

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Arbors at Stow		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 L'Ermitage Pl Stow, OH 44224	

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)
<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297</p> <p>Based on closed medical record review, hospital record review, pharmacy regimen review, policy review, resident representative interview and staff interviews, the facility failed to prevent a significant medication error for Resident #150. This resulted in Immediate Jeopardy and serious life-threatening harm when Resident #150, who had a known history of hypothyroidism and myxedema coma (a life-threatening condition caused when the level of thyroid hormones become very low or hypothyroidism which causes lethargy, confusion, weakness, and difficulty breathing) in 2021 and 2022, was not ordered or administered, Synthroid, used to treat hypothyroidism from admission on 09/07/23 through 04/20/24 when the resident was transferred to the hospital due to a deterioration in the resident's condition. On 04/20/24 the resident was transferred to the hospital with decreased consciousness, weakness, decreased appetite and trouble swallowing. The resident's heart rate was bradycardic at 46 beats per minute. The resident was admitted to the intensive care unit (ICU) for treatment of acute toxic metabolic encephalopathy likely myxedema coma and elevated thyroid stimulating hormone (TSH) of 59.9 (normal 0.5 and 5 microunits per milliliter). The hospital noted a concern for medication non-compliance at the nursing home due to no recent fill history and the medication/Synthroid not being listed on the resident's nursing home paperwork. Information obtained during the investigation revealed following the incident, the resident never walked again, developed a pulmonary embolism, and subsequently passed away on 07/24/24. This affected one resident (Resident #150) of five residents reviewed for medication errors. The census was 128.</p> <p>On 09/19/24 at 10:08 A.M., the Administrator, Director of Nursing (DON), Regional Nurse (RN) Regional #815, Administrator in Training (AIT) #816 and Licensed Practical Nurse (LPN) Unit Manager (UM) #860 were notified Immediate Jeopardy began on 04/20/24 when Resident #150 was transferred to the emergency room and subsequently diagnosed with acute toxic metabolic encephalopathy likely myxedema coma and elevated thyroid stimulating hormone (TSH). At the time of admission (09/07/23) the resident's admission order for Synthroid was not transcribed accurately by the nursing staff and the resident's Synthroid (hypothyroidism medication) was not administered from 09/07/23 until the resident's discharge to the hospital on 04/20/24. The facility failed to identify the lack of Synthroid medication for Resident #150 with a history of myxedema coma in 2021 and 2022.</p> <p>The Immediate Jeopardy was removed on 09/19/24 when the facility implemented the following corrective actions:</p> <p>On 04/20/24 at 7:41 P.M. Resident #150 was transferred to the hospital and did not return to the facility. The resident was subsequently discharged to an alternate facility post-hospitalization .</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365720
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/18/24 from 12:30 P.M. to 12:40 P.M. the facility completed an ADHOC Quality Assurance and Performance Improvement (QAPI) meeting with the Administrator, Physician #825 (medical director), the DON, RN #937 (staff development coordinator), LPN UM #906, Admissions #969, LPN UM #860, Social Service Designee (SSD) #884, Licensed Social Worker (LSW) #820, LPN Minimum Data Set (MDS) #809, Human Resources (HR) #872 to discuss the survey concern and to develop an immediate plan of correction/action that was approved by the Medical Director.</p> <p>On 09/18/24 at 12:30 P.M., RN Regional #815 educated the DON and RN #937 on a new Medication Reconciliation Addendum which included two nurse verification at the time of admission, speaking directly with the provider Certified Nurse Practitioner (CNP)/physician via phone (no texting, faxing or picture taking) and included orders that were discontinued (on admission) must be noted in the admission progress notes.</p> <p>On 09/18/24 from 12:40 P.M. to 4:00 P.M., RN #937 educated 37 of 37 licensed nurses on a new Medication Reconciliation Addendum as well as transcribing physician orders and notifying the physician/CNP when a new admission/readmission entered the facility and verifying medications with two nurses and with the provider as well as entering a progress note reflecting verification of medications and any medications that were discontinued at the time of the verification. All nurses were educated prior to working their next shift.</p> <p>On 09/18/24 from 2:00 P.M. to 3:15 P.M., RN MDS #982 conducted care plan audits for all residents with diagnoses of hypothyroidism and hyperthyroidism to ensure care plans were addressed for their specific health needs. Care plans were revised and updated as needed.</p> <p>On 09/18/24 from 2:00 P.M. to 3:15 P.M., LPN UM #860 and LPN UM #906 audited all admissions/readmissions in the last two weeks to verify medications were transcribed correctly and verified with the physician/CNP timely.</p> <p>On 09/18/24 from 2:00 P.M. to 3:00 P.M. the DON completed chart audits on all residents with a diagnosis of hypothyroidism and all residents receiving Synthroid (Levothyroxine) to ensure the orders were transcribed properly, and the medications was administered as ordered.</p> <p>On 09/18/24 from 2:34 P.M. to 2:44 P.M., RN Regional #815 completed one-to one education for the two nurses who admitted Resident #150, LPN #822 and LPN #823, on medication reconciliation to include two nurse verification at the time of admission, speaking with the provider CNP/physician via telephone (no texting, no faxing and no picture taking) and any orders that were discontinued must be noted in the admission progress note.</p> <p>On 09/19/24 from 1:45 P.M. to 1:50 P.M., Regional RN #815 educated CNP #824 and Physician #825 regarding progress notes and the need for a plan (of care) for diagnosis present in each resident's medical records.</p> <p>On 09/19/24 from 1:50 P.M. to 1:55 P.M., Regional RN #815 educated Pharmacist #840 on ensuring pharmacy reviews included all diagnoses having an appropriate plan of care in place including medications administered to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Beginning 09/19/24 the facility implemented a plan for the DON/designee to review CNP and physician notes weekly for four weeks to ensure the diagnosis of hypothyroidism has an appropriate plan in place.</p> <p>Beginning on 09/19/24 the facility implemented a plan for the DON/designee to review pharmacy recommendations monthly for three months to ensure residents with a diagnosis of hypothyroidism have been reviewed and have an appropriate plan of care in place to address the diagnosis of hypothyroidism.</p> <p>Beginning 09/19/24, the DON/designee would complete daily chart audits, Monday through Sunday for three months on all new admissions/readmissions to ensure the orders were transcribed properly, medications were verified with two nurses and with the provider and the progress note entered in the medical record reflected verification of orders as well as any changes made during the verification progress. The audits would continue until compliance could be maintained for three consecutive months.</p> <p>The facility would complete weekly QAPI meetings for four weeks to review all audits regarding this action plan.</p> <p>Although the Immediate Jeopardy was removed on 09/19/24, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of Resident #150's previous skilled nursing facility (SNF) discharge paperwork (used for the resident's 09/07/23 facility admission) revealed the resident was receiving the thyroid medication, Synthroid 125 micrograms (mcg) one tablet by mouth one time a day for hypothyroidism. The medication order had been in place since 04/12/22.</p> <p>Review of Resident #150's closed medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia, anxiety and hypothyroidism. Resident #150 was transferred to the emergency roiaگون on [DATE] and did not return to the facility.</p> <p>Review of Resident #150's progress note dated 09/07/23 at 6:39 P.M. and authored by LPN #822 revealed the resident arrived at the facility from another SNF around 5:00 P.M. The resident was alert and oriented to self.</p> <p>Resident #150's medical record revealed Guardian/Conservator #801 was listed as the resident's responsible party and included responsibility for financial, clinical and legal needs.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #150's History and Physical form dated 09/11/23 authored by CNP #824 indicated on 09/07/23, the resident was admitted to the SNF from another SNF for continuation of care. Per the previous facility records, the resident became increasingly agitated, exit-seeking, and was wandering in and out of other resident's rooms. At times, the resident would also become combative with staff and refuse care. The power-of-attorney (POA) requested the resident's transfer to a secured nursing facility. The resident's past medical problems included hypertension, anemia, dementia, psychosis, malnutrition, depression, anxiety, insomnia, hypothyroidism, myxedema coma. There was no plan or information related to treatment or monitoring of the resident's hypothyroidism/myxedema coma conditions contained in the history and physical.</p> <p>Review of Resident #150's lab work form dated 09/11/23 revealed the resident's TSH 3 (thyroid stimulating hormone) level was 4.98 (normal 0.340 to 5.50). (TSH levels below 0.4 indicate hyperthyroidism, while levels of about 4.0 and above indicate hypothyroidism.)</p> <p>Review of Resident #150's care plans dated 09/19/23 revealed the resident had impaired metabolic status related to hypothyroidism, malnutrition, hyperlipidemia and myxedema coma with an intervention (dated 09/19/23) to administer medications and treatments as ordered; and an intervention dated 09/19/23 to observe for and report to the physician, CNP changes in signs/symptoms of hypothyroidism (fatigue, increased sensitivity to cold, constipation, dry skin, unplanned weight gain, muscle weakness, elevated cholesterol levels, muscle aches/tenderness, stiffness, joint pain/swelling, thinning hair, slowed heart rate, depression, goiter, decline in memory). Encourage the resident to report onset of new or worsening symptoms to the nurse.</p> <p>A second plan of care related to activities of daily living (ADL) revealed the resident had ADL self-care performance deficits related to dementia, depression, fluctuating ADLs, generalized weakness and hypothyroidism with an intervention dated 09/19/23 to report changes in ADL abilities to the nurse, physician, CNP and/or therapy.</p> <p>Review of Resident #150's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #150's medication administration records (MARS) and treatment administration records (TARS) from 09/07/23 through 05/03/24 revealed no evidence the resident's Synthroid medication for hypothyroidism was ordered or administered from admission (09/07/23) through discharge (04/20/24).</p> <p>Review of Resident #150's monthly pharmacy reviews authored by Consultant Pharmacist #839 and completed from 10/01/23 to 04/20/24 revealed no evidence Consultant Pharmacist #839 identified the resident's hypothyroidism, addressed the resident's lack of medication to treat the hypothyroidism and/or addressed the lack of laboratory testing related to the resident's hypothyroidism during this time period.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #150's progress note dated 04/20/24 at 7:41 P.M. and authored by LPN #826 revealed the resident was observed with a decreased heart rate and increased confusion. The resident had decreased consciousness, weakness, decreased appetite and trouble swallowing. The resident's vital signs included: 110/68 blood pressure, heart rate (HR) of 46 (bradycardic), oxygen level of 94% on room air. New orders were obtained to send the resident to the emergency room (ER). The resident's power of attorney (POA)/(guardian) was notified. The CNP gave new orders to send the resident out via emergency services squad (EMS) to the hospital and the EMS arrived and transferred the resident to the hospital via a cot at 7:40 P.M.</p> <p>Review of Resident #150's progress note dated 04/21/24 at 8:04 A.M. (interdisciplinary progress note or IDT) authored by LPN Unit Manager #827 indicated the resident was admitted to the intensive care unit (ICU) with hypotension and acute metabolic encephalopathy. The CNP and guardian were made aware.</p> <p>Review of Resident #150's hospital History and Physical Progress Note dated 04/21/24 at 12:29 A.M. revealed the resident had a past medical history (PMH) of hypothyroidism, history of myxedema coma in 2022, depression and recurrent admissions related to medication non-compliance. She presented from the SNF to the ER for changes in mental status and after being found on the floor. She had hypotension, hypothermia and multiple lab abnormalities.</p> <p>Review of Resident #150's hospital Initial Consult Endocrinology note dated 04/21/24 at 1:43 P.M. revealed the resident had a known history of hypothyroidism since 2016 according to prior records. The resident was not able to give any history herself. She was admitted on [DATE] for obtundation (state of mild to moderate alertness reduction), felt to be in part due to myxedema coma. She had two previous admissions for myxedema coma in 2021 and 2022. The resident's TSH level on 04/20/24 was 59.9 (normal range 0.270 to 4.200 mIU/L or milli-international units per liter), free T3 was less than 0.4 (normal 2.3 to 4.1 pg/ml or picograms per milliliter) and free T4 was less than 0.1 (normal 0.9 to 1.7 ng/dl or nanograms per deciliter). The assessment impression indicated the resident had myxedema coma because the labs appeared that she had not been receiving Levothyroxine (Synthroid) or it may have been administered incorrectly.</p> <p>Review of Resident #150's hospital Progress Note form dated 04/22/24 at 6:48 A.M. revealed the resident had a PMH of hypothyroidism and major depressive disorder presented from a SNF with altered mental status after being found on the floor. She was not alert or awake and would grimace to painful stimuli but could not arouse her fully to have a conversation. When she presented initially to the ED, she would say only her name but not answer any other questions. In the ED, her blood pressure was 95/60 (hypotensive) with a heart rate of 53 (bradycardic). The resident's TSH level was 59.9 with a T4 blood level of less than 0.1 and a T3 blood level of less than 0.4. She was administered intravenous (IV) Solumedrol 100 mg and 500 cc of dextrose 5% half normal saline (NS) and 200 mcg of IV Levothyroxine. The Assessment and Plan section of the form indicated the resident presented to the ER from the SNF with altered mental status after being found on the floor. She was found to have elevated TSH, low T3-T4 and a concern for central nervous system (CNS) infection given the resident's neck rigidity on presentation. The resident was admitted for treatment of acute toxic metabolic encephalopathy likely myxedema coma and elevated TSH of 59.9. The concern for medication non-compliance at the SNF was identified due to no recent fill history and (no Synthroid) being on the NH paperwork.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/18/24 at 12:01 P.M., LPN #822 was contacted by telephone by the Administrator, Regional RN #815 and surveyor and the nurse indicated she could barely remember admitting Resident #150 but felt the resident came at shift change so she probably started the admission, and the next nurse (LPN #823) would have finished the admission.</p> <p>On 09/18/24 at 12:07 P.M., LPN #823 was contacted by telephone by the Administrator, Regional RN #815 and surveyor and the nurse stated he was new to his nursing role when Resident #150 was admitted , and he felt he had faxed the admission orders to the physician or CNP for review and they would have text him back with any changes. He could not remember if Resident #150 was ordered Synthroid. He stated the morning manager would have helped him with this admission, and he could not remember the details. LPN #823 indicated he had deleted the messages from the physician from his phone.</p> <p>Telephone interview on 09/18/24 at 12:15 P.M. with CNP #824 revealed she did not have a fax machine, and the facility would have to call her for resident admission orders. CNP #824 revealed the standards of practice for new admissions was to draw labs upon admission including a comprehensive metabolic panel which indicates the sodium, potassium, creatinine, calcium and albumin levels; lipid profile which indicates the cholesterol and triglyceride levels; magnesium level; Vitamin B12 level; and TSH level. During the interview, CNP #824 stated she could not remember if she gave admission orders for Resident #150.</p> <p>Telephone interview on 08/18/24 at 12:32 P.M. with Physician #825 indicated the CNP usually handled admission orders, and he did not remember the specifics about Resident #150's admission. Physician #825 stated he would review the resident's chart and return the phone call.</p> <p>Interview on 09/18/24 at 12:54 P.M. with the DON revealed Resident #150's Synthroid was not transcribed accurately during the resident's admission from the previous SNF by the admitting nurse and the resident did not receive the Synthroid (hypothyroidism medication) as ordered (during her stay in the facility).</p> <p>Attempted interviews on 09/18/24 and 09/19/24 with Resident #150's guardian (Guardian #801) revealed the guardian was not available.</p> <p>Interview on 09/19/24 at 8:45 A.M. with the Administrator, DON and AIT #816 confirmed LPN #822 was the nurse who had admitted Resident #150, and the nurse did not transcribe the physician (medication) order (for the resident's Synthroid) correctly. The Administer revealed the facility revised their Medication Reconciliation policy on 09/18/24 (following surveyor investigation) to reflect new procedures on admission orders including the facility must speak to the physician or CNP on the phone (no texting, no faxing etc); two nurses must verify admission orders and any orders that were discontinued by the provider must be put in the admission progress note (spelling out each medication that was discontinued).</p> <p>A second telephone interview on 09/19/24 at 10:42 A.M. with Physician #825 revealed he remembered Resident #150 and stated her heart rate decreased, and she was sent to the hospital with a change in condition in 04/2024. At the time of the interview, Physician #825 stated he was under the impression two nurses always reviewed the resident medication list for accuracy and per the revised policy going forward, the facility would ensure two nurses verified resident orders on admission.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 09/19/24 at 2:37 P.M. with Client Services Manager #400 revealed he worked with Consultant Pharmacist #839, who was the facility pharmacist, but this pharmacist was on vacation. Client Services Manager #400 stated he was unsure how Resident #150's Synthroid hypothyroidism medication was missed for several months.</p> <p>Interview on 09/19/24 at 3:04 P.M. with RN Regional #815 revealed the consultant pharmacist should have caught during the monthly pharmacy reviews that Resident #150's Synthroid was not reordered per the prior facility's physician orders or identified the resident had a diagnosis of hypothyroidism and questioned where the medication was to correct the hypothyroidism. RN Regional #815 stated the facility reviewed the consultant pharmacist recommendations for several months following Resident #150's admission and no recommendations were made regarding the resident's diagnosis of hypothyroidism or the use of Synthroid medication for the hypothyroidism.</p> <p>Review of the Admissions to the Facility policy revised 02/01/22 revealed prior to or at the time of the admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least the type of diet; medication orders including a medical condition or problem associated with each medication; and care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan.</p> <p>Review of the Medication Administration policy revised 01/17/23 revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Review of the Medication Reconciliation policy revised 01/30/24 revealed medication reconciliation involved the collaboration with the resident/representative and multiple disciplines including admission liaisons, licensed nurses, physicians and pharmacy staff. Resident identifiers would be verified on all medication labels and documents containing medication information to verify the correct person and that the documents were placed in the correct resident's medical record.</p> <p>Review of the Medication Reconciliation policy revised 09/18/24 revealed the facility must speak to the physician or CNP on the phone (no texting, no faxing etc) for admission orders. Two nurses must verify admission orders and any orders that were discontinued by the provider must be put in the admission progress note (spell out each medication that was discontinued).</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00157684 and Complaint Number OH00157142.</p>		