STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146124	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street Carmi, IL 62821

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to implement procedures for timely acquisition of medications to administer as ordered for 4 (R1, R4, R5, and R7) out of 5 residents reviewed for pharmacy services in a sample of 8. Findings include: 1. On 10/3/24 at 1:11 PM, V9 (Case Coordinator) stated when R1 was admitted to the facility R1 had two seizures in the first week due to the facility not administering R1's seizure medication. R1's Admission Record documented an admitted [DATE] with diagnoses including dysphagia following cerebral infarction, extrapyramidal and movement disorder, and epilepsy. R1's 9/25/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 was severely cognitively impaired. R1's 9/23/24 After Visit Summary from the hospital documented in part . Start taking these medications . lacosamide 10 mg/ ml solution . Commonly known as: Vimpat . Administer 10 ml through peg tube 2 (two) times a day . Levetiracetam 500 mg/ 5 ml solution . Commonly known as: Keppra . Administer 10 ml (1,000 mg total) through tube 2 (two) times a day . oxcarbazepine 300 mg/ 5 ml (60 mg/ ml) suspension . Commonly known as: Trileptal . Administer 5 ml (300 mg total) through g-tube 2 (two) times a day . R1's September 2024 Order Summary Report documented Keppra solution 100 mg/ ml, oxcarbazepine oral suspension 300 mg/ 5 ml, and Vimpat oral solution 10 mg/ ml as documented on the hospital's After Visit Summary with an order date of 9/23/24. The facility's pharmacy Packing Slip documented R1's Keppra, Vimpat, and Trileptal were shipped to the facility on [DATE]. R1's E-Courier Delivery Status documented R1's medications were delivered to the facility on [DATE] at 12:18 AM. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street Carmi, IL 62821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's September 2024 Medication Administration Record (MAR) documented R1 did not receive the 9/23/24 8:00 PM dose and the 9/24/24 8:00 AM dose of Keppra, Trileptal, or Vimpat. R1's September 2024 MAR documented R1 did not receive the 9/24/24 8:00 PM dose of Trileptal. R1's September 2024 MAR documented that R1 did receive the 9/24/24 8:00 PM dose of Keppra and Vimpat and was documented as being administered by V10 (Licensed Practical Nurse/ LPN). On 10/10/24 at 1:27 PM, V2 (Director of Nursing) stated she did not know why V10 had documented administering R1's 9/24/24 8:00 PM dose of Keppra and Vimpat when the medications were not delivered to the facility until 9/25/24 at 12:18 AM. V2 stated V10 must have documented in error. On 10/10/24 at 10:07 AM, V10 (Licensed Practical Nurse/ LPN) stated resident medications were delivered to the facility daily from approximately 12:00 AM to 2:00 AM. V10 stated if a resident is admitted after 5:00 PM the facility would not receive the resident's medication in that night's medication delivery but the next night's medication delivery, indicating the resident would be without medication for longer than 24 hours. V10 stated she was the nurse caring for R1 on the night shift of 9/24/24 to 9/25/24. V10 stated she did not know why she documented administering R1's Keppra and Vimpat on 9/24/24 at 8:00 PM. V10 stated she did not notify R1's medical provider on 9/24/24 when the facility did not have R1's seizure medications to administer. On 10/9/24 at 12:43 PM, V2 stated she was caring for R1 on the dayshift of 9/24/24. V2 stated on 9/24/24 she had notified R1's medical provider's office via fax of the facility not having R1's Trileptal, Vimpat, or Keppra and had contacted the pharmacy. V2 stated she was not sure if R1's medical provider had contacted the facility back with a substitution order or a medication hold order. The facility was not able to provide reproducible evidence or documentation that V2 had sent a fax to R1's medical provider's office or of V2 contacting the pharmacy on 9/24/24. On 10/8/24 at 9:47 AM, V20 (Pharmacist) stated the pharmacy received orders for R1 Vimpat, Trileptal, and Keppra on 9/23/24 at 9:56 PM. V20 stated the pharmacy sent R1's Vimpat, Trileptal and Keppra on 9/24/24 due to not having an overnight pharmacist. V20 stated there was an overnight pharmacist on call and if a facility needed medications right away that pharmacist could try to get the medications to the facility from a closer pharmacy. V20 stated if the overnight pharmacist could not get the medications to the facility that night from a closer pharmacy they would get the medication from a closer pharmacy the next morning. V20 stated she was not sure if anyone from the facility had called the pharmacy. On 10/8/24 at 9:57 AM, V19 (Pharmacist in Charge) stated she did not see any documentation in her system of the facility contacting the pharmacy on 9/24/24 or ordering R1's Vimpat, Trileptal, or Keppra STAT (stat or immediately) or from a backup pharmacy on 9/24/24. V19 stated if a facility did not have a resident's medications, she would expect the facility to call the resident's medical provider to obtain an order for another medication until the resident's medication could arrive. On 10/3/24 at 3:27 PM, V3 (Care Plan Coordinator/ Registered Nurse) stated R1's Vimpat, Trileptal, or Keppra had not been ordered STAT or from a backup pharmacy. V3 stated when R1 was admitted on the evening of 9/23/24 there were a lot of things going on in the facility so V3 had stayed late to put R1's medication orders into R1's Electronic Medical Record (EMR). V3 stated since it was past 8:00 PM when R1's medication orders were entered R1's September MAR would document R1's 9/23/24 Vimpat, Trileptal, and Keppra were blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 10:25 AM, V4 (Physician) stated he was not made aware the facility was not administering R1's Keppra, Trileptal, or Vimpat due to the facility waiting on the medications to be delivered from the pharmacy. 2. R7's Admission Record documented an admitted [DATE] with diagnoses including: type 2 diabetes mellitus with foot ulcer, morbid obesity, and acute osteomyelitis. R7's 10/1/24 MDS documented a BIMS score of 15, indicating R7 was cognitively intact. R7's October 2024 MAR documented an order for Trulicity subcutaneous solution 0.75 mg/ 0.5 ml inject 0.75 mg subcutaneously one time a day every Wednesday with a start date of 9/25/24. On 10/16/24 at 10:10 AM, V13 (Registered Nurse) stated she did not have R7's Trulicity injection when she was completing the morning medication pass. V13 stated she was going to message the pharmacy and see if the medication had been delivered. On 10/16/24 at 10:40 AM, V2 (DON) stated she had logged into the pharmacy portal and R7's Trulicity had not been delivered to the facility. On 10/16/24 at 11:24 AM, V2 stated R7's Trulicity was going to be held today and would come from pharmacy in that night's delivery. V2 stated she had notified R7's medical provider to get an order to hold R7's 10/16/24 dose of Trulicity until 10/17/24. V2 stated she was not sure why R7's Trulicity had not been delivered to the facility. On 10/16/24 at 12:07 PM, V2 stated R7's Trulicity was scheduled to be given at 8:00 AM. V2 stated she notified R7's medical provider at 10:30 AM to get an order to hold the Trulicity. V2 stated she did not call the pharmacy first because it was not in the facility and wanted to speak with R7's medical provider first to be sure it would be ok to hold the Trulicity dose until the next day. On 10/16/24 at 12:39 PM, V1 was notified V2 had not followed the facility's pharmacy policy titled What to Do If a Medication is Not Available during a Med Pass due to V2 not requesting R7 Trulicity to be delivered to the facility by a backup pharmacy or requesting a stat delivery. 3. R5's Admission Record documented an admitted [DATE] with diagnoses including: vitamin D deficiency, mild protein-calorie malnutrition, alcohol dependance, and adult failure to thrive. R5's 8/12/24 MDS documented a BIMS score of 15, indicating R5 was cognitively intact. On 10/9/24 at 8:50 AM, V13 (Registered Nurse/ RN) was completing the medication administration for R5. V13 stated R5 did not have any Vitamin B12 tablets in the facility and would have to order them from the pharmacy. R5's October MAR documented an order for Vitamin B12 tablet give 1000 mg by mouth one time a day for supplement with a start date of 10/5/23. R5's October MAR documented R5 did not receive a vitamin B12 tablet on 10/9/24 or 10/10/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 1:48 PM, V2 verified R5's did not receive the order vitamin B12 tablet on 10/9/24. V2 stated the pharmacy portal documented R5's vitamin B12 tablets were delivered to the facility on [DATE] at 12:11 AM. V2 stated she was not sure R5's October MAR documented R5 did not receive a vitamin B12 tablet on 10/10/24 because the medication had been delivered prior to the 8:00 AM medication pass. V2 stated R5's vitamin B12 had not been ordered from a backup pharmacy or had a stat delivery request sent. 4. R4's Admission Record documented an admitted [DATE] with diagnoses including: hepatic encephalopathy, and cirrhosis of the liver. R4's September 2024 MAR documented an order for phenazopyridine 200 mg tablet give one tablet via peg tube 3 times a day for urinary health. R4's September 2024 MAR documented R4 did not receive a dose of phenazopyridine on 9/19/24 at 12:00 PM. On 10/17/24 at 1:48 PM, V2 verified R4 did not receive an ordered dose of phenazopyridine on 9/19/24 at 12:00 PM. V2 stated R4 was a new admission to the facility and the pharmacy portal documented R4's phenazopyridine was delivered to the facility on [DATE] at 12:14 AM. V2 stated R4's phenazopyridine had not been ordered from a backup pharmacy or had a stat delivery request sent. On 10/15/24 at 1:15 PM, V1 stated if a resident did not have an over-the-counter medication such as B12 or phenazopyridine V2 or another staff could purchase the medication at the pharmacy across the street from the facility and administer the medication instead of a resident missing a dose of the medication. On 10/15/24 at 1:27 PM, V25 (Pharmacy Nurse Consultant) stated all the resident medications were automatically refilled by the pharmacy. V25 stated all medications in the facility were resident specific medications and the pharmacy did not provide any over the counter stock medications. V25 stated the only medications that were not resident specific were medications that could not be placed into blister packs such as miralax. When V25 was asked how a nurse was to know if a resident's medication would run out before the medication was delivered to the facility V25 stated no resident should be out of medication because they are all automatically refilled. When V25 was asked why R5 did not have any vitamin B12 in the facility on 10/9/24 if all of the resident's medications were automatically reordered V25 stated he was not sure. When V25 was asked why R7 did not have any Trulicity in the facility on 10/16/24 if all of the resident's medications were automatically reordered V25 stated he was not sure. V25 then stated Trulicity is a medication that has to be manually reordered by nursing staff. When V25 was asked how nursing staff would know Trulicity had to be manually reordered V25 stated he was not sure. V25 stated he expected staff to follow the facility's pharmacy policy What to Do If a Medication is Not Available during a Med Pass if a medication is not available during medication pass. V25 stated this policy included what to do when the facility had a new resident admitted and needed their medications. V25 stated he did not expect staff would purchase over the counter medications from the pharmacy across the street from the facility to administer to residents. On 10/17/24 at 9:35 AM, V30 (LPN) stated she had received training on ordering resident medications but was not sure which resident medication were automatically refilled and which medications had to be manually ordered by the nurse. V30 stated due to not knowing which medications were automatically refilled the nurse would not know a resident did not have a medication until the nurse was completing medication pass. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated pharmacy policy titled What to Do If a Medication is Not Available during a Med Pass documented in part . 1. Review the pharmacy packing slip to verify if the medication has been delivered. You may also check the (pharmacy website portal) to review the delivery status of the medication. 2. Check all medication carts for the missing medication. Did the resident recently transfer from room/ unit? 3. Check the medication room and confirm all pharmacy deliveries have been properly checked in. 4. Utilize the (emergency medication stock) for availability of the medication. Remove dose for administration and administer to the resident . 5. If the medication is not available in the (emergency medication stock), Is there an alternative medication (or dose equivalent) available to administer with a prescriber's order? 6. If the medication cannot be located and is not available in the (emergency medication stock), please notify the pharmacy or request delivery from a backup pharmacy, or request a stat delivery, and finally verify the medication will be sent on the next pharmacy delivery. 7. Notify the provider the medication will not be available for administration at the current scheduled time. Request an order to hold the medication and administer upon delivery from the pharmacy . By following the steps above, we will avoid the need to document Medication not available. This will ensure the resident receives the medication timely and avoids any further potential delay in treatment . The facility's March 19, 2020, Administering Medication policy documented in part . Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/ federal regulations . Procedure: . 6. Medications should be administered within one (1) hour of the prescribed times . 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall chart in the Electronic Medical Record (eMAR) and sign off for that particular drug and document a rational . 13. Should a medication be withheld or refused, the physician will be notified when three (3) consecutive doses or a pattern of frequent withholding or refusal is noted. Documentation identifying the explanation of withholding or reason for refusal will be documented in the medical record .

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to obtain scheduled medications from the pharmacy and secure emergency medications for 1 (R1) of 5 residents reviewed for medication administration in the sample of 8. This failure resulted in R1 abruptly stopping and missing his scheduled seizure medication resulting in R1 experiencing two seizures lasting approximately four minutes each. Additionally, this failure has the potential to result in prolonged, life-threatening seizures when abruptly stopping anti-seizure medication. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 9/23/24 at approximately 8:00 PM when the facility was unable to provide R1's scheduled seizure medications. The facility did not administer R1's seizure medications again on 9/24/24 at 8:00 AM and 8:00 PM. V6 (Regional Administrator), V2 (Director of Nursing), V3 (Care Plan Coordinator/ Registered Nurse), and V24 (Dietary Manager) were notified of the Immediate Jeopardy on 10/11/24 at 2:44 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on 10/18/24, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training. Findings include: On 10/3/24 at 1:11 PM, V9 (Case Coordinator) stated when R1 was admitted to the facility R1 had two seizures in the first week due to the facility not administering R1's seizure medication. V9 stated she had been R1's case manager for the past year while R1 was residing in a group home. V9 stated in the year prior to this investigation R1 had three seizures. V9 stated R1 had never had two seizures in the same day. On 10/3/24 at 2:56 PM, V11 (R1's Power of Attorney) stated about two years prior to this investigation, R1 had started having more seizures. V11 stated prior to R1 being admitted to the facility R1 had been in the hospital to have a gastrostomy tube (g-tube) placed. V11 stated R1 had a seizure during the hospitalization . V11 stated R1 had been discharged from the hospital on 9/23/24 around 5:30 PM and the hospital had not sent any medications to the facility for R1. V11 stated you would think the hospital would have sent one or two doses of the medications with (R1) to the facility. R1's Admission Record documented an admitted [DATE] with diagnoses including dysphagia following cerebral infarction, extrapyramidal and movement disorder, and epilepsy. R1's 9/25/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 was severely cognitively impaired. R1's 9/23/24 After Visit Summary from the hospital documented in part . Start taking these medications . lacosamide 10 mg/ ml solution . Commonly known as: Vimpat . Administer 10 ml through peg tube 2 (two) times a day . Levetiracetam 500 mg/ 5 ml solution . Commonly known as: Keppra . Administer 10 ml (1,000 mg total) through tube 2 (two) times a day . oxcarbazepine 300 mg/ 5 ml (60 mg/ ml) suspension . Commonly known as: Trileptal . Administer 5 ml (300 mg total) through g-tube 2 (two) times a day . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's September 2024 Order Summary Report from the facility's Electronic Medical Record documented the orders for Keppra solution 100 mg/ ml, oxcarbazepine oral suspension 300 mg/ 5 ml, and Vimpat oral solution 10 mg/ ml, as ordered on the hospital's Visit Summary, with an order date of 9/23/24. The facility's pharmacy Packing Slip documented R1's Keppra, Vimpat, and Trileptal were shipped to the facility on [DATE]. R1's E-Courier Delivery Status documented R1's medications were delivered to the facility on [DATE] at 12:18 AM. R1's September 2024 Medication Administration Record (MAR) documented R1 did not receive the 9/23/24 8:00 PM dose and the 9/24/24 8:00 AM dose of Keppra, Trileptal, or Vimpat. R1's September 2024 MAR documented R1 did not receive the 9/24/24 8:00 PM dose of Trileptal. R1's September 2024 MAR documented R1 did receive the 9/24/24 8:00 PM dose of Keppra and Vimpat and were initialed as being administered by V10 (Licensed Practical Nurse/ LPN). On 10/10/24 at 1:27 PM, V2 (Director of Nursing) stated she did not know why V10 had documented administering R1's 9/24/24 8:00 PM dose of Keppra and Vimpat when the medications were not delivered to the facility until 9/25/24 at 12:18 AM. V2 stated V10 must have documented in error. On 10/10/24 at 10:07 AM, V10 (Licensed Practical Nurse/ LPN) stated resident medications were delivered to the facility daily from approximately 12:00 AM to 2:00 AM. V10 stated if a resident is admitted after 5:00 PM the facility would not receive the resident's medication in that night's medication delivery but the next night's medication delivery, indicating the resident would be without medication for longer than 24 hours. V10 stated she was the nurse caring for R1 on the night shift of 9/24/24 to 9/25/24. V10 stated she did not know why she documented administering R1's Keppra and Vimpat on 9/24/24 at 8:00 PM. V10 stated she did not notify R1's medical provider on 9/24/24 when the facility did not have R1's seizure medications to administer. On 10/9/24 at 12:43 PM, V2 stated she was caring for R1 on the dayshift of 9/24/24. V2 stated on 9/24/24 she had notified R1's medical provider's office via fax of the facility not having R1's Vimpat, Trileptal, or Keppra and had contacted the pharmacy. V2 stated she was not sure if R1's medical provider had contacted the facility back with a substitution order or a medication hold order. The facility was not able to provide reproducible evidence or documentation that V2 had sent a fax to R1's medical provider's office or of V2 contacting the pharmacy on 9/24/24. On 10/8/24 at 9:47 AM, V20 (Pharmacist) stated the pharmacy received orders for R1 Vimpat, Trileptal, and Keppra on 9/23/24 at 9:56 PM. V20 stated the pharmacy sent R1's Vimpat, Trileptal, and Keppra on 9/24/24 due to not having an overnight pharmacist. V20 stated there was an overnight pharmacist on call and if a facility needed medications right away that pharmacist could try to get the medications to the facility from a closer pharmacy. V20 stated if the overnight pharmacist could not get the medications to the facility that night from a closer pharmacy they would get the medication from another pharmacy the next morning. V20 stated she was not sure if anyone from the facility had called the pharmacy to let them know. On 10/8/24 at 9:57 AM, V19 (Pharmacist in Charge) stated she did not see any documentation in her system of the facility contacting the pharmacy on 9/24/24 or ordering R1's Vimpat, Trileptal, or Keppra STAT (stat or immediately) or from a backup pharmacy on 9/24/24. V19 stated if a facility did not have a resident's medications, she would expect the facility to call the resident's medical provider to obtain an order for another medication until the resident's medication could arrive. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/3/24 at 3:27 PM, V3 (Care Plan Coordinator/ Registered Nurse) stated R1's Vimpat, Trileptal, or Keppra had not been ordered STAT or from a backup pharmacy. V3 stated when R1 was admitted on the evening of 9/23/24 there were a lot of things going on in the facility so V3 had stayed late to put R1's medication orders into R1's Electronic Medical Record (EMR). V3 stated since it was past 8:00 PM when R1's medication orders were entered R1's September MAR would document R1's 9/23/24 Vimpat, Trileptal, and Keppra were blank. On 10/10/24 at 10:25 AM, V4 (Physician) stated he was not made aware the facility was not administering R1's Keppra, Trileptal, or Vimpat due to the facility waiting on the medications to be delivered from the pharmacy. V4 stated R1 missing a dose of R1's seizure medication could cause R1 to have a seizure. The Center for Disease Control (CDC) website Treatment of Epilepsy (https://www.cdc.gov/epilepsy/treatment) documented in part . Medicine . Anti-seizure medicines limit the spread of seizures in the brain. It may take time to find the right medicine. Sometimes you'll need a combination of medicines. It's very important to take your medicine as prescribed . Do not skip or stop your seizure medicine . You should not skip or stop taking your seizure medicine without talking to your provider. Suddenly stopping your medicine might cause withdrawal symptoms, including life-threatening seizures. Taking your medicine is the most important thing you can do to prevent seizures . R1's Progress Note dated 9/24/24 at 4:09 AM documented R1 had a seizure lasting approximately four minutes with R1's oxygen saturation dropping to 80%, R1 becoming febrile, and tachycardic with R1 being lethargic, clammy, pale, and short of breath after the seizure. R1's Progress Note dated 9/24/24 at 11:31 AM documented R1 had another seizure lasting approximately four minutes. On 10/10/24 at 10:07 AM, V10 (LPN) stated she was the nurse caring for R1 on 9/24/24 at 4:09 AM when R1 had the first seizure. V10 stated she was completing medication pass when a Certified Nursing Assistant (CNA) alerted V10 that R1 was having a seizure. V10 stated when she entered R1's room, R1 was seizing with his eyes rolled back and his lips blue. V10 said she applied oxygen and recorded the time R1 was seizing. V10 stated R1's seizure stopped after 4 minutes. V10 stated after R1's seizure stopped R1 was slow to come back, lethargic, and tired. V10 stated she had contacted R1's medical provider and obtained an order to send R1 to the hospital. V10 stated V11 (R1's Power of Attorney) had refused to transfer R1 to the hospital. On 10/15/24 at 10:00 AM, V2 stated she was the nurse caring for R1 on 9/24/24 at 11:31 AM when R1 had the second seizure. V2 stated R1 had a seizure lasting four minutes. V2 stated V11 had refused to send R1 to the hospital and had instructed V2 if R1 had another seizure to send R1 to the hospital. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/9/24 at 1:32 PM, V5 (LPN) was asked what the facility would have done if R1's 9/24/24 seizures would have lasted longer than five minutes and V5 responded the facility would have called 911 for emergency services but there was nothing else the facility could have done for R1 due to the facility pharmacy not allowing the facility to keep injectable Ativan, injectable Valium, or rectal Valium gel in the emergency medication stock. V5 was asked what the facility would have done if R1's 9/24/24 seizures would have lasted longer than five minutes and county's emergency medical services were not able to arrive to the facility in a timely manner and V5 responded she did not know. The facility's medication room was toured and V5 used the pharmacy's emergency stock medication computer to show the facility did not have any injectable Ativan, injectable Valium, or rectal Valium gel available in stock or any other medications that could aide in stopping seizures timely. V5 stated when the facility changed pharmacy companies, about a year prior to this survey, the facility no longer kept any injectable Ativan or injectable Valium in the emergency stock medication. On 10/9/24 at 3:15 PM, V4 (Physician) stated he should be notified anytime a resident is having a seizure. V4 stated he would order the facility to call 911 for emergency services to transfer the resident to the hospital and if the seizure lasted longer than five minutes to administer intramuscular Ativan or Valium, whichever the facility had in stock in the emergency stock medication. V4 stated the facility should have injectable Ativan or Valium in the emergency stock medications and was not aware the facility did not. V4 stated there were several factors on how long a seizure had to last to cause brain damage, but it was possible brain damage could occur with a seizure lasting longer than five minutes. On 10/10/24 at 8:53 AM, V17 (Pharmacist) stated there had been a national shortage of Ativan and Valium periodically for the past 2 years. V17 stated due to the national shortage the pharmacy had not been able to stock the facility's emergency medication stock with injectable Ativan or Valium. V17 stated if the facility had an order for resident specific injectable Ativan or Valium the pharmacy could obtain the medication and have it sent to the facility or find an equivalent medication to be sent to the facility. V17 was asked why the pharmacy would be able to send injectable Ativan or Valium if it was resident specific but not able to send injectable Ativan or Valium for emergency stock medication and V17 stated she was not sure. V17 stated on 9/24/24 the facility had Ativan and Valium tablets in the emergency stock medication. V17 stated the physician could have ordered the facility to crush an Ativan or Valium tablet and administered it rectally. On 10/10/24 at 10:25 AM, V4 stated it is possible to administer an Ativan or Valium tablet rectally but V4 had never ordered it for someone having a seizure. V4 stated the onset of a rectally administered Ativan or Valium tablet would be about half an hour or approximately as long as administering the tablet orally. V4 stated the onset of the medication would take too long and emergency services would still have to be called. V4 stated the gold standard would be intravenous valium but V4 was unsure if the facility had that capability. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146124	A. Building B. Wing	10/23/2024

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's undated pharmacy policy titled What to Do If a Medication is Not Available during a Med Pass documented in part . 1. Review the pharmacy packing slip to verify if the medication has been delivered. You may also check the (pharmacy website portal) to review the delivery status of the medication. 2. Check all medication carts for the missing medication. Did the resident recently transfer from room/ unit? 3. Check the medication room and confirm all pharmacy deliveries have been properly checked in. 4. Utilize the (emergency medication stock) for availability of the medication. Remove dose for administration and administer to the resident . 5. If the medication is not available in the (emergency medication stock), Is there an alternative medication (or dose equivalent) available to administer with a prescriber's order? 6. If the medication cannot be located and is not available in the (emergency medication stock), please notify the pharmacy or request delivery from a backup pharmacy, or request a stat delivery, and finally verify the medication will be sent on the next pharmacy delivery. 7. Notify the provider the medication will not be available for administration at the current scheduled time. Request an order to hold the medication and administer upon delivery from the pharmacy By following the steps above, we will avoid the need to document 'Medication not available.' This will ensure the resident receives the medication timely and avoids any further potential delay in treatment . The facility's March 19, 2020 Administering Medication policy documented in part . Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/ federal regulations . Procedure: . 6. Medications should be administered within one (1) hour of the prescribed times . 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall chart in the Electronic Medical Record (eMAR) and sign off for that particular drug and document a rational . The Immediate Jeopardy that began on 9/23/24 was removed on 10/18/24 when the facility took the following actions to remove the immediacy and correct the deficient practice as confirmed through observation, interview, and record review: 1. The provider was notified of the resident's seizure history and order for PRN (as needed) medication received. The pharmacy has delivered the PRN medication. R1's 10/11/24 progress note documented a 10/10/24 order for diazepam rectal gel 10 mg insert 1 application rectally as needed for seizure activity related to epilepsy give 1 dose then send to emergency room (ER). Order received by V3 (RN/ Care Plan Coordinator) on 10/9/24. Pharmacy notified of STAT delivery needed by V3 on 10/9/24. Medication verified by V17 (Pharmacist). Medication was received by facility on 10/9/24. 2. Review of residents with seizure disorder and last seizure date completed. Presented this information to all providers and requested whether seizure PRN medication needed based on history. An audit was completed by V3 on 10/9/24. 3. Care Plans have been reviewed and reflect current seizure/ epilepsy standards. An audit was completed by V3 on 10/9/24. 4. Licensed Nursing staff educated on: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. What to do if a medication is not available. B. Pharmacy process for ordering medication and checking on order status using the pharmacy portal, phone, and messaging system. C. How to use the (emergency stock medication). D. Updated Seizure policy. E. New admission clarification for need for PRN medication. F. Physician notification when medication not available. G. Delivery needs for any significant medication with any new admit. Education provided to nursing staff on 10/10/2024 by V25 (Pharmacy Nurse Consultant). Education provided by V1 to V2 and V3 on the pharmacy policy of What to do if a medication is not available on 10/18/24. 5. Review of (emergency stock medication) inventory by facility V4 (Physician/ Medical Director) on 10/10/24. 6. Facility to ensure review of admission to include review of potential residents with a history of seizure/ other dx that could have a significant impact without medication prior to admission and if applicable, ask provider if any medications are not available, what substitutions can be made based on availability of medication in the (emergency stock medication) or if medication can be placed on hold. Added to Referral review and admission checklist (update date 10/9/24). Audit 10/9/24 by V26 (RN); Admission check list updated 10/9/24 by V26. 7. Facility to ensure continued compliance, Preadmission screen/ admission question to provider if PRN antiseizure medication/ medication that could have a significant impact without its administration is needed for new admission weekly x 4 weeks and then present to the QAPI for review. Audits will continue based on the recommendations of the QAPI on review of the admission audit findings. V2 or Designee is responsible for implementing this plan of correction. The first audit was completed 10/9/24 for seizure med.