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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS #23616 at the facility on 02/14/24. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #23616 for medication storage and cited F761 at past non-compliance and the facility had corrected all deficient practices on 12/12/23 prior to the SA entrance into the facility on 02/14/24. The SA reentered the facility on 02/26/24-02/27/24 to investigate CI MS #24271 for medication administration and cited F656, F755, and F760 at a G Level and at past non compliance. The facility had corrected all measures on 02/23/24 prior to the SA's entrance into the facility on 02/26/24. At the time of the survey the facility held a census of 43 and was licensed for 60 beds.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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

Electronically Signed | 03/08/2024

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F 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review the facility failed to ensure that a comprehensive care plan was implemented when a resident did not receive two (2) doses of a scheduled antiarrhythmic medication for one (1) of three (3) residents reviewed. Resident #4.	F 656	Past noncompliance: no plan of correction required.	

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Based on the facility's implementation of corrective actions completed on 2/23/24, the State Agency determined that the deficiency was Past Non-Compliance.

Findings Include:

Record review of the facility policy titled "Care Plans" updated on 02/20/20 revealed that, "Each resident will have a person centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care...Procedure:..6. Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the interventions."

Record review of Resident #4's "Care Plan" with start date of 02/16/2024 revealed an intervention to receive "Multaq 400 mg tablet - one tablet by mouth nightly."

Record review of the facility "Reportable Incident Form" revealed that Resident #4 was admitted to the facility with orders for Multaq 400 milligram (mg) tablet to be administered nightly related to diagnosis of atrial fibrillation. The pharmacy was unable to provide Multaq 400 mg tablets on 02/16/24, due to backorder of the medication. Resident #4 did not receive Multaq on Saturday 02/17/24, or on Sunday 02/18/24. Multaq 400 mg tablets were delivered to the facility on 02/20/24 at 1:16 AM. On Monday, 02/19/24, Resident #4 displayed elevated heart rate, decreased blood pressure with dizziness and nausea while attending therapy and was sent out to the hospital for evaluation. While reviewing facility records, Administrator discovered that Licensed Practical Nurse (LPN) #2, documented Multaq 400 mg as

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administered on Saturday, 02/17/24. The medication was not available in the facility on this date to be administered. LPN #2, did not administer Multaq 400 mg nightly on 02/18/24 and did not attempt to obtain the medication from the pharmacy or notify administration of medication not being available. LPN #2 was terminated from facility related to incorrect documentation of medication administration and failure to administer prescribed medication.

During an interview with the Administrator (ADM) on 02/26/24 at 9:45 AM, revealed that she did not realize that Resident #4 had missed two doses of Multaq until she began her investigation after the resident had reported it to the Director of Nursing (DON). ADM revealed that LPN #2 did not give it on two (2) days, 02/17/24 and 02/18/24. ADM also agreed that Resident #4's Care Plan was not followed when LPN #2 failed to administer the ordered medication

During an interview with LPN #3 on 02/26/24 at 2:05 PM, revealed that the purpose of the care plan was to put things in place for each individual resident so the nurses could know what medications to give, what they were given for and to see if they were helping or not. LPN #3 agreed that when LPN #2 did not give Resident #4's medication, she failed to follow the care plan.

During an interview with Assistant Director of Nursing (ADON) on 02/26/24 at 3:25 PM, confirmed that the order for Multaq 400 mg tablet-one tablet by mouth nightly was on Resident #4's Care Plan and was effective 02/16/2024. The ADON, also confirmed that LPN #2 did not follow the care plan when she failed to give the Multaq 400 mg on 02/17/24 and

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02/18/24.

Record review of Resident #4's "eMAR (electronic Medication Administration Record) for the month of February of 2024 revealed that Multaq 400 mg tablet was marked administered on 02/17/24. On 02/18/24, the Multaq 400 mg was marked "N" for Not Administered by LPN #2.

Record review of Resident #4's "Physician Orders List" revealed an order dated 02/16/24 for Multaq 400 mg tablet - one tablet by mouth nightly and an order dated 02/19/24 to transfer to ER related to tachycardia.

Record review of Resident #4's "Facesheet" revealed an admission date of 02/16/2024 and that he had diagnoses which included Acute systolic (congestive) heart failure, Anemia, Ascites, Acute kidney failure, Unspecified Atrial Fibrillation, Chronic Kidney Disease and Localized Edema.

Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date of 02/22/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he was cognitively intact.

The State Agency (SA) validated through interview with the Administrator and record review that the facility reported incident related to a resident not receiving two doses of heart medication was immediately investigated by the facility Administrator on 02/20/24.

The State Agency (SA) validated through interview with the Administrator and record review that in-services were conducted with all nursing

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F 656	Continued From page 5 staff on medication administration on 02/20/24. The SA validated through interview with the Administrator and record review that a Quality Assurance meeting was held on 02/23/24 concerning the medication signed off on the MAR and not administered according to physician orders or the care plan. The SA determined the facility was in compliance on 02/23/24 when LPN #2 was formerly terminated, and in-services completed and investigation concluded.	F 656		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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F 755	Continued From page 6 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review the facility failed to ensure that an antiarrhythmic medication was available for a resident which resulted in the resident being transported to the hospital emergency department for one (1) of three (3) residents reviewed. Resident #4. Based on the facility's implementation of corrective actions completed on 2/23/24, the State Agency determined that the deficiency was Past Non-Compliance. Cross reference F760 Findings Include: Record review of the facility policy, "Medication Shortages/Unavailable Medications" with revision date of 01/01/13 revealed under "Procedure:..3. If a medication shortage is discovered after normal Pharmacy hours: If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: Emergency delivery; or, Use of an emergency	F 755	Past noncompliance: no plan of correction required.	

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(back-up) Third Party Pharmacy... 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..."

Record review of the facility "Reportable Incident Form" revealed that Resident #4 was admitted to the facility for skilled services on Friday, 02/16/24 following hospitalization for diagnosis of Congestive Heart Failure (CHF). Resident #4 was admitted with orders for Multaq 400 milligram (mg) tablet to be administered nightly related to diagnosis of atrial fibrillation. The local hospital provided the facility with one dose of Multaq 400 mg tablet to be administered on the night of 02/16/24. The resident's medication orders were electronically sent to the pharmacy by the facility on 02/16/24. The pharmacy was unable to provide Multaq 400 mg tablets on 02/16/24, due to backorder of the medication. Resident #4 did not receive Multaq on Saturday 02/17/24, or on Sunday 02/18/24. Multaq 400 mg tablets were delivered to the facility on 02/20/24 at 1:16 AM. On Monday, 02/19/24, Resident #4 displayed elevated heart rate, decreased blood pressure with dizziness and nausea while attending therapy and was sent out to the hospital for evaluation. Resident #4 was evaluated and returned to the facility on 02/19/24 with new orders to increase Multaq 400 mg to twice daily for one week and if tachycardia greater than 110 persist Wednesday morning to return to the emergency room. While reviewing facility records, the Administrator discovered that Licensed Practical Nurse (LPN) #2, documented Multaq 400 mg as administered on Saturday, 02/17/24. The medication was not available in the facility on this date to be administered. LPN #2 did not administer Multaq 400 mg nightly on 02/18/24

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and did not attempt to obtain the medication from the pharmacy or notify administration of medication not being available. LPN #2 was terminated from facility related to incorrect documentation of medication administration and failure to administer prescribed medication. In-Services initiated with nursing staff on documentation of medication administration and pharmacy protocols. This reportable incident form was signed by the Administrator and dated 02/23/24.

On 02/26/24 at 9:45 AM, an interview with Administrator (ADM), revealed that Resident #4 was sent out to the hospital on 02/19/24 with symptoms of nausea, tachycardia, dizziness, and hypotension. ADM stated that she did not realize that Resident #4 had missed two doses of medication until she began her investigation after the resident had reported it to the Director of Nursing (DON). ADM revealed that she contacted the pharmacy who told her that they had sent a slip to the facility with the delivered medications on 02/16/24 with documentation that Resident #4's Multaq was on backorder. ADM stated that LPN #2 did not give it on two (2) days, 02/17/24 and 02/18/24. The ADM revealed that LPN #2 had signed out that she gave it on 02/17/24. The ADM revealed that LPN #2 did not notify anyone of the medication being on back order, and stated, "She did nothing." ADM revealed that Resident #4 was sent out to the Emergency Room (ER) on 02/19/24, they treated him for Atrial Fibrillation (A-Fib) and he returned to the facility with an order to increase Multaq from once a day to twice a day to attempt to get his heart out of A-Fib. ADM stated that on 02/20/24, the Director of Nursing (DON) went in to check on Resident #4 and he told her that he had not

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received his heart medication for several days prior to the ER visit. The ADM revealed the DON reported this to her and they immediately started investigating. ADM stated she called LPN #2 by phone and she told the ADM that she did not call or report that Resident #4's medication was not in the medication cart to anyone. ADM revealed that she asked LPN #2 about the medications being signed off as given on the MAR on 02/17/24 and LPN #2 said that she accidentally clicked it off as administered. LPN #2 told her that she didn't have the medication to give Resident #4 on 02/17/24 or 02/18/24. ADM revealed that LPN #2 should have called the pharmacy and had the medication sent to another local pharmacy, or she could have called the doctor to see what to do next. ADM stated, "That's common sense and she didn't do it." ADM revealed that LPN #2 didn't tell anyone the medication wasn't available and stated, "She could have killed him." ADM revealed that LPN #2 would not come into the facility when she called her, so she terminated her over the phone. ADM agreed that Resident #4's medication needs were not met and revealed that he went into A-fib as a result of missing the two doses of Multaq. ADM stated, "I hate it happened, but I'm glad it wasn't any worse." She revealed that they already had plans in place to correct the issue with medication storage and administration and were working diligently to make things better to prevent anything like this from happening again.

On 02/26/24 at 10:50 AM, an interview with Nurse Practitioner (NP), revealed that she was not aware that Resident #4 had missed two doses of his medication on 02/17/24 and 02/18/24 until after it happened. She (NP) revealed that she was not in the facility those days and that LPN #2

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had not contacted her about it. Nurse Practitioner revealed that Resident #4 should not have missed two doses of his heart medication, and that this could have been detrimental. She revealed that Multaq or any heart medication should not be skipped.

On 02/26/24 at 11:20 AM, an interview with DON, revealed that on 02/19/24, Resident #4 went out to the ER for tachycardia and hypotension, and he was given medication to try to get his heart back into rhythm. She revealed that the hospital sent an order to the facility with Resident #4 to hold the Multaq on 02/19/24 because he had received it in the hospital. DON revealed that on 02/20/24, at around 8:30 AM, she went into Resident #4's room to check on him and he told her that he hadn't been given his Multaq since he had been here. DON revealed that she reported this to the Administrator, and they immediately investigated the situation and found that resident had received the one dose of Multaq on 02/16/24. The DON revealed that on 02/17/24, the Multaq had been signed out on the Medication Administration Record (MAR) as given by LPN #2 and on 02/18/24, it was documented that the Multaq wasn't there by the same LPN. DON revealed that they investigated the situation and found that Resident #4 had received the one dose of Multaq that was sent with him from the hospital on 02/16/24 and that he had missed the doses on 02/17/24 and 02/18/24. DON revealed that when LPN #2 found that the Multaq was missing, she should have contacted the pharmacy to find out about the medication and called the doctor to see what to do from there. DON agreed that Resident #4's medication needs were not met and resulted in him having to go to the ER.

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Record review of Pharmacy "Delivery Receipt" revealed that on 02/16/24, Resident #4's Multaq 400 mg tablet had the following documented status: "Backorder-remaining to follow"

Record review of "Monthly Schedule February 2024" and Timecards revealed that LPN #2 was working on the 7P-7A shift on 02/17/24 and 02/18/24.

Record review of "Disciplinary Report" on LPN #2 revealed she was terminated on 02/21/24 with the following offenses: Carelessness, Dishonesty, Falsification of Records, Medication Errors, Poor Performance, Breaking Nursing Home Rules, and Non-Compliance of Policy and Procedures. Details of Offense: "Employee falsified documentation of medication administration on 02/17/24 and failed to administer a physician ordered medication on 02/17/24 and 02/18/24. On 02/17/24 LPN #2 documented she administered Multaq 400 mg and the medication was not delivered by the pharmacy until 02/20/24 and not available. On 02/18/24 LPN #2 documented the same medication was not given because it was not available. She stated she did not mean to click that she gave the medication on 02/17/24. On 02/17/24 or 2/18/24 she did not contact the Registered Nurse (RN) SPV (supervisor), Assistant Director of Nursing (ADON), or Administrator, or MD to notify the medication was unavailable. She also failed to contact the pharmacy to check on this medication. When asked if she contacted anyone to notify the medication was not available or the pharmacy to get an update on the medication, she stated she did not and did not know why. Employee refused to come to the

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facility ..."

Record review of Resident #4's "eMAR (electronic Medication Administration Record) for the month of February of 2024 revealed that Multaq 400 mg tablet was administered on 02/17/24. On 02/18/24, the Multaq 400 mg was marked "N" for Not Administered by (Proper Name) LPN #2.

Record review of Resident #4's "ED (Emergency Department) Provider Notes" revealed that he was seen in the emergency room on 02/19/24 for tachycardia, dizziness, fatigue, and shortness of breath. Under "History" was documented, "70 year old male presents to the ED with the complaint of tachycardia x (times) 2 (two) days ago. The patient suffers from Afib (Atrial Fibrillation) that he normally treats with Multaq and Midodrine. He did have an unsuccessful ablation and has been using the medications instead. He has been out of Multaq since leaving the hospital Friday. He reports that he began having an underlying attack and began having labored breathing ...."

Record review of "Procedure Results" revealed that Resident #4 had two, 12 (twelve) lead EKGs (Electrocardiograms) completed during the time he was in the emergency department on 02/19/24 and was given Multaq 400 mg and Cardizem 30 mg by mouth. The results of both EKGs were abnormal, his heart rate was tachycardic and the clinical impression stated, "Atrial Fibrillation with rapid ventricular response." The EKGs were completed at 3:12 PM and at 4:36 PM on 02/19/24.

Record review of Resident #4's "Facesheet"

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revealed an admission date of 02/16/2024 and that he had diagnoses which included Acute systolic (congestive) heart failure, Anemia, Ascites, Acute kidney failure, Unspecified Atrial Fibrillation, Chronic Kidney Disease and Localized Edema.

Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date of 02/22/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he was cognitively intact.

Record review of Resident #4's "Physician Orders List" revealed an order dated 02/16/24 for Multaq 400 mg tablet - one tablet by mouth nightly and an order dated 02/19/24 to transfer to ER related to tachycardia.

The State Agency (SA) validated through interview with the Administrator and record review that the facility reported incident related to a resident not receiving two doses of heart medication was immediately investigated by the facility Administrator on 02/20/24.

The SA validated through interview with the Administrator and record review that a Quality Assurance Meeting was held on 02/23/24 concerning the resident not receiving two doses of heart medications. The Plan to improve performance included 1. In-Services on medication deliveries 100% nursing, 2. Match backs will be performed on third shift each night. 100% on both carts. 3. Mandatory Meeting with pharmacist 100% nursing. 4. In-Service on pharmacy policy and procedures. 5. Mandatory meeting with nursing staff with Administrator/Director of Nursing and 6. Nurse

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F 755	Continued From page 14 Consultant from pharmacy will do a match back audit on March 4th and 5th for 100% match back on both carts. The SA validated through interview with Administrator and record review of the sign in sheets that inservices were conducted with all nursing staff on proper medication administration on 02/20/24. The SA determined that the facility was in compliance on 02/23/24 when LPN #2 was formerly terminated, inservices and investigation was concluded.	F 755		
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, record review, and facility policy review the facility failed to ensure that a resident was free from a significant medication error as evidenced by not receiving two (2) doses of an antiarrhythmic medication which resulted in the resident being transported to the hospital emergency department for one (1) of three (3) residents reviewed. Resident #4. Based on the facility's implementation of corrective actions completed on 2/23/24, the State Agency determined that the deficiency was Past Non-Compliance. Cross Reference F755 Findings Include:	F 760	Past noncompliance: no plan of correction required.	

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Record review of the facility policy "Medication Errors" updated on 02/03/2023 revealed, "Medication/Treatment errors shall be documented on the Medication Error Report. An error shall be defined as any variation in administration of medication from the physician's orders and/or facility policy." The facility policy also revealed under "Procedure: 1. Report all medication errors/drug reactions to the shift charge nurse/supervisor. 2. Notify the physician/alternate physician, resident and/or legal representative, Director of Nursing and consulting pharmacist of all occurrences..."

Record review of the facility "Reportable Incident Form" dated 2/23/24 and signed by the Administrator revealed that Resident #4 was admitted to the facility with orders for Multaq 400 milligram (mg) tablet to be administered nightly related to diagnosis of atrial fibrillation. The resident's medication orders were electronically sent to the pharmacy by the facility on 02/16/24. The pharmacy was unable to provide Multaq 400 mg tablets on 02/16/24, due to backorder of the medication. Resident #4 did not receive Multaq on Saturday 02/17/24, or on Sunday 02/18/24. Multaq 400 mg tablets were delivered to the facility on 02/20/24 at 1:16 AM. On Monday, 02/19/24, Resident #4 displayed elevated heart rate, decreased blood pressure with dizziness and nausea while attending therapy and was sent out to the hospital for evaluation. While reviewing facility records, Administrator discovered that Licensed Practical Nurse (LPN) #2, documented Multaq 400 mg as administered on Saturday, 02/17/24. The medication was not available in the facility on this date to be administered. LPN #2, did not administer Multaq 400 mg nightly on

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02/18/24 and did not attempt to obtain the medication from the pharmacy or notify administration of medication not being available. LPN #2 was terminated from facility related to incorrect documentation of medication administration and failure to administer prescribed medication.

An interview with Administrator (ADM) on 02/26/24 at 9:45 AM, revealed that she did not realize that Resident #4 had missed two doses of Multaq until she began her investigation after the resident had reported it to the Director of Nursing (DON). ADM revealed LPN #2 did not give it on two (2) days, 02/17/24 and 02/18/24. LPN #2 had signed out that she gave Multaq 400 mg on 02/17/24 and that this same medication was unavailable on 02/18/24. Resident #4 was sent out to the Emergency Room (ER) on 02/19/24, they treated him for Atrial Fibrillation (A-Fib) and he returned to the facility with an order to increase Multaq from once a day to twice a day to attempt to get his heart out of A-Fib. On 02/20/24, the DON went in to check on Resident #4 and he told her that he had not received his heart medication at the facility in several days prior to the Emergency Room visit. The DON reported this to her and they immediately started investigating. ADM revealed that she asked LPN #2 about the medication being signed off as given on the MAR on 02/17/24 and LPN #2 said that she accidentally clicked it off as administered. ADM stated, "She didn't click as she went." LPN #2 told her that she didn't have the medication to give Resident #4 on 02/17/24 or 02/18/24. LPN #2 didn't tell anyone the medication wasn't available and stated, "She could have killed him." ADM revealed that LPN #2 would not come into the facility when she called her, so she

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terminated her over the phone. ADM confirmed that LPN #2 failed to give two doses of Resident #4's ordered heart medication and this caused him to go into Atrial Fibrillation and resulted in him having to be sent to the hospital. The ADM stated, "I hate it happened, but I'm glad it wasn't any worse." She revealed that they already had plans in place to correct the issue with medication storage and administration and were working diligently to make things better to prevent anything like this from happening again.

An interview with Nurse Practitioner (NP), on 02/26/24 at 10:50 AM, revealed that she was not aware that Resident #4 had missed two doses of his medication on 02/17/24 and 02/18/24 until after it happened. She (NP) revealed that she was not in the facility those days and that LPN #2 had not contacted her about it. Nurse Practitioner revealed that Resident #4 should not have missed two doses of his heart medication, and that this could have been detrimental. She revealed that Multaq or any heart medication should not be skipped.

An interview with DON on 02/26/24 at 11:20 AM, revealed that on 02/20/24, at around 8:30 AM, she went into Resident #4's room to check on him and he told her that he hadn't been given his Multaq. DON revealed that she reported this to the Administrator, and they immediately investigated the situation and found that resident had received the one dose of Multaq on 02/16/24 and had not received doses on 02/17/24 or 02/18/24.

An interview with LPN #3 on 02/26/24 at 2:05 PM, revealed that they had a two-step process to complete in the computer when they administered

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medications. She revealed that when she pulled the medication out of the medication cart drawer, she checked it against the MAR, placed it in a medication cup and then marked it off as prepared on the computer screen. LPN #3 revealed that after all medications were pulled and prepared, she went into the resident's room and administered them. She revealed that after the resident took the medications, she went back to the medication cart and checked off each medication as administered on the computer. LPN #3 revealed that a nurse could not document that a medication was administered unless it had first been documented as prepared. LPN #3 confirmed that there was no way to accidentally click the administration of a medication.

Record review of "Disciplinary Report" on LPN #2 revealed she was terminated on 02/21/24 with the following offenses: Carelessness, Dishonesty, Falsification of Records, Medication Errors, Poor Performance, Breaking Nursing Home Rules, and Non-Compliance of Policy and Procedures. Details of Offense: "Employee falsified documentation of medication administration on 02/17/24 and failed to administer a physician ordered medication on 02/17/24 and 02/18/24. On 02/17/24 LPN #2 documented she administered Multaq 400 mg and the medication was not delivered by the pharmacy until 02/20/24 and not available. On 02/18/24 documented the same medication was not given because it was not available. She stated she did not mean to click that she gave the medication on 02/17/24. On 02/17/24 or 2/18/24 she did not contact the Registered Nurse (RN) SPV (supervisor), Assistant Director of Nursing (ADON), or Administrator, or MD to notify the medication was unavailable. She also failed to contact the

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pharmacy to check on this medication. When asked if LPN #2 contacted anyone to notify the medication was not available or the pharmacy to get an update on the medication, she stated she did not and did not know why. Employee refused to come to the facility ..."

Record review of Resident #4's "eMAR (electronic Medication Administration Record) for the month of February of 2024 revealed that Multaq 400 mg tablet was marked administered on 02/17/24. On 02/18/24, the Multaq 400 mg was marked "N" for Not Administered by (Proper Name) LPN #2.

Record review of Resident #4's "Physician Orders List" revealed an order dated 02/16/24 for Multaq 400 mg tablet - one tablet by mouth nightly and an order dated 02/19/24 to transfer to ER related to tachycardia.

Record review of "Procedure Results" revealed that Resident #4 had two 12 (twelve) lead EKGs (Electrocardiograms) completed during the time he was in the emergency department on 02/19/24 and was given Multaq 400 mg and Cardizem 30 mg by mouth. The results of both EKGs were abnormal, his heart rate was tachycardic and the clinical impression stated, "Atrial Fibrillation with rapid ventricular response." The EKGs were completed at 3:12 PM and at 4:36 PM on 02/19/24.

Record review of Resident #4's "Facesheet" revealed an admission date of 02/16/2024 and that he had diagnoses which included Acute systolic (congestive) heart failure, Anemia, Ascites, Acute kidney failure, Unspecified Atrial Fibrillation, Chronic Kidney Disease and

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Localized Edema.

Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date of 02/22/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he was cognitively intact.

The State Agency (SA) validated through interview with the Administrator and record review that the facility reported incident related to a resident not receiving two doses of heart medication was immediately investigated by the facility Administrator on 02/20/24.

The SA validated through interview with the Administrator and record review that a Quality Assurance Meeting was held on 02/23/24 concerning the resident not receiving two doses of heart medications. The Plan to improve performance included 1. In-Services on medication deliveries 100% nursing, 2. Match backs will be performed on third shift each night. 100% on both carts. 3. Mandatory Meeting with pharmacist 100% nursing. 4. In-Service on pharmacy policy and procedures. 5. Mandatory meeting with nursing staff with Administrator/Director of Nursing and 6. Nurse Consultant (from pharmacy) will do a match back audit on March 4th and 5th for 100% match back on both carts.

The SA validated through interview with Administrator and record review of the sign in sheets that inservices were conducted with all nursing staff on proper medication administration on 02/20/24.

The SA determined that the facility was in

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F 760	Continued From page 21 compliance on 02/23/24 when LPN #2 was formerly terminated, inservices and investigation was concluded.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to ensure that a bottle of medication was locked securely inside a medication cart to prevent resident access by one (1) of three (3) residents reviewed.	F 761	Past noncompliance: no plan of correction required.	

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Resident #1.

Findings Include:

Record review of the undated facility policy titled, "Medication Storage" revealed, "...All drugs, treatments, and biologicals must be stored securely and following the manufacturer's labeled recommendations, or per facility policy..."

On 02/14/24 at 9:05 AM, an interview with the Administrator (ADM), revealed that she had reported the incident where Resident #1 took the bottle of Vitamin D3 off the med cart. They watched the surveillance camera videos and saw that on 12/09/23 at 10:13 AM, the bottle of Vitamin D3 was given to Licensed Practical Nurse (LPN) #1 by Registered Nurse (RN) Supervisor, and she placed it on top of the medication cart. The ADM revealed that camera footage showed that Resident #1 walked down the hall, stopped at the medication cart and obtained the bottle of Vitamin D3 and then walked to the dining room. At 11:36 AM resident poured the pills in his hand and took them. She revealed that at 11:36 AM, video camera showed that Activities Assistant looked at the pill bottle and noticed that resident was chewing, saw the pills in his mouth and called Certified Nursing Assistant (CNA) #1 who was there in the dining room. ADM revealed that CNA #1 got resident to spit the pills out at 11:37 AM and then she notified LPN #1. ADM revealed that LPN #1 should have put the bottle of Vitamin D3 into her med cart and locked it up as soon as she received it to prevent Resident #1 or any other resident from getting it. Administrator also revealed that they were thankful for no negative outcomes; but it could have been worse.

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On 02/14/24 at 10:20 AM, an interview with CNA #1, revealed that she was working the day that Resident #1 took the medication. She revealed that Resident #1 had walked into the dining room and the Activities Assistant told her that Resident #1 had a medicine bottle and had something in his mouth he was chewing on. CNA #1 revealed that she put on a glove and asked the resident to give them to her and he spit them out in her hand about ten pills. CNA #1 revealed that she took the bottle from him and gave it to LPN #1, and told her what happened. She revealed that LPN #1 told her to throw the pills away and she disposed of them in the trash on the medication cart. CNA #1 revealed that Resident #1 was quick and they all knew to try and keep up with him.

On 02/14/24 at 10:40 AM, a phone interview with Registered Nurse (RN) Supervisor, revealed that she was working on the day of 12/09/24. She revealed that a nurse had informed her that there was not any Vitamin D3 on the medication cart. RN Supervisor revealed that she went into the medication room, found a bottle of Vitamin D3, brought it back and handed it to LPN #1. RN Supervisor revealed that a few hours later, she was told that Resident #1 had taken some medication, RN Supervisor was shown the pills and LPN #1 revealed that it was the same bottle that she had brought to her earlier, the Vitamin D3. RN Supervisor revealed that Resident #1 was seen in the dining room with the pill bottle and was seen with something in his mouth, so it was immediate action on CNA #1's part who got him to spit them out. She stated, "After watching the camera footage, we're pretty certain that they got all of the pills and feel like this was an isolated incident." RN Supervisor, revealed that they did call the Nurse Practitioner and consulted with the

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Pharmacist, had a Vitamin D level drawn, and monitored the resident closely. She revealed that they did initiate education and In-Services on 100% of the nurses regarding medication carts. RN Supervisor revealed that LPN #1 should have placed the bottle of Vitamin D3 in the medication cart drawer and locked it up immediately when she received it and this would have prevented Resident #1 from picking it up off the medication cart and taking it. She stated, "Thankfully, he didn't suffer."

On 02/14/24 at 11:35 AM, an interview with Activities Assistant, revealed that she was working on the day of 12/09/24 and was in the dining room putting up her balloons after an activity when she noticed Resident #1 entering the dining room with something in his mouth. She revealed that his cheeks were big and he was chewing on something. Activities Assistant revealed that she went and asked him to open up his mouth and she saw that he had several pills in his mouth. She revealed that about that time, CNA #1 entered the dining room and she reported it to her. Activities Assistant revealed that CNA #1 put some gloves on and asked Resident #1 to spit the pills out and he did.

On 02/14/24 at 2:05 PM an interview with Assistant Director of Nursing (ADON), revealed that the Nurse Practitioner was notified, and the Pharmacist was consulted on what to watch for. She revealed that they did a thorough full investigation on the incident and LPN #1 was terminated on 12/12/23.

On 02/14/24 at 2:30 PM, an interview with the ADM, revealed that the incident with Resident #1 happened on Saturday, 12/09/23. She revealed

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(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
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that RN Supervisor, told her that Resident #1 had picked up a Vitamin D3 bottle off the medication cart and had put several in his mouth, this was noticed immediately, and he had spit them out in a CNA's hand. ADM revealed that after a full investigation was completed and they found out that LPN #1 had left the medication out on the medication cart unattended, she was terminated. In-services were initiated about keeping the medication carts locked and keeping all medications inside the medication cart. She also revealed that LPN #1 had been trained and had been evaluated for medication administration competency not long ago and she knew better than to leave a bottle of medication out like that. ADM revealed that LPN #1 should have locked the bottle of Vitamin D3 up in the medication cart as soon as the Registered Nursing Supervisor handed it to her and not left it on top of her cart unattended.

Record review of the "Reportable Incident Form" completed on 12/12/23 by Administrator, revealed the following: Incident Date: 12/9/23. Incident Location: Medication Cart on South Hall and Dining Room.
Brief Summary of Incident: "On December 9, 2023, at approximately 10:13 AM, (Proper Name), LPN (#1) was preparing medications for her medication pass and a bottle of Vitamin D3 was placed on top of the medication cart. At 11:31 AM, (Proper Name) LPN (#1) leaves her medication cart and goes into a resident's room on South Hall. (Proper Name) (Resident #1)enters the hallway from his room at approximately 11:32 AM and obtains the bottle of Vitamin D3 from the top of the medication cart. (Proper Name) (Resident #1) continues down the hallway with his rolling walker holding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255299	A. BUILDING _____ B. WING _____	C 02/27/2024

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medication and takes it with him to the dining room. At 11:36:29 AM, (Proper Name) (Resident #1) pours the medication into his hand and puts his hand to his mouth putting the medication into his mouth. At 11:36:40, (Proper Name) activity assistant, notices (Proper Name) (Resident #1) has a bottle of medication with medication in his mouth and notified (Proper Name) CNA (#1). At 11:37:12, (Proper Name)CNA (#1), immediately put on a glove and had the resident spit out the medication into her glove. (Proper Name) CNA (#1), notifies (Proper Name) LPN (#1) at 11:40 AM and shows her the medication in her glove. (Proper Name) LPN, (#1) notified (Proper Name), RN Supervisor ..."

Record review of Resident #1's "Facesheet" revealed admission date of 08/20/2018 and had the following diagnoses that included Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Unspecified Dementia, Generalized Anxiety disorder, Restlessness and Agitation.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/12/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 12 which indicated that he had moderate cognitive deficits..

The SA validated through interviews, record review, inservices and observations that the facility had corrected the deficient practice on 12/12/23 prior to the SA entrance into the facility on 02/14/24.