STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106017	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Cross Reference F842 Based on observation, interview, and record review, the facility failed to ensure a newly admitted resident (#6) out of five newly admitted residents reviewed was free from significant medication errors as evidenced by not receiving physician ordered medications for a period of seven days resulting in a readmission to a local hospital due to a hematoma and exacerbation of her medical diagnoses to include a flare-up of Multiple Sclerosis (MS) symptoms to include paralysis in her hands, confusion, and a low hemoglobin requiring a transfusion of packed red blood cells (PRBCs) . On 8/9/24, Resident #6 was admitted to the facility with medication orders from the acute facility. Resident #6's ordered medications were not entered into the electronic medical record. On 8/16/24, Resident #6 went to a scheduled outside medical appointment, which resulted in a transfer and admission back to the hospital on 8/16/24 with a hematoma. Facility staff did not discover Resident #6's missed medications until the re-admission back to the hospital. The failure to administer significant medications for a period of 7 days to include Prednisone, Amiodarone, Gabapentin, Ferrous Sulfate, and Wellbutrin resulted in serious harm and could have led to additional medical complications to include further serious medical complications, injury and possible death. This failure resulted in the determination of Immediate Jeopardy on 8/9/24. The findings of Immediate Jeopardy were determined to be removed on 8/29/24 and the severity and scope was reduced to a D. Findings included: Review of the census page in the electronical medical record revealed Resident #6 was initially admitted to the facility on Friday, 08/09/24 at 4:20 PM from an acute care facility. Review of the Admission Record showed Resident #6 was readmitted to the facility on [DATE] and had diagnoses to include subsequent encounter fracture with routine healing, multiple sclerosis (MS), paraplegia, urinary tract infection (UTI), major depressive disorder recurrent, ventricular fibrillation, paroxysmal atrial fibrillation and other pulmonary embolism without acute COR pulmonale (alteration in the structure and function of the right ventricle of the heart caused by a primary disorder of the respiratory system), acute kidney failure, anemia, acute respiratory failure with hypoxia, and personal history of other venous thrombosis and embolism. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [Local Hospital] Discharge Patient Med Rec (Medication Reconciliation) - Single report, dated 08/08/24, showed: This is the list of medications for you to take upon discharge. Please take this list to your primary care doctor at the next visit. Your hospital doctor wants you to take the drugs on this list when you go home. The list of medications included the following: - Amiodarone 200 MG (milligrams), trade name Cordarone, Oral, twice daily. A note showed this order was sent to the resident's preferred pharmacy. - Atorvastatin 10 MG, trade name Lipitor, Oral, daily. - Bupropion HCL 100 MG, trade name Wellbutrin, Oral, daily. - Collagenase Clostridium 1 application, trade name Santyl, Topical, twice daily. A note showed this order was sent to the resident's preferred pharmacy. - Ferrous Sulfate 325 MG, trade name Feosol, Oral, every other day. - Gabapentin 300 MG, trade name Neurontin, per feeding tube, three times daily. A note showed this prescription was printed. - Guaifenesin/Dextromethorphan 5 ML (milliliters), per feeding tube, Q6H (every six hours). A note showed this order was sent to the resident's preferred pharmacy. - Metoprolol Tartrate 25 MG, trade name Lopressor, Oral, twice daily. - Multivitamin 1 tablet, trade name Multivitamin-Mineral Daily, Oral, daily. - Pantoprazole 40 MG, trade name Protonix, Oral, before breakfast and dinner. - Polyethylene Glycol 3350 17 MG, trade name Miralax, Oral, daily as needed. A note showed this prescription was printed. - Prednisone 5 MG, trade name Prednisone, Oral, take 1 tablet by mouth 1 time every 72 hours. - Rivaroxaban 20 40 MG, trade name Xarelto, Oral, with breakfast. - Sennosides 1 tablet, trade name Senokot, Oral, daily as needed. A note showed this order was sent to the resident's preferred pharmacy. - Sodium Chloride 3% Inhalation Solution 4 ML, trade name Sodium Chloride 3% Inhalation Solution, inhalation every 6 hours while awake. A note showed this order was sent to the resident's preferred pharmacy. Review of the complete Order Summary Report and the August Medication Administration (MAR) showed only two of the 15 medications were ordered by the facility on 08/09/24 during Resident #6's initial admission: - Metoprolol Tartrate oral tablet 25 milligrams (MG)- Give 1 tablet by mouth twice daily. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Multivitamin 1 tablet, trade name Multivitamin-Mineral Daily, Oral, daily. Review of the Medication Reconciliation dated 08/09/24 showed A. Completed medication reconciliation utilizing the following data sources (check all that apply); 2. Discharge Summary Section B. Medication Issues Identified was blank. Section C. Physician Contact was blank. Review of Resident #6's Admission Minimum Data Set (MDS), dated [DATE], showed in Section C-Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Section I-Active Diagnosis showed Resident #6 had the following diagnoses: anemia, deep venous thrombosis (DVT) or pulmonary embolism (EP), hypertension, renal insufficiency, multidrug-resistant organism (MDRO), urinary tract infection (UTI), wound infection, hyperlipemia, paraplegia, multiple sclerosis, depression and respiratory failure. Section N-Medications showed Resident #6 was taking none of the above medication classifications that included: antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic diuretic, opioid and antiplatelet. Review of a Nursing Progress Note, dated 08/13/24, showed Resident complained of being hot. Temp in room was decreased to 60 degrees. NP [Nurse Practitioner] notified. Nurse gave resident some PRN [as needed] Tylenol. NP states it could be MS [Multiple Sclerosis] flush. Nurse also put wet washcloth on neck and forehead. Will continue to observe. Review of a Nursing Progress Note, dated 08/14/24, showed, Resident [family member] has concern that his [Resident #6] has an UTI, he stated her current orientation is not her baseline the pt [patient] is showing signs of increased confusion and would like for her to be tested for an UTI. The writer notified the house NP about [family member] concerns, NP gave new orders to give for UA C&S [Urine Analysis Culture and Sensitivity] and to monitor for other s/s[signs and symptoms]. Review of a Physician Progress Note dated 08/15/24, with a service date of 08/12/24, showed Patient seen today is new to provider. She was in the hospital for hypoxia due to respiratory failure. She was also found to be tachycardia, hypotensive, and had a fever, she was a sepsis alert. She has multiple sclerosis is a paraplegic. She has a foley catheter for urinary retention. She is seen at bedside and states she is doing well .She is currently on 2L [liters] oxygen, she is at baseline. She has tube feeds and states that she eats regular food too. Medications Reconciled .Medications: Metoprolol Tartrate Oral Tablet 25 MG, Multivitamin-Minerals Oral Tablet, Tubersol Solution 5 unit/0.1 ml, Fleet Enema 7-19 GM [gram]/118 ML, Milk of Magnesia Suspension 400 MG/5ML, Biscolax Suppository 10 MG, Acetaminophen Tablet 325 MG, Santyl External Ointment 250 Unit/GM. Review of a Nursing Progress Note, dated 08/16/24, showed, Resident went to [Local Hospital] wound care appointment this am [morning]. Received a call from them approximately 11:30 am stating that the resident is being sent to the ER to evaluate a hematoma to her left arm. NP made aware. Review of the Emergency Provider Report, dated 8/16/24, revealed the chief complaint was left arm swelling and reports extremity pain, extremity swelling. The section for Home Medications - Active Scripts included: - Amiodarone 200 MG, PO (by mouth). - Collagenase Clostridium 1 application, trade name Santyl, Topical, BID (two times daily). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Ferrous Sulfate 325 MG, PO Q48HR (every other day). - Gabapentin 300 MG, per feeding tube, TID (three times daily). - Guaifenesin/Dextromethorphan 5 ML (milliliters), per feeding tube, Q6H (every six hours), 7 days. - Multivitamin 1 tablet, PO daily. - Pantoprazole 40 MG, PO AC BK DIN (before breakfast and dinner). - Polyethylene Glycol 3350 17 GM, PO daily, PRN (as needed). - Rivaroxaban 20 MG, PO (by mouth). - Sennosides 1 tablet, PRN daily as needed. - Sodium Chloride 3% Inhalation Solution 4 ML, INH RTQ6H (inhalation every 6 hours while awake). Reported Medications included: - Prednisone 5 MG, PO Q72HR (every 72 hours). - Bupropion HCL 100 MG, PO daily. - Atorvastatin 10 MG, PO daily. - Metoprolol Tartrate 25 MG, PO BID. The Impression for the vascular Lab, dated 8/16/24, of her upper left arm showed: No sonographic evidence of deep venous thrombosis. Left upper arm soft tissue mass most consistent with fluid which may reflect hematoma, seroma, abscess of lymphocele. Ultrasound-guided aspiration appears technically possible if clinically indicated. The Impression for the radiology report, dated 8/16/24, of the left forearm showed: Diffuse infiltrative changes soft tissues distal left upper arm and proximal-mid forearm consistent with edema or cellulitis. The Re-Evaluation/Progress #1 note showed: Left upper extremity shows a moderate-sized hematoma. There is no DVT. I consulted with plastics, and they recommended admission for hematoma evacuation. The patient will require cardiology clearance given her recent cardiac arrest. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the History and Physical Report from the local hospital and dated 8/17/24 revealed Patient is a . year old female with a past medical history paroxysmal atrial fibrillation, VFib [ventricular fibrillation] cardia arrest, MS, anxiety, OSA [obstructive sleep apnea], hyperlipidemia, PE [pulmonary embolism]/DVT previously on Xarelto, sacral decubitus ulcer, and ESBL [extended spectrum beta-lactamase] E [Escherichia] coli bacteremia that presented to [local hospital] for evaluation of upper extremity swelling and pain. Patient was found to have a hematoma. Plastics evaluated and recommended no intervention at this time .Labs were remarkable for hemoglobin 6.6 and given a unit of PRBCs. Review of https://medlineplus.gov/ency/article/003645.htm showed Hemoglobin is a protein in red blood cells that carries oxygen . Normal results for adults vary, but in general are: . Female: 12.1 to 15.1 . The ranges above are common measurements for results of these tests. Normal value ranges may vary slightly among different laboratories During an interview on 08/27/24 at 9:50 a.m. Resident #6 stated she was out of it and did not remember much about her stay at the facility between 08/09/24 and 08/16/24. Resident #6 stated she knew the medications she took and why. Resident #6 stated that had she not been confused during the initial admission on 08/09/24. She reported that if she had not become confused, she would have asked about the facility not administering her regular medications. Resident #6 stated her family member was very upset about the facility not administering all the medications as ordered during the initial admission. Resident #6 stated both she and her family member still did not understand why the facility was not treating the multiple sclerosis (MS) flareup causing her hands to be paralyzed and did not understand why the facility would not provide her with Prednisone, which assists her in regaining her functions when MS attacks. Resident #6 stated because of the latest MS flareup she was not able to feed herself because the MS flareup attacked her hands. During an interview on 08/27/24 at 10:32 a.m. Resident #6's family member stated the Director of Nursing (DON) from the facility called him to let him know Resident #6 did not receive her medications from the initial admitted on 08/09/24 through her hospitalization on [DATE]. The family member stated the DON told him the facility did not input Resident #6's medications into the medical record. The family member stated when he came to visit Resident #6, he spoke with staff who came into Resident #6's room and voiced his concerns that Resident #6 seemed to be out of it. The family member stated Resident #6 was fuzzy about things and was not able to pay attention, which was not her normal. The family member stated prior to her initial admission on 08/09/24 Resident #6 was her normal self, and he noticed the change in her status during the week after her initial admission to the facility until the time of discharge to the hospital on 08/16/24. The family member stated Resident #6 went out to the wound center and when the wound care physician was looking at the wound, they noticed the hematoma on her arm. The family member stated the wound care center immediately sent her over to the ER (emergency room) where she was admitted into the hospital. The family member stated he noticed a positive change in her mental status back to normal once she was at the hospital and stated she began acting more like her coherent self again. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/27/24 at 2:50 p.m. the DON stated Resident #6 went to a scheduled outside appointment on 08/16/24. The DON stated it was then that the outside provider sent Resident #6 to the ER. The DON stated she reviewed Resident #6's medical record when Resident #6 was hospitalized . This was when she recognized Resident #6 was not administered all her physician ordered medications. The DON stated Resident #6 did not have a DVT (deep vein thrombosis) and the hospital said it was just cellulitis. The DON stated upon reviewing Resident #6's medications it was discovered they were not reconciled and were not entered into the medical record. The DON stated that Staff E, Licensed Practical Nurse (LPN), was the admitting nurse for Resident #6 on Friday, 08/09/24. The DON stated that Staff E, LPN should have ensured all medications were entered into the electronical medical record as medications are a priority. The DON stated her understanding was Staff E, LPN started the admission process and was called away and failed to communicate with the oncoming nurse that all the medications were not added into the electronical medical record. The DON stated nurses are supposed to document the medication reconciliation. The DON stated after speaking with Staff E, LPN she was informed that Staff E, LPN left at 7:00 p.m., the end of her scheduled shift, and assumed the oncoming nurse scheduled for the 7:00 p.m. to 7:00 a.m. shift would complete Resident #6's physician ordered medications. The DON stated she then spoke with Staff F, LPN (the oncoming nurse) for the 7:00 p.m. to 7:00 a.m. shift. The DON discovered Staff F, LPN thought the admission was completed by the 7:00 a.m. to 7:00 p.m. nurse since some entries were completed in the physician orders of Resident #6's medical record. The DON stated chart scrubs (reviews) should be completed on Mondays (more than 48 hours after Resident #6's admission), however the Unit Manager ended up having to work on the medication cart passing medications and the Assistant Director of Nursing (ADON) was not in the facility. During an interview on 08/27/24 at 5:50 p.m. Staff E, LPN stated the admission process was to get a list of admissions, and the nurses were responsible for getting the chart ready. Staff E, LPN stated the nurse was also responsible for checking the new admissions' medication lists. Staff E, LPN stated that her work schedule was usually 7:00 a.m. to 7:00 p.m. shift and medications were the responsibility of the night shift nurse working 7:00 p.m. to 7:00 a.m. since the medications were usually delivered after 7:00 p.m. During an interview on 08/28/24 at 1:45 p.m. Staff F, LPN stated he has worked in the facility for two years. Staff F, LPN stated when the new admission comes to the facility it is the nurse's responsibility to complete the admission, however if the nurse is new, a seasoned nurse will help to train them. Staff F, LPN stated the nurse's responsibility for a resident who is newly admitted would consist of assessments to include skin and wounds, consents for treatment, and then the physician orders for medications are entered into the electronical medical record. Staff F, LPN stated, ensuring everything is entered into the electronical medical record, a seasoned nurse would check to make sure a medication reconciliation was completed. Staff F, LPN stated if medications were not available the nurse could also look in the [Emergency Drug Kit] for the medications. An interview was conducted with the Consultant Pharmacist on 8/28/24 at 8:37 a.m. The consultant reported that although he does not review new admissions, new admission medications should arrive to the facility within 24 hours. During an interview on 08/28/24 at 12:00 p.m. the NP confirmed Resident #6 had medications that were not entered into the medical record when she was initially admitted into the facility on [DATE]. The NP stated the missing medications were not found until after Resident #6 went out to the hospital. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/28/24 at 3:11p.m., the Pharmacist in Charge (PC) stated in review of Resident #6's medications upon admission all the medications put into the electronical medical record system were house stocked medications except for Metoprolol. The PC stated that should the drug Amiodarone be stopped abruptly this drug was a serious drug for the heart and should be tapered off if possible. The PC stated for the drug Gabapentin this drug should be tapered off gradually over a week's time and had withdrawal side effects such as Tachycardia and Seizures. The PC stated for the drug Wellbutrin this drug should also be tapered off and if stopped abruptly withdrawal symptoms would be depression, irritation and confusion however all these medications could cause confusion. Review of the website medlineplus.gov showed: Gabapentin should be gradually reduced. Do not stop taking gabapentin without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking gabapentin tablets, capsules, oral solution, you may experience withdrawal symptoms such as anxiety, difficulty falling asleep or staying asleep, nausea, pain, and sweating. If you are taking gabapentin to treat seizures and you suddenly stop taking the medication, you may experience seizures more often. Your doctor may decrease your dose gradually over at least a week. Review of the website addictionresources.com showed: Wellbutrin if discontinued may cause the following withdrawal symptoms within two to four days after discontinuation of the drug: Mood Changes: Mood swings, irritability, heightened emotional sensitivity Physical Symptoms: Headaches, fatigue, dizziness and flu-like symptoms Cognitive Effects: Difficulty concentrating, memory lapse and cognitive fog. Review of the website medlineplus.gov showed: Amiodarone You may need to be closely monitored or even hospitalized when you stop taking amiodarone . Review of the website https://my.clevelandclinic.org/health/drugs/14568-iron-oral-supplements-for-anemia showed: Ferrous sulfate is a type of iron supplement. Iron is one of the minerals your body needs to function properly. Your body needs iron to produce hemoglobin and myoglobin. Hemoglobin is a protein in your red blood cells. Hemoglobin helps your blood carry oxygen from your lungs to all your body's tissues and organs. Myoglobin is a protein in your muscles and helps supply oxygen to the cells in your muscles. If you don't have enough iron, your body can't make these proteins, and you may develop iron-deficiency anemia. Iron-deficiency anemia is the most common type of anemia. Anemia is a blood disorder in which your body doesn't have enough red blood cells. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/28/24 at 4:12 p.m., the Medical Director (MD)(who was the resident's primary care physician at the facility) stated the process for new admissions would be medications are uploaded into the electronic medical record system by the nurse and then facility staff would message him so he could look at the new resident's profile within 24 hours. The MD stated he was not aware that Resident #6 was not getting all her medications. The MD stated that he was at the facility and met with Resident #6 on 08/12/24. The MD stated that according to his physician notes, he only discussed Metoprolol with Resident #6 so that must have been the only medication that was documented in her medical record. The MD stated he was not aware all the medications were not entered into the electronic medical record system, but stated he did remember questioning that she only had one medication and had found it odd. The MD stated that if you review my physician note when I came to the facility and examined Resident #6 for her re-admission you will see I listed a lot more medications because the facility had entered all the medications into the electronic medical record system during the re-admission process. During an interview on 08/29/24 at 4:00 p.m. Registered Nurse (RN)/Regional Director of Clinical Services (RDCS) confirmed the medication errors for Resident #6 at the time of her initial admission on 8/9/24. The RN/RDCS stated a resident missing a cardiac medication is significant. Review of the policy titled, Physician Orders, revised 3/3/21, revealed: The center will ensure that physician orders are appropriately and timely documented in the medical record. The policy described the procedure for admission orders as Information received from the referring facility or agency to be reviewed, verified with the physician, and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practical after it is provided, to maintain an accurate medical record. Review of the facility's policy Administering Medications revised date 04/2019 showed Policy Statement: Medications are administered in a safe and timely manner, and as prescribed .3. Staffing schedules are arranged to ensure that medications are administered without necessary interruption. 4. Medications are administered in accordance with prescriber orders, including any required time frame .6. Medication errors are documented, reported and reviewed by the QAPI committee to inform process changes and or the need for additional staffing. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before or after meal orders). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Nursing Documentation Guidelines, not dated, revealed Policy: Pertinent Information should be documented in the individual's record in an accurate, timely and legible manner. Procedure: General Guidelines When to Chart 1. Record resident's condition, nursing actions and individual responses as soon as possible after they occur What to Chart 1. Symptoms/Subjective Data 2. Your observations and/or Assessments, 3. All injuries, illness and unusual health changes until they are resolved. There should be entries in the nursing notes on a regular basis until the problem is no longer present. When the problem is resolved, it should be documented. 4. All contacts with the primary care prescriber. A. document what information was relayed to the primary care prescriber. b. If the primary care prescriber sees or reviews an individual's specific health problem, document what occurred: the chart was reviewed, the individual was seen or if the individual was examined. c. contact is made by phone document what was discussed and results of the contact (e.g. [for example] no orders given, observe) d. document the plan for follow-up (e.g. to see the physician on morning rounds) e. Documentation on all meds. 5. response to a medication or treatment this includes therapeutic effects as well as side effects 6. new symptoms or conditions document in then nurses notes at time of occurrence or as soon as possible. Document nursing action taken and person's response. Facility immediate actions to remove the Immediate Jeopardy included: Immediate and Five (5) day reports were completed for Resident #6 on 8/17/24 and 8/23/24 related to neglect respectively. Resident was discharged on [DATE] from a physician office visit to the hospital. readmitted to facility on 8/19/24. Medication reconciliation completed on 8/19/2024 by licensed nurse. Education completed with one identified nurse directly related to Resident #6's identified deficiency on 8/17/24. Education provided reviewed the process of new admissions, medication reconciliation of physician orders, and follow up with pharmacy regarding delivery of medications. As of 8/28/24, corrective action was written for the one identified nurse. A thirty (30) day look back of all admissions and readmissions from 7/16/2024 to 8/16/2024 to ensure systems are in place to confirm residents are admitted into the facility's electronic medical record and medications ordered at the time of admission are received and administered per physician orders. As of 8/27/2024, a MAR to cart audit reconciliation was completed by the Director of Nursing/designee to ensure medications are available according to physician order. A pharmacy representative also conducted a full cart audit on 8/28/2024. Facility personnel received education beginning on 8/28/2024 related to abuse policy to include preventing abuse, identification, protection, investigating and reporting and reporting inappropriate resident behaviors to the nurse. Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. As of 8/17/2024 all license nurses were educated by Director of Nursing/Designee on the admission process to ensure discharge medications are reconciled before clarifying with physician and ensure residents are receiving their physician ordered medications to meet their needs. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Nurses received additional education beginning on 8/27/2024 on errors in medication administration to include: -omissions of medications not given -transcribing and reconciliation of discharge orders -following physician orders -steps taken when medication is not available (check med bank backup machine, check central supply, call pharmacy and notify physician of medication unavailability and document in progress note) If unable to reach physician in timely manner, contact Director of Nursing/Designee Any staff member that did not receive education related to the above-mentioned items will be sent a letter as of 8/29/2024 indicating they may not return to work until the education is received. Newly hired staff will receive education in orientation. Verification of the facility's removal plan was conducted by the survey team on 8/29/24. All steps contained in the removal plan were reviewed and verified. Interviews were conducted with 15 of the 20 licensed nurses employed by the facility. The LPN's and RN's interviewed worked across all shifts. All nurses were able to provide details on the medication order process for new admissions. The nurses responded appropriately when asked what they would do in various situations if a concern was to arise. No concerns were identified with the answers provided. Based on verification of the facility's Immediate Jeopardy removal plan, the immediate jeopardy was determined to be removed on 08/29/24 and the non-compliance was reduced to a scope and severity of D.

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Cross Reference F760 Based on observation, review of medical records, policy and procedure review, interviews with residents, resident representative, nursing staff, key management staff, the residents' physician and pharmacist, it was determined the facility failed to ensure the medical records were complete and accurate in accordance to accepted professional standards and practices for two residents (#3, and #6) out of 9 residents reviewed. This failure contributed to the lack of communication amongst staff in delivering care and services for Resident #3 and Resident #6 resulting in the residents not receiving physician ordered medications. The facility staff did not ensure documentation was completed upon admission for Resident #6 related to medication reconciliation. The facility failed to enter physician ordered medications resulting in the resident not receiving prescribed medications from 8/9/24 to 8/16/24. In addition, an antibiotic, deemed to be ineffective for Resident #6's urinary tract infection (UTI) by a lab result, was administered eight times upon the readmission of Resident #6. The nursing staff administered two different antibiotic medications on the same day at the same time for the same infection without consulting the physician. The facility staff did not ensure Resident #3's physician order for Methadone was obtained or administered for approximately 77 hours resulting in the resident suffering pain and withdrawal symptoms. The facility staff failed to complete the medication reconciliation by not clarifying the physicians order for Methadone timely with the physician. The report did not document if the physician or the date and time the physician had been contacted to reconcile the discharged medications. The failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death and resulted in the determination of Immediate Jeopardy on 8/9/24. The findings of Immediate Jeopardy were determined to be removed on 8/29/24 and the severity and scope was reduced to a D. Findings included: (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the facility's policy titled, Nursing Documentation Guidelines, not dated, revealed Policy: Pertinent Information should be documented in the individual's record in an accurate, timely and legible manner. Procedure: General Guidelines When to Chart 1. Record resident's condition, nursing actions and individual responses as soon as possible after they occur What to Chart 1. Symptoms/Subjective Data 2. Your observations and/or Assessments, 3. All injuries, illness and unusual health changes until they are resolved. There should be entries in the nursing notes on a regular basis until the problem is no longer present. When the problem is resolved, it should be documented. 4. All contacts with the primary care prescriber. A. document what information was relayed to the primary care prescriber. b. If the primary care prescriber sees or reviews an individual's specific health problem, document what occurred: the chart was reviewed, the individual was seen or if the individual was examined. c. contact is made by phone document what was discussed and results of the contact (e.g. [for example] no orders given, observe) d. document the plan for follow-up (e.g. to see the physician on morning rounds) e. Documentation on all meds. 5. response to a medication or treatment this includes therapeutic effects as well as side effects 6. new symptoms or conditions document in then nurses notes at time of occurrence or as soon as possible. Document nursing action taken and person's response. Further review of the policy titled, Nursing Documentation Guideline, undated, showed the policy defined an individual's record as A permanent legal document that provides a comprehensive account of information about the individual's health care status. Review of the policy titled, Physician Orders, revised 3/3/21, revealed: The center will ensure that physician orders are appropriately and timely documented in the medical record. The policy described the procedure for admission orders as Information received from the referring facility or agency to be reviewed, verified with the physician, and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practical after it is provided, to maintain an accurate medical record. Review of the census page in the electronical medical record revealed Resident #6 was initially admitted to the facility on Friday, 08/09/24 at 4:20 PM. Review of the Admission Record confirmed the initial admission on 08/09/24 and a re-admission to the facility on [DATE] with diagnoses that included subsequent encounter fracture with routine healing, multiple sclerosis (MS), paraplegia, urinary tract infection (UTI), major depressive disorder recurrent, ventricular fibrillation, paroxysmal atrial fibrillation and other pulmonary embolism without acute COR pulmonale (alteration in the structure and function of the right ventricle of the heart caused by a primary disorder of the respiratory system), acute kidney failure, anemia, acute respiratory failure with hypoxia, personal history of other venous thrombosis and embolism. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008), dated 8/8/24, revealed Resident #6 had no medication due near the time of transfer on 08/09/24, and a script was checked as not attached for a controlled substance. Resident #6 had ESBL (extended spectrum beta-lactamase) of the urine, a pressure ulcer on coccyx, and the reason for transfer was for care/rehabilitation with a poor prognosis for rehabilitation potential. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [Local Hospital] Discharge Patient Med Rec (Medication Reconciliation) - Single report, dated 08/08/24, showed: This is the list of medications for you to take upon discharge. Please take this list to your primary care doctor at the next visit. Your hospital doctor wants you to take the drugs on this list when you go home. The list of medications included the following: - Amiodarone 200 MG (milligrams), trade name Cordarone, Oral, twice daily. A note showed this order was sent to the resident's preferred pharmacy. - Atorvastatin 10 MG, trade name Lipitor, Oral, daily. - Bupropion HCL 100 MG, trade name Wellbutrin, Oral, daily. - Collagenase Clostridium 1 application, trade name Santyl, Topical, twice daily. A note showed this order was sent to the resident's preferred pharmacy. - Ferrous Sulfate 325 MG, trade name Feosol, Oral, every other day. - Gabapentin 300 MG, trade name Neurontin, per feeding tube, three times daily. A note showed this prescription was printed. - Guaifenesin/Dextromethorphan 5 ML (milliliters), per feeding tube, Q6H (every six hours). A note showed this order was sent to the resident's preferred pharmacy. - Metoprolol Tartrate 25 MG, trade name Lopressor, Oral, twice daily. - Multivitamin 1 tablet, trade name Multivitamin-Mineral Daily, Oral, daily. - Pantoprazole 40 MG, trade name Protonix, Oral, before breakfast and dinner. - Polyethylene Glycol 3350 17 MG, trade name Miralax, Oral, daily as needed. A note showed this prescription was printed. - Prednisone 5 MG, trade name Prednisone, Oral, take 1 tablet by mouth 1 time every 72 hours. - Rivaroxaban 20 40 MG, trade name Xarelto, Oral, with breakfast. - Sennosides 1 tablet, trade name Senokot, Oral, daily as needed. A note showed this order was sent to the resident's preferred pharmacy. - Sodium Chloride 3% Inhalation Solution 4 ML, trade name Sodium Chloride 3% Inhalation Solution, inhalation every 6 hours while awake. A note showed this order was sent to the resident's preferred pharmacy. Review of the Order Summary Report for Active Orders as of 8/9/24 and the August 2024 Medication Administration Report (MAR) revealed the following medications were ordered on 08/09/24 during Resident #6's initial admission: - Metoprolol Tartrate oral tablet 25 MG- Give 1 tablet by mouth twice daily. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Multivitamin-Minerals Oral Tablet Give 1 tablet by mouth one time a day. Review of the Medication Reconciliation form, dated 08/09/24, showed: Section A. Completed medication reconciliation utilizing the following data sources (check all that apply) - 2. Discharge Summary: Section B. Medication Issues Identified was blank and showed no medications listed or needing clarification; Section C. Physician Contact was blank. Review of the baseline care plan for the 8/9/24 admission showed for the Problem of Pain that Goal was for Resident #6 will maintain comfort to highest degree possible and the Interventions included to administer pain medication as ordered. The Problems of Psychotropic Use, Infection, Altered Cardiac/Respiratory Functioning and Altered Mood State and/or Behavior were blank. Review of Resident #6's Admission Minimum Data Set (MDS), dated [DATE], showed in Section C-Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). Section I-Active Diagnosis showed Resident #6 had the following diagnoses: anemia, deep venous thrombosis (DVT) or pulmonary embolism (EP), hypertension, renal insufficiency, multidrug-resistant organism (MDRO), urinary tract infection (UTI), wound infection, hyperlipidemia, paraplegia, multiple sclerosis, depression and respiratory failure. Section N-Medications showed Resident #6 was taking none of the above medication classifications that included: antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, opioid and antiplatelet. Review of a Nursing Progress Note, dated 08/14/24, showed, Resident [family member] has concern that [Resident #6] has an UTI, he stated her current orientation is not her baseline the pt [patient] is showing signs of increased confusion and would like for her to be tested for an UTI. The writer notified the house NP about [family member's] concerns, NP gave new orders to give for UA C&S [Urine Culture and Sensitivity] and to monitor for other s/s [signs and symptoms]. Review of a SBAR (Situation, Background, Action, Response) Communication Form, dated 8/14/24, showed since the situation started the staff member was unable to determine if it had gotten worse and the condition, symptom or sign occurring prior was unknown. The Resident/Patient Evaluation showed increased confusion or disorientation. Review of a Physician Progress Note, dated 08/15/24, with a service date of 08/12/24, showed, Patient seen today is new to provider. She was in the hospital for hypoxia due to respiratory failure. She was also found to be tachycardia, hypotensive, and had a fever, she was a sepsis alert. She has multiple sclerosis is a paraplegic. She has a foley catheter for urinary retention. She is seen at bedside and states she is doing well .She is currently on 2L [liters] oxygen, she is at baseline. She has tube feeds and states that she eats regular food too. Medications Reconciled .Medications: Metoprolol Tartrate Oral Tablet 25 MG, Multivitamin-Minerals Oral Tablet, Tubersol Solution 5 unit/0.1 ml, Fleet Enema 7-19 GM [gram]/118 ML, Milk of Magnesia Suspension 400 MG/5ML, Biscolax Suppository 10 MG, Acetaminophen Tablet 325 MG, Santyl External Ointment 250 Unit/GM. Review of a Nursing Progress Note, dated 08/16/24, showed, Resident went to [Local Hospital] wound care appointment this am [morning]. Received a call from them approximately 11:30 am stating that the resident is being sent to the ER [emergency room] to evaluate a hematoma to her left arm. NP made aware. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Progress Note, dated 08/16/24, showed, [Local] hospital was called to check the resident's status; the nurse informed this writer that resident was admitted to the hospital with dx [diagnosis] of hematoma to the left arm and resident is scheduled for surgery on Monday. [Medical Director] made aware. Review of the Emergency Provider Report, dated 8/16/24, revealed the chief complaint was left arm swelling and reports extremity pain, extremity swelling. The section for Home Medications - Active Scripts included: - Amiodarone 200 MG, PO (by mouth). - Collagenase Clostridium 1 application, trade name Santyl, Topical, BID (two times daily). - Ferrous Sulfate 325 MG, PO Q48HR (every other day). - Gabapentin 300 MG, per feeding tube, TID (three times daily). - Guaifenesin/Dextromethorphan 5 ML (milliliters), per feeding tube, Q6H (every six hours), 7 days. - Multivitamin 1 tablet, PO daily. - Pantoprazole 40 MG, PO AC BK DIN (before breakfast and dinner). - Polyethylene Glycol 3350 17 GM, PO daily, PRN (as needed). - Rivaroxaban 20 MG, PO (by mouth). - Sennosides 1 tablet, PRN daily as needed. - Sodium Chloride 3% Inhalation Solution 4 ML, INH RTQ6H (inhalation every 6 hours while awake). Reported Medications included: - Prednisone 5 MG, PO Q72HR (every 72 hours). - Bupropion HCL 100 MG, PO daily. - Atorvastatin 10 MG, PO daily. - Metoprolol Tartrate 25 MG, PO BID. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the History and Physical Report from the local hospital dated 8/17/24 revealed Patient is a . year old female with a past medical history paroxysmal atrial fibrillation, VFib [ventricular fibrillation] cardiac arrest, MS, anxiety, OSA [obstructive sleep apnea], hyperlipidemia, PE[pulmonary embolism]/DVT previously on Xarelto, sacral decubitus ulcer, and ESBL E coli bacteremia that presented to [local hospital] for evaluation of upper extremity swelling and pain. Patient was found to have a hematoma. Plastics evaluated and recommended no intervention at this time .Labs were remarkable for hemoglobin 6.6 and given a unit of PRBCs [packed red blood cells - transfusion]. Review of the August physician orders, and the August MAR showed the following medications were ordered on or after 08/19/24 during Resident #6's re-admission: - Amiodarone HCl Oral Tablet 200 MG- Give 1 tablet by mouth one time a day related to htn (hypertension) with start date of 08/20/24 and d/c (discontinue) date of 8/20/24. - Amiodarone HCl Oral Tablet 200 MG- Give 1 tablet by mouth one time a day related to Paroxysmal Atrial Fibrillation with start date of 08/21/24. Atorvastatin Calcium Oral Tablet 10 MG- Give one tablet by mouth at bedtime for hyperlipidemia with start date of 08/20/24. Cipro Oral Tablet 500 MG- Give 1 tablet by mouth two times a day for UTI for 7 days with start date 08/17/24 and d/c 8/23/24. Bactrim DS Oral Tablet 800-160 MG- Give 1 tablet by mouth two times a day for infection for 14 days with start date of 08/23/24. Bupropion HCl Oral Tablet 100 MG- Give 1 tablet by mouth one time a day related to Mood Disorder, Recurrent with start date of 08/20/24 and d/c date of 8/20/24. Bupropion HCl Oral Tablet 100 MG- Give 1 tablet by mouth one time a day related to Major Depressive Disorder, Recurrent with start date of 08/21/24. Ferrous Sulfate Oral Tablet 325 MG- Give 1 tablet by mouth in the morning every 2 day(s) for anemia with start date of 08/20/24 and d/c date of 8/20/24. Ferrous Sulfate Oral Tablet 325 MG- Give 1 tablet by mouth in the morning every other day for anemia with start date of 08/21/24. Metoprolol Tartrate Oral Table 25 MG Give 1 tablet by mouth two times a day for HTN with a start date of 8/9/24. Gabapentin Oral Capsule 300 MG- Give 1 capsule by mouth three times a day for neuropathy with start date 08/20/24. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG- Give 1 tablet by mouth two times a day for GERD with start date 08/20/24. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Lab Results Report, with a report date of 08/17/24 at 10:03 a.m., showed the NP reviewed the Urinalysis (UA) results, Urine Culture and Sensitivity (C&S) results on 08/19/24 at 8:09 a.m. The results of the Urine C&S revealed Ciprofloxacin (Trade Name Cipro) was R meaning resistant greater than four. Review of a Physician Progress Note, dated 08/19/24 at 3:09 p.m., showed, Patient seen today for a follow up visit . She is seen at bedside and states she was positive for a UTI while in the hospital but did not receive any antibiotics . A UA was obtained and is positive for UTI. Cipro 500 was started until C&S is completed. Further review of the August MAR showed Resident #6 was administered Cipro Oral Tablet 500 MG eight doses between the first administration on 08/19/24 at 5:00 p.m. to the last administration on 08/23/24 at 9:00 a.m. In addition, Resident #6 was also administered Bactrim DS Oral Tablet 800-160 MG on 08/23/24 at 9:00 a.m. The August MAR showed both the medications of Cipro and Bactrim were administered at their scheduled times of 9:00 a.m. on 08/23/24 prior to the discontinuation of Cipro. During an interview on 08/27/24 at 9:50 a.m. Resident #6 stated she was out of it and did not remember much about her stay at the facility between 08/09/24 and 08/16/24. Resident #6 stated she knew the medications she took and why. Resident #6 stated that had she not been confused during the initial admission on 08/09/24, she would have asked about the facility not administering her regular medications. Resident #6 stated her family member was very upset about the facility not administering all the medications as ordered during the initial admission. Resident #6 stated both she and her family member still did not understand why the facility was not treating the multiple sclerosis (MS) flareup causing her hands to be paralyzed and did not understand why the facility would not provide her with Prednisone, which assists her in regaining her functions when MS attacks. Resident #6 stated because of the latest MS flareup she was not able to feed herself because the MS flareup attacked her hands. During an interview on 08/27/24 at 10:32 a.m. Resident #6's family member stated the Director of Nursing (DON) from the facility called him to let him know Resident #6 did not receive her medications from the initial admitted on 08/09/24 through her hospitalization on [DATE]. The family member stated the DON told him the facility did not input Resident #6's medications into the medical record. The family member stated when he came to visit Resident #6, he spoke with staff who came into Resident #6's room and voiced his concerns that Resident #6 seemed to be out of it. The family member stated Resident #6 was fuzzy about things and was not able to pay attention, which was not her normal. The family member stated prior to her initial admission on 08/09/24 Resident #6 was her normal self, and he noticed the change in her status during the week after her initial admission to the facility until the time of discharge to the hospital on 08/16/24. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/27/24 at 2:50 p.m. the DON stated Resident #6 went to a scheduled outside appointment on 08/16/24. The DON stated it was then that the outside provider sent Resident #6 to the ER. The DON stated she reviewed Resident #6's medical record when Resident #6 was hospitalized . This was when she recognized Resident #6 was not administered all her physician ordered medications. The DON stated Resident #6 did not have a DVT (deep vein thrombosis) and the hospital said it was just cellulitis. The DON stated upon reviewing Resident #6's medications it was discovered they were not reconciled and were not entered into the medical record. The DON stated that Staff E, Licensed Practical Nurse (LPN), was the admitting nurse for Resident #6 on Friday, 08/09/24. The DON stated that Staff E, LPN should have ensured all medications were entered into the electronical medical record as medications are a priority. The DON stated her understanding was Staff E, LPN started the admission process and was called away and failed to communicate with the oncoming nurse that all the medications were not added into the electronical medical record. The DON stated after speaking with Staff E, LPN she was informed that Staff E, LPN left at 7:00 p.m. , the end of her scheduled shift, and assumed the oncoming nurse scheduled for the 7:00 p.m. to 7:00 a.m. shift would complete Resident #6's physician ordered medications. The DON stated she then spoke with Staff F, LPN (the oncoming nurse) for the 7:00 p.m. to 7:00 a.m. shift. The DON discovered Staff F, LPN thought the admission was completed by the 7:00 a.m. to 7:00 p.m. nurse since some entries were completed in the physician orders of Resident #6's medical record. The DON stated chart scrubs (reviews) should be completed on Mondays (more than 48 hours after Resident #6's admission). The DON stated Resident #6's medical record and medication reconciliation was just overlooked. The DON stated the nurses were continually being educated on the importance of completing medication reconciliation, documentation of admissions assessments, and who they spoke to in clarifying any medications. The DON stated that both Staff E, LPN and Staff F, LPN were educated about the admission process after Resident #6's 08/09/24 incident. During an interview on 08/28/24 at 10:42 a.m. the DON stated all UA C&S results were reviewed by the facility's nurse practitioner. The DON reviewed Resident #6's Lab Results Report with a reported date of 08/17/24 and stated that the R (resistance greater than four for Ciprofloxacin) meant that this specific medication would not help Resident #6's UTI if administered. The DON stated after reviewing the Lab Results Report she was not sure why the NP did not change the medication when reviewed. The DON stated the only thing that could have happened was when Resident #6 was hospitalized , I didn't clear the medication list, and when Resident #6 was readmitted on [DATE] the medications that were ordered were just resumed. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/28/24 at 12:00 p.m. the NP reviewed Resident #6's Lab Results with a report date of 08/17/24. The NP stated she ordered Ciprofloxacin but once Resident #6's Lab Report was reviewed and showed Ciprofloxacin was resistant it was not administered. The NP stated Resident #6 did not get a dose of Ciprofloxacin when readmitted to the facility on [DATE]. The NP was presented with Resident #6's August MAR and the NP responded, What is this? The NP reviewed Resident #6's August MAR, and the NP responded, I don't ever look at that. The NP stated she did not have access to residents' electronic medical records but had asked about obtaining access to the electronic medical record system in the past. The NP confirmed that Ciprofloxacin being R resistant to the UTI bacteria would not have helped clear Resident #6's UTI. The NP reviewed Resident #6's August MAR and stated Bactrim was prescribed on 08/23/24 and this was S sensitive to the bacteria for Resident #6's UTI. The NP stated when Resident #6 returned to the facility on [DATE] there should have been another order for labs. The NP looked in Resident #6's electronical medical record and confirmed no further lab testing was completed upon re-admission on 08/19/24. Further interview with the NP was conducted regarding medication reconciliation during admission. The NP stated Resident #6 had medications that were not entered into the medical record when she was initially admitted into the facility on [DATE]. The NP stated the missing medications were not found until after Resident #6 went out to the hospital. The NP stated that Xarelto was held upon Resident #6's admission because she believed Resident #6 had some bleeding. The NP stated that any medications that are considered on hold are not entered into a resident's medical record because the facility was afraid the nursing staff would disregard the hold and give those medications anyway. The NP stated that any medications on hold would not show up on a resident's MAR because it was simply not entered in the medical record as a physician ordered medication. The NP stated that either the NP or the Medical Director (MD) would revisit all medications on hold for a later time. The NP stated that no medications were revisited for Resident #6 because she went out to the hospital and when she readmitted the medications were reconciled again off the hospital discharge summary. The NP stated that if the hospital wanted Resident #6 to be on any additional medication the hospital would have made those changes there and sent the updated medication list back on the discharge summary. The NP stated some medications placed on hold may never be resumed or are not lifelong medications but stated the MD may have different views about this. During an interview on 08/28/24 at 3:11p.m. the Pharmacist in Charge (PC) stated in review of Resident #6's medications upon admission on 08/09/24 all the medications put into the electronical medical record system were house stocked medications except for Metoprolol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106017	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/28/24 at 4:12 p.m. the Medical Director (MD) (who was the resident's primary care physician at the facility) stated the process for new admissions would be medications are uploaded into [Electronical Medical Record System] by the nurse and then facility staff would message me so that I can look at the new resident's profile within 24 hours. The MD stated he was not aware that Resident #6 was not getting all of her medications. The MD stated he was at the facility and met with Resident #6 on Monday, 08/12/24. The MD stated that according to his physician notes, he only discussed Metoprolol with Resident #6 so that must have been the only medication that was documented in her medical record. The MD stated he was not aware all the medications were not entered into the electronic medical record system, but stated he did remember questioning that she only had one physician ordered medication and had found it odd. The MD stated if you review my physician note when I came to the facility and examined Resident #6 for her re-admission, you will see I listed a lot more medications because the facility had entered all the medications into the electronic medical record system during that re-admission process. The MD stated as far as Resident #6 being administered Ciprofloxacin for the UTI, it would not have made a significant change in the UTI because it was resistant. The MD stated he remembered addressing the concern as to why Resident #6 was ordered two antibiotics (Bactrim and Ciprofloxacin) when he visited with Resident #6 and ordered the Ciprofloxacin at that time to be discontinued. The MD stated he was not presented with the results of Resident #6's Urinalysis with Sensitivities for review. The MD reported this was only reviewed by the NP. Review of a Physician Progress Note, dated 08/22/24, showed: - -Cont. [continue] Metoprolol for BP [blood pressure] Cont. Atorvastatin for HLD [Hyperlipidemia] - Cont. Pantoprazole for GERD [Gastroesophageal Reflux Disease] - Cont. Amiodarone for cardiac dysrhythmia (history of VF[Ventricular Fibrillation] arrest) - Cont. bowel regimen - Cont. Burprion [trade name Wellbutrin] for mood - Currently on Cipro [Ciprofloxacin] and Bactrim for undefined source. Clarify need for both antibiotics. During an interview on 08/29/24 at 10:16 a.m. the DON stated the nurse does assessments, checks the papers, reconciles orders, and verifies MD orders, especially if they have a discrepancy. They should call the acute care facility for clarification if needed. They are supposed to reconcile medications with the primary care physician (PCP) with every admission. They reconcile the hospital records with the PCP. The DON stated they review admissions over the weekend. She looks through what is uploaded. She checks to see if the records are accurate with proper diagnoses based on what is uploaded in the computer. The DON stated that she does not always get notification when the admit comes, but she would like to be notified when they arrive. The DON stated that she does not look at the MAR; she looks on the dashboard to see what was and was not done. The DON stated they (nurses) should be looking for new orders. When they get a new admit, the next nurse would audit the admission. During an interview on 08/29/24 at 4:00 p.m. RN/Regional Director of Clinical Services (RDCS) confirmed the medication errors for Resident #6. She stated a resident missing a cardiac medication is significant. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	37999 2. On 8/27/24 at 11:15 a.m. Resident #3 was sitting in his wheelchair at bedside. The resident was frail-looking, with bony prominences noted, pleasant, and able to answer questions appropriately. Resident #3 reported having pain all the time, has taken the opioid, Methadone, for the last 5 years, and has been on pain management for the past [AGE] years. The resident described his current pain as achy sharp pains, and rated the current pain between 7 and 8 out of a scale of 1 to 10, with 10 being the worst. The resident stated while at the facility the pain has not been below a 6. Resident #3 reported being at the facility for 5 days and has started to go through withdraw symptoms. Resident #3 described those symptoms as watery eyes, watery nose, nausea, and loose stools. Resident #3 stated he was normally constipated. The resident stated nurses say they are doing what they can, and the Methadone was on order. Resident #3 reported the facility made an admission exception for him due to his use of Methadone. Review of the Admission Data Collection form revealed an initial admitted on Friday, 8/23/24. The admission nurse's note showed Patient arrived to facility at 1905 [7:05PM] . Review of the Admission Record showed Resident #3 admission diagnoses to include malignant neoplasm of unspecified part of left bronchus or lung, malignant neoplasm of parietal lobe, lumbar region osteomyelitis of vertebra, unspecified site other specified arthritis, lumbar region fusion of spine, unspecified site unspecified discitis, right shoulder abscess of bursa, and other low back pain. Review of the admission MDS dated [DATE] showed in Section C - a BIMS score of 15 out of 15, indicating intact cognition. Review of the care plan, dated 8/26/24 for Resident #3 revealed the following: - Resident is on pain medication therapy r/t (related to) cancer. The goal was for the resident to be free of any discomfort or adverse side effects from pain medication through the review date. Interventions related to the resident's pain instructed staff to Administer medications as ordered by physician. Monitor/document side effects and effectiveness every shift. - Resident has actual/potential for pain r/t cancer (and) chronic back pain. The goals were for the resident to have minimal interruption in normal activities due to pain through the review date, and resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions included: Administer analgesia as per orders; Anticipate the resident's need for pain relief and respond immediately to any complaint of pain; and evaluate the effectiveness of pain interventions and review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Review of the acute facility's Finalized Discharge Medications, dated 8/22/24 at 12:55 p.m., showed Resident #3 was ordered Methadone Dispersible 40 mg orally daily for non-acute pain. The medication summary revealed the last dose was given on 8/22/24 at 8:52 a.m. with a note showing a prescription had been sent to an outside chain pharmacy. A note on the bottom of the summary revealed, If the pharmacy is unable to fill your prescription, ask the pharmacist if your prescription can be transferred to another pharmacy. If not, please contact the prescribing doctor for a new prescription. (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the August 2024 MAR, printed on 8/27/24 at 10:20 p.m., showed Resident #3 was scheduled at 9:00 a.m. to receive Methadone Hydrochloride (HCl) oral tablet soluble 40 mg - Give one tablet by mouth one time a day for pain. This order started on 8/24/24 and was discontinued at 9:57 a.m. on 8/27/24. The MAR revealed three different nursing signatures documented on 8/24/24, 8/25/24, 8/26/24, and 8/27/24 with a 9 documented in the administ