STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445105	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shannondale Health Care Center	7424 Middlebrook Pike Knoxville, TN 37909

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure medications were administered according to Physician Orders for 1 resident (Resident #7) of 3 residents reviewed for hospice respite care. The findings include: Review of a facility policy titled, Medication and Treatment Orders, revised April 2019, revealed .Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in the state .Orders for medication should include .name and strength of the drug; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed .therapeutic medication monitoring . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], for 5 days of respite care with diagnoses including Normal Pressure Hydrocephalus (A rare condition that occurs when too much cerebrospinal fluid builds up in the brain) , Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease, Dementia, and Hospice Status. Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed a score of 9 which indicated the resident had moderate cognitive impairment. Review of the Hospice Physician's Orders for Resident #7 dated 8/8/2024, revealed Morphine Concentrate 100 milligrams (mg) per 5 milliliters (ml) or 20 mg per 1 ml, give 0.25 ml or 5 mg every 2 hours orally as needed (PRN) for shortness of breath (SOB). Review of a Drug Receipt/Record/Disposition Form for Resident #7 dated 8/8/2024, revealed Morphine Sulfate 100 mg per 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours routinely was removed from the facilities emergency narcotic box for administration to Resident #7. Review of the Medication Administration Record (MAR) for Resident #7 dated August 2024, revealed Morphine Sulfate oral solution 20 mg per 5 ml place and dissolve 0.25 ml (1 mg) every 2 hours for pain/Shortness of Breath (SOB) (scheduled and not PRN). The MAR for Resident #7 revealed doses of morphine were administered 8/9/2024 every 2 hours routinely from 12:00 AM to 10:00 PM (12 doses); on 8/10/2024 from 12:00 AM to 10:00 PM (12 doses); on 8/11/2024 from 12:00 AM to 10:00 PM (12 doses); on 8/12/2024 from 12:00 AM to 8:00 PM (11 doses). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 ' s MAR should have documented Morphine Sulfate oral solution 100 mg per 5 ml place and dissolve 0.25 ml (5 mg), instead of 20 mg per 5 ml place and dissolve 0.25 ml (1 mg). The order was transcribed incorrectly by nursing staff with the incorrect concentration and as a scheduled order instead of a PRN order, as ordered by the Physician. During an interview 2/21/2025, at 4:30 PM, the Director of Nursing (DON) stated the Hospice provider ordered Morphine Sulfate 100 mg per 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours by mouth as needed for SOB. The DON stated Licensed Practical Nurse (LPN) A transcribed the order as Morphine Sulfate 20 mg per 5 ml give 0.25 ml or 1mg (and not the ordered 5 mg) buccally every 2 hours for pain/SOB (scheduled and not PRN). The DON confirmed the concentration and dose of Morphine that LPN A entered into the electronic medical record was incorrect. The DON stated staff obtained Morphine Sulfate 100 mg per 5 milliliters or 20 mg per 1 ml from the emergency narcotic box. The DON further confirmed the resident ' s order for the Morphine was transcribed incorrectly by LPN A (order for 5 mg and transcribed as 1 mg and ordered PRN and not routinely) and the Morphine Sulfate 5 mg was administered every 2 hours routinely to Resident #7. The DON confirmed the correct concentration of Morphine Sulfate 5 mg was administered; however, the frequency was transcribed as scheduled and not PRN as the provider had ordered. The DON confirmed Resident #7 received the correct dose of morphine but not the correct frequency and the morphine was not administered as prescribed according to the physician's order.

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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 - 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** 49786 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure the Pharmacist identified an order for Morphine Concentrate was transcribed to Point Click Care (PCC) correctly on 1 resident (Resident #7's) of 3 sampled hospice respite residents ' Medication Administration Record (MAR) for accurate transcription of physician orders. The findings included: Review of the facility policy titled, Medication Regimen Review, effective 1/08/2024, revealed .A Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication .review includes preventing, identifying, reporting and resolving medication-related problems .medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] for 5 days of respite care with diagnoses including Normal Pressure Hydrocephalus (A rare condition that occurs when too much cerebrospinal fluid builds up in the brain) , Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease, Dementia, and Hospice Status. Review of a Brief Interview for Mental Status (BIMS) evaluation for Resident #7 dated 8/8/2024, revealed a score of 9 indicating the resident had mild cognitive delay. Review of the Hospice Physician's Orders for Resident #7 dated 8/8/2024, revealed Morphine Concentrate 100 mg per 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours orally as needed (PRN) for shortness of breath (SOB) Review of a Drug Receipt/Record/Disposition Form for Resident #7 dated 8/8/2024, revealed Morphine Sulfate 100 mg per 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours routine was removed from the emergency narcotic box for administration to Resident #7. Review of the Medication Administration Record (MAR) for Resident #7 dated August 2024, revealed Morphine Sulfate oral solution 20 mg per 5 ml place and dissolve 0.25 ml (1 mg) buccally every 2 hours for pain/SOB. Resident #7 ' s MAR should have documented Morphine Sulfate oral solution 100 mg per 5 ml place and dissolve 0.25 ml (5 mg), instead of 20 mg per 5 ml place and dissolve 0.25 ml (1 mg). The order was transcribed incorrectly by nursing staff with the incorrect concentration and as a scheduled order instead of a PRN order, as ordered by the Physician. Further review of Patient # 7's MAR revealed 5mg doses of morphine were administered 8/9/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM. 8/10/2024 at 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM. 8/11/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM. 8/12/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for Resident #7 dated August 2024, revealed Morphine Sulfate oral solution 20 mg per 5 ml give 0.25 ml (1 mg) by mouth at bedtime for pain. Resident #7 ' s MAR should have documented Morphine Sulfate oral solution 100 mg per 5 ml, give 0.25 ml (5 mg), instead of 20 mg per 5 ml give 0.25 ml (1 mg). The order was transcribed incorrectly by nursing staff with the incorrect concentration, as ordered by the Physician. Further review of Resident # 7's MAR revealed 5mg doses of morphine were administered 8/9/2024 at 8:00 PM, 8/10/2024 at 8:00 PM, and 8/11/2024 at 8:00 PM Review of a Medication Removal Form Emergency Kit After Hours form for Resident #7 dated 8/8/2024 and faxed to the pharmacy on 8/8/2024 at 11:46 PM, revealed Morphine 20 mg/1 ml 0.25 by mouth routine. Review of a Medical Record Review (MRR) for Resident #7 dated 8/9/2024, revealed Pharmacist A completed a MRR for Resident #7 listing no recommendations. Pharmacist A failed to identify the inaccurate transcription of Resident #7's Morphine Sulfate order. During an interview on 2/21/25 at 4:30 PM, the Director of Nursing (DON) stated Licensed Practical Nurse (LPN) A transcribed Morphine Sulfate 20 mg per 5 ml, give 0.25 ml or 1mg buccally every 2 hours for pain/SOB and another order for Morphine Sulfate 20 mg per 5 ml give 0.25 ml or 1 mg by mouth at bedtime for pain into the electronic medical record (EMR), and this was incorrect. She stated the facility nurse faxed the Drug Receipt/Record/Disposition Form and Medication Removal From Emergency Kit After Hours form to the pharmacy with the correct concentration dose but incorrect frequency on 8/8/2024 and the MRR conducted by Pharmacist A did not catch the morphine error despite receiving orders from the hospice agency, the Drug Receipt/Record/Disposition Form and Medication Removal From Emergency Kit After Hours form from the facility. During an interview on 2/27/24 AT 11:00 AM, Pharmacist A stated the process for hospice patients is for the pharmacy to put orders into a profile. The orders the pharmacy puts into the profile populates into a web-based program the contracting pharmacists use to complete the MRR. Pharmacist A confirmed the profile entered by the pharmacy into the shared program was Morphine 100 mg/5 ml give 0.25 ml or 5 mg every 2 hours PRN. Pharmacist A stated on 8/8/2024 the facility removed Morphine 100 mg/ 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours routinely from the emergency narcotic box. Pharmacist A stated this was faxed to the pharmacy and considered a new order. Pharmacist A stated the facility has 7 days to send the pharmacy a new signed prescription (script) by the provider to have on file. Pharmacist A stated he performed his MRR on 8/9/2024 and the MAR in the EMR reads Morphine 20 mg per 5 ml give 0.25 ml q 2 hours routine. Pharmacist A confirmed he should have caught the incorrect concentration, and he missed it. Pharmacist A stated he didn't question the frequency because a hospice patient going from PRN to scheduled morphine is not unusual. Pharmacist A stated he is not certain if the MAR is rechecked once the facility sends the signed script to the pharmacy, or if the order in the profile is changed. Pharmacist A stated once he completes his original admission MRR his portion is finished, and he doesn't see any other orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786 Based on facility policy review, medical record review, hospice medical record review, and interview the facility failed to protect the residents right to be free from a significant medication error for 1 resident (Resident #7) of 3 sampled hospice respite residents. The facility's failure to prevent a significant medication error resulted in actual HARM for Resident #7. The facility's failure to prevent a significant medication error resulted in actual HARM for Resident #7 when the resident's order for Morphine Sulfate was transcribed incorrectly by nursing staff and Resident #7 was administered the medication on a scheduled basis instead of as needed, according to the physician order. On the fourth day of Resident #7's respite stay in the facility, she was semi-comatose, had constricted pupils, a weak and irregular pulse, slightly labored respirations of 12 with increased oxygen, and was hypotensive (low blood pressure), after she received the incorrect amount of Morphine for 4 days. The findings include: 1.Review of the facility's undated policy titled, Admission for Respite Care, revealed .Hospice personnel will be responsible for Provider (Medical Doctor/Nurse Practitioner) services and be available 24 hours a day for clinical consultation to the facility's personnel . 2.Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] for 5 days of respite care with diagnoses including Normal Pressure Hydrocephalus (A rare condition that occurs when too much cerebrospinal fluid builds up in the brain), Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease, Dementia, and Hospice Status. Review of a Brief Interview for Mental Status (BIMS) assessment for Resident #7 dated 8/8/2024, revealed a score of 9 which indicated the resident had moderate cognitive impairment. Review of the Hospice Physician Orders for Resident #7 dated 8/8/2024, revealed Morphine Concentrate 100 milligrams (mg) per 5 milliliters (ml) or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours orally as needed (PRN) for shortness of breath (SOB) Review of a Drug Receipt/Record/Disposition Form for Resident #7 dated 8/8/2024, revealed Morphine Sulfate 100 milligrams (mg) per 5 milliliters (ml) or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours routine was removed from the emergency narcotic box for administration to Resident #7. Review of the Medication Administration Record (MAR) for Resident #7 dated August 2024, revealed Morphine Sulfate oral solution 20 mg per 5 ml place and dissolve 0.25 ml (1 mg) buccally (inside the cheek) every 2 hours for pain/shortness of breath (SOB). Resident #7's MAR should have documented Morphine Sulfate oral solution 100 mg per 5 ml place and dissolve 0.25 ml (5 mg), instead of 20 mg per 5 ml place and dissolve 0.25 ml (1 mg). The order was transcribed incorrectly by nursing staff with the incorrect concentration and as a scheduled order instead of a PRN order, as ordered by the Physician. Further review of Resident # 7's MAR revealed 5 mg doses of morphine were administered: A. On 8/9/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	A. On 8/10/2024 at 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. A. On 8/11/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. A. On 8/12/2024 at midnight, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, and 8:00 PM. Review of the Medication Administration Record (MAR) for Resident #7 dated August 2024, revealed Morphine Sulfate oral solution 20 mg per 5 ml give 0.25 ml (1 mg) by mouth scheduled at bedtime for pain. Resident #7's MAR should have documented Morphine Sulfate oral solution 100 mg per 5 ml, give 0.25 ml (5 mg), instead of 20 mg per 5 ml give 0.25 ml (1 mg). The order was transcribed incorrectly by nursing staff with the incorrect concentration, and not as ordered by the Physician. Further review of Resident # 7's MAR revealed 5 mg doses of morphine were administered at 8:00 PM on 8/9/2024, 8/10/2024, and 8/11/2024. Review of an undated, untimed Client Medication Report revealed Licensed Practical Nurse (LPN) B performed a medication verification for Resident #7's hospice morphine. LPN B placed check marks beside each morphine order indicating she verified the order was correct on the MAR but the concentration on both morphine orders were incorrect and the frequency of one order was incorrect. Review of a facility progress note for Resident #7 dated 8/8/2024, revealed Resident #7 was at the facility for 5 days of respite. Resident #7 was able to make needs known, respirations were even and unlabored on 3 liters of oxygen via nasal cannula .continue to monitor and report any changes . Review of a facility social services and initial assessment dated [DATE], revealed Resident #7 was alert, communicated verbally, was oriented to person, place and time and usually understood and responded adequately to simple, direct communication. Review of a Medical Regimen Review (MRR) for Resident #7 dated 8/9/2024, revealed Pharmacist A did not identify the incorrect order transcription when the pharmacist completed the MRR for Resident #7. Review of a Medication Error Report for Resident #7 dated 8/13/2024, revealed Morphine Sulfate oral solution, 20 mg/5 ml 0.25 ml every 2 hours, was ordered and transcribed as scheduled, not PRN. The outcome of the investigation indicated no harm came to the resident and Resident #7's daughter reported her mother had increased drowsiness. The corrective action revealed the facility attempted to correct the morphine order on 8/13/2024 prior to Resident #7's discharge. The person making the error was LPN A, an agency nurse. The type of error listed the medication was ordered every 2 hours instead of every 2 hours PRN, and the reason for the error was listed as a transcription error. The form was signed by LPN B and the Director of Nursing (DON). Review of the Medication Administration Record (MAR) for Resident #7 dated August 13, 2024, revealed a corrected order for Morphine Sulfate oral solution was documented as Morphine Sulfate 20 mg per 5 ml give 0.25 ml (1 mg) by mouth every 2 hours as needed for pain. The concentration on the corrected order for Morphine Sulfate was still documented incorrectly as 1 mg and should have been 5 mg. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation of vital signs in the Electronic Medical Record (EMR) revealed there were no vital signs documented on Resident #7 from 8/8/2024 - 8/13/2024. 3.Review of the hospice medical record dated 8/5/2024, revealed Resident #7 was on Morphine Sulfate, a quantity of 30 MS Con (MS Contin, Morphine Sulfate controlled-release) was dispensed on 7/7/2024 and the quantity that remained on 8/5/2024 was 28. Further review revealed Resident #7 was administered 2 doses of Morphine in 24 hours and Resident #7 was not residing in a nursing facility at the time. Resident #7 had no communication deficits, was calm, alert, oriented to person and place with minimal verbiage (wording on dictation) and periods of confusion. Further review revealed Resident #7 slept 10 out of 24 hours per day and ate 50 percent (%) of meals if someone prepared them for her. Review of a hospice visit note dated 8/12/2024 at 10:38 AM, revealed Resident #7 resided in the facility, had a pulse of 75 beats per minute (BPM) with an irregular pulse and respirations of 12 on 3 liters of oxygen with shortness of breath with normal respirations. Further review revealed Resident #7 was on Morphine Sulfate which was managed by the facility. Resident #7 was asleep but easily awakened, was alert to person, confused, difficult to understand, ate 50-75% of her meals, and slept 12 of 24 hours per day. Review of a Hospice visit note dated 8/12/2024 at 5:56 PM, revealed Resident #7 was visited in the facility a second time on 8/12/2024 at the request of the family for changes in behavior. Resident #7's pulse was 71, weak and irregular, she was hypotensive (low blood pressure) with blood pressure of 86/70, her respirations were 12 and slightly labored, and her oxygen saturation was 91% on 5 liters via (by way of) nasal cannula. Further review revealed Resident #7 was lethargic, minimally arousable but would open her eyes, her pupils were constricted, was semi-comatose (in a state of partial coma or almost comatose), confused, unable to understand and participate in care, and constantly sleeping. Continued review revealed the Hospice nurse documented Resident #7 received Morphine Concentrate 0.25 ml every 2 hours scheduled, instead of PRN and contacted a provider who advised discontinuing the morphine and continuing to monitor the resident. Review of a Hospice visit note dated 8/13/2024, after Resident #7 was discharged home from the facility, revealed an irregular pulse of 94 and shallow respirations of 20 on 3 liters of oxygen via nasal cannula. Resident #7 was alert and oriented to person, place and situation with confusion and minimal speech. Further review revealed Resident #7 slept 12 out of 24 hours and ate 0-25 % of meals. Resident #7 was unable to assist with positioning her legs during transfer, feed herself or bring liquids to her mouth as she did prior to admission to the skilled nursing facility. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	4.During an interview on 2/18/2025 at 10:30 AM, LPN B stated the hospice respite admission process was to transcribe orders provided by Hospice into the EMR. LPN B stated medications transcribed into EMR populate the MAR. LPN B stated when respite hospice patients are admitted the only assessments completed are the skin and initial nursing assessment. LPN B stated she recalled Resident #7, she did not admit her but did complete her MAR although she was unsure of the date/time it was completed. LPN B stated she recalled 2 orders for Morphine, one scheduled every 4 hours and one scheduled for every 4 hours PRN. LPN B stated she questioned the order because the resident had scheduled morphine and was not actively dying, so she spoke to her Supervisor, Registered Nurse (RN) A. LPN B stated RN A said, That's not right, I'll take care of it. LPN B stated she assumed RN A took care of it by writing it in the Doctor's Book or talking to the provider. LPN B stated any time facility nurses have questions about medications, the questions are placed in the Doctor's Book. LPN B emphasized they do not call the provider. When asked to clarify what she would do about a medication question, LPN B stated again she would write the question in the book and would not call the provider. LPN B stated Resident #7 was alert/oriented and after she had given the dose of morphine Resident #7 asked what she had taken. LPN B stated she explained to Resident #7 it was her morphine and Resident #7 stated she only takes that at bedtime. LPN B stated she told Resident #7 she could refuse the morphine any time she didn't want it. LPN B stated she also told all the other nurses to make sure they asked Resident #7 before giving her morphine. LPN B stated she was not able to recall Resident #7's level of consciousness after that evening because Resident #7 was discharged before she came back to work. LPN B stated she only gave her a few more doses of morphine and didn't give it to her routinely (scheduled). During an interview on 2/20/2025 at 3:30 PM, the Hospice Staff Nurse (RN B), stated he was not able to recall everything from his visits with Resident #7 in August but reviewed the medical record. RN B stated he saw Resident #7 in the facility on 8/12/2024 and at home on 8/13/2024. RN B stated he had only seen her a few times and was not her routine nurse, so he was unsure of her baseline. RN B stated his note said she was asleep, easily awakened, confused, speech was unintelligible, and she was able to answer simple questions. RN B stated they had a visit the next day at her home, and she recognized him from the day before because she had not had any morphine. RN B stated he noted no pain but an increase in tremors and she was able to make her needs known. RN B stated when she was transferred to the wheelchair at home, she was not able to assist at all with positioning her legs, feeding herself or bringing liquids to her mouth. RN B stated she was able to do these things before her admission to the nursing facility. RN B stated he does not complete medication reconciliation for hospice patients (residents) in nursing facilities. During an interview on 2/21/2025 at 3:45 PM, the Hospice Medical Director (MD) stated he reviewed Resident #7's medical record, and Resident #7 was administered 2 doses of Morphine in the 24 hours prior to her admission to the nursing facility. The Hospice MD stated jumping from 0.25 ml a couple of times a day to every 2 hours is significant and he would be concerned with drowsiness and decreased respiratory effort. The Hospice MD stated this patient had COPD and that was significant as well. The Hospice MD stated administration (of Morphine) every 2 hours scheduled would be appropriate for someone who was actively dying. The Hospice MD stated this was not the case for this patient and a jump from 2 doses a day to every 2 hours was cause for concern and he wouldn't recommend it. The Hospice MD stated if there had been a question about a medication, he would expect facility staff to reach out because hospice has providers available 24 hours a day 7 days a week. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/21/25 at 4:00 PM, the Facility MD stated she was not the medical director until January 2025. The facility MD stated the facility had an on-call service to utilize after hours and there was a nurse practitioner at the facility on day shift during the week. The Facility MD stated if a nurse had a question about a medication, her expectation would be to receive a phone call, especially about Morphine because it was a significant drug. The Facility MD stated she received notes from nurses about patients but for something minor. The Facility MD stated she expected phone call verification of any medicine. The Facility MD stated even an antibiotic, if it was not available, should be called so they could find a possible alternative. The Facility MD stated if there was a question about a hospice patient, the hospice provider should be notified. The Facility MD stated if they were not able to reach hospice staff, the facility should reach out to the facility's on call provider. The Facility MD stated someone receiving Morphine on a schedule after only receiving PRN doses twice in 24 hours, would cause concern for over sedation and respiratory compromise. During an interview on 2/21/2025 at 3:45 PM, Resident #7's daughter stated she was traveling home from Ohio on 8/12/2024 and received a call from Resident #7's sitter that her mother was going from out of control, to out of it. Resident #7's daughter stated her mother had Dementia but was mostly calm unless she had a urinary tract infection (UTI). She stated typically Resident #7's sitter could calm her mother (Resident #7) if she got upset, but when her sitter was not able to console her, she called her (Resident #7's Daughter). Resident #7's Daughter stated she wasn't able to calm her mother and when her sister tried and wasn't successful, she called hospice. Resident #7's Daughter stated hospice went out the day she called (8/12/2024) to check on her mother. Resident #7's Daughter stated she saw her mother at the facility the next day and her mother was out of it and couldn't speak. Resident #7's Daughter stated her mother was not able to feed herself or give herself a drink. Resident #7's Daughter stated she told Resident #7's nurse she was only supposed to receive Morphine at bedtime to relax her lungs before she takes her inhaler. Resident #7's Daughter stated the nurse told her that she (Resident #7's Daughter) couldn't tell the nurse what to do; (the nurse) goes by the order. Resident #7's Daughter stated she was very upset, and it took her mother a few days to start making sense and to start feeding herself again. Resident #7's Daughter was asked if her mother was diagnosed with UTI, and she stated she was not. During an interview on 2/21/2025 at 4:10 PM, Resident #7's Sitter stated she saw Resident #7 for a few hours every day while her daughter was gone. Resident #7's Sitter stated she recalled Resident #7 was confused and she thought Resident #7's Daughter figured out they were giving her too much Morphine. Resident #7's Sitter stated she recalled Resident #7 went from out of it to hallucinating and then was difficult to arouse. Resident #7's Sitter stated she was there when Resident #7's Daughter spoke to the nurse on her phone. Resident #7's Sitter stated Resident #7's Daughter tried to explain Resident #7 wasn't supposed to get Morphine every 2 hours, only at bedtime. Resident #7's Sitter stated the nurse told Resident #7's Daughter she had to keep giving the medication until there was an order to change the medication. Resident #7's Sitter stated Resident #7's Daughter was yelling at the nurse and told the nurse to stop giving Resident #7 anything. Resident #7's Sitter stated she believed the facility wrote Resident #7's order for Morphine down wrong. (continued on next page)

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	445105	A. Building B. Wing	02/27/2025

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/21/25, at 4:30 PM, the Director of Nursing (DON) stated the Hospice Medication Orders listed Morphine Sulfate 100 mg per 5 ml or 20 mg per 1 ml give 0.25 ml or 5 mg every 2 hours by mouth as needed for shortness of breath (SOB). The DON stated there was another order for Morphine Sulfate 100 mg per 5 ml or 20 mg per 1 ml give 0.25ml or 5 mg at bedtime for pain. The DON stated LPN A entered Morphine Sulfate 20 mg per 5 ml give 0.25 ml or 1mg buccally (inside cheek) every 2 hours for pain/SOB and another order for Morphine Sulfate 20 mg per 5 ml give 0.25 ml or 1mg by mouth at bedtime for pain into the EMR. The DON confirmed she had not realized at the time of the incident that the concentration and the dose of Morphine LPN A entered into the EMR was incorrect. The DON stated when Resident #7 entered the building staff contacted her because of concerns the liquid in the Morphine bottle Resident #7's family brought to the facility was water instead of Morphine. The DON stated she instructed staff to obtain Morphine from the emergency narcotic box and to lock the suspicious vial of Morphine from the family in the medication room. The DON stated staff obtained Morphine Sulfate 100 mg per 5 milliliters or 20 mg per 1 ml from the emergency narcotic box. The DON confirmed a 0.25 ml or 5 mg of this morphine concentration was administered to Resident #7 on a schedule every 2 hours, instead of PRN. The DON confirmed Resident #7 did not receive the concentration transcribed on the MAR. The DON stated the facility process is to have medication orders transcribed into the EMR by a nurse, have it double checked by another nurse, then checked by the pharmacy. The DON stated the orders were checked off by LPN B using the orders hospice sent to the facility. The DON confirmed the sheet LPN B used to check the medication off was not dated or timed so she is unsure if the orders were checked off within 24 hours, as should be done. The DON confirmed an additional check was completed by Pharmacist A and the incorrect concentration and frequency were not identified. This surveyor and the DON reviewed the corrected order LPN B put into the EMR. The DON had not identified that the morphine concentration on the corrected order was still incorrect. The DON stated the medication error was identified by the facility on 8/13/2024 by LPN C who discussed the issue with Resident #7's daughter. The DON stated the Facility MD was notified, a Medication Error Form was completed, an investigation was conducted, and a Performance Improvement Plan (PIP) was put in place. The DON stated her investigation revealed Morphine Sulfate oral solution 20 mg/5 ml 0.25 ml every 2 hours was ordered and transcribed as scheduled, not PRN. This surveyor and the DON discussed all assessments completed on Resident #7 as well as what symptoms Resident #7 demonstrated related to getting Morphine 5mg every 2 hours instead of PRN. The DON stated the service hospice pays for gives patients a certain number of respite days per year. She confirmed the facility only conducts a skin assessment and administers medications and treatments on respite hospice patients admitted to the facility. The DON confirmed there were no nursing assessments or vital signs completed on Resident #7 and no indication of how getting 5 mg of Morphine every 2 hours effected Resident #7. This surveyor and the DON reviewed Hospice documentation. The DON was not aware the hospice service had been in the facility twice on 8/12/2024, once for a routine visit and again at the family's request due to concerns regarding Resident #7's behavior and level of consciousness (LOC). This surveyor asked the DON why she was not aware the hospice agency was in the facility the day prior Resident #7's discharge, the DON stated hospice should have communicated the fact they were in the facility to staff, and this was not done. Refer to F684, F756, F760 and F867

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policy review, medical record review, and interview the facility failed to ensure resident medical records were complete and accurate for 5 residents (Residents #2, #17, #18, #19, and #10) of 19 resident records reviewed. The findings include: Review of the facility's policy titled, Emptying a Urinary Collection Bag, dated 2001, revealed .The following information should be recorded in the resident's medical record .The amount of urine emptied from the drainage bag . Review of the facility's policy titled, Change in a Resident's Condition or Status, dated 2001, revealed . promptly notifies .his or her attending physician .changes in the resident's medical/mental condition and/or status .Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including .information prompted by the Interact SBAR [situation, background, assessment, recommendation] Communication Form . Review of the medical record for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Neuromuscular Dysfunction of Bladder, Hemiplegia/Hemiparesis, and Vascular Dementia. Review of a baseline care plan dated 11/21/2024, revealed Resident #2 had an indwelling urinary catheter. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated moderate cognitive impairment. Continued review revealed Resident #2 had an indwelling urinary catheter. Review of a 7:00 PM-7:00 AM shift report dated 12/4/2024, revealed Resident #2's indwelling urinary catheter was changed during the shift. Review of a nurse's note for Resident #2 dated 12/5/2024 at 11:30 AM, revealed Resident #2 reported the indwelling urinary catheter had been replaced on 12/4/2024 at approximately 11:00 PM. Review of the medical record for Resident #2 from 11/21/2024-12/5/2024 revealed no documentation the resident's indwelling urinary catheter had been replaced. Review of the medical record for Resident #2 revealed there was no documentation of the resident's urine output from 11/21/2024-12/5/2024. Review of the medical record for Resident #17 revealed the resident was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease and Pressure Ulcer of Sacral Region, Unspecified Stage. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a significant change in status MDS assessment for Resident #17 dated 2/9/2025, revealed the resident had an indwelling urinary catheter. Review of a comprehensive care plan for Resident #17 dated 2/20/2025, revealed .[indwelling urinary] catheter and is at risk for complications and UTI [urinary tract infection] .Monitor and document intake and output as per facility policy . Review of the medical record for Resident #17 for 1/2025-2/2025 revealed there was no documentation of the resident's urine output. Review of the medical record for Resident #18 revealed the resident was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. Review of a comprehensive care plan for Resident #18, dated 1/24/2025, revealed .Indwelling [urinary] Catheter related to Pressure Ulcer .Monitor intake and output as per facility policy . Review of an annual MDS assessment dated [DATE], revealed Resident #18 had an indwelling urinary catheter. Review of the medical record for Resident #18 dated 1/1/2025-2/21/2025 revealed no documentation of the resident's urine output. Review of the medical record for Resident #19 revealed the resident was admitted to the facility on [DATE] with diagnoses included Neuromuscular Dysfunction of Bladder and Stage 3 Chronic Kidney Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #19 had an indwelling urinary catheter. Review of a comprehensive care plan for Resident #19 dated 1/21/2025, revealed .Indwelling [urinary] Catheter related to urinary retention .Monitor/record/report to MD [medical doctor] for .no output . Review of the medical record for Resident #19 dated 1/1/2025-2/21/2025 revealed no documentation of the resident's urine output. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Neuromuscular Dysfunction of the Bladder, Retention of Urine, Urinary Tract Infection (UTI), and Functional Quadriplegia. Review of a comprehensive care plan for Resident #10 dated 3/14/2024, revealed .Potential for UTI R/T [related to indwelling catheter]. Recent CAUTI [catheter associated urinary tract infection] with sepsis, neuromuscular dysfunction of the bladder .Observe for confusion, temp [temperature], decreased output, c/o [complaint of] abd. [abdominal] or flank [either side of lower back] pain, abdominal distension, clamminess, change in LOC [level of consciousness] qs [every shift] and prn [as needed]. Report abnormal to m.d. [medical doctor] prn . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a quarterly MDS assessment dated [DATE], revealed Resident #10 had an indwelling urinary catheter. Review of an alert note (nurse's note) dated 7/12/2024 at 1:47 PM, revealed Resident #10 reported extreme discomfort in the resident's genital area and reported a pain level of 10 (pain rating score 1-10, with 10 being highest level of pain). The nursing supervisor was notified of the resident's complaint.Offered to change [indwelling urinary catheter] and resident declined, requesting to be transported from facility to ER [emergency room] . Review of the medical record for Resident #10 revealed a SBAR communication tool was not in the medical record. During an interview on 2/21/2025 at 2:20 PM, the Director of Nursing (DON) confirmed staff were expected to document resident's urine output and indwelling catheter changes in the medical record and confirmed staff were expected to complete a SBAR communication tool for resident's who were transferred to the ER. The DON confirmed Resident #2's urine output, and a catheter change performed for Resident #2 on 12/4/2024 had not been documented in the medical record and confirmed a SBAR communication tool was not completed when Resident #10 was transferred to theER on [DATE]. During an interview on 2/21/2025 at 4:00 PM, the Assistant Director of Nursing (ADON) confirmed urine output had not been documented in the medical record for Resident's #17, #18, and #19.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786 Based on facility policy review, medical record review, facility document review, Quality Assurance and Performance Improvement (QAPI) Plan review, and interview, the facility's QAPI committee failed to ensure an effective QAPI program that identified quality deficiencies, implemented performance improvement activities to address quality concerns, and performed a root cause analysis related to medication errors. The QAPI committee failed recognize, identify, develop and implement corrective systems to ensure appropriate care and safety by all disciplines involved in the medication transcription error. The QAPI committee failed to ensure facility wide education was conducted to ensure understanding of the transcription of hospice admission orders after a significant medication error was identified for 1 resident (Resident #7) related to the resident's Morphine orders. The QAPI committee failed to identify and implement an effective action plan to correct deficiencies when hospice orders were incorrectly transcribed on admission, and failed to identify, educate, and put action steps in place with the facility, agency and hospice staff. The QAPI committee failed to implement effective processes, to include effective training, for all facility staff nurses responsible for medication transcription orders and all agency staff nurses responsible for transcription of medication orders, as well as, education and coordination with hospice staff to ensure clear concise provider orders are sent on admission to mitigate transcription errors. The findings included: Review of the medical record revealed Resident #7 admitted to the facility on [DATE] for 5 days of respite care. The hospice agency orders in place at the time of admission revealed Resident #7 was to receive Morphine Concentrate 100 milligrams (mg) per 5 milliliters (ml) or 20 mg per 1 ml, give 0.25 ml or 5 mg, every 2 hours orally as needed (PRN) for shortness of breath (SOB). On admission to the facility, Licensed Practical Nurse (LPN) A incorrectly transcribed Resident #7's order for Morphine Sulfate and the facility administered the medication on a 2-hour schedule instead of as needed. Resident #7 was administered 12 doses of morphine on 8/9/2024, 8 doses of morphine on 8/10/2024, 12 doses of morphine on 8/11/2024 and 11 doses on 8/12/2024. When Resident #7's daughter returned from her trip, Resident #7 was out of it and couldn't speak. The facility identified the medication error when it was brought to the Director of Nursing (DON) and Assistant Director of Nursing's (ADON) attention by Resident #7's daughter and LPN B changed the order to PRN but did not change the concentration. The facility was unaware the concentration they had documented on the Medication Administration Record was still incorrect until it was brought to their attention on survey. Review of a Performance Improvement Plan (PIP) for the medication error put into place to address significant medication errors related to errors in transcription dated 8/13/2024, was as follows: a. Identification of resident involved or likely to be affected. b. Education to LPN B the staff nurse who missed the error in transcription by LPN A. c. Interdisciplinary Team meeting to discuss hospice orders, noted the format of hospice orders and made note to look at the PRN column. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Process for admission orders was to ensure they are checked off by the DON or ADON. During an interview on 2/21/25 at 4:30 PM, the DON stated the medication error was identified by the facility on 8/13/2024 by LPN C who discussed the issue with Resident #7's daughter. The DON stated the facility Medical Director (MD) was notified, a Medication Error Form was completed, an investigation was conducted, and a PIP was put in place. The DON stated her IDT team met for QAPI to include the DON, ADON, Unit Manager, MDS Nurse, and Wound Care Nurse. The DON stated her investigation revealed Morphine Sulfate oral solution 20 mg/5 ml 0.25 ml every 2 hours was ordered and transcribed as scheduled, not PRN. The DON stated no harm came to the resident except that the patient's daughter reported her mother was drowsy. The DON stated her corrective action was to correct the Morphine order on 8/13/2024 prior to discharge but just realized today the concentration on the corrected order was incorrect. The DON stated measures taken to prevent recurrence of this incident were to educate LPN B, note the format of hospice orders and to ensure staff were looking at the PRN column. The DON stated orders were still transcribed by a staff nurse, checked by another nurse, an MRR was still completed within 3 days and now the DON and ADON check all resident orders. The DON stated they perform routine random audits as well, but these audits were not documented anywhere, and she had no record of audits being completed. The DON stated LPN B was educated on her mistake. The DON stated she did not educate the agency nurse who transcribed the morphine incorrectly because she was not her (facility) employee. The DON stated she did not educate any other staff nurses on medication errors and did not include hospice, agency or pharmacy in her PIP. The DON confirmed the QAPI Committee had identified a significant medication error as an area of concern for the facility but was not aware of the extent of the problem. Continued interview confirmed the facility failed to perform a root cause analysis or thorough investigation for the significant medication error as the errors in morphine concentration were not identified even after the error was caught. Further interview confirmed the facility failed to implement an effective plan to mitigate errors in transcribing orders by not including facility or agency staff nurses responsible for transcribing orders and not communicating the need for clear concise hospice orders with the hospice agency. The QAPI Committee failed to ensure an effective Quality Assurance Program was in place to monitor and evaluate concerns related to significant medication errors. Refer to F684, F756, and F760.