STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Port Arthur	6600 Ninth Ave Port Arthur, TX 77642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 25115 Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 10 residents (Resident #1) reviewed for pharmacy services. The facility failed to transcribe Resident #1's discharge orders dated 04/08/24 and failed to follow-up to ensure Resident #1's hospital discharge orders were implemented to include her Rivaroxaban (Xarelto-used to prevent blood clots). Resident #1 was not administered Rivaroxaban (Xarelto) for 38 days. Resident #1 was admitted to hospital on 05/17/24 and diagnosed Iliac artery occlusion (part of the body, usually leg or foot isn't getting enough oxygen-rich blood, a medical emergency). She was discharged on hospice care on 05/18/24 and passed away on 05/23/24 due to heart failure. An IJ was identified on 06/14/24 at 12:05 p.m. The IJ template was provided to the facility on [DATE] at 12:20 p.m. While the IJ was removed on 06/16/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could cause a delay in appropriate medical care and a worsening in symptoms, condition or illness up to and including death. The findings included: Record review of Resident #1's face sheet dated 06/13/2024 indicated she was a [AGE] year-old female admitted on [DATE]. Resident #1's diagnoses included chronic respiratory failure with hypoxia (not enough oxygen in the body's tissues), hypertension (high blood pressure), cardiac pacemaker, peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), hypertensive heart disease with heart failure, atherosclerotic heart disease of naive coronary artery with unspecified angina pectoris (buildup of fats, cholesterol and other substances in and on artery wall with chest pain), and chronic atrial fibrillation (irregular heart beat). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's MDS assessment dated [DATE] indicated she was usually understood and usually understood others. She had severe cognitive impairment (BIMS score 7). The MDS indicated Resident #1 was not taking anticoagulants. Record review of Resident #1's hospital records dated 04/08/24 indicated Rivaroxaban (Xarelto) 15 mg was started on 04/05/24. Record review of Resident #1's Discharge Home Medication List dated 04/08/24 indicated Continue taking these medications . Rivaroxaban (Xarelto) 15 oral. Handwriting on this list by an unidentified staff indicated there was no documentation on the Discharge Home Medication List of the medication clarification. Record review of text message dated 04/11/24 at 11:42 a.m. sent by LVN E to NP A included Resident #1's Discharge Home Medication List indicated Resident #1's Discharge Home Medication List needed clarification of frequency. NP A texted back (time not visible) and responded she would be there in a bit. Record review of Resident #1's medication order summary dated 04/08/24 was reconciled on 04/11/24 without Xarelto by MD B. Record review of Resident #1's physician orders dated 06/13/24 indicated there was no Rivaroxaban (Xarelto) ordered, started, or discontinued. Record review of Resident #1's April 2024 MAR indicated there was no Xarelto administered. Record review of Resident #1s May 2024 MAR indicated there was no Xarelto administered. Record review of Resident #1's physician progress notes dated 04/09/24 at 5:15 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis (blood thinner medicine that reduces blood clotting) or ASA (Aspirin, also known as acetylsalicylic acid). Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). MD B agreed with NP A's notes and signed as the responsible party on 04/12/24. Record review of Resident #1's physician progress notes dated 04/10/24 at 8:15 a.m., completed by NP E indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 04/11/24 5:30 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 04/16/24 at 2:05 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's physician progress notes dated 04/17/24 at 10:00 a.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto Record review of Resident #1's physician progress notes dated 04/18/24 at 4:09 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 04/23/24 9:15 a.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 04/25/24 4:04 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 04/30/24 at 3:54 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's physician progress notes dated 05/16/24 at 5:00 p.m., completed by NP A indicated Complaint of discoloration of right foot. Skin: dark erythema to right foot.poor peripheral circulation . STAT arterial and venous doppler of RLE . Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's Extremity Arteries Duplex-Bilateral Lower dated 05/16/24 indicated moderate to severe bilateral low extremity arterial atherosclerosis, occlusive disease in left distal femoral artery and bilateral posterior tibial arteries, and CT angiogram was recommended for further evaluation. Record review of Resident #1's Extremity Veins-Lower Bilateral dated 05/17/24 indicated no deep vein thrombosis was visualized in the left lower extremity. Reduced venous flow was visualized in the right posterior tibial vein and the partial venous thrombosis could not be excluded. The right peroneal vein was not visualized. Short term follow-up was suggested. Record review of Resident #1's progress note dated 05/17/24 at 10:56 a.m., completed by the DON, indicated Resident #1 was administered Eliquis 2.5 mg related to atherosclerotic heart disease of native coronary with unspecified angina pectoris. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's progress note dated 05/17/24 at 4:45 p.m., completed by LVN G indicated Resident #1 was transported to the hospital related to coffee ground emesis (vomit that looks like coffee grounds)). The DON and MD were notified. RP was at bedside. Record review of Resident #1's hospital records dated 05/17/24 indicated Resident #1's legs have become mottled and cool. She was diagnosed with Iliac artery occlusion (part of the body, usually leg or foot isn't getting enough oxygen-rich blood, a medical emergency). She was discharged on hospice care on 05/18/24. Record review of Resident #1's hospice records dated 05/23/24 indicated resident passed away on 05/23/24 of heart failure. During an interview on 06/13/24 at 12:30 p.m., the DON said the admitting nurse (LVN D) was supposed to call and reconcile Resident #1's medications with the MD or NP. She said she was not able to locate documentation or verification that the physician or NP was called to reconcile and verify Resident #1's medication upon admission on 04/08/24. She said if Resident #1 did not receive her Xarelto as ordered, it could result in a blood clot. She said it was the facility's expectation the admitting nurse would reconcile medications with the physician or NP upon resident admission. She said the physician or NP were usually at the facility every Tuesday and Thursday and the medications should have been reconciled. She said she was not able to locate any documentation related to Resident #1's Xarelto. She said the hospital records were uploaded in Resident #1's EHR on 04/08/24 and available for the MD or NP to review. During an interview on 06/13/24 at 1:42 p.m., NP A said Resident #1 was not on Eliquis or ASA upon admission. She said the hospital records were not available for review when Resident #1 was admitted . She said she would not start a resident on a blood thinner if they were not already on the medication. She said Eliquis and Xarelto were similar medications and used for atrial fibrillation. She said the negative outcome of not receiving blood thinner could be blood clots, strokes, and heart attack. She said she never reviewed the hospital records. She said Resident #1 had a doppler on 5/16/24 due to mottling and coolness and discoloration to her right foot . She said the Doppler indicated some occlusion. She said she started Resident #1 on Eliquis on 05/17/24. She said Resident #1 was sent to the hospital on 05/17/24 due to vomiting. During an interview on 06/13/24 at 1:58 p.m., MD B said he believed NP A reviewed Resident #1's medications and Resident #1 was not on Xarelto. He said if Resident #1 was on Xarelto prior to admission and her cardiologist wanted her on Xarelto to prevent strokes then the Xarelto should have been continued. He said the process for medication reconciliation upon admission was the staff should call the NP or NP on call to review the medication discharge list. He said everyone was responsible, himself, the nurses, and the hospital at discharge for ensuring residents had the appropriate orders to meet their needs and maintain their safety. He said the negative outcome of not receiving the Xarelto as need could be blood clots, stroke, or heart attack. During an interview on 06/14/24 at 10:18 a.m., the DON said she was unable to locate the 24 hour reports and subsequent reviews of Resident #1's admission and medications. During an interview on 06/14/24 at 12:30 p.m., the administrator said he expected the facility nurses and attending MD and NP to ensure the residents received the care and medications they required. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 06/14/24 at 1:12 p.m., MD B said Resident #1's Xarelto was missed. He said he, his NPs, the facility administrator, DON, ADON held IDT meetings every Tuesday to review residents and their care. He said he did not know how the Xarelto was missed. During an interview on 06/15/24 at 2:30 p.m., the DON said NP A notes from 04-09-24 through 05/17/24 indicated Resident #1 required follow up on the Eliquis and ASA and cardiologist appointment. She said NP A never wrote orders for the Eliquis or ASA or cardiologist follow-up. During an interview on 06/17/24 at 11:54 a.m., MD F (Resident #1's cardiologist) said Resident #1 was on Xarelto and her condition was stable. He said the medication was prescribed for atrial fibrillation and the prevention of stroke. He said if the medication was not continued, most likely would have resulted in a pulmonary embolism (blood clot in the lung that creates a blockage) or a blood clot due to DVT. During an interview on 06/18/24 at 6:18 a.m., LVN C said he sent NP A a text with Resident #1's Discharge Home Medication List dated 04/08/24 that included Xarelto. He said the text indicated the medications needed frequency clarification. He said NP A texted back she would be at the facility. He said he did not speak to NP A about the medications and did not hear anything about the medications being reconciled. He said he did not document Resident #1's medications required clarification in the nurse notes. He said he was trained to document communication with the MD or NP in the progress notes. LVN C was no longer employed with the facility and was not available for an interview. Record review of the facility's Attending Physicians Responsibilities policy dated 2001 (revised 2014) indicated . Each attending Physician will be responsible for the following: 1. Accepting the responsibility for initial and subsequent resident care; . 5. Providing appropriate, timely medical orders; 6. Providing appropriate, timely, and pertinent documentation; .Accepting Responsibility for Resident Care: . 2. The Attending Physician will seek, provide, analyze information regarding a resident's current status, recent history, and medications and treatments to enable safe, effective continuing care and to support facility compliance with care standards. 4. The attending physician or a covering practitioner will authorize timely admission orders. Record review of the facility's Medication Reconciliation Policy dated 2001 (revised 2017) indicated The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation 1. Gather the information needed to reconcile the medication list: 1. Discharge summary from referring facility; 2. Admission order sheet; (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3. All prescription and supplement information obtained from the resident/family during the medication history; and 4. Most recent medication administration record (MAR), if this is a readmission. 2. Find a quiet place that is free from distractions. General Guidelines 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. 2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. 3. Medication reconciliation helps to ensure that all medications, routes and dosages on the list are appropriate for the resident and his/her condition, and do not interact in a negative way with other medications/supplements on the list. 4. Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team. Steps in the Procedure 1. If a medication history has not been obtained from the resident or family, complete this first. Information from the medication history should include: 1. Prescription medications, including those taken only as needed; 2. Non-prescription/over-the-counter medications, including those taken only as needed; 3. Herbal or dietary supplements, including vitamins and minerals; 4. Patches, eye drops, creams, inhalers, shots, sample medications; 5. Dose, route, frequency and last dose taken for all items; and 6. Reason(s) for taking each medication/supplement. 2. Ask the resident to list all physicians and pharmacies from which he or she has obtained medications. 3. Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders (sources). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	4. List the dose, route and frequency for all medications. 5. Review the list carefully to determine if there are discrepancies/conflicts. For example: 1. The dosage on the discharge summary does not match the dosage from the resident's previous MAR; 2. There is a potential medication interaction between a medication from the admitting orders and a supplement from the resident's medication history; or 3. There is a medication listed on the discharge summary for which there is no diagnosis or condition to support the use of the medication. 6. If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy. For example: 1. Contact the nurse from the referring facility; 2. Contact the physician from the referring facility; 3. Discuss with the resident or family; 4. Contact the resident's primary physician in the community; 5. Contact the resident's secondary physician(s) in the community; 6. Contact the community pharmacy used by the resident; or 7. Contact the admitting and/or Attending Physician. 7. Document findings and actions (see Documentation below). 8. When a resident is transferred to another facility, or within the organization, the reconciled medication list will be sent to the receiving care provider and the communication will be documented. Documentation 1. Document the medication discrepancy on the medication reconciliation form. 2. Document what actions were taken by the nurse to resolve the discrepancy. 3. If the discrepancy was unresolved, document how the discrepancy was communicated to the charge nurse, physician, pharmacy, and/or next shift. 4. If the discrepancy was resolved, document how the discrepancy was resolved. This was determined to be an Immediate Jeopardy (IJ) on 06/14/24. The Administrator, DON, and ADON were notified. The Administrator was provide with the IJ template on 06/14/24 at 12:20 p.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility's plan of removal was accepted on 06/14/24 at 5:08 p.m. and included the following: Resident #1 was discharged to the hospital on 5/17/24 and no longer resides in the facility. A facility audit to be completed by the Director of Nursing/Designee by 6.15.24 at 7 pm of all residents that are currently admitted in the facility to assure that their most recent admission orders were correctly verified and transcribed into the EHR For any orders identified as not properly transcribed, the MD will be notified of the discrepancy and any new orders implemented. If a trend is established then we will QAPI the trend and in-service staff on root cause to prevent in the future. Facility will implement system changes requiring the admitting nurse to put in a progress note indicating that they have reviewed the admission orders with the MD. Facility will implement a system requiring the primary care physicians to put in a progress note indicating that they have reviewed and reconciled hospital discharge orders with admission orders within 72 hours of admission. PCP's will be made aware of the new system today on 6/14/2024. The DON/Administrator and, or designee will notify all facility PCPs of the new system. If the physician cannot reconcile the orders then the patient will be sent out to the hospital. In-services initiated by DON/Designee on 6.14.24 with licensed nursing staff present in facility related to verifying and transcribing medications at time of admission and notification of DON/ADON if unable to verify orders after 2 attempts within 4 hours. DON/ADON will then notify the medical director. All other licensed staff will be in-serviced prior to working next shift. Ad Hoc QAPI meeting completed with IDT and Medical Director on 6.14.24 at 3 pm Facilities Plan to ensure compliance quickly: Facility interventions were implemented to remove immediate jeopardy: A facility audit to be completed by the Director of Nursing/Designee by 6.15.24 by 7 pm of all residents that are currently admitted in the facility to assure that their most recent admission orders were correctly verified and transcribed into the EHR For any orders identified as not properly transcribed, the MD will be notified of the discrepancy and any new orders implemented. Education was completed with the administrative nursing team by the Regional Nurse Consultant related to completing chart audits of new admissions to assure that orders were transcribed correctly on 6.14.24. In-services initiated by DON/Designee on 6.14.24 with licensed nursing staff present in facility related to verifying and transcribing medications at time of admission and notification of DON/ADON if unable to verify orders after 2 attempts within 4 hours. DON/ADON will then notify the medical director. *Education to be completed with all nursing staff working by 6.14.24 at 6 PM either in person or via phone call. Staff who did not receive the training will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the trainings. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 06/16/24, the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the facility audit completed by the Director of Nursing/Designee on 06/15/24 indicated of all current residents in the facility most recent admission orders were correctly verified and transcribed into the EHR. The MD was notified of any orders identified as not properly transcribed the MD and any new orders were implemented. There were no trends identified. Record review of in-services conducted by DON/Designee on 06/15/24 indicated licensed nursing staff were trained related to verifying and transcribing medications at time of admission and notification of DON/ADON if unable to verify orders after 2 attempts within 4 hours. The DON/ADON would then notify the medical director. All other licensed staff would be in-serviced prior to their working next shift. The admitting nurse would update the progress note to indicate they reviewed the admission orders with the MD/NP. All new admissions and re-admissions would have orders verified by the admitting physician. Facility nursing staff were to document the notification in the resident record and indicated if there were any medications the physician discontinued. Record review of an Ad Hoc QAPI meeting completed with IDT and Medical Director on 06/14/24 indicated the facility interventions implemented to remove immediate jeopardy included the DON and ADON were educated by the RNC to complete chart audits of new admissions to ensure orders were transcribed correctly. Record review of the resident census dated 06/16/24 indicated there was no new admissions to the facility. Interviews conducted on 06/15/24 from 9:00 a.m. to 11:15 a.m., included RN H and LVNs G, I, J, K, L, M, N, O, P, and Q, who worked all shifts (6:00 a.m.-6:00 p.m. and 6:00 p.m.-6:00 a.m.) indicated they were aware they were required to verify and transcribe medications at time of admission and notify of DON/ADON if they were unable to verify orders after 2 attempts within 4 hours. The nursing staff were able to verbalize ensuring residents who were admitted or readmitted to the facility had a medication reconciliation completed with the MD or NP and then documented in the progress notes. During an interview on 06/15/24 at 9:30 a.m., the DON said she and the ADON would review all new admits and charts to ensure the medications were reconciled and had orders as required. She said she would contact the NP or MD to address any issues and if she was not able to contact the MD or NP she would contact the medical director. She said the MD and NP visit notes would also be reviewed in the physician's portal to reconcile any medication or consult not ordered. She said all physicians and NPs were notified of the new system and if the physician was not able to reconcile the orders the resident would be sent out to the hospital. During an interview on 06/15/24 at 9:43 a.m., the ADON said she and the DON would review all new admits and charts to ensure the medications were reconciled and had orders as required. She said she would contact the NP or MD to address any issues and if she was not able to contact the MD or NP she would contact the medical director. She said the MD and NP visit notes would also be reviewed in the physician's portal to reconcile any medication or consult not ordered. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An IJ was identified on 06/14/24. The IJ template was provided to the facility on [DATE] at 12:20 p.m. While the IJ was removed on 06/16/24 at 1:20 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675172	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Port Arthur	6600 Ninth Ave Port Arthur, TX 77642

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 10 residents (Resident #1) reviewed for medication errors. The facility failed to administer Resident #1's Rivaroxaban (Xarelto-used to prevent blood clots) for 38 days (04/09/24 through 05/17/24). Resident #1's hospital discharge orders were not implemented to include her Rivaroxaban (Xarelto). Resident #1 was admitted to hospital on 05/17/24 and diagnosed Iliac artery occlusion (part of the body, usually leg or foot isn't getting enough oxygen-rich blood, a medical emergency). She was discharged on hospice care on 05/18/24 and passed away on 05/23/24 due to heart failure. An IJ was identified on 06/14/24 at 12:05 p.m. The IJ template was provided to the facility on [DATE] at 12:20 p.m. While the IJ was removed on 06/16/24 at 1:20 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving their medications as ordered, illness, hospitalization s, exacerbation of their disease processes, and death. Findings included: Record review of Resident #1's face sheet dated 06/13/2024 indicated she was a [AGE] year-old female admitted on [DATE]. Resident #1's diagnoses included chronic respiratory failure with hypoxia (not enough oxygen in the body's tissues), hypertension (high blood pressure), cardiac pacemaker, peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), hypertensive heart disease with heart failure, atherosclerotic heart disease of naive coronary artery with unspecified angina pectoris (buildup of fats, cholesterol and other substances in and on artery wall with chest pain), and chronic atrial fibrillation (irregular heart beat). Record review of Resident #1's MDS assessment dated [DATE] indicated she was usually understood and usually understood others. She had severe cognitive impairment (BIMS score 7). The MDS indicated Resident #1 was not taking anticoagulants. Record review of Resident #1's Discharge Home Medication List dated 04/08/24 indicated Continue taking these medications . Rivaroxaban (Xarelto) 15 oral. An unidentified staff indicated the order needed clarification. There was no documentation on the Discharge Home Medication List of the medication clarification. Record review of Resident #1's hospital records dated 04/08/24 indicated Rivaroxaban (Xarelto) 15 mg was started on 04/05/24. Record review of Resident #1's physician orders dated 06/13/24 indicated there was no Rivaroxaban (Xarelto) ordered, started, or discontinued. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's April 2024 MAR indicated there was no Xarelto administered. Record review of Resident #1s May 2024 MAR indicated there was no Xarelto administered. Record review of Resident #1's physician progress notes dated 04/09/24 at 5:15 p.m., completed by NP A indicated Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis (blood thinner medicine that reduces blood clotting) or ASA (Aspirin, also known as acetylsalicylic acid). Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). MD B agreed with NP A's notes and signed as the responsible party on 04/12/24. Record review of Resident #1's physician progress notes dated 05/16/24 at 5:00 p.m., completed by NP A indicated Complaint of discoloration of right foot. Skin: dark erythema to right foot.poor peripheral circulation . STAT arterial and venous doppler of RLE . Chronic atrial fibrillation-Keep follow-up with cardiologist-currently not on Eliquis or ASA. Will need to review hospital records to see if need to restart med. Rivaroxaban (Xarelto) was not included in the medication list. There was no order to discontinue the Rivaroxaban (Xarelto). Record review of Resident #1's Extremity Arteries Duplex-Bilateral Lower dated 05/16/24 indicated moderate to severe bilateral low extremity arterial atherosclerosis, occlusive disease in left distal femoral artery and bilateral posterior tibial arteries, and CT angiogram was recommended for further evaluation. Record review of Resident #1's Extremity Veins-Lower Bilateral dated 05/17/24 indicated no deep vein thrombosis was visualized in the left lower extremity. Reduced venous flow was visualized in the right posterior tibial vein and the partial venous thrombosis could not be excluded. The right peroneal vein was not visualized. Short term follow-up was suggested. Record review of Resident #1's progress note dated 05/17/24 at 10:56 a.m., completed by the DON, indicated Resident #1 was administered Eliquis 2.5 mg. related to atherosclerotic heart disease of native coronary with unspecified angina pectoris. Record review of Resident #1's progress note dated 05/17/24 at 4:45 p.m., completed by LVN G indicated Resident #1 was transported to the hospital related coffee ground emesis (vomit). The DON and MD were notified. RP was at bedside. Record review of Resident #1's hospital records dated 05/17/24 indicated Resident #1's legs had become mottled and cool. She was diagnosed Iliac artery occlusion (part of the body, usually leg or foot isn't getting enough oxygen-rich blood, a medical emergency). She was discharged on hospice care on 05/18/24. Record review of Resident #1's hospice records dated 05/23/24 indicated passed away on 05/23/24 of heart failure. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 06/13/24 at 12:30 p.m., the DON said the admitting nurse (LVN D) was supposed to call and reconcile Resident #1's medications with the MD or NP. She said she was not able to locate documentation or verification that the physician or NP was called to reconcile and verify Resident #1's medication upon admission on 04/08/24. She said if Resident #1 did not receive her Xarelto as ordered, it could result in a blood clot. She said it was the facility's expectation the admitting nurse would reconcile medications with the physician or NP upon resident admission. She said the physician or NP were usually at the facility every Tuesday and Thursday and the medications should have been reconciled. She said she was not able to locate any documentation related to Resident #1's Xarelto. During an interview on 06/13/24 at 1:42 p.m., NP A said Resident #1 was not on Eliquis or ASA upon admission. She said the hospital records were not available for review when Resident #1 was admitted . She said she would not start a resident on a blood thinner if they were not already on the medication. She said Eliquis and Xarelto were similar medications and used for atrial fibrillation. She said the negative outcome of not receiving blood thinner could be blood clots, strokes, and heart attack. She said she never reviewed the hospital records. She said Resident #1 had a doppler on 5/16/24 due to mottling and coolness. She said the Doppler indicated some occlusion. She said she started Resident #1 on Eliquis on 05/17/24. She said Resident #1 was sent to the hospital on 05/17/24 due to vomiting. During an interview on 06/13/24 at 1:58 p.m., MD B said he believed NP A reviewed Resident #1's medications and Resident #1 was not on Xarelto. He said if Resident #1 was on Xarelto prior to admission and her cardiologist wanted her on Xarelto to prevent strokes then the Xarelto should have been continued. He said the process for medication reconciliation upon admission was the staff should call the NP or NP on call to review the medication discharge list. He said everyone was responsible, himself, the nurses, and the hospital at discharge for ensuring residents had the appropriate orders to meet their needs and maintain their safety. He said the negative outcome of not receiving the Xarelto as need could be blood clots, stroke, or heart attack. During an interview on 06/14/24 at 12:30 p.m., the administrator said he expected the facility nurses and attending MD and NP to ensure the residents received the care and medications they required. During an interview on 06/14/24 at 1:12 p.m., MD B said Resident #1's Xarelto was missed. He said he, his NPs, the facility administrator, DON, ADON held IDT meetings every Tuesday to review residents and their care. He said he did not know how the Xarelto was missed. During an interview on 06/15/24 at 2:30 p.m., the DON said NP A notes from 04-09-24 through 05/17/24 indicated Resident #1 required follow up on the Eliquis and ASA. She said NP A never wrote orders for the Eliquis or ASA or Xarelto. During an interview on 06/17/24 at 11:54 a.m., MD F (Resident #1's cardiologist) said Resident #1 was on Xarelto and her condition was stable. He said the medication was prescribed for atrial fibrillation and the prevention of stroke. He said if the medication was not continued, most likely would have resulted in a pulmonary embolism or a blood clot due to DVT. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 06/18/24 at 6:18 a.m., LVN C said he sent NP A a text with Resident #1's Discharge Home Medication List dated 04/08/24 that included Xarelto. He said the text indicated the medications needed frequency clarification. He said NP A texted back she would be at the facility. He said he did not speak to NP A about the medications and did not hear anything about the medications being reconciled. He said he did not document Resident #1's medications required clarification in the nurse notes. LVN C was no longer employed with the facility and was not available for an interview. Record review of the facility's Medication Therapy policy dated 2001 (revised 2007) indicated 1. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. 2. Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. 3. All medication orders will be supported by appropriate care processes and practices. Policy Interpretation and Implementation 1. The resident's clinical record must contain a written order for all prescription and over-the-counter medications taken by the resident. 2. All decisions related to medications shall include appropriate elements of the care process, such as: a. Adequately detailed assessment; b. Review of causes of symptoms; c. Consideration of the clinical relevance of symptoms and abnormal diagnostic test results; d. Principles of prescribing for the elderly; and e. Each resident's wishes, values, goals, condition, and prognosis. Record review of the facility's Attending Physicians Responsibilities policy dated 2001 (revised 2014) indicated . Each attending Physician will be responsible for the following: 1. Accepting the responsibility for initial and subsequent resident care; . 5. Providing appropriate, timely medical orders; 6. Providing appropriate, timely, and pertinent documentation; .Accepting Responsibility for Resident Care: . 2. The Attending Physician will seek, provide, analyze information regarding a resident's current status, recent history, and medications and treatments to enable safe, effective continuing care and to support facility compliance with care standards. 4. The attending physician or a covering practitioner will authorize timely admission orders. This was determined to be an Immediate Jeopardy (IJ) on 06/14/24. The Administrator, DON, and ADON were notified. The Administrator was provide with the IJ template on 06/14/24 at 12:20 p.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility's plan of removal was accepted on 06/14/24 at 5:08 p.m. and included the following: Resident #1 was discharged to the hospital on 5/17 24 and no longer resides in the facility. A facility audit to be completed by the Director of Nursing/Designee by 6.15.24 at 7 pm of all residents that are currently admitted in the facility to assure that their most recent admission orders were correctly verified and transcribed into the EHR For any orders identified as not properly transcribed, the MD will be notified of the discrepancy and any new orders implemented. If a trend is established then we will QAPI the trend and in-service staff on root cause to prevent in the future. In-services initiated by DON/Designee on 6.14.24 with licensed nursing staff present in facility related to verifying and transcribing medications at time of admission and notification of DON/ADON if unable to verify orders after 2 attempts within 4 hours. DON/ADON will then notify the medical director - All other licensed staff will be in-serviced prior to working next shift. Ad Hoc QAPI meeting completed with IDT and Medical Director on 6.14.24 at 3 pm Facilities Plan to ensure compliance quickly: Facility interventions were implemented to remove immediate jeopardy: A facility audit to be completed by the Director of Nursing/Designee by 6.15.24 by 7 pm of all residents that are currently admitted in the facility to assure that their most recent admission orders were correctly verified and transcribed into the EHR For any orders identified as not properly transcribed, the MD will be notified of the discrepancy and any new orders implemented. Education was completed with the Administrative nursing team by the Regional Nurse Consultant related to completing chart audits of new admissions to assure that orders were transcribed correctly on 6.14.24. In-services initiated by DON/Designee on 6.14.24 with licensed nursing staff present in facility related to verifying and transcribing medications at time of admission and notification of DON if unable to verify orders after 2 attempts. DON/ADON will then notify the medical director. *Education to be completed with all nursing staff working by 6.14.24 at 6 PM either in person or via phone call. Staff who did not receive the training will receive this training prior to their next shift and will not be allowed to provide direct resident care until they have completed the trainings. On 06/16/24, the surveyor confirmed the facility implement their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the facility audit completed by the Director of Nursing/Designee on 06/15/24 indicated of all current residents in the facility most recent admission orders were correctly verified and transcribed into the HER. The MD was notified of any orders identified as not properly transcribed the MD and any new orders were implemented. There were no trends identified. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of in-services conducted by DON/Designee on 06/15/24 indicated licensed nursing staff were trained related to verifying and transcribing medications at time of admission and notification of DON/ADON if unable to verify orders after 2 attempts within 4 hours. The DON/ADON would then notify the medical director. All other licensed staff would be in-serviced prior to their working next shift. The admitting nurse would update the progress note to indicate they reviewed the admission orders with the MD/NP. All new admissions and re-admissions would have orders verified by the admitting physician. Facility nursing staff were to document the notification in the resident record and indicated if there were any medications the physician discontinued. Record review of an Ad Hoc QAPI meeting completed with IDT and Medical Director on 06/14/24 indicated the facility interventions implemented to remove immediate jeopardy included the DON and ADON were educated by the RNC to complete chart audits of new admissions to ensure orders were transcribed correctly. Record review of the resident census dated 06/16/24 indicated here were no new admissions to the facility. Interviews conducted on 06/15/24 from 9:00 a.m. to 11:15 a.m. and included RN H and LVNs G, I, J, K, L, M, N, O, P, and Q, who worked all shifts (6:00 a.m.-6:00 p.m. and 6:00 p.m. to 6:00 a.m.) indicated they were aware they were required to verify and transcribe medications at time of admission and notify of DON/ADON if they were unable to verify orders after 2 attempts within 4 hours. The nursing staff were able to verbalize ensuring residents who were admitted or readmitted to the facility had a medication reconciliation completed with the practitioner and documented in the progress notes. During an interview on 06/15/24 at 9:30 a.m., the DON said she and the ADON would review all new admits and charts to ensure the medications were reconciled and had orders as required. She said she would contact the NP or MD to address any issues and if she was not able to contact the MD or NP she would contact the medical director. She said the MD and NP visit notes would also be reviewed in the physician's portal to reconcile any medication or consult not ordered. She said all physicians and NPs were notified of the new system and if the physician was not able to reconcile the orders the resident would be sent out to the hospital. During an interview on 06/15/24 at 9:43 a.m., the ADON said she and the DON would review all new admits and charts to ensure the medications were reconciled and had orders as required. She said she would contact the NP or MD to address any issues and if she was not able to contact the MD or NP she would contact the medical director. She said the MD and NP visit notes would also be reviewed in the physician's portal to reconcile any medication or consult not ordered. On 06/16/24 at 1:20 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.