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	345575	A. BUILDING _____ B. WING _____	C 10/05/2023

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at the facility from 10/3/23 through 10/5/23. Event ID # HPT811. The following intakes were investigated: Intake Numbers: NC00196831, NC00196853, NC00198946, NC00199828, NC00200857, NC00203408, NC00204175, NC00204226, NC00205088. 1 of the 16 complaint allegations resulted in a deficiency.	F 000		
F 756 SS=E	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 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,	F 756		10/27/23

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

Electronically Signed | 10/18/2023

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F 756	Continued From page 1 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, staff, Physician and Consultant Pharmacist interviews, the monthly Medication Regimen Reviews for May, June, and July 2023 failed to identify the omission of the thyroid medication, levothyroxine from the orders entered following readmission to the facility on 5/8/23 for a resident with known diagnosis of hypothyroidism (Resident #2) resulting in 108 missed doses for 1 of 3 residents reviewed for medication errors. Findings included: Resident #2 was admitted to the facility on 7/29/22 with medical diagnoses which included in part hypothyroidism. Review of Resident #2's medical record revealed a physician order written on 7/30/22 for levothyroxine 100 micrograms once per day. The order for levothyroxine was discontinued on 5/6/23 when Resident #2 was discharged to the hospital. Review of Resident #2's 5/8/23 hospital discharge	F 756	1.) Once it was determined that resident #2 was missing an order for levothyroxine, the MD was notified. Labs were ordered and he was started on levothyroxine 25 mcg daily. The order was obtained on 8/25/2023. 2.) The Director of Nursing (DON)and or designee(s), will review the Medication Administration Record (MAR)for all residents admitted between 8/28/2023 and 9/27/2023 by 10/23/2023 to ensure there have been no other medications omitted on admission that were not identified during the last monthly Medication Regimen Reviews (MRR) conducted by the pharmacist. Any issues identified will be reported to the MD for further follow up. 3.) The facility has established a new system for the MRR's. The DON and or designee(s)will provide a list of new admissions and readmissions to the pharmacist prior to the monthly MRR.	

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F 756	Continued From page 2 medication list signed by the Nurse Practitioner indicated an order for levothyroxine 100 micrograms once per day. Review of the 5/8/23 physician orders in the electronic health record for Resident #2 revealed the order for levothyroxine 100 micrograms once per day included on the discharge medication list had not been entered. Review of Resident #2's May 2023 Medication Administration Record (MAR) revealed resident received levothyroxine 100 micrograms daily from 5/1/23 through 5/5/23. The MAR further indicated levothyroxine 100 micrograms was discontinued on 5/6/23 and was not reordered on 5/8/23. Review of Resident #2's 5/10/23 history and physical by the Physician indicated a medication list which included levothyroxine 100 micrograms once per day. Review of Resident #2's medical record revealed a Pharmacy Review Note written by the Consultant Pharmacist: on 5/26/23 at 11:00 AM indicated no recommendations at this time. Review of Resident #2's June 2023 MAR revealed resident did not receive levothyroxine 100 micrograms daily. Review of Resident #2's medical record revealed a Pharmacy Review Note written by the Consultant Pharmacist: on 6/26/23 at 2:36 PM indicated no recommendations at this time. Review of Resident #2's July 2023 MAR revealed resident did not receive levothyroxine 100 micrograms daily.	F 756	The pharmacist will review the admission medications and report any recommendations or omissions to the DON. The pharmacist will make note in the Electronical Medical Record (EMR)indicating the admission review was complete. The DON and or designee(s) will educate the pharmacist and the administrative nurses on the process by 10/23/2023. 4.) The DON and or designee(s) will audit the MRR's completed by the pharmacist for 3 months to ensure new admission orders are being reviewed by the pharmacist. The results of the audits will be reviewed monthly by our Quality Assurance Performance Improvement (QAPI) committee. The QAPI committee may modify the plan of correction or extend the audits to ensure ongoing compliance. The next scheduled MRR is scheduled for the end of October 2023.	

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Review of Resident #2's medical record revealed a Pharmacy Review Note written by the Consultant Pharmacist: on 7/28/23 at 6:21 AM indicated no recommendations at this time.

Review of an 8/2/23 Nurse Practitioner (NP) progress note indicated a plan regarding acquired hypothyroidism was to continue with levothyroxine.

Review of Resident #2's medical record revealed a Pharmacy Review Note written by the Consultant Pharmacist: on 8/24/23 at 5:56 PM indicated no recommendations at this time.

Review of Resident #2's August 2023 MAR revealed levothyroxine 25 micrograms daily was administered starting on 8/26/23 through 8/30/23.

Interview with the Physician on 10/4/23 at 12:15 PM revealed Resident #2 did not have any negative effects from omitting levothyroxine from 5/8/23 through 8/25/23, but had the potential for changes in memory, mental status, depression, dry skin, change in appetite and weight.

Interview with the Consultant Pharmacist on 10/4/23 at 1:04 PM revealed he completed a medication review of all residents' medications. The Consultant Pharmacist stated he was responsible for the monthly medication regimen reviews. The Consultant Pharmacist indicated the review consisted of review of the medications entered in the computer and any other pertinent information including the hospital discharge medication list, physician progress notes and laboratory results. The Consultant Pharmacist stated he did not look at the discharge summary

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F 756	Continued From page 4 for Resident #2 when he completed the medication review on 5/26/23 and did not look at the medication list from prior to hospitalization. The Pharmacy Consultant stated he did not have an answer to why he did not catch that Resident #2 had been on levothyroxine prior to going to the hospital in May and was not receiving this medication after returning from the hospital. The Consultant Pharmacist stated sometimes he did not review the hospital discharge medication list and it was up to the facility to be sure that the medications were entered in the computer accurately. The Consultant Pharmacist indicated a resident with hypothyroid not receiving levothyroxine thyroid medication could experience side effects including tiredness, dizziness, increased depression, weight loss and increased risk of falls while not on the medication. Interview with the Director of Nursing (DON) on 10/5/23 at 10:30 AM revealed the facility relied on the monthly medication regimen reviews completed by the Consultant Pharmacist to prevent errors due to omission of medications during the transition of care from the hospital to the facility. The DON further stated it was important for the Consultant Pharmacist to review all pertinent information to perform a complete medication regimen review.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Physician and	F 760	Past noncompliance: no plan of	

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Consultant Pharmacist interviews, the facility failed to accurately transcribe and administer a thyroid medication, levothyroxine, listed on the discharge medication summary list resulting in the medication not administered from 5/8/23 through 8/25/23 for a total of 108 missed doses for 1 of 3 residents (Resident #2) reviewed for medication error.

Findings included:

Resident #2 was admitted to the facility on 7/29/22 with medical diagnoses which included hypothyroidism, expressive and receptive aphasia.

Review of Resident #2's medical record revealed a 7/30/22 physician order for levothyroxine 100 micrograms once per day. The order was discontinued on 5/6/23 when resident was sent to the hospital.

Review of the hospital discharge medication list dated 5/8/23 for Resident #2 indicated an order for levothyroxine 100 micrograms once per day. There was a handwritten signature by the Nurse Practitioner approving the medication orders as written. The discharge medication list also had the handwritten initials of Nurse #1.

Interview with Nurse #1 on 10/4/23 at 11:00 AM indicated she entered the orders in the computer on 5/8/23 when Resident #1 was readmitted to the facility. Nurse #1 indicated it was human error that she missed the order for levothyroxine that was listed on Resident #2's 5/8/23 discharge medication list.

Review of Resident #2's 5/10/23 history and

correction required.

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physical documented by the Physician indicated a medication list which included levothyroxine 100 micrograms once per day.

Review of Resident #2's electronic health record revealed an 8/2/23 Nurse Practitioner (NP) progress note with a plan regarding diagnosis of hypothyroid to continue with the medication levothyroxine.

Review of Resident #2's May, June, July, and August 2023 Medication Administration Record (MAR) from 5/8/23 through 8/24/23 revealed there was no order entered for levothyroxine 100 micrograms once per day.

Review of Resident #2's 8/5/23 annual Minimum Data Set (MDS) assessment indicated resident was cognitively intact, had unclear speech, was usually able to make himself understood and usually understood others. Resident #2's weight was 277 pounds with no weight loss or gain in the last 6 months.

Review of Resident #2's electronic health record revealed a physician order dated 8/25/23 for levothyroxine 25 micrograms give 1 tablet by mouth one time per day for hypothyroidism.

Review of Resident #2's electronic health record revealed an elevated thyroid stimulating hormone (TSH) level of 5.07 obtained on 8/25/23 with the normal range for this 0.4-4.0 milliunits per liter.

Interview on 10/3/23 at 12:20 PM revealed Resident #2 answered the simple questions of are you having a good day and are you being well taken care of with Yes. Resident answered No when asked if he had experienced increased

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fatigue, sensitivity to cold or muscle aches recently. Resident was unable to provide further information due to expressive and receptive aphasia with limited communication.

Interview with the Physician on 10/4/23 at 12:15 PM revealed omitting the medication levothyroxine in a resident with a diagnosis of hypothyroidism could cause changes in memory and mental status, worsening depression, dry skin, and changes in appetite and weight. The Physician further stated the abrupt discontinuation of levothyroxine could result in significant complications. The Physician stated he reviewed Resident #2's medical record and concluded the resident did not experience negative effects from not receiving levothyroxine from 5/8/23 through 8/25/23. The Physician indicated the facility made system changes to ensure medication transcription errors did not occur.

Interview with the Consultant Pharmacist on 10/4/23 at 1:04 PM revealed not administering levothyroxine could cause tiredness, dizziness, increased depression, weight loss and increased risk of falls. Abrupt discontinuation of thyroid medication had the potential for significant effects.

An interview with the Director of Nursing (DON) on 10/5/23 at 10:30 AM revealed the orders for a new admission or readmission to the facility were transcribed from the discharge summary medication list. The DON stated Nurse #1 entered the orders into the computer when Resident #2 was readmitted to the facility on 5/8/23. The DON stated it was human error that the order for levothyroxine was omitted from the

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medications that were entered in the computer when Resident #2 was readmitted. The DON stated the facility implemented a Plan of Correction on August 1, 2023, that required confirmation of the admission or readmission orders by two nurses to ensure all orders were transcribed correctly. The DON indicated the medication error noted on 8/25/23 with Resident #2's medication was added to a Plan of Correction that was already in place.

The facility provided the following Plan of Correction (POC) with a completion date of 8/26/23:

1. The facility identified a system issue regarding medication transcription errors. An error in transcription with medications from admission orders from the hospital to the Electronic Medical Administration Record (EMAR) system was identified on 08/01/2023. The order was transcribed into the resident's EMAR for 2 tablets of Metoprolol Tartrate, and the written order was for 1 tablet. This was corrected for this resident on August 1, 2023 for Metoprolol Tartrate.

2. On August 1, 2023, the Director of Nursing (DON) and/or designee(s) ensured that all nurses received education prior to returning to work at the facility. Licensed nurses that were not educated on the new process on August 1, 2023, received education prior to taking an assignment. DON/Designee(s) will track all employees after August 1, 2023, that have not received education and will provide prior to start of their next scheduled shift.

3. On August 1, 2023, all admissions admitted

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to the facility in the past 30 days were audited to ensure orders were transcribed correctly to the EMAR system from the approved hospital orders starting July 1, 2023, through August 1, 2023. On August 2, 2023, the DON and or designee(s) began monitoring all new admissions/re-admission hospital orders to ensure they were transcribed correctly daily Monday thru Friday. The DON and or designee(s) also ensured two nurses have checked and initialed the approved order set. This process review was initiated on August 2, 2023 and continues daily Monday thru Friday in clinical review. The assigned weekend "on call' nurse manager will audit all new admission/re-admission orders on Saturday and Sunday to verify the orders are verified by two nurses and transcribed correctly. If transcription error is noted the nurse not complying with the process will be called in for 1:1 education with the on-call nurse supervisor. Nurse management was educated on the expectation on 8/1/2023 by DON.

4. An audit was initiated on 8/25/23 of all provider consultations in order to review accuracy of dictation from the consultations to the transcription of orders in the EMAR system. This was initiated after the identification of a missed consultation order. The consultation review was conducted by the Assistant Director of Nursing (ADON) on 8/25/23 of consultation notes in resident electronic health records. A consultation was noted in Resident #2's electronic health record that stated the resident had a diagnosis of hypothyroidism. A review of Resident #2's medications was completed, and it was noted the Levothyroxine was not initiated on the resident's re-admission on May 8, 2023. After reviewing the

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Thyroid-stimulating hormone test results dated August 25, 2023, and previous Levothyroxine dose with the Nurse Practitioner, Levothyroxine was initiated on August 26, 2023.

5. The DON and or designee(s) will review all audits monthly in our Quality Assurance Performance Improvement (QAPI) meeting to ensure this process is followed for three months. An Ad-Hoc QAPI meeting was held on August 2, 2023, and August 7, 2023 to discuss findings of medication error. A monthly QAPI review occurred on August 30, 2023, and September 27, 2023. During these meetings it was determined that there were no further new admission/re-admission errors noted with audits.

The Plan of Correction was validated on 10/5/23 and concluded the facility had implemented an acceptable corrective action plan with a completion date of 8/26/23. Interviews with the nursing staff and DON revealed the facility provided education and training regarding transcription of medications for admissions and readmissions to prevent medication errors.

Review of the monitoring tools for audits that began on 8/1/23 revealed the tools were completed as outlined in the Plan of Correction. All concerns with medication transcription errors were identified and addressed.