DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265405	A. BUILDING _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BROOKFIELD	315 HUNT STREET BROOKFIELD, MO 64628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760 SS=G	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 interview and record review, the facility failed to ensure one resident (Resident #1), in a review of three sampled residents, was free from significant medication error. Staff administered Resident #1 another resident's (Resident #3's) 8:00 A.M. scheduled medications\and then following the error, administered Resident #1's scheduled 8:00 A.M. medications. Resident #1 experienced low blood pressure, lethargy, increased weakness, and required intravenous (IV) fluids. The facility census was 78. Review of the facility policy Administration of Medications, dated 9/16/24, showed the following: -The facility would ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms; -Significant medication error meant one which caused the resident discomfort or jeopardized his/her health and safety. Significance may be subjective or relative depending on the individual situation and duration; -Medication administration was the responsibility of those individuals who through certification and licensure were authorized to administer mediations in a facility; -Staff who are responsible for medication administration will adhere to the 10 rights of medication administration; -Right drug. Every drug administered must have an order from the provider. Compare the order	F 760		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carl Wright | TITLE: ED | (X6) DATE: 3-10-25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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with medication administration record (MAR) for accuracy. Compare the label on the drug to the information on the MAR three times, before removing the container from the drawer, as the drug is removed from the container and at the bedside before administering it to the resident. Do not prepare unmarked drug containers or illegible containers;
-Right resident. Use two identifiers;
-Right dose. Check the MAR and the physician's order before medications are administered;
-Right to refuse. Give the resident enough autonomy to refuse the medication after thoroughly explaining the effects. Medication refusals should be documented on the MAR with the reason for the refusal and follow up from the licensed professional;
-All verbal orders and telephone orders must be read back and verified to ensure accuracy;
-Any order that is incomplete, illegible or unclear, should be clarified;
-Be aware of high-alert and hazardous medications.

Review of the facility policy Resident Medication Rights, dated 6/1/24, showed the following:
-Document when a resident refuses a medication or treatment;
-Discuss the health and safety consequences of refused medications or treatments with the resident and/or representative as appropriate;
-Notify the physician of a resident's refusal of treatment. Physician notification should include resident refusal of medications for periods greater than 24 hours. Facility should notify physician immediately if refused medication could affect the health or safety of the resident;
-Wasted single doses of medication for disposal should be disposed of in a manner that limited

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F 760	Continued From page 2 access to them by unauthorized personnel or residents. 1. Review of Resident #1's Physician Order Sheet (POS), dated 2/3/25, showed the following: -Diagnoses of anxiety, depression, sleep apnea, chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause airflow obstruction and breathing difficulties), lymphedema (swelling of the lymph tissue causing fluid filled tissue in the lower extremities), interstitial pulmonary disease (lung disease causing difficulty breathing), chronic respiratory failure with hypoxia (severe difficulty breathing with low oxygen levels), congestive heart failure (inability of the heart to pump blood effectively resulting in swelling of the tissues, shortness of breath, weakness, fatigue and chest pain), chronic kidney disease stage 2 (decline of the kidney function), atrial fibrillation (irregular heart rhythm) high blood pressure, pulmonary hypertension (a type of high blood pressure that affected the arteries in the heart and lungs), cardiomegaly (enlarged heart); -Lexapro (antidepressant medication) 20 milligrams (mg) daily; -Jardiance (medication used to treat heart failure and other diseases) 10 mg daily; -Cyanocobalamin (vitamin B-12 supplement) 2500 micrograms (mcg) daily; -Furosemide (medication used to treat fluid retention caused by congestive heart failure and other illnesses) 80 mg daily; -Gabapentin (medication used to treat nerve pain) 300 mg twice daily; -Isosorbide (medication used to treat chest pain in coronary heart disease) Extended Release (ER) 30 mg daily; -Macrobid (antibiotic medication) 100 mg daily;	F 760		

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F 760	Continued From page 3 -Metoprolol (medication used to treat high blood pressure) ER 50 mg daily; -Namenda (mediation used to treat dementia) 10 mg daily; -Spironolactone (medication used to treat fluid retention and high blood pressure) 25 mg daily. Review of the resident's Care Plan dated 2/4/25 showed the following: -At risk for adverse effects from medications. The resident will have o serious or life-threatening complications related to the use of medications. Administer medications as ordered, monitor for serious or life-threatening complications such as respiratory distress, facial welling, chest pain and report to the physician; -The resident had congestive heart failure. The resident will have no complications related to CHF. Check breath sounds, observe for labored breathing, offer small frequent feedings, give cardiac medications as ordered, inform physician or any insomnia or anxiety, observe and report any signs or symptoms of CHF, swelling of the legs and feet, swelling about the eyes, shortness of breath upon exertion, cook skin, dry cough, weakness, weight gain unrelated to intake, crackles and wheezes of lung sounds, increased heart rate, lethargy, difficulty breathing when lying down flat; -The resident had hypertension. Goal ro remain free of complications related to hypertension. Administer medications as ordered, notify the physician of swelling, observe for abnormal urine output; -At risk for ineffective communication due to cognitive deficit and hearing deficit. Make basic needs known on a daily basis. Anticipate and meet need, allow time to respond, repeat as necessary, observe for physical/nonverbal	F 760		

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indicators of discomfort or distress and follow-up as needed;
-At risk for fluid volume deficit related to diuretic use. The resident will be free of symptoms of dehydration. Administer medications as ordered, vital signs as ordered per protocol and record. Notify physician or significant abnormalities;
-The resident had COPD. Observe and report any signs or symptoms of respiratory infection, difficulty breathing, anxiety, confusion, restlessness, shortness of breath at rest;
-Supplemental oxygen.

Review of the resident's admission Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 2/6/25 showed the following:
-Moderately impaired cognition;
-Short of breath with exertion (such as walking, bathing, transferring) and at rest and when lying flat;
-Received antipsychotic, antidepressant and diuretic medications.

Review of the resident's nurses' notes showed staff documented the following the following:
-On 2/10/25 at 9:00 A.M. blood pressure 172/83 (normal 120/80) and at 8:19 P.M. blood pressure 131/58;
-On 2/11/25 at 10:06 A.M. blood pressure 110/60;
-On 2/12/25 at 10:29 A.M. blood pressure 175/91;
-On 2/13/25 at 9:31 A.M. blood pressure 162/86 and at 8:17 P.M. blood pressure 133/69;
-On 2/14/25 at 8:25 A.M. blood pressure 148/73.

Review of the resident's MAR dated 2/14/25 showed Certified Medication Technician (CMT) A documented he/she administered the following medications at 8:00 A.M.:

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F 760	Continued From page 5 -Lexapro 20 mg; -Jardiance 10 mg; -Cyanocobalamin 2500 mcg; -Furosemide 80 mg; -Gabapentin 300 mg; -Isosorbide ER 30 mg; -Macrobid 100 mg; -Metoprolol ER 50 mg; -Namenda 10 mg daily; -Spironolactone 25 mg. Review of the resident's nurses note, dated 2/14/25 showed at 9:42 A.M., Licensed Practical Nurse (LPN) B documented the CMT reported he/she gave the resident the wrong medications, and resident also received his/her scheduled medications. The resident was alert and oriented, denied feeling dizzy or lightheaded. Physician notified and instructed staff to monitor the resident's blood pressure. Review of the resident's MAR, dated 2/14/25 at 11:00 A.M., showed staff documented the resident's blood pressure was 117/65. Review of the resident's nurses note dated 2/14/25, showed at 11:51 A.M. LPN B documented the resident came out of the shower and said he/she did not feel well, complained of feeling dizzy. Blood pressure 72/44. Physician notified. New order received for intravenous (IV) fluids. IV (needle and catheter inserted into the vein to administer medications or fluids directly into the vein and circulatory system) started, 500 ml administered with blood pressure of 92/62. Physician notified of changes, orders received to continue IV fluids for one more bag, blood pressure now 120/64.	F 760		

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Review of the resident's POS, dated 2/14/25, showed the following:
-Monitor blood pressure and pulse every two hours for 24 hours;
-Sodium chloride (normal saline fluid) 0.9 percent intravenous solution, 1000 ml intravenously over one hour for low blood pressure followed by 1000 ml intravenously at 150 ml per hour.

Review of the resident's MAR dated 2/14/25 at 1:00 P.M., showed staff documented the resident's blood pressure was 110/58.

Review of the resident's nurses note dated 2/14/25, showed at 12:58 P.M., the Director of Nursing (DON) documented she was notified by LPN B the physician wanted to start IV fluids due to low blood pressure. IV started, normal saline 0.9 percent ran in at 999 ml/hour 1000 ml bag. Physician notified 1000 ml bag was finished and blood pressure was 120/64. New order received to start IV fluids at 150 ml/hour, 1000 ml bag until finished. Resident sat up in bed, communicating.

Review of the resident's MAR, dated 2/14/25, showed staff documented the following:
-At 3:00 P.M. blood pressure was 82/48;
-At 5:00 P.M. blood pressure was 98/58;
-At 7:00 P.M. blood pressure was 90/50;
-At 9:00 P.M. blood pressure was 95/56;
-At 11:00 P.M. blood pressure was 90/60.

Review of the resident's MAR, dated 2/15/25, showed staff documented the following:
-At 1:00 A.M. blood pressure was 92/62;
-At 3:00 A.M. blood pressure was 96/64;
-At 5:00 A.M. blood pressure was 100/70;
-At 7:00 A.M. blood pressure was 98/52;
-At 9:00 A.M. blood pressure was 98/56.

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F 760	Continued From page 7 Review of the resident's nurses note, dated 2/15/25, showed Registered Nurse (RN) E documented the following: -At 1:34 P.M. blood pressure 98/58; -At 4:06 P.M. nurse called to resident's room by CNA, who said the resident felt dizzy and family member wanted the nurse. The resident sat in the wheelchair and complained of shakiness, awake and oriented. Blood pressure 96/56. Staff assisted the resident to bed, transferred without difficulty. Nurse Practitioner (NP) updated, the family questioned more IV fluid administration. NP declined IV fluids, did not want to overload the resident with his/her CHF diagnosis. Review of the resident's nurses notes showed staff documented the following: -On 2/15/25 at 9:27 P.M. blood pressure 137/53; -On 2/16/25 at 9:31 A.M. blood pressure 92/52; -On 2/16/25 at 10:32 P.M. blood pressure 138/83; -On 2/17/25 at 8:42 A.M., the resident had trouble breathing, physician notified and orders received for x-ray and laboratory tests; -On 2/17/25 at 9:24 A.M., blood pressure 115/70, lung sounds coarse respirations even and unlabored, occasional cough noted, complained of shortness of breath, weakness noted; -On 2/17/25 at 10:14 A.M., resident continued to complain of shortness of breath, increased weakness, NP aware and ordered chest x-ray and laboratory tests; -On 2/17/25 at 12:15 P.M., resident complained of increased shortness of breath while eating, oxygen saturation level 86 - 90 percent (normal greater than 92 percent), resident agreed to hospital transfer. Transported to local hospital by ambulance.	F 760		

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F 760	Continued From page 8 Review of the resident's Emergency Department Physician's Note, dated 2/17/25, showed the following: -Complaints of shortness of breath, low blood pressures on Friday (2/14/25) with 1500 ml of IV fluid ordered; -Acute hypoxic respiratory failure; -Pneumonia (lung infection); -Acute on chronic renal failure (acute kidney failure with underlying chronic kidney failure). IV fluids given in emergency department; -Transfer to nephrology (kidney specialist) unit at a regional hospital. 2. Review of Resident #3's POS dated 3/25/24 showed the following: -Diagnoses of dementia and obstructive uropathy (swelling of the urinary system causing difficulty with urination and urine retention), hypertension (high blood pressure), retention of urine, and prostate cancer; -Prozac (antidepressant medication) 10 mg daily; -Seroquel (antipsychotic medication) 50 mg two times daily; -Amlodipine (antihypertensive medication given for high blood pressure and chest pain) 5 mg daily; -Bethanechol (medication used to treat urinary retention or trouble urinating) 10 mg three times daily; -Lisinopril (antihypertensive medication) 10 mg daily; -Propranolol (beta-blocker medication used to treat high blood pressure, heart rhythm disorders, chest pain and other heart or circulatory conditions) 20 mg three times daily; -Tamsulosin (medication used to treat enlarged prostate) 0.4 mg daily.	F 760		

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Review of the resident's MAR dated 2/14/25 showed the following:
-Prozac (antidepressant medication) 10 mg at 8:00 A.M. not administered, the resident refused;
-Seroquel (antipsychotic medication) 50 mg at 8:00 A.M. not administered, the resident refused;
-Amlodipine (antihypertensive medication given for high blood pressure and chest pain) 5 mg at 8:00 A.M. not administered, the resident refused;
-Bethanechol (medication used to treat urinary retention or trouble urinating) 10 mg at 8:00 A.M. not administered, the resident refused;
-Lisinopril (antihypertensive medication) 10 mg at 8:00 A.M. not administered, the resident refused;
-Propranolol (beta-blocker medication used to treat high blood pressure, heart rhythm disorders, chest pain and other heart or circulatory conditions) 20 mg at 8:00 A.M. not administered, the resident refused;
-Tamsulosin (medication used to treat enlarged prostate) 0.4 mg at 8:00 A.M. not administered, the resident refused.

4. During an interview on 2/19/25 at 11:50 A.M. CMT A said the following:
-On 2/14/25 he/she was running behind passing morning medications. Resident #3 refused to take his/her 8:00 A.M. medications from CMT A. LPN B said he/she would try to give Resident #3 his/her cup of medications. While LPN B tried to administer Resident #3's 8:00 A.M. medications, CMT A prepared Resident #1's 8:00 A.M. medications and sat the cup of medications on the medication cart. Resident #3 refused to take the medications from LPN B. LPN B handed Resident #3's cup of 8:00 A.M. medications back to CMT A. CMT A sat Resident #3's cup full of medications on the med cart, picked up the wrong cup and administered Resident #3's 8:00

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F 760	Continued From page 10 A.M. medications to Resident #1; -CMT A immediately told LPN B he/she had given Resident #1 the wrong medication. LPN B said to go ahead and give Resident #1 his/her 8:00 A.M. medications. CMT A administered Resident #1's 8:00 A.M. medications. The resident took all of his/her regularly scheduled 8:00 A.M. medications after taking the cup of Resident #3's 8:00 A.M. medications; -He/She needed to stay more focused while preparing and administering resident medications to prevent medication errors. He/She should not prepare more than one resident's medications at a time. During interview on 2/19/25 at 10:50 A.M. and 2:30 P.M., LPN B said the following: -On 2/14/25 at about 8:30 A.M., CMT A informed LPN B of a medication error. CMT A gave Resident #3's 8:00 A.M. medications to Resident #1. The medications included bethanechol chloride 10 mg, Seroquel 50 mg, Prozac 10 mg, propranolol 20 mg, amlodipine 50 mg, lisinopril 10 mg and Flomax 0.4 mg; -LPN B called the physician and explained the medication error and the medications administered. LPN B read the list of Resident #1's routine 8:00 A.M. medications as well as the list of medications given to Resident #1 in error. The physician said to give Resident #1 his/her 8:00 A.M. medications. LPN B hollered down the hall and told CMT A to go ahead and administer Resident #1's 8:00 A.M. medications; -LPN B did not question the physician regarding administration of Resident #1's 8:00 A.M. medications including additional blood pressure and cardiac medications after the resident received other medications in error; -LPN B then informed the Director of Nurses	F 760		

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(DON) of the medication error;
-LPN A attempted to administer Resident #3's 8:00 A.M. medications after the resident refused to take the medications from CMT A. When Resident #3 refused his/her morning medications, LPN B should have destroyed the medications and not given the full medication cup back to CMT A.

During an interview on 2/20/25 at 8:40 A.M. RN E said he/she was aware a medication error occurred with Resident #1 on 2/14/25. Resident #1's routine morning medications included cardiac and blood pressure medications. The charge nurse and CMT involved should have consulted the DON, stopped and figured out the situation and clarified clearly with the physician before proceeding. The resident required IV fluids in response to the drop in blood pressure. The medication error should not have occurred. The staff member passing medications should not prepare more than one resident's medications at a time.

During an interview on 2/19/25 at 3:00 P.M. RN/Staff Development Coordinator D said on 2/17/25 the DON asked her to provide nursing staff education on the seven rights of medication administration for all staff who administered resident medications. She had not provided CMT A any in-service education regarding medication administration since 2/14/25. The in-service education also included CMT staff should inform the charge nurse if a resident refused medication. The charge nurse should intervene, talk to the resident and notify the physician of refused medications. She did not educate staff on destroying medications if the medications were refused and did not educate staff to avoid

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preparing more than one resident's medications at a time. Errors occurred when staff was not focused on one resident's medications at a time. She did not know the circumstances of the 2/14/25 medication error and did not know what medications were given in error. The charge nurse should communicate effectively with the physician and review the situation again if any concerns occurred. Any concerns should be addressed with the physician and DON before administration of multiple medications following a known medication error.

During an interview on 2/19/25 at 12:30 P.M., the DON said the medication error led to the resident's change in condition. The resident required IV fluids for treatment of low blood pressure. The physician and NP were notified multiple times of the resident's change in condition on 2/14/25, 2/15/25 and 2/16/25. Family was present and declined transfer to the hospital until 2/17/25 when the resident's condition worsened.

During an interview on 2/19/25 at 3:45 P.M., the NP said the medication error should not have occurred. The error led to a change in condition and need for the resident to receive IV fluids due to a drop in blood pressure. Communication with the physician and NP was very important to ensure complete understanding of the situation.

During an interview on 2/19/25 at 1:00 P.M. the resident's physician said he was aware of the medication error involving Resident #1 on 2/14/25. He understood the nurse who called him to say staff had administered Resident #1's morning routine medications prior to the medication error. The nurse gave him the list of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265405	A. BUILDING _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BROOKFIELD	315 HUNT STREET BROOKFIELD, MO 64628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 13 medications the resident received. If he had understood staff had not administered Resident #1's 8:00 A.M. medications, he would have told staff to hold the medications and not administer Resident #1's 8:00 A.M. medications on top of the medications given in error. This was a major medication error and caused the resident's blood pressure to drop and the resident's decline in condition. The resident required IV fluids in response to the low blood pressure. If a resident refused their medications staff should destroy the medications immediately and avoid preparing multiple residents' medications at the same time. During an interview on 2/19/25 at 1:30 P.M. the administrator said CMT A made a significant medication error. The resident's blood pressure dropped and required IV fluids for treatment. He expected staff to communicate clearly with the physician when explaining a resident's condition. Staff should ensure the physician understood the situation clearly and correctly. Staff should follow the medication pass policy and if a resident refused medications, destroy the refused medications immediately. Staff preparing more than one resident's medications at a time increased the risk of errors. MO 249731 MO 249733	F 760		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00822	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BROOKFIELD	315 HUNT STREET BROOKFIELD, MO 64628

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4060	19 CSR 30-85.042(51) Medication Errors/Adverse Reactions Reported All medication errors and adverse reactions shall be reported immediately to the nursing supervisor and the resident's physician and, if there was a dispensing error, to the issuing pharmacist. II/III This regulation is not met as evidenced by: Class II* Refer to F 760 *The higher classification merited due to the violation's effect on the resident.	A4060		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carl W. Wright

TITLE: ED

(X6) DATE: 3-10-25

PLAN OF CORRECTION

Provider/Supplier Name:	Life Care Center of Brookfield
Street Address, City, Zip:	315 Hunt St Brookfield MO 64628
Date of Survey:	2-20-25

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 760	**What Corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice:** 1. Resident #1 is currently not residing in the facility. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** 1. Residents residing in the facility receiving medications have the potential to be affected by the alleged deficient practice. No residents received any ill effects. 2. The Staff Development Coordinator and/or a designee have provided in-service training for CMTs, LPNs and RNs related to the proper procedures for passing medications per facility Policy and Procedure. • This includes proper handling and disposal of medications when a resident refuses their medications. • Proper communication with the physician when a medication error occurs. • The 7 rights of passing medications. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** 1. The Staff Development Coordinator and/or a designee will provide 10-15 medication pass competencies monthly. 2. The facility will provide in-service education related to medication pass quarterly and as needed	3-21-25

	per the Staff Development Coordinator and/or a designee. 3. Licensed nurses will contact a member of the nurse admin team or the ED to review new orders following a medication error prior to completing those orders. **How the facility plans to monitor its performance to make sure that solutions are sustained:** 1. The Staff Development Coordinator and/or a designee will complete 5-10 medication pass competencies weekly for 4 weeks then 10-15 medication pass competencies monthly for 4 months. The competencies will be reviewed in the monthly QAPI Meeting with the plan updated as indicated.	
A4060	See F760	3-21-25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.