STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 21613 Based on record review and staff interview, it has been determined the facility failed to ensure that medication irregularities were identified by the pharmacist during the monthly drug regimen review for 2 of 4 residents reviewed, Resident ID #s 1 and 3. Findings are as follows: Review of the facility policy titled, Medication Regimen Review and Reporting revised 1/2023, revealed Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risk associated with medications. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. Additional, review of the facility's policy revealed that the pharmacy consultant reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. According to the document released by the Food and Drug Administration, revised 8/2021, indicates Abiraterone Acetate in combination with prednisone is indicated for the treatment of patients with metastatic prostate cancer. For patients with baseline moderate hepatic (liver) impairment, reduce the recommended dose of Abiraterone Acetate to 250 mg once daily and to monitor liver function tests prior to the start of the medication and weekly for the first month. Patients with severe hepatic impairment, this medication is to be avoided. Abiraterone Acetate may cause high blood pressure, low potassium levels and fluid retention. Additional review revealed adverse reactions of this medication includes, but are not limited to, fatigue, high blood pressure, nausea, vomiting, swelling, low potassium levels, diarrhea and upper respiratory infections. 1. Record review revealed Resident ID #1 has a diagnosis including, but not limited to, liver cancer. Additionally, the record failed to reveal evidence that Resident ID #1 has a diagnosis of prostate cancer. Record review revealed a physician's order dated 12/20/2024 for Abiraterone Acetate (a medication prescribed to treat prostate cancer), 1000 milligrams (mg) daily. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Further record review revealed that the Abiraterone Acetate was incorrectly transcribed into Resident ID #1's medical record, as it was intended for another resident. Review of the December 2024 and January 2025 Medication Administration Records revealed Resident ID #1 received Abiraterone Acetate from 12/21/2024 through 1/2/2025, for a total of 13 days. Further record review revealed that the pharmacy monthly medication review was completed for Resident ID #1 on 12/28/2024 and the pharmacist failed to identify any irregularities. During a surveyor interview on 1/22/2025 at 10:13 AM with the Pharmacy Consultant, she revealed that she completed the MRR for Resident ID #1 on 12/28/2024. She further revealed that the Abiraterone Acetate is typically ordered for a diagnosis of prostate cancer. Additionally, she revealed that she should have verified if Resident ID #1 had a diagnosis of prostate cancer and acknowledged that she failed to identify the irregularity when completing the MRR. During a surveyor interview on 1/23/2025 at 2:06 PM with the Oncologist, he revealed that the medication Abiraterone Acetate is only prescribed for an individual with a diagnosis of prostate cancer. The facility's failure to review Resident ID #1's medical chart to confirm that the medications s/he was receiving were appropriate when completing his/her MRR on 12/28/2024, resulted in him/her continuing to receive Abiraterone Acetate, a medication intended for another resident. This placed Resident ID #1 at risk for serious injury, serious harm, serious impairment, or death. 2. Record review revealed Resident ID #3 was readmitted to the facility with a diagnosis of clostridium difficile (C. diff; a type of bacterial infection effecting the colon causing diarrhea). Review of the hospital Continuity of Care document dated 1/16/2025 revealed a new order for Fidaxomicin (an antibiotic prescribed to treat C.diff infections) 200 mg twice daily for 5 days, for a total of 10 doses. Record review revealed the Fidaxomicin was transcribed to start on 1/17/2025 with an end date of 1/20/2025, indicating that the medication was to be administered for a duration of only 4 days, for a total of 8 doses. Further record review revealed Resident ID #3's MRR was completed by the Pharmacy Consultant on 1/20/2025 and the consultant failed to identify the Fidaxomicin transcription error, resulting in Resident ID #3 not receiving the full course of his/her medication. During a surveyor interview on 1/24/2025 at 9:07 AM with Registered Nurse, Staff A, she acknowledged that the Fidaxomicin was transcribed for a total of 4 days instead of the 5 days, as ordered. During a surveyor interview on 1/24/2025 at approximately 11:37 AM with the Administrator and the [NAME] President of Clinical Operations, they acknowledged that the Pharmacy Consultant failed to identify the irregularities during the MMR review for Resident ID #'s 1 and 3. Cross reference F-757 and F-842 37158

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. 21613 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from unnecessary medications for 1 of 2 residents reviewed who have cancer diagnoses, Resident ID #1. Findings are as follows: Review of a community reported complaint dated 1/17/2025 alleged that a cancer medication was given to the wrong resident for 14 days. During a surveyor interview on 1/21/2025 at 9:35 AM with Registered Nurse, Staff A, she indicated that she mistakenly transcribed Resident ID #2's Abiraterone Acetate into Resident ID #1's medical record. Staff A acknowledged that Resident ID #1 received Abiraterone Acetate 1000 mg daily from 12/21/2024 through 1/2/2025 in error, for a total of 13 days. She further revealed that the prescription bottle for Abiraterone Acetate was delivered from the cancer center and labeled with Resident ID #2's name. According to the document released by the Food and Drug Administration, revised 8/2021, indicates Abiraterone Acetate in combination with prednisone is indicated for the treatment of patients with metastatic prostate cancer. For patients with baseline moderate hepatic (liver) impairment, reduce the recommended dose of Abiraterone Acetate to 250 mg once daily and to monitor liver function tests prior to the start of the medication and weekly for the first month. Patients with severe hepatic impairment, this medication is to be avoided. Abiraterone Acetate may cause high blood pressure, low potassium level and fluid retention. Additional review revealed adverse reactions of this medication includes, but are not limited to, fatigue, high blood pressure, nausea, vomiting, swelling, low potassium levels, diarrhea and upper respiratory infections. Review of the facility policy titled, Administering Medications revised 4/2019, revealed the individual administering medications verifies the resident's identity before giving his/her medications. Additionally, the facility's policy revealed that the individual administering the medication, is to check the label 3 times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before administering the medication. Additionally, the policy indicates medications ordered for a particular resident may not be administered to another resident. Record review revealed Resident ID #1 was admitted to the facility with a diagnosis including, but not limited to, liver cancer and Resident ID #2 was admitted to the facility with a diagnosis including, but not limited to, prostate cancer. Review of a Cancer Center document for Resident ID #2 dated 12/11/2024, revealed a recommendation to restart Abiraterone Acetate. Additional review of the Cancer Center document revealed the recommendation was approved by the Nurse Practitioner (NP), Staff G, on 12/20/2024 for Resident ID #2 to receive Abiraterone Acetate 1000 milligrams (mg) daily. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Further record review revealed the order for Abiraterone Acetate was mistakenly transcribed into Resident ID #1's medical record, instead of Resident ID #2's record, for whom the medication was intended. Further record review of Resident ID #1's physician orders revealed that the same NP, Staff G, signed off approval for the order of Abiraterone Acetate on 12/21/2024 and failed to identify that Resident ID #1 was not the same resident that Staff G had approved the Abiraterone Acetate recommendation for on 12/11/2024. During a surveyor interview on 1/22/2025 at 11:40 AM with Staff G, she revealed that she did not recall being contacted by the facility regarding the resident's Abiraterone Acetate order or that she had any knowledge that Abiraterone Acetate was recommended by the Cancer Center for either resident until the medication error was identified. Record review of Resident ID #1's provider progress notes, revealed two notes authored by another NP, Staff H, with the dates of 12/23/2024 and 12/31/2024, revealed that she documented in each progress note that the resident has an order for Abiraterone Acetate 1000 mg daily and that she had completed her medication reconciliation (the process of comparing the medication orders to the medications that the resident has been taking in order to prevent and/or identify any errors or irregularities). Additional review of the progress notes by Staff H, failed to reveal evidence that she identified that this medication is prescribed to treat prostate cancer, and that Resident ID #1 did not have a diagnosis of prostate cancer. Furthermore, record review of the Consultant Pharmacist's progress note revealed a monthly medication regimen review was completed on 12/28/2024 for Resident ID #1 and with no recommendations noted. The pharmacist failed to identify that Abiraterone Acetate is prescribed to treat prostate cancer, and that Resident ID #1 did not have a diagnosis of prostate cancer. During a surveyor interview on 1/22/2025 at 10:13 AM with the Consultant Pharmacist, she revealed that she completed the MRR for Resident ID #1 on 12/28/2024. She further revealed that the Abiraterone Acetate is typically ordered for an individual with a diagnosis of prostate cancer. Additionally, she revealed that she should have verified if Resident ID #1 had a diagnosis of prostate cancer and she acknowledged that she failed to identify the irregularity when completing the MRR. Record review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed Resident ID #1 received Abiraterone Acetate 1000 mg daily at 6:00 AM from 12/21/2024 through 1/2/2025, in error. Further review of the December 2024 and January 2025 MARs revealed the following staff members administered the medication to Resident ID #1 on the following dates: -Licensed Practical Nurse (LPN), Staff B, 12/21/2024 -LPN, Staff C, 12/24/2024, 12/27/2024, 12/28/2024 and 1/1/2025 -LPN, Staff D, 12/22/2024 (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	-Registered Nurse, Staff E, 12/23/2024, 12/25/2024, 12/29/2024, 12/30/2024, 12/31/2024 and 1/2/2025 -Medication Technician, Staff F, 12/26/2024 During a surveyor interview on 1/21/2025 at 2:00 PM, with LPN, Staff B, she revealed that she had administered the Abiraterone Acetate to Resident ID #1 in error, and failed to verify the resident's name on the prescription bottle. During a surveyor interview on 1/21/2025 at 2:39 PM with LPN, Staff C, he revealed that he had administered the Abiraterone Acetate to Resident ID #1 in error, and failed to verify the resident's name on the prescription bottle. During a surveyor interview on 1/21/2025 at 2:50 PM with with LPN, Staff D, he revealed that he had administered the Abiraterone Acetate to Resident ID #1 in error, and failed to verify the resident's name on the prescription bottle. During surveyor interviews on 1/21/2025 at approximately 4:00 PM and 1/24/2025 at approximately 11:30 AM with the Administrator and the Acting Director of Nursing Services, they acknowledged that Staff A transcribed Resident ID #2's Abiraterone Acetate order into Resident ID #1's medical record, in error. Additionally, they acknowledged that the above-mentioned staff, who administered the medication, failed to follow the facility's policy for medication administration. Furthermore, they acknowledged that the two NPs failed to identify that Resident ID #1 had an order for a medication to treat prostate cancer when s/he did not have a diagnosis of prostate cancer. During a surveyor interview on 1/23/2025 at 2:06 PM with the Oncologist, he revealed that the Abiraterone Acetate is only prescribed for an individual with a diagnosis of prostate cancer. The failure of the facility to transcribe this medication into the correct resident's medical record resulted in Resident ID #1 receiving thirteen doses of a medication that s/he received unnecessarily. Additional failures included two NPs and a Consultant Pharmacist failing to identify that Resident ID #1 was being administered a drug without an adequate indication for its use. Furthermore, Staff B, C, D, E and F administered this medication to Resident ID #1 when the medication bottle had Resident ID #2's name on it. The above-mentioned facility failures placed Resident ID #1 at risk for serious injury, serious harm, serious impairment, or death. Cross reference F-756 and F-842

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free from significant medication errors for 1 of 1 resident reviewed receiving an antibiotic, Resident ID #3. Findings are as follows: Record review revealed Resident ID #3 was readmitted to the facility with a diagnosis of clostridium difficile (C. diff; a type of bacterial infection effecting the colon causing diarrhea). Record review of the resident's Admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 13 out of 15, indicating the resident is cognitively intact. Review of the hospital Continuity of Care document dated 1/16/2025 revealed a new order for Fidaxomicin (an antibiotic prescribed to treat C. diff infections) 200 milligrams twice daily for 5 days, for a total of 10 doses. Review of the January 2025 Medication Administration Record (MAR) revealed Fidaxomicin was transcribed to start on 1/17/2025 with an end date of 1/20/2025, indicating that the medication was to be administered for a duration of only 4 days for a total of 8 doses, not 5 days for a total of 10 doses, as ordered. Additional review of the January 2025 MAR revealed that the resident was not administered both doses of his/her Fidaxomicin on 1/17/2025. Record review failed to reveal evidence that the provider was made aware of the 2 missed doses of Fidaxomicin on 1/17/2025. During a surveyor interview on 1/24/2025 at 9:07 AM with Registered Nurse, Staff A, she acknowledged that the Fidaxomicin order was transcribed for only 4 days and not 5 days, as ordered. Additionally, she was unable to provide evidence that the resident received the Fidaxomicin on 1/17/2025. During a surveyor interview on 1/24/2025 at 10:10 AM with the resident's Nurse Practitioner, Staff G, she acknowledged that she was unaware that the Fidaxomicin was not transcribed for the full 5 day course or that the resident missed 2 doses on 1/17/2025. Additionally, she revealed that she would not extend the antibiotics because the resident had formed stools in his/her bowel movements. Although Staff G revealed that the resident was having formed stools, record review of the resident's bowel movement report revealed documentation that the resident was still having loose stools from 1/16/2025 through 1/24/2025. During a surveyor interview on 1/24/2025 at 10:17 AM with the Chief Nursing Officer, she revealed that on 1/23/2025, the resident expressed to her that s/he was still having loose stools. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a surveyor interview on 1/24/2025 at approximately 11:30 AM with the Administrator and the Acting Director of Nursing, they acknowledged that the resident did not receive the full course of the antibiotic, as ordered. 37158

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 21613 Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident records are complete and accurately documented, relative to medication transcription errors, for 2 of 4 residents reviewed, Resident ID #s 1 and 3. Findings are as follows: 1. According to the document released by the Food and Drug Administration, revised 8/2021, Abiraterone Acetate in combination with prednisone is indicated for the treatment of patients with metastatic prostate cancer. Additionally, for patients with baseline moderate hepatic (liver) impairment, reduce the recommended dose of Abiraterone Acetate to 250 mg once daily and to monitor liver function tests prior to the start of the medication and weekly for the first month. In patients with severe hepatic impairment, this medication is to be avoided. Abiraterone Acetate may cause high blood pressure, low potassium level and fluid retention. Additional review of the document revealed an adverse reaction of this medication includes, but is not limited to fatigue, high blood pressure, nausea, vomiting, swelling, low potassium levels, diarrhea and upper respiratory infections. Record review revealed Resident ID #1 has a diagnosis including, but not limited to, liver cancer. Additional record review failed to reveal evidence that the resident has a diagnosis of prostate cancer. Record review revealed that Resident ID #2 was admitted to the facility with a diagnosis including, but not limited to, prostate cancer. Review of the Cancer Center document dated 12/11/2024 for Resident ID #2 revealed a recommendation to restart Abiraterone Acetate 250 milligrams (mg) to give four tablets (1000 mg) daily. Additional review of the Cancer Center document revealed the recommendation was approved by the Nurse Practitioner (NP), Staff G, on 12/20/2024 for Resident ID #2. However, record review revealed the order for Abiraterone Acetate was mistakenly transcribed into Resident ID #1's medical record, instead of Resident ID #2, for whom the medication was intended. Further record review of Resident ID #1's physician's orders revealed that the same NP, Staff G, signed off approval for the order for Abiraterone Acetate on 12/21/2024 and failed to identify that Resident ID #1 was not the same resident that the NP had approved the recommendation for. Review of a physician's order dated 12/20/2024 revealed Abiraterone Acetate 250 mg, give four tablets (1000 mg) daily, was incorrectly transcribed into Resident ID #1's medical record and not Resident ID #2. Record review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed Resident ID #1 received Abiraterone Acetate 1000 mg daily at 6:00 AM from 12/21/2024 through 1/2/2025, in error for a total of 13 days. Further review of the MARs revealed the following staff members administered the medication to Resident ID #1 on the following dates: (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Licensed Practical Nurse (LPN), Staff B, 12/21/2024 -LPN, Staff C, 12/24/2024, 12/27/2024, 12/28/2024 and 1/1/2025 -LPN, Staff D, 12/22/2024 -Registered Nurse, Staff E, 12/23/2024, 12/25/2024, 12/29/2024, 12/30/2024, 12/31/2024 and 1/2/2025 -Medication Technician, Staff F, 12/26/2024 During an interview on 1/21/2025 at 9:35 AM with Registered Nurse, Staff A, she revealed that she transcribed the Abiraterone Acetate intended for Resident ID #2, into Resident ID #1's medical record in error. During a surveyor interview on 1/21/2025 at approximately 4:00 PM with the Administrator and the Acting Director of Nursing Services, they acknowledged that Staff A transcribed Abiraterone Acetate into the wrong resident's record, resulting in Resident ID #1 receiving the medication in error. This transcription error resulted in a resident who has a diagnosis of liver cancer, Resident ID #1, receiving a hepatotoxic medication not intended for him/her, which put the resident at risk for serious injury, serious harm, serious impairment, and/or death. 2. Record review revealed Resident ID #3 was readmitted to the facility with a diagnosis of clostridium difficile (C. Diff; a type of bacterial infection affecting the colon causing diarrhea). Review of the hospital Continuity of Care document dated 1/16/2025 revealed a new order for Fidaxomicin (an antibiotic prescribed to treat C. Diff infections) 200 milligrams (mg) twice daily, for 5 days. Record review revealed Fidaxomicin was transcribed to start on 1/17/2025 with a stop date of 1/20/2025, indicating the medication was transcribed to be administered for only 4 days, instead of the 5 days, as ordered. Record review of the January 2025 Medication Administration Record (MAR) revealed the Fidaxomicin was documented as not administered to the resident on 1/17/2025, indicating s/he missed 2 doses of the antibiotic. During a surveyor interview on 1/24/2025 at 9:07 AM with Registered Nurse, Staff A, she acknowledged that the Fidaxomicin order was incorrectly transcribed by Licensed Practical Nurse, Staff B for a total of 4 days and not the 5 days, as ordered. Additionally, she acknowledged that the Fidaxomicin order was not administered to the resident twice on 1/17/2025. During a surveyor interview on 1/24/2025 at approximately 11:30 AM with the Administrator and the Acting Director of Nursing Services, they acknowledged that the Fidaxomicin order was transcribed inaccurately for Resident ID #3, resulting in him/her not receiving the full course of his/her antibiotic, as ordered. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Cross reference F-756 and F-757 37158

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Have a plan that describes the process for conducting QAPI and QAA activities. 21613 Based on record review and staff interview, it has been determined that the facility failed to implement and maintain an effective Quality Assurance and Performance Improvement (QAPI) program with a focus related to medication administration. Additionally, the facility failed to provide evidence that new orders were audited per their QAPI plan. Findings are as follows: Review of a document titled, Quality Assurance and Performance Improvement Plan revealed a focus area on ensuring residents are free from unnecessary medications with interventions including, but not limited to, auditing all new medications routinely with a start date of 9/24/2024 and a goal date of 12/24/2024. Additional review of the QAPI document revealed that the goal date for the above-mentioned focus area was extended to 3/24/2025 as a result of a medication error that was identified by the facility on 1/2/2025. Further review revealed an additional QAPI document dated 1/3/2025 with a focus area for medication errors, due to a medication transcription error that was identified on 1/2/2025. The interventions included, but were not limited to, continue to review orders for all new medications during their morning meetings. During a surveyor interview on 1/24/2025 at 9:30 AM with the Administrator and the [NAME] President of Clinical Operations, they revealed that as part of the QAPI plan, one of the interventions is to audit all new orders daily. however they were unable to provide evidence that medication auditing for all new orders were completed, per the QAPI plan. Record review failed to reveal evidence that all new orders were audited daily. As a result of the facility's failure to implement their QAPI for daily auditing of new medication orders, the following medication errors were not identified: 1. Record review revealed Resident ID #1 was admitted to the facility with a diagnosis including, but not limited to, liver cancer and Resident ID #2 was admitted to the facility with a diagnosis including, but not limited to, prostate cancer. Review of a Cancer Center document for Resident ID #2 dated 12/11/2024, revealed a recommendation to restart Abiraterone Acetate (a medication prescribed to treat prostate cancer). Additional review of the Cancer Center document revealed the recommendation was approved by Resident ID #2's Nurse Practitioner on 12/20/2024 for him/her to receive Abiraterone Acetate 1000 milligrams (mg) daily. Record review revealed the order for Abiraterone Acetate was mistakenly transcribed into Resident ID #1's medical record, instead of Resident ID #2, for whom the medication was intended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415084	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhurst Rehabilitation & Healthcare Center	50 Maude Street Providence, RI 02908

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the December 2024 and January 2025 Medication Administration Records (MARs) revealed that Resident ID #1 received Abiraterone Acetate 1000 mg daily from 12/21/2024 through 1/2/2025 in error. During a surveyor interview on 1/21/2025 at 9:35 AM with Registered Nurse, Staff A, she indicated that she mistakenly transcribed Resident ID #2's order for Abiraterone Acetate into Resident ID #1's medical record. Staff A acknowledged that Resident ID #1 received Abiraterone Acetate 1000 mg daily from 12/21/2024 through 1/2/2025, for a total of 13 days in error. 2. Record review revealed Resident ID #3 was readmitted to the facility with a diagnosis of clostridium difficile (a type of bacterial infection effecting the colon causing diarrhea). Review of the hospital Continuity of Care document dated 1/16/2025 revealed a new order for Fidaxomicin (an antibiotic prescribed to treat bacterial infections) 200 mg twice daily for 5 days. Record review revealed Fidaxomicin was transcribed with a start date of 1/17/2025 and an end date of 1/20/2025, indicating that the medication was transcribed to be administered for only 4 days instead of 5. During a surveyor interview on 1/24/2025 at 9:07 AM with Staff A, she acknowledged that the Fidaxomicin order was transcribed for only 4 days and not 5 days, as ordered. During a surveyor interview on 1/24/2025 at 11:30 AM with the Administrator, the Acting Director of Nursing and the [NAME] President of Clinical Operations,they were unable to provide evidence that medication auditing for all new orders were completed, per the QAPI plan. Cross reference F-757