveyor reviewed the 3/20/25 Education Sheet with Unit Manager #1. Unit Manager #1 reviewed the Education Sheet and confirmed her signature was on it. Unit Manager #1 said she thought the education was related to when a Resident or their family member wanted the staff to review the Resident's medications with them. Unit Manager #1 said if the education was specific to a resident, the resident's initials would be on the Education Sheet and there were no initials on the 3/20/25 Education Sheet. Unit Manager #1 said she did not recall any education being done on admission/readmission medication reconciliation procedures. During an interview on 5/8/25 at 10:52 A.M., the Regional Director of Operations said the PIP implemented as a result of the identified medication error was reviewed at the last monthly QAPI meeting. The Medication Incident and Discrepancy Report Form and PIP failed to indicate the facility had failed to obtain the Resident's tacrolimus level on 3/3/25 as recommended in the hospital After Visit Summary, failed to ensure the abnormal tacrolimus level results reported to the facility on [DATE] and reviewed by the PA on 3/13/25 were addressed, failed to indicate a breakdown in communication between facility staff and the Resident's consulting cardiology clinic, and failed to indicate the pharmacy AMRR had not been completed after the Resident returned to the facility on [DATE]. The PIP also failed to include any identified benchmarks or targets established by the facility for monitoring of performance improvement activities.

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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 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49424 Based on documentation review and interview, the facility failed to provide training and education to all their staff to outline elements and goals of the facility's Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement, revised 4/2022, indicated, but was not limited to, the following: -Small group education sessions on QAPI are provided to all caregivers working in the building. QAPI is also part of orientation for new staff members joining the team. -Administrator is responsible to ensure ongoing orientation, education and training on QAPI. In addition, as part of annual evaluations, staff members are expected to answer questions regarding performance improvement and how QAPI is used in operations of the facility. Review of five education records (including the electronic training system) for direct care staff, which included two nurses, a unit manager, a social worker, and the staff development coordinator, failed to indicate QAPI training had been completed for five out of the five education records reviewed. During an interview on 5/8/25 at 11:18 A.M., Nurse #1 said she was not familiar with the facility's QAPI program. She said she was not sure what the goals of the program were or what her role in it was. She said she had not received any training on the QAPI program. During an interview on 5/8/25 at 11:20 A.M., Unit Manager #2 said she attended the QAPI meetings but could not recall any in-servicing or education she completed in relation to the process. During an interview on 5/8/25 at 11:28 A.M., the Social Worker said she completed all her training online and there was not any information related to the QAPI program during orientation or after she was hired. During an interview on 5/8/25/ at 1:59 P.M., Nurse #2 said he had not received any training or orientation to the QAPI program. During an interview on 5/8/25 at 11:59 A.M., the Staff Development Coordinator said she recently attended orientation upon hire in February 2025 and did not recall completing any training on the facility's QAPI program. She said that she believed there was a slide in the orientation PowerPoint presentation that informed staff of the program but could not recall any details. The Staff Development Coordinator said she did not review QAPI with staff during orientation.