STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care of Rutherford	901 County Farm Rd Murfreesboro, TN 37127

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 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** 47127 Based on facility policy review, medical record review, and interview, the facility failed to ensure a resident was free of significant medication errors for 1 (Resident #3) of 7 sampled residents reviewed. The findings include: Review of the policy titled [Named Facility's] Incidents and Accidents Policy dated 1/17/24 (1/17/2024) revealed .It is the policy of this facility to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident .The following incidents/accidents require an incident/accident report but are not limited to .Medication or treatment errors . The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders .The resident's family or representative will be notified .documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained . Review of the policy titled Consulting Physician/Practitioner Orders dated February 2023, revealed .The attending physician shall authenticate orders for the care and treatment of assigned residents. For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: a. Call the attending physician to verify the order. b. Document the verification order by entering the order and the time, date, and signature on the physician order sheet .c. Follow facility procedures for verbal or telephone orders including: noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses which included Dementia, psychotic disturbance, mood disturbance and anxiety, Major Depressive disorder, Heart Failure and Atrial Fibrillation (Afib). Review of Comprehensive Care Plan for Resident #3 with goals and interventions that included .12/01/2021 risk for alteration in neurological status r/t [related to] dementia .have A Fib .Give atrial fibrillation medication as ordered . Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed, a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Order Recap Report dated 6/1/2023-3/31/2024 revealed a physician's order dated 5/17/2021 for Donepezil Tab 10mg (milligram) give one tablet by mouth at bedtime. The Donepezil order was discontinued on 2/22/2024. Review of the Order Recap Report dated 6/1/2023-3/31/2024 revealed a physician's order dated 5/17/2021 for Eliquis Tab 5mg give one tablet by mouth two times a day. The Eliquis 5mg order was discontinued on 10/30/2023. Review of the hospital Final Report dated 10/30/2023, revealed Resident #3 was directly admitted from the office of PCP (Primary Care Physician).Discharge Medications .apixaban (Eliquis 5mg oral tablet) 5 Milligram 1[one] tab(s) By mouth Twice daily for 30 Days .donepezil (donepezil 10mg oral tablet) 10 Milligram 1 tab (s) By mouth once daily, at bedtime . Review of the October 2023 Medication Administration Record (MAR) revealed physician orders for . 11/22/2021 ELIQUIS TAB 5MG, Give 1 tablet by mouth two times a day related to .ATRIAL FIBRILLATION (D/C 10/30/2023) .10/31/2023 ELIQUIS TAB 5MG, Give 1 tablet by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION .for 30 Days . Review of the October 2023 MAR revealed a physician order for .11/22/2021 Donepezil Tab 10mg (milligram), Give 1[one] tablet orally at bedtime related to .DEMENTIA . Review of the November 2023 MAR revealed a physician's order for .10/31/2023 ELIQUIS TAB 5MG, give 1 tablet by mouth two times a day related to UNSPECIFIED ATRIAL FIBRILLATION for 30 days . The physician's order was automatically discontinued on 11/29/2023. Review of the PCP notes dated 12/22/2023, revealed resident was seen as a follow up. It had been confirmed that the resident does have a diagnosis of dementia and restarted donepezil. The resident had a history of A-fib and was on Eliquis 5mg tab as directed. Review of the January 2024 MAR revealed physician's orders for Donepezil Tab 10mg give 1 tablet orally at bedtime and Donepezil HCL Oral Tablet 5mg give 5mg by mouth one time a day for memory and cognition. There had been 31 days that both dosages were administered. Review of the January 2024 MAR revealed Eliquis 5mg was not restarted as ordered by the provider after hospital discharge. Review of the February 2024 MAR revealed a physician's order dated 11/22/2021 Donepezil Tab 10mg give 1 tablet orally at bedtime. The physician's order for Donepezil was discontinued on 2/22/2023. There was a physician's order for 2/20/2023 Donepezil HCL Oral Tablet give 5mg by mouth one time a day for memory and cognition. There had been 17 doses of Donepezil 10mg administered. Review of the February 2024 MAR revealed a physician's order dated 2/22/2024 to resume Eliquis Tab 5 give one tablet by mouth two times a day related to Atrial Fibrillation. There had been 43 doses of blood thinner missed during the month of February. Monitoring for blood thinner side effects had been discontinued on 2/17/2024 and 25 shifts of monitoring had not been documented on the MAR. Review of the March 2024 MAR revealed there had been no order for monitoring of blood thinner side effects. (There had been 36 shifts without monitoring order as of March 19 at 3:18 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/2024 at 1:30 AM, Family Member (FM) #1 stated Resident #3 had been hospitalized and upon discharge, she had been given a prescription for blood thinner for Afib (Arterial Fibrillation) and the prescription was for 30 days therefore, it fell off the Medication Administration Record (MAR) at the end of November 2023. Since they were unable to contact the NP (Nurse Practitioner/MD (Medical Director), they decided to get an outside provider Family Nurse Practitioner (FNP). Resident #3 needed to be assessed for Dementia following COVID. FM #1 stated that the FNP wanted Resident #3 off Donepezil for dementia for 9 weeks prior to neurology appointment and this did not happen. FM #1 stated it had also been discovered that Resident #3, allegedly had been taking, 3 times the amount of medication prescribed for dementia. During an interview on 3/19/2024 at 1:10 PM, the Unit Manager (UM)/ RN #1 stated when it had been discovered that Resident #3's blood thinner had been discontinued, a request was sent to the NP for an order to resume the blood thinner. During an interview on 3/21/2024 at 1:30 PM, the Director of Nursing (DON) reviewed the order written by the Neurologist. When asked what she would do with the order that was written for Donepezil 5 MG knowing the resident was already on this medication at a different strength, the DON stated she would contact the outside provider to clarify whether the medication was meant to replace the order currently in place or whether the new dosage should be added to the dosage presently in place. During an interview on 3/21/2024 at 3:00 PM, the NP stated Resident #3's daughter chose to transfer physician services to an outside physician. When the NP was asked what the risks for a resident with Afib not being on an anticoagulant, the NP stated they have an increased risk for developing a blood clot and having a stroke. When residents under the care of the facility's physician services return from hospitalization , the resident has been seen by the NP or MD for stabilization visit/evaluation and medication review. At that visit, they monitor the length of medication care, and they may need prescriptions for them to be extended. During an additional interview on 3/21/2024 at 5:45 PM, the DON stated when a resident goes to an outside provider, they are sent with a copy of their current medication list. If they have new medications, then a prescription should be sent to the facility. The facility will then enter the order into the Electronic Medical Record and the MD will sign off on the medication. There was a prescription sent to the facility from the Neurologist dated 12/19/2023. This prescription was for Resident #3 and was for Donepezil 5MG daily. When the DON was asked how she would process this prescription, she stated she would clarify with the provider that wrote the prescription to see whether this medication should be added to her current dose or whether this prescription was meant to replace the current dosage. The DON agreed that the 5 MG dose was added to the 10mg dose already in place and should not have been. When the DON was asked if this was written up as a medication error, she stated No. She stated, when the resident returned from the provider there was no communication/visit summary sent to the facility from the physician.