STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Health Services of Kannapolis	1810 Concord Lake Road Kannapolis, NC 28083

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, and physician and staff interviews, the facility failed to notify the Physician when a prescribed dose of hydrocortisone was not administered for 1 of 1 resident reviewed for notification (Resident #137). The findings included: Resident #137 was admitted to the facility on [DATE] with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. Review of Resident #137's medication administration record (MAR) documented by Nurse #1 that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. There were no nursing notes indicating the physician had been notified Resident #137 had not received the dose of hydrocortisone on 8/29/24. Nurse #1 was interviewed by phone on 1/16/25 at 7:48 AM. Nurse #1 reported she did not specifically recall why the medication was not available for Resident #137 on 8/29/24. Nurse #1 reported if she did not document she had called the physician, she probably had not called him. Nurse #1 reported she should have notified the physician the medication was not administered. Unit Manager #1 was interviewed by phone on 1/16/25 at 10:39 AM. Unit Manager #1 reported she did not recall Nurse #1 reporting the hydrocortisone was not in the facility to administer to Resident #137. Unit Manager #1 reported she did not know if the physician was notified the medication was not administered to Resident #137. An interview was conducted by phone with the Physician on 1/15/25 at 2:48 PM. The Physician reported he had not been notified the hydrocortisone was not administered to Resident #137 on 8/29/24 and he would have expected to be notified of any medication not administered.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of swallowing for 1 of 4 residents (Resident #75) reviewed for MDS accuracy. The findings included: Resident #75 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction and oropharyngeal dysphagia. Review of Resident #75's care plan, last revised on 12/06/24, included a focus area that read Resident #75 had a nutritional problem or potential problem due to mechanically altered diet related to obesity, cerebral infarction and dysphagia. The interventions included for staff to monitor/record/report to physician, as needed, signs and symptoms of malnutrition, emaciation, muscle wasting, significant weight loss. Registered Dietician to evaluate and make diet change recommendations as needed. Resident #75's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated her cognition was moderately impaired. She had no range of motion limitations and required set-up/ clean-up assistance with eating. The area of swallowing for Resident #75 was coded for no swallowing disorders. A phone interview was conducted on 01/08/25 at 11:50 AM with the Registered Dietician. She verified she does complete the nutrition section of the MDS assessment. She explained that Resident #75 did have swallowing problems which resulted in choking and coughing when eating and drinking fluids. She stated it was an oversight that she did not accurately code the quarterly MDS assessment in the area of nutrition. An Interview was conducted on 01/09/25 at 1:15 PM with the Administrator. He stated he expected the MDS assessments to be accurately coded to reflect the residents' conditions, abilities, concerns, and diagnoses.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to transcribe orders for inserting a peripheral intravenous (IV) line, 0.9% normal saline (NS) (water and salt) solution, and flushes (solution that's injected into an IV line to clean it and prevent blockages) for a midline (a type of peripheral IV that is longer than a peripheral IV). This was for 1 of 1 resident (Resident #75) reviewed for IV fluids. The findings included: Resident #75 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, diabetes mellitus, and diverticulitis of intestines. Resident #75's quarterly Minimum Data Set (MDS) dated [DATE] indicated her cognition was moderately impaired. A review of the January 2025 physician orders revealed an order dated 01/01/25 to have a midline IV placed. The orders did not reveal orders for 0.9% NS at 500 milliliters (ml)/hour, a peripheral IV, or midline flushes to maintain patency. A review of the nursing progress notes revealed a note dated 01/02/25 that read Resident #75 had a midline IV placed in the right upper arm. The midline catheter was patent with 0.9% NS flowing per orders. An interview was conducted on 01/07/25 at 12:27 PM with Unit Manager #1. She stated Nurse #3 entered the order for Resident #75 to have a midline IV put in if staff were unable to get a peripheral line inserted. The midline IV was inserted by a healthcare company that specialized in vascular access on 01/02/25. She was aware Nurse #3 did not enter the order for the peripheral IV line, 0.9% NS fluids, or the midline IV flushes. A phone interview was conducted on 01/08/25 at 1:00 PM with Nurse #3. He stated he did not originally obtain the orders for Resident #75 to receive NS fluids and peripheral IV. He was told verbally by Supervisor #1 to try and get a peripheral IV line started on Resident #75 and that if he was unable to get the peripheral IV line inserted, they had an order for a midline IV to be placed. He then stated he did not enter the orders because he thought the Supervisor #1 had entered them. An interview was conducted on 01/08/25 at 3:18 PM with Unit Manager #1. She stated she was working on 01/02/25 when the healthcare company that specialized in vascular access inserted the midline IV for Resident #75. She also stated the policy did not include maintenance orders for the midline which included to flush lumen with NS followed by heparin every shift. She explained she forgot to transcribe the flush orders after the midline was inserted. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was conducted on 01/08/25 at 6:15 PM with Supervisor #1. She stated she did receive orders to attempt to insert a peripheral IV line and to start 0.9% NS at 500ml/hr because Resident #75's eating and drinking had slowed down. Supervisor #1 indicated Resident #75 was alert and verbally responsive and was displaying no signs or symptoms of distress. She explained she communicated with Physician Assistant (PA) #1 through the tele triage in the electronic documentation system. She also stated PA#1 gave orders that if they were unable to insert the peripheral IV line, they could order for a midline IV to be inserted. Supervisor #1 indicated she passed this on to Nurse #3 and asked him if he would transcribe the orders to the electronic medical record. She then explained the orders did not get transcribed due to a miscommunication between her and Nurse #3. A follow-up phone interview was conducted on 01/09/25 at 9:22 AM with Nurse #3 related to the orders not being entered into the electronic medical record. He stated that when he got an order for peripheral IV line insertion and fluids on a resident that he had attempted to insert the peripheral IV line prior to entering the order. If he was unable to successfully place the peripheral IV line, he would have called to get healthcare company specialized in vascular access to place a midline. He indicated he did not see an order for starting the 0.9% fluids on the electronic medical record although he was aware that was the reason for starting the peripheral IV line to begin with. He explained that he misunderstood Supervisor #1 related to transcribing the orders, he thought she had transcribed them. He also stated Resident #75 was alert and verbally responsive with no signs or symptoms of acute distress. An interview was conducted on 01/09/25 at 10:58 AM with Nurse Practitioner #3. She stated all orders should be entered into the electronic medical record when they are received. Orders for any IVs, 0.9% NS fluids, and IV flushes should be entered. Flushes should have been performed per facility policy. An interview was conducted on 01/08/25 at 2:50 PM with the Director of Nursing (DON). She indicated she was unaware the IV, IV flushes, or 0.9% NS orders for Resident #75 were not entered into the electronic medical record. The DON stated she expected the nurse who received the order to transcribe it when they received it. An interview was conducted on 01/09/25 at 1:15 PM with the Administrator. He stated he expected all orders to be entered into the electronic medical record as soon as they are received.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, and staff and Responsible Party interviews, the facility failed to send 2 of 9 residents (Resident # 188 and Resident # 189) with a list of their ordered medications and Discharge Summary when they were discharged from the facility on 7/26/2024. Resident #188 was discharged on [DATE] with Resident #189's Discharge Summary and Medication List. Resident #188 did not receive the correct Discharge Summary and Medication List until 7/29/2024. Resident #189 was discharged without a Discharge Summary and Medication List on 7/26/2024 and the Family Member returned to the facility on [DATE] to obtain the Discharge Summary and Medication List. Findings included: 1. Resident #188 was admitted to the facility on [DATE] with diagnoses of arthritis and fractures. An admission Minimum Data set assessment dated [DATE] indicated Resident #188 was cognitively intact and she planned to discharge home. Resident #188's Care Plan dated 7/11/2024 indicated she planned to discharge back to the community. Resident #188 discharged on [DATE]. A complaint/grievance report dated 7/31/2024 indicated Resident #188 was given another resident's (Resident #189's) discharge summary and medication list when she was discharged home from the facility. During an interview with Nurse #2 on 1/8/2025 at 11:09 am she stated she did remember Resident #188 receiving the wrong discharge summary and medication list, but she did not remember being made aware she made the mistake. The Director of Nursing was interviewed on 1/9/2025 at 1:37 pm and stated she spoke with Nurse #2 who discharged Resident #188 on 7/26/2024 and Nurse #2 stated she accidentally picked up the wrong packet and sent it home with Resident #188. The Director of Nursing stated Nurse #2 was responsible for placing the Discharge Summary and Medication List in Resident #188's packet and ensuring it was sent with her at discharge. 2. Resident #189 was admitted to the facility on [DATE] with diagnoses of traumatic subdural hematoma and history of fall. An admission Minimum Data Set assessment dated ,d+[DATE] indicated Resident #189 was mildly cognitively impaired and planned to discharge back to the community. Resident #189's Care Plan dated 6/28/2024 indicated she planned to return home with family assistance. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Responsible Party on 1/8/2025 at 1:02 pm she stated Resident #189's discharge paperwork that included her medication list was not sent home with her and the family returned to the facility to obtain the medication on the day Resident #189 discharged . Nurse #1 was interviewed on 1/8/2025 at 12:25 pm and stated the Social Worker had mixed up the discharge folder when Resident #189 was discharged home, and she was sent home with Resident #188's Discharge Summary and Medication List. Nurse #1 stated she was Resident #188's nurse on 7/26/2024 but she did not discharge her from the facility and did not remember who had discharged her. The Director of Nursing was interviewed on 1/9/2025 at 1:37 pm and she stated Nurse #1 was responsible for ensuring the discharged resident received the correct packet with a discharge summary and medication list at discharged . She stated Nurse #1 should have ensured Resident #189 had the packet when she was discharged home. On 1/9/2025 at 2:11 pm the Administrator was interviewed and stated Nurse #1 and Nurse #2 should have ensured the correct discharge paperwork was sent home with Resident #188 and Resident #189.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49160 Based on observations, record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) hours for 3 of 94 days reviewed for posted nurse staffing (11/23/24, 1/06/25 and 1/07/25). The findings included: A review of the daily posted nurse staffing sheets from October 2024 through January 2025 indicated the staffing sheet dated 11/23/24 had no RN hours documented for any of the 3 shifts. An observation conducted on 1/06/25 at 3:02 PM revealed the daily posted nurse staffing sheet had no RN hours documented for any of the 3 shifts on 1/06/25. An observation conducted on 1/07/25 at 8:30 AM revealed the daily posted nurse staffing sheet had no RN hours documented for any of the 3 shifts on 1/07/25. An interview with the Staffing Coordinator on 1/09/25 at 8:50 AM indicated she was responsible for completing the daily posted nurse staffing sheets. She revealed there was an RN in the facility at least 8 hours a day but she only documented RN hours on the staffing sheet if they worked on the floor and provided direct resident care. The Staffing Coordinator stated the Weekend Nursing Supervisor was the RN on 1st shift (7am-3pm) 11/23/24 and the MDS Coordinator was the RN on 1st shift 1/06/25 and 1/07/25, but she did not document their hours on the staffing sheet because they were supervisors and not working on the floor. An interview conducted with the Director of Nursing (DON) on 1/09/25 at 9:00 AM revealed the Staffing Coordinator was responsible for completing the daily posted nurse staffing sheets. She indicated there was an RN in the facility at least 8 hours a day and was either a nurse working the floor, the MDS Coordinator, Assistant Director of Nursing or the Weekend Nursing Supervisor. She stated the RN hours on the nurse staffing sheets from 11/23/24, 1/06/25 and 1/07/25 were not accurate. She stated the Weekend Nursing Supervisor worked 1st shift on 11/23/24 and the MDS Coordinator worked 1st shift on 1/06/25 and 1/07/25 and the hours they worked should have been documented on the posted nurse staffing sheet as RN hours.

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F 0756 Level of Harm - Minimal harm or potential for actual harm 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** 37281 Based on record review, and Consultant Pharmacist, and Director of Nursing interviews the Consultant Pharmacist failed to recognize a medication error when the facility failed to follow admission orders for hydrocortisone used for adrenal insufficiency. This was for 1 of 9 residents reviewed for medication errors (Resident #137). The findings included: Review of the hospital discharge orders for Resident #137 dated 8/28/24 revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.) Resident #137 was admitted to the facility on [DATE] with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The order concluded on 9/1/24. Review of Resident #137's medication administration record (MAR) documented that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on 8/30/24 and 8/31/24. Review of the medication administration record for September 2024 documented Resident #137 did not receive hydrocortisone 9/1/24 to 9/18/24. A pharmacist note written by Pharmacist #1 and dated 8/30/24 documented based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities . A phone interview was conducted on 1/8/25 at 3:03 PM with Pharmacist #1 and Pharmacist #3, her clinical manager. Pharmacist #1 reported she conducted a remote review of the admission orders for Resident #137 on 8/30/24. Pharmacist #1 reported during the admission review of information for new residents, she reviewed the information that was available in the electronic documentation system, and if the hospital discharge orders were not uploaded into the system, she would have looked at only the orders in the electronic documentation system. Pharmacist #3 explained that the facilities are encouraged to upload all information into the electronic documentation system, so all information is available to the pharmacist, but she did not recall if the hospital discharge orders were available during her review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up phone interview was conducted on 1/15/25 at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #2 performed a medication review for Resident #137 on 9/19/24 and reported she had not reviewed the hospital discharge orders, only the medication orders available in the electronic documentation system. Pharmacist #3 explained that after the interview on 1/8/25, she had investigated when the hospital discharge orders were available in the electronic documentation system and discovered that the facility had not scanned the orders in for 2 weeks. The Director of Nursing (DON) and Administrator were interviewed by phone on 1/16/25 at 11:09 AM. The DON reported the admission orders for Resident #137 were not uploaded into the electronic documentation system until 9/12/24 and the admission orders were not available for Pharmacist #1 to review on 8/30/24. The Administrator explained that typically the hospital discharge orders were put into the system by the corporate admissions team, but the orders for Resident #137 were emailed to the DON and that caused the delay loading the orders into the electronic documentation system.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, and Nurse Practitioner and staff interviews, the facility failed to prevent Resident #27 from receiving an extra dose of Lyrica (a medication used to treat nerve and muscle pain). This was for 1 of 9 residents whose medications were reviewed. The findings included: Resident #27 was admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis. A review of Resident #27's physician orders included an order dated 4/12/24 for Pregabalin (Lyrica) 75 milligrams (mg), give two capsules by mouth every 12 hours for pain. Review of a facility incident report dated 7/25/24 indicated that Resident #27 had received 300 mg of Lyrica instead of 150 mg. The nurse practitioner (NP) and responsible party were notified. A review of the Controlled Medication Utilization Record indicated the Lyrica was packaged in 150 mg capsules. On 7/25/24 at 9:00 AM Nurse #3 administered two capsules of Lyrica 150 mg instead of one as ordered. On 1/9/25 at 9:20 AM, a phone interview occurred with Nurse #3. He stated it was an oversight to have provided Resident #27 with 300 mg of Lyrica instead of 150 mg and most likely didn't review the narcotic card label that read 150 mg tablets were present. On 1/8/25 at 1:32 PM, an interview occurred with the Unit Manager #2, who completed the incident report dated 7/25/24. She explained that the pharmacy had packaged the Lyrica in 150 mg capsules and the order read to give two 75 mg capsules. During the investigation, Nurse #3 stated he inadvertently provided two capsules without looking at the medication label for the strength. The NP was notified and provided an order to monitor Resident #27. She recalled Resident #27 showed no ill effects from receiving 300 mg of Lyrica instead of 150 mg. An interview was conducted with the Director of Nursing (DON) on 1/9/25 at 9:07 AM, who reviewed the Controlled Medication Utilization Record and physician orders. It was discovered during the investigation, that Nurse #3 didn't review the medication label and inadvertently gave 300 mg instead of 150 mg of Lyrica. She added that she would expect the right dosage of medication to be given as ordered. A phone interview was completed with NP #2 on 1/9/25 at 9:17 AM and was able to recall Resident #27 receiving 300 mg of Lyrica instead of 150 mg in July 2024. She stated the extra dose of medication would not have caused any serious side effects as Resident #27 had been taking the medication for an extended period and most likely would have only caused drowsiness. She didn't feel this was a significant medication error and recalled ordering the staff to monitor Resident #27. NP #2 stated she would expect the nursing staff to provide the correct dosage of medication.

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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** 37281 Based on record reviews, and Nurse Practitioner (NP), Physician, Pharmacist, Endocrinologist, and staff interviews, the facility failed to prevent a significant medication error related to hydrocortisone prescribed for Resident #137 (hydrocortisone tablets are a steroid medication that works by decreasing inflammation, slowing down an overactive immune system or replacing the cortisol hormone that helps the body respond to stress) when Resident #137 missed a dose of hydrocortisone on ([DATE]), received the wrong dose of hydrocortisone for two days ([DATE] and [DATE]) and then the medication was abruptly stopped. Abrupt cessation of hydrocortisone for adrenal insufficiency can cause an adrenal crisis, where the body experiences a sudden drop in cortisol levels and can lead to life-threatening complications such as low blood pressure. Resident #137 went 18 days without receiving hydrocortisone. Resident #137 was scheduled to be seen by the Endocrinologist on [DATE] for the missed doses of hydrocortisone but she was transferred to the hospital on [DATE] at the request of family and admitted for weakness and low blood pressure ,d+[DATE] (normal blood pressure is ,d+[DATE]). This was for 1 of 9 residents reviewed for significant medication errors (Resident #137). The findings included: Review of the hospital discharge orders for Resident #137 dated [DATE] revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.) Resident #137 was admitted to the facility on [DATE] with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. Additional diagnoses for Resident #137 included diabetes, malnutrition, high blood sodium levels, breast cancer, syncope and collapse (fainting), and abnormal gait. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated [DATE] specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The stop date for the order was [DATE]. A physician order dated [DATE] for midodrine (a medication that elevates blood pressure) 10 mg every 8 hours for low blood pressure, do not give fore blood pressure over ,d+[DATE]. An NP admission note written by NP #4 dated [DATE] was reviewed. NP #4 documented Resident #137 was to take hydrocortisone 10 mg 1.5 tablets every evening with a stop date of [DATE]. Review of Resident #137's medication administration record (MAR) documented by Nurse #1 that on [DATE] Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on [DATE] and [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Health Services of Kannapolis	1810 Concord Lake Road Kannapolis, NC 28083

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medication administration record for [DATE] documented Resident #137 did not receive hydrocortisone from [DATE] to [DATE]. Review of the blood pressures for Resident #137 revealed the following: (normal blood pressure ,d+[DATE]) - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM - [DATE] ,d+[DATE] at 2:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Manager #1 was interviewed on [DATE] at 8:47 AM. Unit Manager #1 reported she transcribed the discharge hospital orders for Resident #137 upon her admission to the facility on [DATE]. Unit Manager #1 explained she read the hydrocortisone order to be for 3 days only and transcribed the order as she understood it. Unit Manager #1 reported she had not clarified the order with the hospital, and she had not called the Endocrinologist to ask for clarification. Unit Manager #1 reported she was not certain if the NP or the physician had reviewed the orders for Resident #137. Unit Manager #1 reported after she transcribed the hospital discharge orders, she asked Unit Manager #2 to check the orders and Unit Manager #2 did not report any transcription mistakes to her. When asked how she understood the orders for hydrocortisone, Unit Manager #1 explained she thought that the medication was to be given for only 3 days, and it didn't occur to her to call the Endocrinologist for clarification or ask the physician or NP to review the order. Unit Manager #1 reported she was not aware Resident #137 did not receive the medication on [DATE]. Unit Manager #1 reported she was not aware she had not correctly transcribed the order for hydrocortisone. Unit Manager #2 was interviewed on [DATE] at 10:07 AM. Unit Manager #2 reported she reviewed Resident #137's hospital discharge orders and the orders in the electronic documentation system and she did not notice the hydrocortisone was ordered for only 3 days. Unit Manager #2 reported when she reviewed the hospital discharge orders, she thought the medication was supposed to be ordered for 3 days only and she did not notice the dose was not ordered correctly. Unit Manager #2 reported she did not call the physician, NP, or the Endocrinologist for clarification of the hydrocortisone order. NP #4 was interviewed by phone on [DATE] at 12:50 PM. NP #4 reported she saw Resident #137 for her admission assessment on [DATE]. NP #4 explained she reviewed the hospital discharge orders and the orders in the electronic documentation system, but she did not notice the hydrocortisone was transcribed incorrectly. NP #4 reported hydrocortisone should not have been stopped abruptly because it would cause the body to lose an essential hormone and could cause an adrenal crisis. A pharmacist note written by Pharmacist #1 and dated [DATE] documented based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities . A follow-up phone interview was conducted on [DATE] at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #3 explained that hydrocortisone was used in adrenocortical insufficiency to replace the hormone cortisol the body made to maintain blood pressure and other functions. Pharmacist #3 reported she was unable to say if Resident #137 was affected adversely by the cessation of the hydrocortisone, as the Endocrinologist would have been responsible for managing the dosage of hydrocortisone. A physician history and physical note written by the Physician dated [DATE] documented hydrocortisone was to continue for adrenal insufficiency. The history and physical note did not document the hydrocortisone dose. A phone interview was conducted with the Physician on [DATE] at 1:03 PM. The Physician reported he had reviewed the hospital discharge orders but had not reviewed the orders transcribed into the electronic documentation system. The Physician reported the hydrocortisone was a significant medication error and the medication should not have been stopped abruptly. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The admission Minimum Data Set assessment dated [DATE] assessed Resident #137 to be cognitively intact. A NP progress note dated [DATE] was reviewed. NP #2 documented that on [DATE] Resident #137's family member asked about the hydrocortisone and NP #2 documented that the hydrocortisone appeared to not be ordered. NP #2 documented she discussed Resident #137's symptoms and labs with the Endocrinologist and it appears that (Resident #137) is supposed to be on hydrocortisone 15 mg in the morning and 10 mg in the evening, which is not currently ordered. (Resident #137) received 3 days of hydrocortisone since admission to the facility (per medication administration record). The note documented the Endocrinologist ordered hydrocortisone 20 mg to be given now and 10 mg in the evening for 3 days and then 15 mg in the morning and 10 mg in the evening. The note documented the endocrinologist wanted Resident #137 to come to the office to be seen on [DATE]. A physician order dated [DATE] to administer hydrocortisone 20 mg, give 1 tablet by mouth once per day for 2 days. Administer 10 mg tablet in the evening. Beginning [DATE] administer hydrocortisone 15 mg in the morning and 10 mg in the evening. NP #2 was interviewed on [DATE] at 9:40 AM. The NP reported she was not working on [DATE] when Resident #137 was admitted to the facility and NP #4 did the admission assessment. NP #2 reported she had reviewed Resident #137's medications (she was uncertain of the exact date) and made a call to the Endocrinologist to clarify the hydrocortisone order. NP #2 reported on [DATE] Resident #137's family member inquired about the hydrocortisone and NP #2 was able to talk to the Endocrinologist and received clarification of the order. NP #2 explained Resident #137 should have continued hydrocortisone and it should not have been stopped abruptly because it could cause an adrenal crisis if stopped. A follow-up phone interview was conducted with NP #2 on [DATE] at 10:50 AM. NP #2 clarified that the Endocrinologist had ordered hydrocortisone to be given immediately, plus gave orders for the medication for the following days. A follow-up interview was conducted by phone with the Physician on [DATE] at 2:48 PM and he reported the hydrocortisone dose would have been determined by the Endocrinologist, and NP #2 did the right thing by contacting the Endocrinologist for orders on [DATE]. The Physician explained stopping hydrocortisone abruptly could cause an adrenal crisis. The Physician reported he would have expected the Unit Manager to call him, the NP, the hospital or the Endocrinologist for clarification of orders. A nursing note dated [DATE] at 12:15 PM documented Resident #137 was taken to her endocrinology appointment by her family member but returned to the facility without being seen by the Endocrinologist. The family member reported he was running late and was unable to get Resident #137 to the appointment on time, and he requested Resident #137 be sent to the emergency room . Hospital emergency room records dated [DATE] for Resident #137 documented she was admitted to the hospital for weakness and low blood pressure. Blood pressure on admission to the emergency room was , d+[DATE]. Resident #137 was a [AGE] year-old female with a past medical history significant for adrenal insufficiency. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A computed tomography (CT) scan was completed on [DATE] and a large volume pneumoperitoneum (a condition where air or gas was in the abdominal cavity) was revealed, leading to concerns for a large bowel perforation. The decision was made with Resident #137 and her family member to undergo a laparotomy. Resident #137 was taken urgently to the operating room at 9:00 PM on [DATE] for lysis of adhesions, resection of the colon with a colostomy. After the surgery, Resident #137 was transferred to ICU, and she developed worsening low blood pressure. Lab results showed severe acute blood loss anemia. Resident #137 lost pulses and her abdomen was reopened in the ICU where approximately 750 cubic centimeters of blood were discovered. Resident #137 received several rounds of cardiopulmonary resuscitation efforts, and she died at 5:10 AM on [DATE]. The Endocrinologist was interviewed by phone on [DATE] at 4:49 PM. The Endocrinologist reported she recalled talking to NP #2 and ordered Resident 137 to receive hydrocortisone 20 mg immediately. The Endocrinologist explained that stopping hydrocortisone abruptly would have caused an adrenal crisis and this crisis would have caused Resident #137 difficulties with controlling her blood pressure and caused fatigue, as well as other symptoms. The Endocrinologist explained that the adrenal crisis would not have contributed to the bleeding post-operatively. The Administrator was notified of immediate jeopardy on [DATE] at 10:45 AM. The facility submitted the following corrective action plan with a compliance date of [DATE]. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice On [DATE] Resident #137 was admitted to the facility. The hospital discharge summary orders for Resident #137 read: hydrocortisone 10mg tablet, (administer) 15mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food, double or triple doses for illness for 3 days as directed. Resident #137 had a diagnosis of adrenal insufficiency and was prescribed hydrocortisone. The Unit Manager transcribed the order on [DATE]: hydrocortisone 10 milligrams (mg) give 1.5 tablet by mouth in the afternoon for inflammatory for 3 days until [DATE]. Resident #137's Medication Administration Record (MAR) was reviewed and there was no documentation of any doses of hydrocortisone administered from [DATE] - [DATE]. One 20mg Hydrocortisone was administered the morning of [DATE]. On [DATE], Resident #137 was transferred to the hospital, and she underwent a laparotomy for lysis of adhesions, resections of the sigmoid colon with end colostomy. Post surgery she was transferred to the Intensive Care Unit (ICU) and developed hypotension and was found to have experienced severe acute blood loss anemia and died on [DATE]. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The facility recognizes that all newly admitted and readmitted residents have the potential to be affected from the prior noncompliance with significant medication errors All newly admitted and readmitted residents between [DATE] - [DATE] medication orders were audited by the Director of Nursing and or Unit Managers to ensure orders were transcribed correctly on [DATE]. 30 residents were audited with no discrepancies noted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quality review was completed on [DATE] by the Director of Nursing and or Unit Manager of current residents with a diagnosis of adrenal insufficiency and with hydrocortisone orders to ensure medication is ordered, transcribed correctly, and being given as ordered, no discrepancies noted. On [DATE], a quality review of current residents admitted and readmitted within the past 30 days prior to [DATE] was conducted by the Director of Nursing and Unit Manager to ensure all other newly admitted or readmitted patients' medications are administered per physician orders and transcribed correctly on the Medication Admission Record (MAR). Address what measures will be put into place or systemic changes made to ensure the deficient practice will not recur. On [DATE], a Root Cause Analysis was completed by the Director of Clinical Services, and the Executive Director regarding omission of medication administration for resident #137. It was determined through root cause and analysis that the significant medication error was due to the oversight of transcribing the orders incorrectly and there was no verification conducted by a second nurse. The Director of Nursing and/or the nurse managers provided education on [DATE] to current nurses on the importance of transcribing all new orders from discharge summaries, verified by 2 nurses to ensure medications are transcribed and administered per physician orders to the residents. Newly hired nurses will be educated on hire during the orientation process. The Executive Director provides oversight for the education of nurses to ensure that 100% of all licensed staff were reeducated on the importance of administrating all ordered medications. Education was completed on [DATE]. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and or Nurse Managers will conduct Quality Improvement Monitoring 5 times per week for 4 weeks, 1 time per week for 3 months and 1 time monthly for 3 months in clinical morning meeting to review the medication administration records of all new residents when admitted or readmitted to ensure all medications are transcribed correctly and medications are administered as ordered per physician starting [DATE]. Upon receiving hospital discharge summaries medication orders are verified with the provider, 2 nurse verification system; 1 Nurse transcribes all orders, then 1 Nurse verifies/confirms that orders were transcribed correctly. They also review the previous days admissions during the morning meeting and verify during the meeting. On [DATE], when the deficient practice of transcribing orders that resulted in a significant medication error was identified the center Executive Director conducted an ADHOC Quality Assurance Performance Improvement (QAPI) meeting to determine the root cause analysis of the deficient practice. The QAPI committee put a plan of action in place to include quality improvement monitoring and the frequency of monitoring beginning on [DATE] to ensure medication administration orders were transcribed correctly and medications were administered as ordered. The QAPI committee included the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, a Unit Manager, Wound Care Nurse, and two floor Nurses. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for 4 months. Quality Improvement schedule will be modified based on findings of the monitoring. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Center Executive Director alleges compliance on [DATE]. The corrective action plan was validated on [DATE]. Education for all nurses was reviewed, and interviews were conducted with the Unit Managers and the staff nurses to confirm receipt of the education. Initial audits of new admissions from [DATE] to [DATE] were reviewed and no significant medication errors were identified. Quality reviews of current residents and new admissions were reviewed, and no issues were identified. Morning meeting and QAPI meeting notes were reviewed with the DON and Administrator. The immediate jeopardy removal date of [DATE] and the compliance date of [DATE] was validated.