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F 000	INITIAL COMMENTS The surveyor entered the facility on 4/21/25 to conduct a complain survey and exited on 4/21/25. Additional information was obtained on 4/22/25, 4/23/25, 4/25/25, and 5/1/25. Therefore, the exit date was changed to 5/1/25. The following intake was investigated: NC 00229367 The one allegation resulted in deficiencies. Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity G CFR 483.25 at tag F684 at a scope and severity G	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/13/2025

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with RP (Responsible Party), staff, Nurse Practitioner (NP), and Physician the facility failed to notify the RP when Resident # 1's seizure medication was discontinued. Interview with the RP revealed if she had been notified, she would have been an advocate for Resident # 1 and informed the facility that the resident's seizure medication was not to be discontinued prior to a neurologist evaluating the resident and making the decision.	F 580	Past noncompliance: no plan of correction required.	

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Resident # 1 seized following the seizure medication discontinuation and was hospitalized in the Intensive Care Unit. This was for one (Resident #1) of three sampled residents whose medications were reviewed. The findings included:

Record review revealed Resident # 1 was admitted to the facility on 8/15/24. The resident had the following diagnoses: chronic obstructive pulmonary disease, chronic respiratory failure, ischemic heart disease, history of hip fracture, depressive disorder, history of cerebellar infarcts (stroke), dysphagia (difficulty swallowing), cognitive communication deficit, hypertension, and hyperlipidemia.

A nursing entry on 11/4/24 at 8:20 PM included the following information. Resident # 1 had a change in condition. She was witnessed to have twitching of both sides of her face and abnormal vital signs. The provider and EMS (Emergency Medical Services) were called and the resident was transferred to the hospital.

Review of a hospital discharge summary, dated 11/15/24, revealed Resident # 1 was hospitalized from 11/4/24 until 11/15/24 for the acute principle problem of metabolic encephalopathy. Further review of this hospital discharge summary noted the following information was documented by the physician. Resident # 1 had presented to the hospital with "altered mentation in addition to seizure active (as written) with mouth foaming." The resident's MRI (Magnetic Resonance Imaging) showed areas of her brain which could act as seizure focus. The resident was placed on Keppra (a seizure medication) while hospitalized. The hospital physician noted the resident should

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follow up with neurology regarding the long term plan for Keppra.

According to Resident # 1's facility record she was admitted to the facility and orders were initiated on 11/15/24 for the Levetiracetam (Keppra) 500 mg (milligrams) two times per day.

Review of the record revealed no neurology consult was ordered or initiated after 11/15/24.

On 2/12/25 a verbal order was entered by Nurse #1 into the resident's electronic medical record to discontinue Levetiracetam. There was no documentation of who gave the verbal order. There was no documentation Resident # 1's Responsible Party was notified of the Keppra discontinuation.

An interview with Nurse # 1 on 4/21/25 at 1:50 PM revealed she made rounds with NP # 1 on 2/12/25 and NP # 1 had noted the resident had no definite diagnosis of epilepsy, her Keppra level was in range, and NP # 1 had given the verbal order to discontinue the resident's Keppra.

An interview with NP # 1 on 4/22/25 at 1:27 PM revealed she did not recall giving an order for the Keppra discontinuation and she had not discussed any Keppra discontinuation with Resident # 1's RP.

Review of Resident # 1's nursing notes revealed the following entry at 8:56 PM on 4/9/25 by Nurse # 2. "Resident noted with facial twitching, nonverbal when called but respond to tactile stimuli [touch]. Before this resident noted wheeling self down in hallway and verbal. V/S [vital signs] noted T [Temperature]-98.1, RR

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[Respirations] 16, BP [Blood Pressure] 200/91 and SPO2 [Peripheral Oxygen Saturation]-100% with O2 3 lit/min via NC [oxygen at 3 liters/minute via nasal cannula]. On call [Name of on call NP] NP called and updated. New order received to send resident out for acute change in condition. RP [name of RP] notified. EMS [Emergency Medical Services] called and resident sent out of facility at 7:40 PM to [name of hospital] with even rise and fall of chest."

Review of 4/9/25 ED (emergency department) physician notes revealed Resident # 1 was received by them already intubated (a procedure where a breathing tube is inserted into the windpipe) by EMS. The ED physician noted the nursing home medication list showed the resident had not been receiving Keppra. The physician further noted, "Plan after confirming patient's airway, ordered labs, expedited CT [computed tomography] imaging of patient's head to assess for intracranial hemorrhage. My dependent review of the patient's head CT shows no intracranial hemorrhage. I think we have a good story for why the patient seized. Likely not receiving Keppra." According to the 4/9/25 hospital records, Resident # 1 was admitted to the Intensive Care Unit.

Resident # 1's RP was interviewed on 4/22/25 at 10:10 AM and reported the following information. No one had called to inform her that Resident # 1's Keppra had been discontinued on 2/12/25. She learned about it when Resident # 1 was hospitalized at the hospital with another seizure on 4/9/25. She was an advocate for Resident # 1. When Resident # 1 was hospitalized in November 2024 the hospital physician had told her (the RP) that the resident would have to see a neurologist

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before a determination could be made that she could stop taking the Keppra. If the facility had called her, she would have told them this.

Interview with Resident # 1's physician on 4/23/25 at 9:46 AM revealed he did not know anything about the Keppra discontinuation until 4/21/25, which was after the resident was hospitalized and the RP had been informed by the hospital staff of the Keppra discontinuation.

The facility presented the following corrective action plan.
1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 4/10/2025, Resident's RP notified the Director of Nursing (DON) that she had not been notified regarding the discontinuation of Keppra in February 2025. The DON completed a review of Resident's chart on 4/10/25 and noted that a verbal order had been given to discontinue Keppra on 2/12/25. The Nurse Practitioner (NP) visited the resident on 2/10/25, and ordered labs, to include Keppra level. On 2/11/25, labs were obtained and communicated to the NP. On 2/12/25, the NP visited the facility and gave a verbal order to the Registered Nurse to discontinue Keppra. The RN input the discontinuation order into the EMR for the resident. The nurse did not document in Resident's chart that she notified the RP regarding discontinuation of the medication. Completion Date 4/10/2025

Nurse #1 was in-serviced by the Clinical Nurse Liaison on 4/10/25, on the proper procedure for obtaining orders which include the following: read

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back to the provider to ensure accuracy of the order, entry of the verbal order to include name of resident, order change with date, time, and duration; name of person receiving the order, date and time of order receipt, and provider who gave the order. After the order is entered in the electronic medication administration record, the nurse will complete a progress note to indicate the full order change as listed above with the name of the provider who gave the order, with reason for order change. The nurse will also notify the responsible party and document the name of the person notified. Completion Date 4/10/2025

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The clinical managers completed an audit on 4/10/25, of anticonvulsant orders written to change, add or discontinue for dates of 4/01/25-4/10/25, to validate that residents/RP were notified regarding new or change in orders. No new concerns were identified. Completion date: 4/10/25

100% of all nurses were inserviced by the Director of Nursing/designee on the above process for receiving verbal, in-person or telephone orders, and in-serviced on notification of responsible party and documentation requirements. Nurses who are on medical leave or PRN (as needed) status will be in-serviced prior to the next scheduled shift. Completion date: 4/10/25

Any new hires after 4/10/25 will receive training by the Staff Development Coordinator (SDC) of

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the above during facility orientation. The DON notified the SDC of this responsibility on 4/10/2025.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
Completion Date: 4/11/25 and on-going

New medication orders will be reviewed during the morning clinical meeting by the Clinical Interdisciplinary Team (IDT) team and/or notes will be reviewed for notification and the order reviewed for completeness. The IDT team will complete any outstanding RP notifications at that time. The IDT team was in-serviced on this process on 4/10/25 by the Clinical Nurse Liaison.
Completion date: 4/11/25

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Notification of Change audits implemented to review any new medication changes for documentation and notification to the responsible party 5x a week for 4 weeks and then 3x a week for 8 weeks. Completion date: Audits began 4/11/25 and on-going

Compliance will be discussed weekly by the DON/designee X 4 weeks and then monthly for 6 months during the morning administrative meeting. Any non-compliance will be noted and corrective actions taken. Completion date: weekly audits began 4/11/25 and on-going

Members of the Quality Assurance (QA) team met and made the decision to implement this said

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F 580	Continued From page 8 plan on 4/10/25. The QA committee will revisit the plan with each quarterly meeting x 6 months. Audits will be presented to the quarterly QA committee for x 6 months whereby an IDT approach is held with the Medical Director to discuss effectiveness of the plan. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. Completion date: 4/10/25 and on-going The facility alleges compliance 4/12/2025 On 5/1/25 the following was done to validate the facility's corrective action plan. Multiple nurses were interviewed and reported the process as outlined in the facility's corrective action plan of receiving new orders and notifying Responsible Parties. The facility presented documentation verifying Nurse # 1 had been inserviced on proper procedure of new orders (which included notifying the responsible party). The facility presented evidence of inservices and audits per their corrective action plan. On 5/1/25 the facility's corrective action plan of 4/12/25 was validated.	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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F 684	Continued From page 9 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Physicians, Nurse Practitioners (NPs), and Responsible Party (RP) the facility failed to ensure a resident (Resident #1) received follow-up for a newly diagnosed disorder per a plan of care set forth upon discharge from the hospital and received seizure medication. Resident # 1 was hospitalized from 11/4/24 to 11/15/24 with diffuse encephalopathy (disease of the brain that alters brain function and structure) and seizure like activity. Hospital discharge plans on 11/15/24 included orders for a seizure medication (Keppra) and directions that Resident # 1 should follow up with neurology. The facility never arranged a neurology follow-up visit as directed. On 2/12/25 Resident # 1's Keppra was discontinued per a verbal order taken by a nurse with no explanation for the discontinuation and no indication in the record which provider had given the order. Per interviews with Resident # 1's Nurse Practitioner and Physician, they did not recall discontinuing the Keppra. On 4/9/25 Resident # 1 experienced a seizure, required intubation (a procedure where a breathing tube is inserted into the windpipe) by Emergency Medical Services (EMS), and was hospitalized in the intensive care unit. This was for one of three sampled residents whose medications were reviewed. The findings included: Record review revealed Resident # 1 was admitted to the facility on 8/15/24. The resident had the following diagnoses: chronic obstructive pulmonary disease, chronic respiratory failure, ischemic heart disease, history of hip fracture, depressive disorder, history of cerebellar infarcts	F 684	Past noncompliance: no plan of correction required.	

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(stroke), dysphagia (swallowing difficulties), cognitive communication deficit, hypertension, and hyperlipidemia.

A nursing entry on 11/4/24 at 8:20 PM included the following information. Resident # 1 had a change in condition. She was witnessed to have twitching of both sides of her face and abnormal vital signs. The provider and EMS were called and the resident was transferred to the hospital.

Review of a hospital discharge summary, dated 11/15/24, revealed Resident # 1 was hospitalized from 11/4/24 until 11/15/24 for the acute principle problem of metabolic encephalopathy. Further review of this hospital discharge summary noted the following information was documented by the physician. Resident # 1 had presented to the hospital with "altered mentation in addition to seizure active (as written) with mouth foaming." She was also in a hypertensive emergency. Under the heading "Seizure Like Activity," the physician further noted, "MRI [Magnetic Resonance Imaging] without acute abnormality, EEG [Electroencephalogram-test used to diagnose brain conditions] suggestive of severe diffuse encephalopathy-no seizures or definite epileptiform discharges [abnormal patterns on an EEG that resemble seizure activty]. She was started on Keppra on 11/5, transitioned to PO [oral] 11/8. Discussed case with neurology informally 11/14-14 (as written). Given MRI finding with chronic foci of hemosiderin staining involving the bilateral cerebral hemispheres (could potentially act as seizure focus), will continue Keppra (had briefly held on 11/14 with concern for AMS [altered mental status]-though she's improved today, and [RP] noted she was

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better a few days ago as well-when she was on the same Keppra dose. Follow with neurology outpatient regarding long term plan with Keppra." The hospital discharge summary also included the neurologist's "impression" of the EEG study which included the notation that "the lack of epileptiform activity during interictal EEG does not exclude the diagnosis of epilepsy." Under the hospital physician's recommendations for outpatient follow up, the physician noted the resident should follow up with neurology as an outpatient for a concern for her cognitive deficits as well as determining whether to continue the Keppra long term. Under "discharge instructions" there was a notation which read, "ambulatory referral to Neurology- appointment is requested in approximately: 4 weeks." Discharge medications listed on the hospital discharge summary included Levetiracetam [Keppra] 500 mg [milligrams] by mouth two times per day.

According to Resident # 1's facility record she was readmitted to the facility and orders were initiated on 11/15/24 for the Levetiracetam 500 mg two times per day.

Review of the record revealed no neurology consult was ordered or initiated following 11/15/24.

Nurse # 1, who worked with admitting residents to the facility, was interviewed on 4/21/25 at 1:50 PM and reported the following information. When a newly admitted resident had orders for a specific follow- up that was already arranged by the hospital then the facility would automatically follow through and arrange for the resident to attend the follow-up. If there were recommendations for a follow-up but there were

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no definitive plans or appointments made at time of hospital discharge, then the physician/provider reviewed the discharge summary and would inform staff if they wished for the facility to arrange for any follow-up to be done. At the time of Resident # 1's readmission to the facility on 11/15/24 there had been a different physician who had been the provider. Resident # 1's provider changed in December 2024 to another physician, who now also served as the facility's medical director. Facility providers, who had been responsible for Resident # 1's care in November 2024 were no longer involved with the resident.

Record review revealed Resident # 1 was seen by Nurse Practitioner # 3 on 11/18/24. NP # 3 documented the following information in her 11/18/24 progress note. Resident # 1 had a MRI in the hospital that was unremarkable and her EEG was suggestive of diffuse encephalopathy. Her Keppra would be continued. NP # 3 made no notation about a referral to the neurologist.

Review of Resident # 1's significant change Minimum Data Set assessment, dated 11/24/24, revealed Resident # 1 was severely cognitively impaired. She had a diagnosis of seizures and was receiving an anticonvulsant.

According to the record, NP # 3 again saw Resident # 3 on 11/25/24 and documented the resident was alert, ambulatory with a walker, and the resident and staff did not express any concerns on that date. NP # 3 also noted the resident's Keppra would be continued. There was no mention of a referral to Neurology.

NP # 3 was interviewed on 4/23/25 at 3:10 PM and reported the following information. She had

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worked only part time at the facility one day per week. She no longer worked at the facility and her last day was around 11/25/24. She could no longer recall Resident # 1 or access her records. While working at the facility, she worked full time at a hospital and helped to discharge residents. At the hospital where she worked, follow-up appointments were arranged at hospital discharge. On her visits with Resident # 1 in November she may have assumed the appoinment was set up and the resident would go since this was the practice to which she was accustomed. If she had continued to work at the facility and see Resident # 1, she would have questioned the facility staff why they had not sent Resident # 1 to a neurology appointment. The facility staff should also have seen that the resident needed the neurology appointment and made sure that it had occurred. Although she could not recall specific orders she had given for Resident # 1, while working at the facility she had encountered problems in general with her orders being entered into the electronic system correctly. She was accustomed to placing her own orders in the electronic record. At the facility she was required to write her orders on paper and then rely on the nurses to enter the orders timely and correctly. Although she did not recall specific residents, there had been times when orders were not placed in the computer right away or errors made when the nurse entered orders, but she could not say what had happened specifically with Resident # 1. According to NP # 3, if it had been in the discharge summary that the resident needed to go to the neurologist, then the plan was there, and it should have been carried out.

An interview with the Administrator on 4/21/25 at 12:30 PM revealed that in February 2025

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Resident # 1 began part of a collaborative health care program in which NP # 1 also routinely saw and coordinated her care. The primary physician remained involved also in the care of Resident # 1. She was first seen by the collaborative NP (NP #1) in February 2025 through the collaborative program.

On 2/4/25 NP # 2 (who was part of the physician's practice and not part of the collaborative program) saw Resident # 1 and made a progress note. NP # 2 documented the following information on 2/4/25. There had been no reports of seizure activity at the time and the resident's epilepsy appeared stable. The resident's Keppra would be continued.

NP # 2 was interviewed on 4/23/25 at 12:06 PM and reported the following information. She (NP # 2) first began seeing facility residents in January 2025. On 2/1/25 Resident # 1 had started in the collaborative program of which NP # 1 was a part. She (NP # 2) was trying to make sure all the regulatory visits were done when she first started at the facility. She (NP # 2) did see Resident # 1 on 2/4/25 while not realizing Resident # 1 had become part of the collaborative program and was to be seen primarily by NP # 1 for routine visits. When she (NP # 2) initially saw residents she would ask the nurses about any concerns, review vitals, and look at some of the progress notes. She would have done this for Resident # 1. No concerns had been mentioned to her when she saw Resident # 1. No one had mentioned the resident needed a neurology appointment and she had not been aware of the need. Following 2/4/25, she did not see Resident # 1 again. NP # 1 would have covered Resident # 1.

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Review of the record revealed NP # 1, who was part of the collaborative program, saw Resident # 1 on 2/11/25. Review of NP # 1's 2/11/25 progress note revealed the following information. NP # 1 noted Resident # 1 was confused, chronically ill appearing, frail, and dependent on oxygen for chronic hypoxia (low oxygen levels). The resident was not able to provide reliable information. The NP further noted she had discussed with Resident # 1's RP (responsible party) the goals of care and the RP wished for Resident # 1 to be a full code. There was no documentation that any discussion was held regarding a neurology follow up or that there was a plan to discontinue Resident # 1's Keppra. NP # 1 did note that the resident had chronic kidney disease, stage 3b (stage of kidney disease prior to kidney failure) and her BUN (blood urea nitrogen) on 11/15/24 had been 17 (normal 6-20), and creatinine .64 (normal .50 to 1.20). NP # 1 noted that she would obtain a CMP (complete metabolic panel) the next day and nephrotoxin drugs (drugs that damage the kidneys) would be avoided.

On 2/10/25 an order for labs was entered into the computer by Nurse # 1 for a CBC (Complete Blood Count) Basic Metabolic Panel, and a Keppra level. It was noted to be ordered by Resident # 1's physician.

Review of lab results revealed the resident's 2/11/25 Keppra level was 26.4 which was within the reference range.

Resident # 1's 2/10/25 BUN (blood urea nitrogen) was 20.1, Creatinine was .26 and the BUN/Creatinine ratio was 56.2 (normal 6-25). (These labs can reflect kidney function.)

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On 2/12/25 a verbal order was entered into the resident's electronic record to discontinue Levetiracetam (Keppra) by Nurse # 1. There was no documentation who gave the verbal order or why the Keppra was discontinued.

On 4/21/25 the Administrator printed the verbal order from the Resident's electronic record. The order was on a page with other orders entered into the electronic record for the date of 2/12/25. At the bottom of the page was the physician's electronic signature for the date of 2/12/25 at 4:42 PM.

An interview with Nurse # 1 on 4/21/25 at 1:50 PM revealed she made rounds with NP # 1 on 2/12/25 and NP # 1 had noted the resident had no definite diagnosis of epilepsy, her Keppra level was in range, and NP # 1 had given the verbal order to discontinue the resident's Keppra.

Review of Resident # 1's February 2025 Medication Administration Record revealed Resident # 1 received her last dose of Keppra on the morning of 2/12/25.

NP # 1 was initially interviewed on 4/22/25 at 1:27 PM and reported the following information. The facility did not allow for the providers to enter orders into the electronic medical record themselves. She did not recall giving a verbal order to discontinue the Keppra. She could not speak to something she did not recall doing. While working at the facility she had communicated with the DON (Director of Nursing) that she had a concern about not being able to enter her orders into the electronic record. She recalled talking to Resident # 1's RP once and the

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conversation was focused on advanced directives. She recalled she did not discuss any discontinuation of Keppra with the RP.

On 4/22/25 at 4:15 PM, NP # 1 initiated a call to the surveyor to inform the surveyor that she could access her call records if needed to validate she had talked to the RP. NP # 1 then stated the following information. The facility had called her the previous week and asked her why she had discontinued Resident # 1's Keppra. She could not recall doing it. She (NP # 1) wanted the surveyor to know that it did not make sense to her. She had been a NP for many years and it would not have been her practice to have discontinued Keppra without consulting with a neurologist. NP # 1 reported it did not make medical sense to have done so, and she was concerned that the facility was saying she did something she could not recall doing. She knew she had not signed any order.

On 2/24/25 Resident # 1's physician noted he saw the resident for a required visit. Under medications within the physician's note, it was noted that the resident's Keppra was still an active medication. The physician's progress note also included under diagnoses, "Other epilepsy, not intractable, with status epilepticus. Stable no recurrent seizures."

Review of Resident # 1's nursing notes revealed the following entry at 8:56 PM on 4/9/25 by Nurse # 2. "Resident noted with facial twitching, nonverbal when called but respond to tactile stimuli [touch]. Before this resident noted wheeling self down in hallway and verbal. V/S [vital signs] noted T [Temperature]-98.1, RR [Respirations] 16, BP [Blood Pressure] 200/91

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and SPO2 [Peripheral Oxygen Saturation]-100% with O2 3 lit/min via NC [oxygen at 3 liters/minute via nasal cannula]. On call [Name of on call NP] NP called and updated. New order received to send resident out for acute change in condition. RP [name of RP] notified. EMS [Emergency Medical Services] called and resident sent out of facility at 7:40 PM to [name of hospital] with even rise and fall of chest."

Medication Aide (MA) # 1 was interviewed on 4/21/25 at 1:40 PM and reported the following information. She had been assigned to care for Resident # 1 on 4/9/25. That evening Resident # 1 seemed herself before dinner. She had been rolling up and down the halls in her wheelchair. Around dinner time, she (MA # 1) had entered the room and saw the resident was not talking and that her face was twitching. She immediately got Nurse # 2. Nurse # 2 did an assessment and sent the resident to the hospital.

Nurse # 2 was interviewed on 4/21/25 at 1:09 PM and reported the following information. Earlier in the evening on 4/9/25 she had seen Resident # 1 in the hallway and she was talking. There was nothing abnormal about the resident. Around dinner time, the Medication Aide had called her because she had seen that the resident had twitching in her face. She went to check the resident and saw that her face was twitching and that she was not talking. She called the provider and then 911 to have the resident sent to the hospital.

Review of EMS records revealed on 4/9/25 EMS was called at 7:18 PM and arrived at 7:32 PM. The Paramedic noted the following information. At arrival the resident was unresponsive and

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actively seizing. Her eyes were deviated to the right and she had rhythmic jerking/twitching of her jaw. At baseline the resident was oxygen dependent. Her oxygen level was 67% at 7:36 PM. She was placed on a non-rebreather mask and her oxygen level improved. At 7:45 PM her oxygen level was 100%. She began to have increased salivary secretion and was suctioned. The resident was transferred to the stretcher, secured and loaded into the EMS unit (ambulance). Once in the ambulance the resident was given Versed but her seizure activity persisted. Her respirations dropped to 2 per minute and were shallow. A nasopharyngeal airway was placed and bag-valve-mask ventilations were begun. Additional Versed was administered which stopped the seizure. At that time the resident did not have any respiratory effort on her own and continued to have profuse salivary secretions. Therefore, she was intubated to protect her airway. EMS departed the facility at 8:00 PM and transferred Resident # 1 to the care of the hospital at 8:30 PM.

Review of 4/9/25 ED physician notes revealed Resident # 1 was received by them already intubated by EMS. The ED physician noted the nursing home medication list showed the resident had not been receiving Keppra. The physician further noted, "Plan after confirming patient's airway, ordered labs, expedited CT (computed tomography) imaging of patient's head to assess for intracranial hemorrhage. My dependent review of the patient's head CT shows no intracranial hemorrhage. I think we have a good story for why the patient seized. Likely not receiving Keppra."

The admitting hospitalist on 4/9/25 wrote, "She has a diagnosis of epilepsy and was supposed to

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be on Keppra 500 mg BID [twice daily] (listed on discharge summary from 11/4/24); however, she was apparently not on this at nursing facility for unclear reasons. She was seen normal at 6PM on evening of 4/9/25. When staff checked on her later, she was less responsive and was twitching with a right sided gaze. EMS was called and administered IM [intramuscular] Versed [a medication used for seizures] without improvement before establishing IV [intravenous] access and administering an additional Versed dose IV. There was roughly 45 minutes reported before seizures resolved." Hospital records for the date of 4/9/25 also included a hospital neurology consult report. The hospital neurologist documented on 4/9/25 that the "etiology of her prolonged seizure is probably secondary to not being on AEDs [Antiepileptic drugs]."

Resident # 1's RP was interviewed on 4/22/25 at 10:10 AM and reported the following information. Resident # 1 remained in the hospital. Her speech was now like "mush." When Resident # 1 had been discharged from the hospital in November 2024, the hospital had told her that Resident # 1 would need to see a neurologist before her Keppra could ever been discontinued. The facility had never arranged a neurologist visit and the resident's Keppra had been discontinued without her (the RP) being notified.

Resident # 1's facility physician, who serves as the facility's medical director, was interviewed on 4/21/25 at 1:17 PM and reported the following information. The Keppra had been discontinued by the NP and he had not been consulted about it. The resident's EEG in the hospital had not shown definitive epilepsy. The resident had diffuse encephalopathy. The encephalopathy or

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other conditions could have led to the frothing of her mouth and seizure like activity that had been witnessed when she was hospitalized in November 2024. The Keppra was being administered prophylactically (preventative). Individuals are not kept on seizure medication for a lifetime if there is not a definitive diagnosis of epilepsy. He did not know about the neurology consult recommendation. Often hospitalists make lots of recommendations upon discharge. For a resident with a definitive diagnosis of seizures, the neurology consult would have been warranted. For those with no definitive diagnosis and no further seizures, then sometimes it was not indicated. It was his understanding that was why the NP had discontinued the Keppra. Although he had not been involved in the decision to discontinue the Keppra, he agreed that the decision to discontinue it was an acceptable thing to do. The physician reported that they tried to reduce the number of medications residents received when possible.

A follow up interview was conducted with the facility Physician on 4/23/25 at 9:46 AM and the physician reported the following information. The first he knew about the discontinuation of the Keppra was on 4/21/25. Facility staff told him the Keppra had been discontinued by NP # 1. He (the Physician) often received batches of orders electronically at one time to sign from the facility. He did not recall signing the Keppa discontinuation order. There should have been some documentation by Nurse # 1 who received the discontinuation order or by NP # 1, who he was told gave the order, for the reasoning behind the order in the record.

The Administrator and the Corporate Director of

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Operations were interviewed on 4/21/25 at 4:00 PM. The Corporate Director of Operations reported Resident # 1's RP had come to them after Resident # 1 was hospitalized with the concern that Resident # 1's Keppra had been discontinued. They started looking into the issue. The Administrator reported that they had initiated an investigation and found that NP # 1 had given the verbal order to discontinue the Keppra and they had followed physician orders to do so.

On 4/22/25 at 4:26 PM and 4/23/25 at 10:32 AM interviews were conducted with the Administrator and the Regional Clinical Director via phone. They reported the following information. In their facility investigation, they had talked to NP # 1 on 4/16/25 and she recalled giving other orders and being with Nurse # 1 who took the verbal order for Keppra along with other verbal orders on 4/12/25. It is corporate policy that the providers do not enter their own orders. This is to ensure that there are no errors made in entering orders into the electronic medical record system. Every resident is assigned providers who can go in and view a resident's record. Orders go to the attending physician to review and sign when written by the Nurse Practitioner. There was a way that orders given by the Nurse Practitioner could go to the NP to electronically sign but that would have to be entered manually in order for the order to go to the NP instead of the physician. During the interview on 4/23/25 at 10:32 AM the Regional Clinical Director looked in the electronic system and did not see a notation with the verbal order who had given the verbal order. The Regional Clinical Director reported that the electronic medical record system is set up so that only one provider can sign an order, and that Resident # 1's physician signed the order that NP

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1 gave to discontinue the Keppra on 4/12/25.

The hospital neurologist who saw Resident # 1 on 4/9/25 at the hospital, was interviewed on 4/25/25 at 8:31 AM and reported the following information. Providers have to be careful in stopping medications such as seizure medications. It was his opinion that it would have been good for Resident # 1 to have gone to the neurologist as recommended. He did not work in outpatient neurology, but he would think an outpatient neurologist would have done more history and possibly more work up at a neurology visit. Resident # 1's Keppra dose was the lowest dose so there was nothing to wean. There was a suspicion of seizure activity in November 2024, but he did not think it was dangerous care for the resident to be taken off Keppra if she had not had seizure activity after some months. It would have been his preference that she would have seen a neurologist before that decision was made. He saw Resident # 1 when she came into the hospital on 4/9/25 but had not continued to follow her. During the interview, the hospital neurologist reviewed Resident # 1's progress notes from 4/17/25 and reported Resident # 1 didn't seem to be doing as well as before her seizure, but he commented the resident was 86 years old and it took time for older individuals to bounce back .

The facility presented the following corrective action plan:
1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
Resident # 1 was hospitalized from 11/4/24 to 11/15/24 with diffuse encephalopathy and had been observed with seizure like activity which included facial twitching and foaming at the

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mouth. The hospital physician noted in the 11/15/24 hospital discharge summary the resident's MRI showed there were areas in the resident's brain that could potentially act as a "seizure focus" although the resident's EEG had shown no definite epileptiform discharges. The hospital physician noted in the discharge summary that the resident had been placed on Keppra (an antiseizure medication) while hospitalized and the medication should be continued at the facility and there should be follow- up with a neurologist to determine the long-term use of Keppra. Neurology consultation was not obtained per hospital's recommendation. On 2/12/25 Resident # 1's Keppra was discontinued per a verbal order entered by Nurse # 1 with no documentation in the record why Keppra was discontinued and no documentation in the verbal order which provider gave the order.

Resident #1 was discharged to the hospital on 4/9/25 and remains in the hospital.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
On 4/10/25, a 100% audit was conducted by the Clinical Nurse Liaison to identify all current residents receiving anticonvulsant therapy and all residents with diagnosis of seizure disorder, epilepsy, and convulsions. The audits revealed no negative findings. All identified residents also had a chart review completed by the Clinical Nurse Liaison to determine consult needs from 11/1/24 to 4/10/25; there were no negative findings identified. Completion date: 4/10/25

Nurse #1 was in-serviced by the Clinical Nurse Liaison on 4/10/25, on the proper procedure for

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obtaining orders which include the following: read back to the provider to ensure accuracy of the order, entry of the verbal order to include name of resident, order change with date, time, and duration; name of person receiving the order, date and time of order receipt, and provider who gave the order. After the order is entered in the electronic medication administration record, the nurse will complete a progress note to indicate the full order change as listed above with the name of the provider who gave the order, with reason for order change. The nurse will also notify the family and document the name of the person notified. Completion date: 4/10/25

100% of all nurses were in-serviced by the Director of Nursing Services and the Nurse Manager on the above process for receiving verbal (in-person or telephone) orders and in-serviced on notification of families and documentation requirements. The facility does not utilize agency nurses. Nurses who are on medical leave or PRN status will be in-serviced prior to next scheduled shift. Completion date: 4/10/25

Any new hires after 4/10/25 will receive training of the above by the Staff Development Coordinator during facility orientation. The SDC nurse was trained on 4/10/25 with all other administrative nurses. Completion date: 4/10/25 and thereafter

100% of Administrative Nurses in-serviced on the process of consultation recommendation and MD follow-up by the Clinical Nurse Liaison. Consult sheets and recommended consultations on the discharge summaries will be highlighted and placed in the NP/MD box for MD to review at next scheduled facility visit. MD then returns reviewed

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items to the box. Administrative nurses gather MD reviews from the box daily Monday through Friday. Each consult recommendation is discussed during morning IDT meeting, approved consult recommendation are communicated to Medical Records director to schedule the appointment. MD will be contacted by administrative nurse to discuss reasoning for any consults that were declined. Discussion will be documented in nurse's notes for review during daily morning meeting. Consults will be scheduled as ordered by the medical provider. If the MD declines a recommended consult, the nurse will document her discussion with the MD regarding the reason for the declination of the recommended service. Negative findings will be documented on the Consultation Audit Tool to ensure a complete IDT approach with the medical providers. Completion: Only Administrative nurses process the discharge summaries, and they are available weekends and after hours to accommodate each admission. 4/10/25

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Upon receiving consult sheets and discharge summaries receiving nurse contacts resident's provider and reviews recommended medication. Medication orders are entered into the EMR when approval received. Discharge summaries will be placed in provider's box for review upon next scheduled facility visit, review will include non-medication items such as consultation. Consult sheets from appointments and discharge summaries will be reviewed during the morning clinical meeting by the Clinical IDT team. Clinical IDT will ensure all medication is entered into the

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EMR. Any new medication and approved consult orders will be transcribed to the MAR. Any recommendations from consult sheets will be communicated to the MD and if the MD agrees, orders will be written and transcribed to MAR. If the MD disagrees with any recommendations, including consultations, the nurse will document their discussion with the MD regarding the reason for the decline of the recommended service, and the name of the doctor giving the declination in the nurses' notes. Negative findings will be documented on the Consultation Audit Tool. Completion Date: 4/11/25 and on-going

New medication orders will be reviewed during the morning clinical meeting by the Clinical IDT team and/or notes will be reviewed for notification and the order reviewed for completeness. Any findings will be corrected during the IDT clinical meeting. The IDT team was in-serviced on this process on 4/10/25 by the Clinical Nurse Liaison. Completion date: 4/11/25

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

New admissions/readmissions and appointment consult sheets will be audited by the DNS/designee weekly x4 and then monthly thereafter for 6 months to ensure compliance with the new appointment protocol. Completion date: weekly audits began 4/11/25 and on-going

Notification of Change audits implemented to review any new medication changes and review of the nurse note to ensure family notification is documented. Audits will be conducted 5x a week for 4 weeks and then 3x a week for 8 weeks by

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the DNS/Designee.
Completion date: Audits began 4/11/25 and on-going

Compliance will be discussed weekly by the DNS/designee X 4 weeks and then monthly for 6 months during the morning administrative meeting. Any non-compliance will be noted and corrective actions taken. Completion date: weekly audits began 4/11/25 and on-going

Members of the QA team met and made the decision to implement this said plan on 4/10/25. The QA committee will revisit the plan with each quarterly meeting x 6 months. Audits will be presented to the quarterly QA committee for x 6 months whereby an IDT approach is held with the Medical Director to discuss effectiveness of the plan. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. Completion date: 4/10/25 and on-going

The facility alleges compliance 4/12/2025

On 5/1/25 the facility's corrective action plan was validated by the following actions:
Multiple staff were interviewed about processing orders and were able to report the process outlined in the corrective action plan.

The Medical Records Director was interviewed and validated the process of receipt of consult orders and process for scheduling appointments per the corrective action plan.

The facility presented evidence of inservice records and audits per their corrective action

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F 684	Continued From page 29 plan. On 5/1/25 the facility's compliance date of 4/12/25 was validated.	F 684		
F 711 SS=G	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and Nurse Practitioner (NP) interview the facility failed to ensure during visits the providers reviewed the total plan of care for Resident # 1's newly diagnosed neurological disorder when there was a change in primary providers and collaborative health care providers added to health care decision making for the resident. Multiple providers saw Resident # 1 and failed to recognize the hospital discharge plan was to have the neurologist see the resident and no appointment had been set up for her and completed prior to discontinuation of her seizure	F 711	For the Resident Cited Resident number 1 was discharged from the facility on 4/9/2025and medical record closed at this time. For Residents with the Potential to be Affected An audit conducted of physician□s comprehensive visit notes for all residents receiving seizure medication for accuracy of medication list Clinical Nurse Liaison on	5/17/25

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medication. On 2/12/25 Resident # 1's seizure medication was discontinued. Interviews with Resident # 1's NP and Physician revealed neither recalled giving the order. Following the failure of multiple providers to recognize Resident # 1 needed neurology follow up and following the failure of the providers to recognize the discontinuation of the seizure medication when reviewing the plan of care, the resident seized and was hospitalized in the Intensive Care Unit. This was for one (Resident # 1) of three residents whose medications were reviewed. The findings included:

Record review revealed Resident # 1 was admitted to the facility on 8/15/24. The resident had the following diagnoses: chronic obstructive pulmonary disease, chronic respiratory failure, ischemic heart disease, history of hip fracture, depressive disorder, history of cerebellar infarcts (stroke), dysphagia, cognitive communication deficit, hypertension, and hyperlipidemia.

A nursing entry on 11/4/24 at 8:20 PM included the following information. Resident # 1 had a change in condition. She was witnessed to have twitching of both sides of her face and abnormal vital signs. The provider and EMS (Emergency Medical Services) were called and the resident was transferred to the hospital.

Review of a hospital discharge summary, dated 11/15/24, revealed Resident # 1 was hospitalized from 11/4/24 until 11/15/24 for the acute principle problem of metabolic encephalopathy. Further review of this hospital discharge summary noted the following information was documented by the physician. Resident # 1 had presented to the hospital with "altered mentation in addition to

5/13/25.No other areas were identified.

The facility will notify the MD of any noted discrepancies in the record to include inaccurate medication lists or recommendations for consults that have not been ordered. Any identified areas of concern will be corrected by the physician.

All attending physicians were in-serviced on the process and procedure of comprehensive physician visit documentation, to include an accurate listing of medications and treatments by Director of Clinical Operations on 5/14/25.

All attending physicians were in-serviced regarding documenting reason for declining recommended consultations by Director of Clinical Operations on 5/14/25.

System Changes

Physician comprehensive visit documentation will be reviewed during the morning clinical meeting by the Clinical IDT team and compare against admission/readmissions discharge summaries and medication lists to ensure that medication lists are correct in the progress note and to ensure declination of any consults is documented in the physician progress note. Any areas of concern will be corrected by the physician.

Monitors

Random audits will be conducted of 10% of physician□s comprehensive visit notes

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F 711	Continued From page 31 seizure active (as written) with mouth foaming." She was also in a hypertensive emergency. Under the heading "Seizure Like Activity," the physician further noted, "MRI [Magnetic Resonance Imaging] without acute abnormality, EEG [Electroencephalogram-test used to diagnose brain conditions] suggestive of severe diffuse encephalopathy-no seizures or definite epileptiform discharges [abnormal patterns on an EEG that resemble seizure activty]. She was started on Keppra on 11/5, transitioned to PO [oral] 11/8. Discussed case with neurology informally 11/14-14 (as written). Given MRI finding with chronic foci of hemosiderin staining involving the bilateral cerebral hemispheres (could potentially act as seizure focus), will continue Keppra (had briefly held on 11/14 with concern for AMS [altered mental status]-though she's improved today, and [RP] noted she was better a few days ago as well-when she was on the same Keppra dose. Follow with neurology outpatient regarding long term plan with Keppra." The hospital discharge summary also included the neurologist's "impression" of the EEG study which included the notation that "the lack of epileptiform activity during interictal EEG does not exclude the diagnosis of epilepsy." Under the hospital physician's recommendations for outpatient follow up, the physician noted the resident should follow up with neurology as an outpatient for a concern for her cognitive deficits as well as determining whether to continue the Keppra long term. Under "discharge instructions" there was a notation which read, "ambulatory referral to Neurology- appointment is requested in approximately: 4 weeks." Discharge medications listed on the hospital discharge summary included Levetiracetam [Keppra] 500 mg [milligrams] by mouth two times per day.	F 711	will be audited against the new admissions/readmissions discharge summaries and medication lists by the DNS/designee weekly x4 and then monthly thereafter for 6 months to ensure compliance. A QI tool will be utilized. Compliance will be discussed weekly by the DNS/designee X 4 weeks and then monthly for 6 months during the morning clinical administrative meeting. Any non-compliance will be noted and corrective actions taken. Results of audits were presented to the facility QA committee by the DNS during the first QA meeting held on 5/14/2025. Audits will be presented to the QA committee for 6 more months. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.	

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According to Resident # 1's facility record she was admitted to the facility and orders were initiated on 11/15/24 for the Levetiracetam (Keppra) 500 mg two times per day.

Review of the record revealed no neurology consult was ordered or initiated following 11/15/24.

Nurse # 1, who worked with admitting residents to the facility, was interviewed on 4/21/25 at 1:50 PM and reported the provider reviewed the hospital discharge instructions upon admission and instructed the facility if they needed to arrange follow up appointments. Resident # 1's provider changed in December 2024 to another physician, who now also served as the facility's medical director. Facility providers, who had been responsible for Resident # 1's care in November 2024, were no longer involved with the resident.

Record review revealed Resident # 1 was seen by Nurse Practitioner # 3 on 11/18/24 and on 11/25/24. NP # 3 made no notation about a referral to the neurologist.

NP # 3 was interviewed on 4/23/25 at 3:10 PM and reported the following information. She had worked only part time at the facility one day per week. She was accustomed to the follow-up appointments being arranged by the hospital prior to discharge. She left work at the facility around 11/25/24, but If she had continued to work she would have questioned why the resident was not sent to neurology.

According to information provided by the Administrator on 4/24/25 at 11:00 AM the date of

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12/3/24 was the last date of service by the prior Medical Director and his team. A new Medical Director and new Nurse Practitioners then began seeing residents.

Also interview with the Administrator on 4/21/25 at 12:30 PM revealed that in February 2025 Resident # 1 began part of a collaborative health care program in which NP # 1 also routinely saw and coordinated her care. The primary physician remained involved also in the care of Resident # 1. Resident # 1 was first seen by the collaborative NP (NP #1) in February 2025 through the collaborative program.

Record review revealed on 2/4/25 NP # 2 (who was part of the physician's practice and not part of the collaborative program) saw Resident # 1 and made a progress note. NP # 2 documented the following information on 2/4/25. There had been no reports of seizure activity at the time and the resident's epilepsy appeared stable. The resident's Keppra would be continued. There was no notation about a missed neurology consult.

NP # 2 was interviewed on 4/23/25 at 12:06 PM and reported the following information. She (NP # 2) had first begun seeing facility residents in January 2025. On 2/1/25 Resident # 1 had started in the collaborative program of which NP # 1 was a part. She (NP # 2) was trying to make sure all the regulatory visits were done when she first started at the facility. She (NP # 2) did see Resident # 1 on 2/4/25 while not realizing Resident # 1 had become part of the collaborative program and was to be seen primarily by NP # 1 for routine visits. When she (NP # 2) initially saw residents she would ask the nurses about any concerns, review vitals, and look at some of the

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progress notes. She would have done this for Resident # 1. No concerns had been mentioned to her when she saw Resident # 1. No one had mentioned the resident needed a neurology appointment and she had not been aware of the need by reviewing the record. Following 2/4/25, she did not see Resident # 1 again. NP # 1 would have covered Resident # 1.

Review of the record revealed NP # 1, who was part of the collaborative program, saw Resident # 1 on 2/11/25. Review of NP # 1's 2/11/25 progress note revealed no mention of a missed neurological appointment.

On 2/12/25 a verbal order was entered into the resident's electronic record to discontinue Levetiracetam (Keppra) by Nurse # 1. There was no documentation who gave the verbal order.

On 4/21/25 the Administrator printed the verbal order from the Resident's electronic record. The order was on a page with other orders entered into the electronic record for the date of 2/12/25. At the bottom of the page was the physician's electronic signature for the date of 2/12/25 at 4:42 PM.

Interview with Nurse # 1 on 4/21/25 at 1:50 PM revealed she had made rounds with NP # 1 on 2/12/25 and NP # 1 had noted the resident had no definite diagnosis of epilepsy, her Keppra level was in range, and NP # 1 had given the verbal order to discontinue the resident's Keppra.

Review of Resident # 1's February 2025 Medication Administration Record revealed Resident # 1 received her last dose of Keppra on the morning of 2/12/25.

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NP # 1 was interviewed on 4/22/25 at 1:27 PM and reported the following information. She did not recall giving a verbal order to discontinue the Keppra.

On 2/24/25 Resident # 1's physician noted he saw the resident for a required visit. Under medications within the physician's note, it was noted that the resident's Keppra was still an active medication although the Keppra had been discontinued on 2/12/25. The physician's progress note also included under diagnoses, "Other epilepsy, not intractable, with status epilepticus. Stable no recurrent seizures."

Review of Resident # 1's nursing notes revealed on 4/9/25 the resident was sent to the hospital for seizure activity and admitted.

The admitting hospitalist on 4/9/25 wrote, "She has a diagnosis of epilepsy and was supposed to be on Keppra 500 mg BID [twice daily] (listed on discharge summary from 11/4/24); however, she was apparently not on this at nursing facility for unclear reasons. She was seen normal at 6PM on evening of 4/9/25. When staff checked on her later, she was less responsive and was twitching with a right sided gaze. EMS [Emergency Medical Services] was called and administered IM [intramuscular] Versed [a medication used for seizures] without improvement before establishing IV [intravenous] access and administering an additional Versed dose IV. There was roughly 45 minutes reported before seizures resolved." According to the 4/9/25 hospital records, Resident # 1 was admitted to the Intensive Care Unit.

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F 711	Continued From page 36 Resident # 1's facility physician, who serves as the facility's medical director was interviewed on 4/21/25 at 1:17 PM and again on 4/23/25 at 9:46 AM and the physician reported the following information. The first he knew about the discontinuation of the Keppra was on 4/21/25. Facility staff had told him the Keppra had been discontinued by NP # 1. He (the Physician) often received batches of orders electronically at one time to sign from the facility. He did not recall signing the Keppa discontinuation order. There should have been some documentation by Nurse # 1 who received the discontinuation order or by NP # 1, who he was told gave the order, for the reasoning behind the order in the record. He was also not aware of the recommendation from the hospital in November 2024 that the resident needed to see a neurologist. During an interview with the Administrator on 4/22/25 at 4:26 PM, the Administrator reviewed the physician's progress note of 2/24/25 which noted Keppra was an active medication although it had been discontinued per his signature on an order. The Administrator reported that at times she thought the providers cut and pasted information from past visits, but they were not supposed to do so when seeing and reviewing residents' care.	F 711		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		5/17/25

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F 756	Continued From page 37 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Nurse Practitioner, Physician, Consultant Pharmacist, and Pharmacy Director of Clinical Services, the Consultant Pharmacist failed to report to the attending physician when Resident # 1's record showed the following: 1)a neurological	F 756	For the Resident Cited Resident #1 was discharged to the hospital on 4/9/25 and residents record was closed on 4/9/25.	

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F 756	Continued From page 38 consult never was obtained although recommended when Resident # 1 experienced a newly diagnosed neurological disorder while hospitalized in November 2024 and was placed on Keppra (a seizure medication) with instructions that neurology should be involved in the continued plan for the Keppra; 2) the Keppra was discontinued on 2/12/25 with no documented reason for the discontinuation and the neurological consult still had not been completed at its discontinuation; and 3) following the discontinuation which was signed by the physician, the physician noted in his 2/24/25 progress note that the Keppra was an "active" drug although his signature appeared by the discontinuation order. This was for one (Resident #1) of three sampled residents whose medications were reviewed. The findings included: Record review revealed Resident # 1 was admitted to the facility on 8/15/24. The resident had the following diagnoses: chronic obstructive pulmonary disease, chronic respiratory failure, ischemic heart disease, history of hip fracture, depressive disorder, history of cerebellar infarcts (stroke), dysphagia (swallowing difficulties), cognitive communication deficit, hypertension, and hyperlipidemia. A nursing entry on 11/4/24 at 8:20 PM included the following information. Resident # 1 had a change in condition. She was witnessed to have twitching of both sides of her face and abnormal vital signs. The provider and EMS (Emergency Medical Services) were called, and the resident was transferred to the hospital. Review of a hospital discharge summary, dated	F 756	For Other Residents with the Potential to be Affected The Consultant Pharmacist was in-serviced on 5/13/25 by the Director of Clinical Operations regarding the requirement to complete the drug regimen review monthly and the importance of notifying the MD if a drug is missing pertinent labs, recommended consultations, and/or any other recommended monitoring tools when new diagnosis are obtained and/or when medications are implemented, adjusted, and or discontinued. This in-service also addressed the importance of noting and reporting any documentation discrepancies in the record regarding medication orders and medication administration. 100% of all residents on seizure medication have been reviewed for completeness and accuracy of medical record, medication changes and discontinuations. New admissions, and readmissions since 4/10/25 were audited by the Clinical Nurse Liaison for consultation recommendations. Any discrepancies noted were reported to the Consultant Pharmacist for review. The Consultant Pharmacist will complete record reviews if any residents are identified to ensure accuracy and completion of the medical record. Completed by 5/14/25. System Changes	

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F 756	Continued From page 39 11/15/24 and located in the facility record, revealed Resident # 1 was hospitalized from 11/4/24 until 11/15/24 for the acute principle problem of metabolic encephalopathy. Further review of this hospital discharge summary noted the following information was documented by the physician. Resident # 1 had presented to the hospital with "altered mentation in addition to seizure active (as written) with mouth foaming." The resident's MRI (Magnetic Resonance Imaging) showed areas of her brain which could act as seizure focus. The resident was placed on Keppra (a seizure medication) while hospitalized. The hospital physician noted the resident should follow up with neurology regarding the long term plan for Keppra. The physician included in the discharge summary that the appointment was requested to be done in approximately four weeks. According to Resident # 1's facility record the resident was admitted to the facility and orders were initiated on 11/15/24 for the Levetiracetam (Keppra) 500 mg (milligrams) two times per day. Review of the record revealed no neurology consultation was ordered or initiated after 11/15/24. On 12/18/24 the Consultant Pharmacist completed a pharmacy review and noted Resident # 1 had been readmitted to the facility on 11/15/24 with metabolic encephalopathy and seizure like activity. Keppra had been added to Resident # 1's drug regimen and the pharmacist made a notation "follow for neuro." On 1/14/25 the Consultant Pharmacist noted Keppra had been added in November 2024 for seizures and she again put "follow for neuro." There was no	F 756	Beginning 5/13/25, the facility will provide the Consultant Pharmacy a list of all active residents upon her monthly drug regimen review regimen. The pharmacist will review any admission/readmission paperwork for any recommendations for consultations related to medication management. These consults will be noted on the initial Medication Regimen Review, and reviewed by the IDT during AM meeting. During monthly Medication Regimen Review each discontinued seizure medication will be reviewed for documented reason for discontinuation. Any seizure medication discontinued without a reason will be communicated to the DNS or designee upon discovery for follow up with MD. Findings will be documented on the Pharmacy Recommendation to be communicated to the MD and the facility. The Pharmacy Recommendations will be completed and followed by the DNS or Designee within 72 hours of receipt (5/13/25 and on-going). Monitoring Random chart audits will be conducted by the DNS/Designee on 10% of the medical regimen reviews completed by the Consult Pharmacist for accuracy, completion, and documentation. Audits will be completed monthly x3 and then quarterly thereafter. Audit findings will be taken to the Quarterly QA Meeting x3 for compliance and review by the Committee. Based on discussion and findings the QA Committee will revise said plan to ensure	

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F 756	Continued From page 40	F 756	continued quality and safety for drug regimen review (5/2025 and on-going)	

notation about the missed neurological follow up.

On 2/12/25 a verbal order was entered into the resident's electronic medical record to discontinue Levetiracetam (Keppra) by Nurse # 1.

On 2/19/25 the Consultant Pharmacist again did a review and noted Keppra had been added in November 2024 and discontinued in February 2025. The Consultant Pharmacist did not note she was reporting to the physician that the neurological consult had never been completed.

Review of Resident # 1's February 2025 Medication Administration Record revealed Resident # 1 received her last dose of Keppra on the morning of 2/12/25.

On 2/24/25 Resident # 1's physician noted he saw the resident for a required visit. Under medications within the physician's note, the physician noted that the resident's Keppra was still an active medication although his signature was by the discontinuation order of 2/12/25. The physician's progress note also included under diagnoses, "Other epilepsy, not intractable, with status epilepticus. Stable no recurrent seizures."

On 3/17/25 the Consultant Pharmacist noted again Keppra had been added in November 2024 and discontinued in February 2025. The Consultant Pharmacist did not ask for clarification from the physician regarding why he indicated Keppra was "active" on 2/24/25 although it was discontinued on 2/12/25 per his signature.

The facility's Consultant Pharmacist was interviewed on 4/21/25 at 2:42 PM and reported she could not comment on the provider's choice

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F 756	Continued From page 41 to discontinue the Keppra and not complete a neurology consult. The Pharmacist who serves as Director of Clinical Services for the Pharmacy Consulting Practice was interviewed on 4/23/25 at 10:19 AM and reported the following information. The consultant pharmacists noted newly written orders and orders for discontinuation when doing their reviews. In doing pharmacy reviews, the consultant pharmacist would not question if the provider had not included a rationale in the record for the decision to discontinue the Keppra and they would not have questioned the physician about the resident not going to a neurologist prior to the discontinuation of the Keppra.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		5/17/25

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F 842	Continued From page 42	F 842		

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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F 842	Continued From page 43 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and physician, the facility failed to ensure a record was complete regarding the rationale to discontinue a seizure medication and that a physician's progress note was accurate regarding a seizure medication being discontinued. This was for one (Resident # 1) of three sampled residents whose medications were reviewed. The findings included: 1a. Record review revealed on 2/12/25 there was a verbal order entered into Resident # 1's record by Nurse # 1 to discontinue Keppra (a seizure medication). There was no documentation to show which provider gave the verbal order. An interview with Nurse # 1 on 4/21/25 at 1:50 PM revealed she had made rounds with Nurse Practitioner (NP) # 1 on 2/12/25 and NP # 1 had noted the resident had no definite diagnosis of epilepsy, her Keppra level was in range, and NP # 1 had given the verbal order to discontinue the resident's Keppra. The reason for the discontinuation of the Keppra was not entered into the record. Resident # 1's physician, who serves as the facility's medical director, was interviewed on 4/23/25 at 9:46 AM and reported the reasoning for the Keppra discontinuation should have been documented in Resident # 1's record by the	F 842	For the Resident Cited Resident #1 was discharged to the hospital on 4/9/25 and resident□s record was closed on 4/9/25. For Other Residents with the Potential to be Affected Nurse #1 was in-serviced by the Clinical Nurse Liaison on 4/10/25, on the proper procedure for obtaining verbal (in-person or telephone orders)which include the following: read back to the provider to ensure accuracy of the order, entry of the verbal order to include name of resident, order change with date, time, and duration; name of person receiving the order, date and time of order receipt, and provider who gave the order. After the order is entered in the electronic medication administration record, the nurse will complete a progress note to indicate the full order change as listed above with the name of the provider who gave the order, with reason for order change. The nurse will also notify the family and document the name of the person notified. Physician #1 was in-serviced by the	

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F 842	Continued From page 44 provider who gave the order or by the nurse who took the order. 1b. Review of physician progress notes revealed Resident # 1's physician noted he saw the resident for a required visit on 2/24/25. Under medications within the physician's note, it was noted that the resident's Keppra was still an active medication. Review of physician orders revealed Resident # 1's Keppra had been discontinued on 2/12/25, which was prior to the 2/24/25 note and which therefore indicated the 2/24/25 progress note was not accurate.	F 842	Director of Clinical Operations on the process and procedure for accurate medical record documentation, to include checking active physicians orders before completion of the physician progress note to ensure accuracy. An audit was conducted of physician s comprehensive visit notes for all resident receiving seizure medication for accuracy of medication list for all active residents by the Director of Clinical Operations and Clinical Nurse Liaison on 5/13/25. No other areas identified. 100% of all nurses were in serviced process for receiving verbal (in-person or telephone orders) and in-serviced on notification of families and documentation requirements. Nurses who are on medical leave or PRN status will be in-serviced prior to the next scheduled shift. All attending physicians were in-serviced on the process and procedure for accurate medical record documentation, to include checking active physicians orders before medication or adjusted or discontinued. Any new hire medical providers and any new hire nurses will be in-serviced during orientation on the facility processes. System Changes Consult sheets and admission/readmissions summaries will	

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F 842	Continued From page 45	F 842	be reviewed during the morning clinical meeting by the Clinical IDT team and/or compare against the physician comprehensive visit documentation to ensure that any new medication changes are correct in the progress note and to ensure declination of any consults is documented in the physician progress note. Monitors Random audits will be conducted of 10% of new admissions/readmissions and appointment consult sheets will be audited against the physicians comprehensive visit notes by the DNS/designee weekly x4 and then monthly thereafter for 6 months to ensure compliance with the new appointment protocol. Compliance will be discussed weekly by the DNS/designee X 4 weeks and then monthly for 6 months during morning administrative meeting. Any non-compliance will be noted and corrective actions taken. Results of audits were presented to the facility QA committee by the DNS during the first QA meeting held on 4/21/2025. Audits will be presented to the QA committee for 6 more months. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes.	