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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocoee Transitional Care Center LLC	2320 East Lamar Alexander Pkwy Maryville, TN 37804

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** Based on facility policy review, medical record review, and interview, the facility failed to follow physician's orders related to Intravenous (IV) medications for 1 resident (Residents #1) of 3 residents reviewed for IV medications. The findings include: Review of the facility's policy titled, Medication Orders, revised 11/2014, revealed .Each resident must be under the care of a Licensed Physician . Review of the facility's policy titled, Administering Medications, revised on 4/2019, revealed .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame . Review of the medical record revealed Resident #1 was admitted to facility on 12/5/2025 with diagnoses including Urinary Tract Infection (UTI), Retention of Urine, Enterococcus Faecalis Bacteremia (a common bacterium that can cause serious opportunistic infections). Review of the hospital Discharge Summary for Resident #1 dated 12/5/2025, revealed .admit date : [DATE] .discharge date : [DATE] [12/5/2025] .Active Problems .Urinary tract infection with hematuria due to urinary retention .Enterococcal sepsis [the body's extreme response to infection] .secondary to UTI .Anemia .Left atrial thrombus per TEE [Transesophageal Echocardiogram- a heart imaging test for clear views of the heart's structure and function], presumably [likely based on reasonable assumptions, though not certain .] infected .Blood cultures confirmed persistent Enterococcus faecalis bacteremia, and urine cultures were positive for the same organism. Infectious disease [ID] consultation recommended management as infectious endocarditis [inflammation of the inner layer of the heart] .At the time of discharge planning, he was clinically stable .awaiting transfer to a skilled nursing facility for completion of intravenous antibiotic therapy and further rehabilitation .In summary .Per discussion with ID plan for ampicillin [antibiotic medication] 2 g [grams] IV every 4 hours .until January 13, 2026. This represents 6 weeks of coverage after first set of negative blood cultures .It is medically necessary to admit from the hospital to SNF [skilled nursing facility] .Discharge Medication List .ampicillin .Infuse 2 g into a venous catheter every 4 (four) hours .Last Dose .December 5, 2025 at 10:07 AM .see infectious disease orders . Review of the hospital Infectious Disease Physician Progress Note dated 12/5/2025, revealed .Orders for .long-term care facility .Ampicillin 2 g IV every 4 hours .to continue through 2 PM [2:00 PM] on Tuesday, January, 13, 2026 . Review of the physician's order entered into the facility's computer system dated 12/5/2025, revealed .Order Date .12.5.2025 [12/5/2025] .Ampicillin Sodium Solution .2 GM .intravenously every 4 hours for bacterial infection until 12/13/2025 14:07 [2:07 PM] .Start Date .12/5/2025 .1600 [4:00 PM] .End Date .12/13/2025 . The order was entered into the facility's computer system by the Admission's Nurse on 12/5/2025 at 2:08 PM and confirmed by the Registered Nurse (RN) Charge Nurse on 12/5/2025 at 9:31 PM (the order was to be continued through 1/13/2025). Review of Resident #1's physical chart revealed the hospital Discharge Summary and the hospital Infectious Disease Physician Progress Note dated 12/5/2025 with the order for .Ampicillin 2 g [grams] IV every 4 hours .to continue through 2 (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM on Tuesday January 13, 2026 . was signed by the Admission's Nurse on 12/5/2025 at 2:06 PM and the RN Charge Nurse on 12/5/2025 at 9:58 PM. Review of the comprehensive care plan initiated on 12/6/2025, revealed . ANTIBIOTIC THERAPY r/t [related to] urinary tract infections (UTI) . Ampicillin Sodium 12/05/2025-12/13/2025 . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #1 received antibiotic medication during the look back period. Resident #1 received IV medications at the facility. Review of the Physician/Nurse Practitioner (NP) Progress Note dated 12/17/2025, revealed .Labs [laboratory test] yest [yesterday] WNL [within normal limits] .denies any fever, chills, chest pain, shortness of breath, nausea, vomiting, abdominal pain, or dysuria .PHYSICAL EXAMINATION .in no apparent distress .IMPRESSION/PLAN .Enterococcus faecalis bacteremia .UTI - Continue Rocephin [Ceftriaxone] 2 g every 12 hours through 1/13/2026 . Review of a physician's order dated 12/24/2025, revealed .Ampicillin Sodium .Use 2 gram intravenously every 4 hours for antibiotic therapy . Review of the MEDICATION ADMINISTRATION RECORD (MAR) dated 12/1/2025 - 12/31/2025, revealed Resident #1 received Ampicillin Sodium Solution 2 grams IV every four hours starting on 12/5/2025 at 8:00 PM through 12/13/2025 with the last dose being administered on 12/13/2025 at 4:45 PM. Continued review revealed Resident #1 resumed Ampicillin Sodium 2 grams IV every four hours starting on 12/24/2025 at 4:00 PM. [Resident #1 missed 59 doses of Ampicillin from 12/13/2025 - 12/24/2025]. Review of the MEDICATION OCCURRENCE REPORT for Resident #1 revealed .Drug Name: Ampicillin .Occurrence Date .12-13 [12/13/2025] thru 12/24 [12/24/2025] .Medication Order: Ampicillin IV 2 GM Q 4 [every 4 hours] until 1/13/26 [1/13/2026] .Name of Provider Notified .[NP A] .Patient [Resident #1] Notified by: [RN A] .12/24/2025 .1600 [4:00 PM] .Pharmacy notified by: [RN A] .12/24/25 [12/24/2025] .11 am [11:00 AM] .TYPE OF ERROR .Omitted Dosage .CAUSE OF ERROR .admission Order Error .Chart Check Error .admission DIAGNOSES .Sepsis due to Uti [Urinary Tract Infection -UTI] SP [status post] fall, weakness .Additional Information & Patient Condition .Patient condition is stable .What caused this occurrence .Wrong stop date put in on admission .Date Error identified: 12/24/25 [12/24/2025] .11 am [11:00 AM] .Investigation .Order stop date was incorrectly entered on admission. Infectious disease orders present and had correct stop date. Stop date entered as 12/13/25 [12/13/2025] but needed to be 1/13/26 [1/13/2026] per infectious disease orders . Review of the Physician/NP Progress Note dated 12/26/2025 at 1:35 PM, revealed .Patient [Resident #1] seen evaluated today .Patient was discharged from hospital on IV ampicillin .with plans to continue for 6 weeks with last doses on 1/13/2026. Order for ampicillin was noted to be discontinued on 12/13/2025, patient missed doses until restarted on 12/24/2025 [a lapse of 11 days] .no acute distress .Impression and plan .Enterococcus faecalis bacteremia secondary to UTI-spoke with ID today, due to missed doses of ampicillin .need to be extended out until January 28, 2026 stop date after a.m. doses .continue same lab work request while on IV antibiotics . During an interview on 1/20/2026 at 12:26 PM, the Director of Nursing (DON) stated on admission Resident #1 had orders for Ampicillin 2 gram IV q 4 hours through 1/13/2026. The Admission's Nurse entered the incorrect stop date for the Ampicillin as 12/13/2026 and it should have been 1/13/2026. The Admission's Nurse entered the admission orders into the facility's computer system, and the orders were faxed to the pharmacy by a staff member in the admissions office. The Admissions Nurse is to enter the physician's order into the system and the RN Charge Nurse working the floor at the time the resident arrives to the facility confirms the order entered into the computer matches the physical orders sent with the resident. The DON confirmed the RN Charge Nurse did not catch the end date discrepancy entered into the facility's computer system by the Admission's Nurse and neither did the pharmacy consultant. The DON confirmed Resident #1's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ampicillin was discontinued on 12/13/2025 instead of 1/13/2026. The medication error was identified on 12/24/2025 by RN A while doing a chart check. The DON confirmed Resident #1 did not receive Ampicillin as ordered by the physician from 12/14/2025 - 12/24/2025. A new order was obtained to resume the medication after the error was identified on 12/24/2025 and was resumed on 12/24/2025 at 4:00 PM. Resident #1 has had no negative outcomes related to the error. During an interview on 1/22/2026 at 11:14 AM, the Medical Director (MD) stated she had been made aware of Resident #1's medication error. Resident #1's primary source of sepsis was UTI. The MD stated . my understanding . is Resident #1's blood cultures and urine sample were both positive for Enterococcus, so UTI was determined to be source of Resident #1's infection. During the complete workup for Resident #1 the thrombus was found. The diagnosis of infective endocarditis is a presumptive diagnosis and Resident #1 was being empirically (treatment based on practical experience and educated guesswork rather than definitive scientific proof) treated to cover it. Resident #1 continued to receive Rocephin (Ceftriaxone) while the Ampicillin was stopped and had not exhibited any negative outcomes or evidence of worsening infection because of the missed doses of Ampicillin. Resident #1's labs have remained stable, and he has exhibited no concerns with fevers. The MD confirmed it was her expectation that physician's orders were followed. See 755, 760, and 867.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, pharmaceutical service contract review, medical record review, and interview, the facility's consultant pharmacist and pharmacy service provider failed to identify a transcription discrepancy to prevent a medication error for 1 resident (Resident #1) of 3 residents reviewed for intravenous (IV) medications.The findings include: Review of the facility's policy titled, Pharmacy Services - Role of the Consultant Pharmacist, revised 4/2019, revealed .The facility will give the consultant pharmacist a current roster and will inform the consultant pharmacist of all new admissions .to the facility .consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility and collaborate with the facility .to .The consultant pharmacist may also collaborate on other aspects of pharmacy services, including .Helping the facility develop a process for receiving, transcribing, and recapitulating medication orders .The Consultant Pharmacist will provide specific activities related to medication regimen review including .a documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions .Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities . Review of the facility's policy titled, Medication Regimen Review [MRR], dated 5/2019, revealed .The Consultant Pharmacist performs a MRR for every resident in the facility receiving medication .upon admission (or as close to admission as possible) .and at least monthly .The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example .omissions of ordered medications .other medication errors, including those related to documentation .An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice . Review of the PHARMACEUTICAL PRODUCTS AND SERVICES AGREEMENT between the facility and the pharmacy provider dated 10/1/2024, revealed .Pharmacy will provide .pharmacy consulting services .Pharmacy will use a computerized medical record system for managing resident information, physician orders, and medication administration records (MAR) .Operator will timely provide Pharmacy with copies of the prescription and/or medication orders for each new order .PHARMACY CONSULTING SERVICES .consulting services .may include .the provision of a written report regarding .the results of the drug regimen review, noting any irregularities or other areas of concern .Drug Regimen Review .Pharmacy (through a licensed pharmacist) will review the drug regimen of each resident .review must include a review of the resident's medical chart. The Pharmacy must report any irregularities to the attending physician and the Facility's medical director and director of nursing .The Parties intend to use an electronic operating system to provide medication administration record services ('eMAR [electronic medication administration record] Services') .eMAR Services are intended to .provide the Parties with access to updated resident information .and enhance communication between Operator and Pharmacy .The Parties have identified PointClickCare (PCC) as such a third-party eMAR vendor . Review of the medical record revealed Resident #1 was admitted to facility on 12/5/2025 with diagnoses including Urinary Tract Infection (UTI), Retention of Urine, Enterococcus Faecalis Bacteremia (a common bacterium that can cause serious opportunistic infections). Review of the hospital Discharge Summary for Resident #1 dated 12/5/2025, revealed .Discharge Medication List .ampicillin [antibiotic medication] .Infuse 2 g [grams] into a venous catheter every 4 (four) hours .Last Dose .December 5, 2025 at 10:07 AM .see infectious disease orders . Review of the hospital Infectious Disease Physician Progress Note dated 12/5/2025, revealed .Orders for .long-term care facility .Ampicillin 2 g (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[grams] IV every 4 hours .to continue through 2 PM [2:00 PM] on Tuesday, January, 13, 2026 . Continued review revealed the pharmacy provider received faxed copies of Resident #1's orders on 12/5/2025 at 1:07 PM. Review of the physician's order entered into the facility's computer system (Point Click Care) (PCC) dated 12/5/2025, revealed .Ampicillin Sodium Solution .2 GM .intravenously every 4 hours for bacterial infection until 12/13/2025 14:07 [2:07 PM] .Start Date .12/5/2025 .1600 [4:00 PM] .End Date .12/13/2025 . The order was entered into the facility's computer system (PCC) on 12/5/2025 at 2:08 PM and confirmed on 12/5/2025 at 9:31 PM. Review of the facility's pharmacy provider Note to the Director of Nursing dated 12/5/2025, revealed .CMS [Centers for Medicare and Medicaid] guidelines .require a licensed pharmacist's review of a resident's medications at least monthly or a more frequent review of the regimen depending on the resident's condition and the risks or adverse consequences related to current medications .This resident [Resident #1] was reported to have recently been admitted [to the facility] .the resident's [Resident #1] medications have been reviewed .Reviewed with no recommendations . Review of the admission Pharmacy Drug Regimen Review dated 12/8/2025, revealed .medications reviewed with no recommendations or irregularities at this time . The admission Pharmacy Drug Regimen Review was completed by the facility's Pharmacy Consultant (a contracted Pharmacist not employed by the facility's pharmacy provider). Review of the MAR dated 12/1/2025 - 12/31/2025, revealed Resident #1 received Ampicillin Sodium Solution 2 GM IV every four hours starting on 12/5/2025 at 8:00 PM through 12/13/2025 with the last dose being administered on 12/13/2025 at 4:45 PM (a lapse in 11 days of treatment). Continued review revealed Resident #1 resumed Ampicillin Sodium 2 GM IV every four hours starting on 12/24/2025 at 4:00 PM. [Resident #1 missed 59 doses of Ampicillin from 12/13/2025 - 12/24/2025]. Review of the MEDICATION OCCURRENCE REPORT for Resident #1 revealed .Drug Name: Ampicillin .Occurrence Date .12-13 [12/13/2025] thru 12/24 [12/24/2025] .Medication Order: Ampicillin IV 2 GM Q 4 [every 4 hours] until 1/13/26 [1/13/2026] .Pharmacy notified by: [RN A] .12/24/25 [12/24/2025] .11 am .TYPE OF ERROR .Omitted Dosage .CAUSE OF ERROR .admission Order Error .Chart Check Error .What caused this occurrence .Wrong stop date put in on admission .Date Error identified: 12/24/25 [12/24/2025] .11 am [11:00 AM] .Investigation .Order stop date was incorrectly entered on admission. Infectious disease orders present and had correct stop date. Stop date entered as 12/13/25 [12/13/2025] but needed to be 1/13/26 [1/13/2026] per infectious disease orders . During an interview on 1/21/2026 at 1:30 PM, the Director of Nursing (DON) stated Resident #1 was admitted to the facility on [DATE] with an order for Ampicillin 2 grams IV every 4 hours with a stop date of 1/13/2026. The Admissions Nurse entered the order for Ampicillin and entered the stop date incorrectly as 12/13/2025. The stop date for the Ampicillin should have been 1/13/2026 according to the physician's order. The DON confirmed Resident #1's Ampicillin had been stopped in error on 12/13/2025 due to the incorrect stop date being entered by the Admissions Nurse. The error was identified on 12/24/2025 (11 days after the medication was stopped in error) and an order was obtained to resume the medication. The DON confirmed Resident #1's Ampicillin was ordered every 4 hours and the resident had missed doses from 12/13/2025 until it was resumed on 12/24/2025 due to the error. The facility's pharmacy provider received a copy of Resident #1's admission orders via fax on 12/5/2025 and did a Drug Regimen Review on 12/5/2025 with no recommendations noted. The Consultant Pharmacist (independent contractor that is not employed by the facility's pharmacy provider) reviewed Resident #1's medication regimen on 12/8/2025 and identified no recommendations or irregularities. The DON confirmed the facility's pharmacy provider, nor the Consultant Pharmacist identified the stop date for Ampicillin had been entered incorrectly into the PCC system. During a telephone interview on 1/21/2026 at 2:39 PM, the Consultant Pharmacist stated she was contracted and did not work for the facility's pharmacy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider. The Consultant Pharmacist stated she reviewed new admission medications and compared the physician's orders matched what was entered into PCC. If the Consultant Pharmacist noticed any discrepancies in what was ordered versus what was entered, she would notify the DON or Assistant Director of Nursing (ADON) through written communication or via text if it needed to be corrected immediately. The Consultant Pharmacist stated she did not recall Resident #1 directly and did not have access to the record at the time of the interview and stated .I should have . when this surveyor asked if she would have identified that a stop date was entered incorrectly into the computer. The Consultant Pharmacist stated stop dates were reviewed as part of the medication regimen review for accuracy. During a telephone interview on 1/22/2026 at 11:40 AM, the Director of Operations for the facility's pharmacy provider stated the facility faxed each resident's admission orders to the pharmacy provider. Medication orders were entered into PCC by the facility. The pharmacy provider's .medical records department . were responsible to ensure the orders that were faxed to the pharmacy provider matched what was entered by the facility into PCC. The review by the .medical records department . was not done right away and was completed for Resident #1 on 12/8/2025 (they don't work weekends). The Director of Operations confirmed the order faxed to the pharmacy provider for Resident #1 on 12/5/2025 showed Ampicillin 2g IV every 4 hours with a stop date of 1/13/2026. The Director of Operations confirmed the facility entered the stop date as 12/13/2025 into PCC. The Director of Operations confirmed the verification by the .medical records department . should have identified the stop date in PCC was not correct and the pharmacy provider should have notified the facility. The Drug Regimen Review (DRR) that was done by the pharmacy provider on 12/5/2025 is a different function where the pharmacist does .basically a clinical view looking at therapeutic things . but would not do a medication reconciliation to verify orders entered in PCC by the facility matched what was faxed to the pharmacy provider. See 684, 760, and 867

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interviews, the facility failed to ensure 1 resident (Resident #1) was free from significant medication errors (59 omitted doses of Intravenous (IV) antibiotics) of 3 residents reviewed for IV medications. The findings include: Review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/2014, revealed .The interdisciplinary team evaluates medication usage in order to prevent and detect .medication-related problems .A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders .Examples of medications errors include .Omission- a drug is ordered but not administered .When a resident receives a new medication, the medication order is evaluated for the following .The dose, route of administration, duration .In the event of a significant medication-related error .immediate action is taken .to protect the resident's safety and welfare . Review of the facility's policy titled, Administering Medications, revised on 4/2019, revealed .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection (UTI), Retention of Urine, Enterococcus Faecalis Bacteremia (a common bacterium that can cause serious opportunistic infections). Review of the hospital Discharge Summary for Resident #1 dated 12/5/2025, revealed .admit date : [DATE] .discharge date : [DATE] [12/5/2025] .Active Problems .Urinary tract infection with hematuria due to urinary retention .Enterococcal sepsis [the body's extreme response to infection] .secondary to UTI .Anemia .Left atrial thrombus per TEE [Transesophageal Echocardiogram- a heart imaging test for clear views of the heart's structure and function], presumably [likely based on reasonable assumptions, though not certain .] infected .Blood cultures confirmed persistent Enterococcus faecalis bacteremia, and urine cultures were positive for the same organism. Infectious disease [ID] consultation recommended management as infectious endocarditis [inflammation of the inner layer of the heart] .At the time of discharge planning, he was clinically stable .awaiting transfer to a skilled nursing facility for completion of intravenous antibiotic therapy and further rehabilitation .In summary .Per discussion with ID plan for ampicillin [antibiotic medication] 2 g [grams] IV every 4 hours and Rocephin [Ceftriaxone- antibiotic medication] 2 g IV every 12 hours until January 13, 2026. This represents 6 weeks of coverage after first set of negative blood cultures .It is medical necessary to admit from the hospital to SNF [skilled nursing facility] .Discharge Medication List .ampicillin .Infuse 2 g into a venous catheter every 4 (four) hours .Last Dose .December 5, 2025 at 10:07 AM .see infectious disease orders .cefTRIAXone [Rocephin] .Infuse 2 g into a venous catheter every 12 (twelve) hours .Last Dose .December 5, 2025 11:08 AM .see infectious disease orders . Review of the hospital Infectious Disease Physician Progress Note dated 12/5/2025, revealed .Orders for .long-term care facility .Ampicillin 2 g IV every 4 hours, and Rocephin [Ceftriaxone] 2 g IV every 12 hours, to continue through 2 PM [2:00 PM] on Tuesday, January, 13, 2026. This will be 6 weeks after the first set of negative blood cultures . Continued review revealed .CMP [Comprehensive Metabolic Panel], CBC [Complete Blood Count] with differential, on Mondays and Thursdays through January 13 [1/13/2026] . Review of the physician's order entered into the facility's electronic computer system (Point Click Care) (PCC) dated 12/5/2025, revealed .Order Date .12.5.2025 [12/5/2025] .Ampicillin Sodium Solution .2 GM .intravenously every 4 hours for bacterial infection until 12/13/2025 14:07 [2:07 PM] .Start Date .12/5/2025 .1600 [4:00 PM] .End Date .12/13/2025 [1 month prior the physician's ordered medication end date] . The physician's order was entered into the facility's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	computer system by the Admission's Nurse on 12/5/2025 at 2:08 PM and confirmed by the Registered Nurse (RN) Charge Nurse on 12/5/2025 at 9:31 PM. Continued review revealed the order for Ceftriaxone [Rocephin] had been entered into the facility's computer system correctly with the correct stop date of 1/13/2025 and the physician's order for the stop date for the Ampicillin had been entered incorrectly. Review of Resident #1's physical chart revealed the hospital Discharge Summary and the hospital Infectious Disease Physician Progress Note dated 12/5/2025 with the order for .Ampicillin 2 g IV every 4 hours, and Rocephin 2 g IV every 12 hours, to continue through 2 PM [2:00 PM] on Tuesday January 13, 2026 . was signed by the Admission's Nurse on 12/5/2025 at 2:06 PM and the RN Charge Nurse on 12/5/2025 at 9:58 PM. Review of the 24 Hour Chart Check dated 12/6/2025 at 1:00 AM, revealed Licensed Practical Nurse (LPN) A had performed the 24 Hour Chart Check including for Resident #1's admitting physician's orders. Review of the comprehensive care plan initiated on 12/6/2025, revealed . ANTIBIOTIC THERAPY r/t [related to] urinary tract infections (UTI) ceftriaxone [Rocephin] 2 GM IV 12/05/2025-01/13/2026 . Ampicillin Sodium 12/05/2025-12/13/2025 [the order was thru 1/13/2026] . Review of the Physician/Nurse Practitioner (NP) Progress Note dated 12/8/2025 at 12:32 PM, revealed .Patient [Resident #1] seen evaluated today XXX[AGE] year-old male status post acute anemia found by PCP [Primary Care Physician], required hemicolectomy [surgical procedure to remove one side of the colon] for cancerous polyp .approximately 5 weeks ago .was discharged .home, felt he was developing UTI and presented to ER [Emergency Room] for recent falls weakness. He was found to have sepsis secondary to UTI, Enterococcus faecalis bacteremia, left atrial appendage thrombus on TEE .was seen by ID for Enterococcus faecalis bacteremia, is on IV ampicillin and Rocephin [Ceftriaxone] plan for 6 weeks total .no acute distress, frail .Impression and plan .Enterococcus faecalis bacteremia secondary to UTI-continue antibiotics as scheduled per ID .Anemia-patient has routine blood work ordered for IV antibiotics .Left atrial thrombus-patient on loading dose Eliquis [anticoagulant medication] . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #1 received antibiotic medication during the look back period. Resident #1 received IV medications at the facility. Review of the Physician/NP Progress Note dated 12/16/2025 at 9:09 PM, revealed .CHIEF COMPLAINT: Lab [laboratory test] review .HISTORY OF PRESENT ILLNESS: Patient [Resident #1] seen resting in bed. Evaluating today and review of labs .Overall his labs appear stable and without acute concern. He denies any fever, chills, chest pain, shortness of breath, nausea, vomiting, abdominal pain or dysuria .PHYSICAL EXAMINATION .no apparent distress .IMPRESSION/PLAN .Enterococcus faecalis bacteremia .Continue Rocephin [Ceftriaxone] 2 g [grams] every 12 hours through 1/13/2026 . Review of the Physician/NP Progress Noted dated 12/17/2025, revealed .Labs yest [yesterday] WNL [within normal limits] .denies any fever, chills, chest pain, shortness of breath, nausea, vomiting, abdominal pain, or dysuria .PHYSICAL EXAMINATION .in no apparent distress .IMPRESSION/PLAN .Enterococcus faecalis bacteremia .UTI - Continue Rocephin [Ceftriaxone] 2 g every 12 hours through 1/13/2026 . Review of a physician's order dated 12/24/2025, revealed .Ampicillin Sodium .Use 2 gram intravenously every 4 hours for antibiotic therapy until 01/13/2026 [1/13/2026] 23:59 [11:59 PM] . The order was discontinued on 12/26/2025. Review of a physician's order dated 12/26/2025, revealed .Ampicillin Sodium .Use 2 gram intravenously every 4 hours for antibiotic therapy until 01/28/2026 [1/28/2026] 06:00 [6:00 AM] . Continued review revealed .cefTRIAXone Sodium [Rocephin] .Use 2 gram intravenously every 12 hours for infection until 01/28/2026 [1/28/2026] 11:00 [11:00 AM] [the Ampicillin IV was continued through 1/28/2026 due to the lapse in treatment from 12/13/2025 thru 12/24/2025] . Review of the MEDICATION ADMINISTRATION RECORD (MAR) dated 12/1/2025 - 12/31/2025, revealed Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Ocoee Transitional Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 East Lamar Alexander Pkwy Maryville, TN 37804	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	#1 received Ampicillin Sodium Solution 2 g IV every four hours starting on 12/5/2025 at 8:00 PM through 12/13/2025 with the last dose being administered on 12/13/2025 at 4:45 PM. Continued review revealed Resident #1 resumed Ampicillin Sodium 2 grams IV every four hours starting on 12/24/2025 at 4:00 PM. (Resident #1 missed 59 doses of Ampicillin from 12/13/2025 - 12/24/2025). Further review revealed Ceftriaxone [Rocephin] was administered as ordered by the physician with no missed doses. Review of the MEDICATION OCCURRENCE REPORT for Resident #1 revealed .Drug Name: Ampicillin .Occurrence Date .12-13 [12/13/2025] thru 12/24 [12/24/2025] .Medication Order: Ampicillin IV 2 GM Q 4 [every 4 hours] until 1/13/26 [1/13/2026] .Name of Provider Notified .[NP A] .Patient Notified by: [RN A] .12/24/2025 .1600 [4:00 PM] .Pharmacy notified by: [RN A] .12/24/25 [12/24/2025] .11 am .TYPE OF ERROR .Omitted Dosage .CAUSE OF ERROR .admission Order Error .Chart Check Error .admission DIAGNOSES .Sepsis due to Uti [Urinary Tract Infection -UTI] SP [status post] fall, weakness .Additional Information & Patient Condition .Patient condition is stable .What caused this occurrence .Wrong stop date put in on admission .Date Error identified: 12/24/25 [12/24/2025] .11 am [11:00 AM] .Investigation .Order stop date was incorrectly entered on admission. Infectious disease orders present and had correct stop date. Stop date entered as 12/13/25 [12/13/2025] but needed to be 1/13/26 [1/13/2026] per infectious disease orders .Initials & Title of staff involved with this error: [Admission's Nurse], [RN Charge Nurse], [LPN A] .Were processes followed .NO .If No, who did not .[Admission's Nurse], [RN Charge Nurse] .Was counseling form completed .YES .What corrective action was taken .1:1 [One on One] [with] nurses involved .DON [Director of Nursing] 1:1 verbal conversation with admit nurse . Review of a COMMUNICATION note dated 12/26/2025 at 9:30 AM, revealed . RN informed the son that several doses of Ampicillin were missed inadvertently . Review of the Physician/NP Progress Note dated 12/26/2025 at 1:35 PM, revealed .Patient [Resident #1] seen evaluated today .Patient was discharged from hospital on IV ampicillin and Rocephin [Ceftriaxone] with plans to continue for 6 weeks with last doses on 1/13/2026. Order for ampicillin was noted to be discontinued on 12/13/2025, patient missed doses until restarted on 12/24/2025 .Patient has been advised .nursing spoke with son today [12/26/2025] no acute distress .Impression and plan .Enterococcus faecalis bacteremia secondary to UTI-spoke with ID today, due to missed doses of ampicillin, both ampicillin and Rocephin [Ceftriaxone] need to be extended out until January 28, 2026 stop date after a.m. doses of these medications, continue same lab work request while on IV antibiotics . Review of Resident #1's medical record from 12/5/2025 - 1/21/2026 revealed no evidence Resident #1 suffered a negative outcome related to the 59 omitted doses of Ampicillin 2 gram IV from 12/13/2025 - 12/24/2025. During an interview on 1/20/2026 at 12:26 PM, the DON stated on admission Resident #1 had orders for Ampicillin 2 gram IV q 4 hours and Rocephin (Ceftriaxone) 2 gram IV q 12 hours to be continued through 1/13/2026. The nurse [Admission's Nurse] entered the incorrect stop date for the Ampicillin as 12/13/2026 and it should have been 1/13/2026. The Admissions Nurse entered the correct stop date for the Rocephin (Ceftriaxone). The Admission's Nurse enters the admission orders into the facility's computer system, and the orders are faxed to pharmacy by someone in the admissions office. The Admissions Nurse enters the order and the RN Charge Nurse working the floor at the time the resident arrives at the facility confirms the order entered into the computer matches the physical orders sent with the resident. The DON confirmed the RN Charge Nurse didn't catch the end date discrepancy entered into the facility's computer system by the Admission's Nurse and neither did the pharmacy. The DON confirmed Resident #1's Ampicillin was discontinued on 12/13/2025 instead of 1/13/2026. The medication error was identified on 12/24/2025 by RN A while doing a chart check. Resident #1, Resident #1's representative, and the provider were made aware of the error. The DON confirmed Resident #1 did not receive Ampicillin as ordered by the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician from 12/14/2025 - 12/24/2025. A new order was obtained to resume the medication after the error was identified on 12/24/2025 and it resumed on 12/24/2025 at 4:00 PM. NP B notified the ID provider (ordering physician) of the error and the ID provider instructed that both the Rocephin and Ampicillin needed to be continued until 1/28/2026. The Admission's Nurse and the RN Charge Nurse were counseled after the error was identified. Resident #1 has had no negative outcomes related to the error. During an interview on 1/20/2026 at 3:14 PM, Resident #1 stated he was made aware by the facility that a mistake had been made with his antibiotics. During an interview on 1/20/2025 at 3:16 PM, NP B stated Resident #1 was admitted to the facility with orders for IV Ampicillin and Rocephin for bacteremia. The stop date for both antibiotics was ordered to be 1/13/2026 and stated .for some reason the Ampicillin was discontinued on 12/13/2025 . NP B stated she was unaware why the Ampicillin had been discontinued and stated .it was not intended to be discontinued on 12/13/2025 .I can't speak to why it was discontinued .I just know that was not the original stop date . NP B stated the Ampicillin was restarted on 12/24/2025. NP B notified the hospital ID physician that originally ordered the antibiotics regarding the error, and the hospital ID physician wanted both antibiotics (Rocephin and Ampicillin) to be extended until 1/28/2026 even though the Rocephin had been given as ordered. The hospital ID physician stated both antibiotics needed to be continued because they needed to .run congruently . NP B stated she was seeing Resident #1 frequently to monitor his labs and was unaware of any negative outcome related to Resident #1 not receiving the ordered antibiotics according to the physician's order. During an interview on 1/21/2026 at 1:30 PM, the DON stated Resident #1 was admitted to the facility on [DATE] with an order for Ampicillin 2 grams IV every 4 hours and Rocephin (Ceftriaxone) 2 grams IV every 12 hours with a stop date of 1/13/2026. The Admissions Nurse entered the order for Ampicillin and entered the stop date incorrectly as 12/13/2025. The stop date for the Ampicillin should have been 1/13/2026 according to the physician's order. The RN Charge Nurse confirmed the order entered by the Admissions Nurse and failed to recognize the stop date had been ordered incorrectly. A 24 hour Chart Check is performed by the night shift LPN to verify the orders entered into the computer were accurate and matched the physician's orders in the chart. LPN A did a 24 hour chart check on 12/6/2025 at 1:00 AM and failed to recognize the discrepancy in the stop date for the Ampicillin. The DON confirmed Resident #1's Ampicillin had been stopped in error on 12/13/2025 due to the incorrect stop date being entered by the Admissions Nurse. RN A identified the error on 12/24/2025 while doing a chart check and notified NP A. An order was obtained to resume the Ampicillin every 4 hours on 12/24/2025 from NP A. When NP B returned to the facility on [DATE], she called to discuss the error with the hospital ID physician that ordered the medication. The hospital ID physician ordered for both the Rocephin and Ampicillin to be continued until 1/28/2026 because the medications needed to run concurrently. The DON confirmed Resident #1's Ampicillin was ordered every 4 hours and the resident had missed doses from 12/13/2025 until it was resumed on 12/24/2025 due to the error. The DON stated Resident #1 had lab work drawn twice weekly that was reviewed by NP B. The DON stated she was unaware of any negative outcome to Resident #1 from not receiving the antibiotics. The DON confirmed the facility's medication verification processes had not been followed to ensure the medication ordered by the physician had been entered correctly into the computer system. During an interview on 1/21/2026 at 3:11 PM, RN A stated she was checking the medication (med) room to ensure any meds not used were ready for the pharmacy provider to collect the next day. RN A noticed .quite a few Ampicillin bags on the counter in the medication room . for Resident #1 which prompted her to look at the order due to the number of bags there were to see if the order had been discontinued. RN A stated the stop date for the Ampicillin on the physician's order was 1/13/2026 and the stop date (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the computer system was listed as 12/13/2025. RN A notified NP A on 12/24/2025 at 11:00 AM. NP A stated she would notify the hospital ID physician. NP A called back and told RN A to resume the Ampicillin with the stop date of 1/13/2026. RN A reported the error to the ADON via the MEDICATION OCCURRENCE REPORT in the ADON's mailbox on 12/24/2025. RN A stated she provided care for Resident #1 and was unaware of any negative outcomes related to not receiving the antibiotic as scheduled. During an interview on 1/21/2026 at 3:36 PM, NP A stated she was made aware the Resident #1 had missed multiple doses of the IV Ampicillin due to the stop date being entered incorrectly in the computer system. NP A notified the ID provider through the secure messaging system and received an order to restart the Ampicillin and to continue the Rocephin (Ceftriaxone) until the Ampicillin was completed because the 2 antibiotics needed to be given in conjunction to give .adequate coverage . NP A stated Resident #1 received regular lab work and was unaware of any negative outcomes related to the omitted doses of Ampicillin. During an interview on 1/22/2026 at 11:14 AM, the Medical Director (MD) stated she had been made aware of Resident #1's medication error. Resident #1's primary source of sepsis was UTI. The MD stated . my understanding . is Resident #1's blood cultures and urine sample were both positive for Enterococcus, so UTI was determined to be source of Resident #1's infection. During the complete workup for Resident #1 the thrombus was found. The diagnosis of infective endocarditis is a presumptive diagnosis and Resident #1 is being empirically (treatment based on practical experience and educated guesswork rather than definitive scientific proof) treated to cover it. Resident #1 continued to receive Rocephin (Ceftriaxone) while the Ampicillin was stopped and had not exhibited any negative outcomes or evidence of worsening infection because of the missed doses of Ampicillin. Resident #1's labs have remained stable, and he has exhibited no concerns with fevers. The MD confirmed it was her expectation that physician's orders were followed. The MD stated the likelihood was low that Resident #1 would have any adverse outcomes due to not receiving the Ampicillin as ordered .especially since he was still receiving the Rocephin [Ceftriaxone] . During an interview on 1/22/2026 at 3:07 PM, the DON confirmed Resident #1's medication error resulted in Resident #1 missing antibiotic doses from 12/13/2025 until the error was identified and the medication resumed on 12/24/2025. Resident #1 had no negative outcomes as a result of the error according to lab results, vital signs, and observation. The DON stated Resident #1 missed .a lot of doses .In my opinion any med error is significant. See 684, 755, and 867.

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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** Based on facility policy review, medical record review, facility document review, and interview, the facility failed to timely identify a quality deficiency (significant medication error of 59 omitted doses of intravenous (IV) antibiotics) for Resident #1 and failed to implement a Process Improvement Project (PIP) to prevent recurrence. The findings include: Review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/2014, revealed .A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders .Examples of medications errors include .Omission- a drug is ordered but not administered .When a resident receives a new medication, the medication order is evaluated for the following .The dose, route of administration, duration .In the event of a significant medication-related error .immediate action is taken .to protect the resident's safety and welfare .The Attending Physician is notified promptly of any significant error .The QAPI [Quality Assurance Performance Improvement] Committee will conduct a root cause analysis of medication administration errors to determine the source of errors, implements process improvement steps, and compare results over time to determine that system improvements are effective in reducing errors . Review of the facility's policy titled, Administering Medications, revised on 4/2019, revealed .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame .Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training . Review of the facility's policy titled, Medication Regimen Review (MRR), dated 5/2019, revealed .The Consultant Pharmacist performs a MRR for every resident in the facility receiving medication .upon admission (or as close to admission as possible) .and at least monthly .The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example .omissions of ordered medications .other medication errors, including those related to documentation .An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice .The facility includes a review of key issues related to medication and medication irregularities as part of the QAPI program . Review of the facility's undated policy titled, Quality Assurance Performance Improvement Process, revealed .will enable the identification of problems at every level and will ensure appropriate measures are taken .The ultimate goals of committees at all levels are to identify trends, perform root cause analyses, prioritize issues in order of importance, initiate Process Improvement Projects to enable an effective and sustainable solution, monitor and revise as needed .Facility responsibilities .Obtain feedback from direct care staff .to identify problems and opportunities for improvement .Collect, analyze, trend and monitor facility data including outcomes of subpopulations to address any health equity issues .Determine the root cause of each identified opportunities for improvement .Prioritize the order to develop PIPs .Develop Performance Improvement Projects (PIP) .Monitor and update the PIPS as necessary . Review of the medical record revealed Resident #1 was admitted to facility on 12/5/2025 with diagnoses including Urinary Tract Infection (UTI), Retention of Urine, Enterococcus Faecalis Bacteremia (a common bacterium that can cause serious opportunistic infections). Review of the MEDICATION OCCURRENCE REPORT for Resident #1 revealed .Drug Name: Ampicillin .Occurrence Date .12-13 [12/13/2025] thru 12/24 [12/24/2025] .Medication Order: Ampicillin IV 2 GM [grams] Q 4 [every 4 hours] until 1/13/26 [1/13/2026] .TYPE OF ERROR .Omitted Dosage .CAUSE OF ERROR .admission Order Error .Chart Check Error .admission DIAGNOSES .Sepsis due to Uti [Urinary Tract (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Infection -UTI] SP [status post] fall, weakness .Additional Information & Patient Condition .Patient condition is stable .What caused this occurrence .Wrong stop date put in on admission .Date Error identified: 12/24/25 [12/24/2025] .11 am [11:00 AM] .Investigation .Order stop date was incorrectly entered on admission. Infectious disease orders present and had correct stop date. Stop date entered as 12/13/25 [12/13/2025]but needed to be 1/13/26 [1/13/2026] per infectious disease orders .Initials & Title of staff involved with this error: [Admissions Nurse], Registered Nurse (RN) Charge Nurse], [Licensed Practical Nurse (LPN) A] .Were processes followed .NO .Was counseling form completed .YES .What corrective action was taken .1:1 [One on One] [with] nurses involved .DON [Director of Nursing] 1:1 verbal conversation with admit nurse . Review of the facility's QAPI sign in sheets revealed the last QAPI meeting was held on 12/9/2025 (15 days prior to the identification of the medication error for Resident #1). During an interview on 1/21/2026 at 4:18 PM, the Assistant Director of Nursing (ADON) stated she was responsible for investigating medication errors to present to the QAPI committee. Resident #1's Ampicillin was ordered on admission [DATE]) every 4 hours with a stop date of 1/13/2026. The Admissions Nurse entered the order with a stop date of 12/13/2025 instead of 1/13/2026. The confirming nurse (RN Charge Nurse) confirmed the order with the incorrect stop date and failed to identify the stop date entered by the Admissions Nurse was incorrect. LPN A did the 24 Hour Chart Check on 12/6/2026 at 1:00 AM and failed to identify the stop date was entered incorrectly. The procedure of confirming orders and for the 24 Hour Chart Check included checking the written physician's order matched what was entered into the computer system. The pharmacy provider entered the stop date in their system correctly as 1/13/2026 and continued sending the Ampicillin to the facility. RN A noticed an abundance of Ampicillin in the medication room on 12/24/2025, which prompted her to do a chart check and the error was identified (11 days after the medication was stopped). The ADON confirmed the Admissions Nurse failed to enter the correct stop date, the RN Charge Nurse failed to identify the stop date was entered incorrectly when she confirmed the order, and LPN A failed to identify the error during the 24 Hour Chart Check. The ADON confirmed the facility's medication verification processes were not followed. The ADON stated her investigation revealed the error was .an admission order error .we will discuss in QAPI .the last week in January . The Admissions Nurse and the RN Charge Nurse were educated to confirm all aspects of the order were entered correctly. The ADON confirmed no new processes had been put into place to prevent recurrence and would be discussed in QAPI .the last week in January . During an interview on 1/22/2206 at 2:10 PM, the Interim Administrator stated she started at the facility on 1/6/2026. The Interim Administrator stated she was aware of Resident #1's medication error (medication error identified on 12/24/2025 prior to the Interim Administrator arriving at the facility). The Interim Administrator was unaware of any current PIP related to Resident #1's medication error. The Interim Administrator stated the facility's QAPI committee met monthly and would discuss the medication error at the January QAPI meeting. During an interview on 1/22/2026 at 3:07 PM, the DON confirmed Resident #1's medication error resulted in Resident #1 missing antibiotic doses from 12/13/2025 until the error was identified and the medication resumed on 12/24/2025 (59 missed doses). Resident #1 had no negative outcomes because of the error according to lab results, vital signs, and observation. The DON stated Resident #1 missed .a lot of doses .In my opinion any med error is significant . The DON confirmed the facility had not had an ad Hoc QAPI meeting to discuss the medication error and the failure of the Admissions Nurse, the facility's pharmacy provider, the Pharmacy Consultant, the RN Charge Nurse, and LPN A to identify the error. The DON stated the error would be discussed in the next QAPI meeting on 1/29/2026 (36 days after the error was identified by the facility) and a PIP would be put into place after the QAPI meeting. The DON (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed there was no current PIP in place to prevent recurrence. Corrective actions taken after the incident included education to the RN Charge Nurse and the Admissions Nurse, and the ADON was confirming all orders entered by the Admissions Nurse. The DON stated there was no documentation of the ADON checking the orders entered by the Admissions Nurse were correct and stated .that will be part of the PIP . See 684, 755, and 760.