

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Heritagespring Healthcare Center of West Chester		STREET ADDRESS, CITY, STATE, ZIP CODE 7235 Heritagespring Drive West Chester, OH 45069	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, facility document review, and policy review, the facility failed to ensure medication was dispensed and administered as ordered to one (#149) of six residents reviewed for unnecessary medication. The census was 126. Findings included: Review of a medical record revealed the facility admitted Resident #149 on 05/23/25. The resident had a medical history that included a diagnosis of insomnia. Further review revealed the facility discharged Resident #149 home on [DATE]. Review of an admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/29/25, revealed Resident #149 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS assessment revealed Resident #149 received hypnotic medication during the assessment's look-back period. Review of Resident #149's care plan included a focus area initiated on 05/23/25, that indicated the resident was receiving a sedative/hypnotic medication, zolpidem for a diagnosis of insomnia. The interventions instructed staff to administer the medication as ordered by the physician (initiated 05/23/25). Review of Resident #149's hospital Discharge summary dated [DATE] revealed an order for zolpidem 10 milligrams (mg) at bedtime. Review of Resident #149's order recapitulation report included an order dated 05/23/25 for zolpidem tartrate 10 mg at bedtime for insomnia. Review of Resident #149's medication administration record (MAR) for May and June 2025 revealed the resident's zolpidem was due to be administered at 9:00 P.M., nightly. The MARs revealed no documented evidence (the MAR was blank) that staff administered the 05/23/25 (day of admission) and 06/01/25 doses of medication. The MAR revealed that on 05/24/25, 05/25/25, 05/30/25, and 06/02/25, staff documented 16 for the doses. Per the MAR, code 16 indicated Medication Unavailable/Pharmacy Notified. The MAR also indicated that staff documented 9 for the resident's 05/31/25 dose of zolpidem, which indicated, Other: See Progress Notes. Review of Resident #149's progress notes dated 05/26/25 at 10:08 P.M. revealed the facility nurse contacted the on-call physician for a new prescription for zolpidem 10 mg for insomnia at bedtime and the nurse was awaiting a response. Review of Resident #149's document titled, Controlled Drug Receipt Record/Disposition Form, revealed staff documented that the pharmacy delivered three zolpidem 10 mg pills for Resident #149 on 05/27/25. Review of Resident #149's progress notes dated 05/31/25 at 10:52 A.M. revealed the pharmacy stated a new prescription was needed. Review of Resident #149's document titled, Controlled Drug Receipt Record/Disposition Form, revealed the pharmacy did not deliver zolpidem medication again until 06/03/25, the day the resident discharged from the facility. The facility provided a list of medications stocked in their Pyxis (an automated medication dispensing system) and the list revealed zolpidem was not one of the medications available. During an interview on 09/17/25 at 2:25 P.M., Licensed Practical Nurse (LPN) #6 stated that when a resident's medication was not available, the requirement was for nursing staff to contact the pharmacy and document the communication. LPN #6 further stated that staff could get medication from the Pyxis if the medication was available. During an interview on 09/17/25 at 2:31 P.M., Registered Nurse (RN) #5 stated the pharmacy notified the facility if a medication was missing, when an order required clarification, or a new prescription was needed. RN #5 stated the facility communicated the needs as soon as possible or had pharmacy contact the physician for a prescription. RN #5 further stated it was critical for medications to be delivered timely, particularly when they were not available in the Pyxis. On 09/17/25 at 3:15 P.M., Unit Manager (UM) #3 stated that upon admission, medication orders were sent to the pharmacy, and pharmacy usually delivered the medications the same night. UM #3 stated that if the medication was not in the Pyxis, the nurse must call the pharmacy, and delivery typically occurred within two hours. He stated for Resident #149, the prescribed hypnotic was not available, and the nurse documented the pharmacy was notified. During an interview on 09/17/25 at 3:57 P.M., the Director of Nursing (DON) stated the best practice was to have signed prescriptions available on admission so staff could fax them to the pharmacy and have medications delivered that evening. The DON stated that she was not aware that Resident #149's medication had not been available. The DON stated the facility contacted an on-call nurse practitioner (NP) who called the pharmacy and gave an order for three zolpidem; however, neither staff nor pharmacy called to get another prescription. She stated it was not the facility's standard not to administer medications. The DON stated that she expected staff to call the physician and get a prescription or reach out to her to assist so they could give the resident their medication. During a telephone interview on 09/19/25 at 10:06 A.M. Pharmacist #25 stated that when prescriptions were needed, the pharmacy contacted the</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>Ensure that residents are free from significant medication errors.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on record review, staff interview, and policy review, the facility failed to ensure a resident was free from significant medication errors. This resulted in Immediate Jeopardy and serious life-threatening harm to Resident #148, when on [DATE], during admission from another long-term care facility, the facility failed to identify that pages of admission orders were missing from Resident #148's facsimiled (faxed) documents from the referring facility. Subsequently, the facility failed to accurately reconcile Resident #148's medication list and failed to identify an order for apixaban (an anticoagulant medication used to prevent blood clots), which resulted in the resident not receiving the medication. On [DATE], Resident #148 became short of breath and was transferred to a hospital where it was determined Resident #148 had a pulmonary embolism (blood clot in the lungs) and later expired. This affected one (Resident #148) of six residents reviewed for unnecessary medications. The census was 126. On [DATE] at 9:00 A.M., the Administrator, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #100, Corporate Nurse Educator (CNE) #200, and Regional Nurse #350 were notified Immediate Jeopardy began on [DATE] when, upon admission to the facility, admission orders for administration of apixaban were missing from Resident #148's transfer documents from a previous facility. Resident #148 did not receive the medication throughout the stay in the facility, and on [DATE] Resident #148 began to experience shortness of breath and increased heart rate prompting an evaluation in the hospital. While in the hospital, Resident #148 was diagnosed with a pulmonary embolism and subsequently died as a result. The Immediate Jeopardy was removed and corrected on [DATE] when the facility implemented the following corrective action: Resident #148 no longer resided in the facility. Resident #148's medical record was reviewed by the DON on [DATE]. This included but was not limited to a review of Resident #148's medication list from admission and the admission orders transcribed into electronic medical record (EMR). On [DATE], CNE #200 conducted a review of Resident #148's medical record including but not limited to physician orders, care plans, and administration records. On [DATE], Regional Minimum Data Set (MDS) Nurses #220, #230, #235, and #240 completed an audit of all residents who were admitted to the facility in the last 60 days to ensure admission orders were transcribed correctly into the resident's medical record. Any concerns noted were reviewed with the Nurse Practitioner (NP) #360 and orders updated as needed by licensed nurses by [DATE]. On [DATE], Regional MDS Nurses #220, #230, #235, and #240 verified that all pages of admission orders from transferring facilities were received/present. On [DATE], the DON or designee completed an audit of current residents with atrial fibrillation diagnosis and residents receiving anticoagulant medications for appropriateness. On [DATE], the NP #360 reviewed current residents with atrial fibrillation diagnosis and residents receiving anticoagulant medications for appropriateness. On [DATE], Nurse Educator #280 completed a medication administration observation. No concerns were noted. On [DATE], Registered Nurse (RN) #15 and RN #16 were immediately provided education by the DON. This education included but was not limited to ensuring admitting orders are received and transcribed into the medical record, that all pages of the orders are received, and hard copy of the orders are received upon resident's arrival to facility. By [DATE], licensed nurses were provided with an additional in-service education by the DON and ADON #100. This education included but was not limited to ensuring admission medication orders are reviewed and transcribed into resident medical records, that all pages of the orders are received and that a hard copy of orders is received upon resident's arrival to the facility. A performance improvement (PI) audit worksheet was being completed to verify residents' admitting orders are transcribed completely (including all pages are verified) into the medical record. The PI was being completed by the DON or designee for any residents admitting to the facility for the previous day, completing the audit daily for seven (7) days, then three (3) times per week for four (4) weeks, then weekly for 4 weeks, and then monthly. The results of this worksheet will be reviewed by the Quality Assurance and Performance Improvement (QAPI) team. Quality Assurance meetings were held on [DATE] and [DATE] with the Administrator, Medical Director, the DON, CNE #200, Regional Nurse #350, and Consultant Pharmacist #400. On [DATE] through [DATE], five (Residents #6, #9, #11, #58, and #80) additional medical records were reviewed with no concerns for significant medication errors identified. Findings include: Review of the medical record revealed the facility admitted Resident #148 on [DATE] from another nursing home. Resident</p>		