STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175361	A. Building B. Wing	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topside Manor Inc	210 Kansas Avenue Goodland, KS 67735

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 44 residents with three residents reviewed for pain. Based on record review, observation, and interview, the facility failed to develop and implement a comprehensive person-centered care plan for Resident (R) 1 respiratory needs and equipment. This deficient practice placed R1 at risk for respiratory well-being due to uncommunicated care needs. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), polyneuropathy (the simultaneous malfunction of peripheral nerves throughout the body), chronic pain, hypokalemia (low level of potassium in the blood), and edema (swelling). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 required oxygen and a non-invasive ventilator (a machine that provides ventilatory support without using an artificial airway). The MDS documented R1 had received diuretics (medication to promote the formation and excretion of urine), opioids (a class of medications derived from the poppy plant to relieve pain), and anti-depressants (a class of medications used to treat mood disorders) medications. The Activities of Daily Living/Rehabilitation Potential Care Area Assessment (CAA), dated 06/27/23, documented R1 reported having frequent pain in her bilateral hips. R1 was generally independent with bed mobility, but required limited assistance for transfer, supervision for ambulation and locomotion, and required assistance with dressing and toileting. The Pain CAA, dated 06/27/23, documented R1 had diagnoses of COPD, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and myalgia (muscle pain). R1 reported she had an increase in pain when sitting too long in one position and had improvement in pain with pain medication and repositioning. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan, dated 02/27/24, documented R1 received Lasix (diuretic), duloxetine (anti-depressant, used for pain control), and Norco (an opioid pain medication) and staff were directed to administer the medications as ordered. The care plan directed staff R1 required limited staff assistance for her activities of daily living. The care plan lacked any documentation or direction regarding R1's Trilogy non-invasive ventilator. On 03/04/24 at 10:30 AM, observation revealed R1 sat in her wheelchair and visited with her daughter in her room. R1 had on oxygen via nasal cannula. R1 had two-to-three-word dyspnea (shortness of air). A Trilogy non-invasive ventilator sat on a table behind R1's recliner to the right of her bed. On 03/04/24 at 10:30 AM, R1 stated she had missed medication multiple times in February. R1 stated that her pain had been uncontrollable in the middle of February, she could hardly move or sleep. R1 stated she felt it was the facility's responsibility to make sure that she had all her medications available for her to take and she felt it showed irresponsibility on the facility's part in not making sure she had those medications. R1 stated she had difficulty at night getting staff to hook up the Trilogy and make sure the oxygen settings were moved up to seven liters because the nurse was not always on the unit. R1 stated she often fell asleep sitting in her chair waiting for someone to come and assist her with the Trilogy. R1 stated she felt like staff would then yell at her about why she did not call somebody to put it on or have the Certified Nurse's Aides (CNA) put it on. R1 stated she was told the CNAs could not touch her Trilogy or titrate oxygen and she just could not understand why the nurses were not taking responsibility for it. On 03/04/24 at 10:15 AM, Licensed Nurse (LN) G verified there were no orders for R1's Trilogy non-invasive ventilator and nothing in R1's care plan regarding R1's Trilogy non-invasive ventilator. On 03/04/24 at 01:00 PM, Administrative Staff A was unaware there were no orders for R1's Trilogy non-invasive ventilator or that R1's care plan did not reflect R1's usage of the Trilogy. The Care Plans, Comprehensive Person-Centered, policy revised March 2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; any specialized services to be provided as a result of recommendations; and which professional services are responsible for each element of care. The facility failed to develop and implement a comprehensive person-centered care plan for R1's respiratory needs and equipment. This deficient practice placed R1 at risk for respiratory well-being due to uncommunicated care needs.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 44 residents with three residents reviewed for pain. Based on record review, observation, and interview, the facility failed to provide appropriate care and services to provide respiratory care with the Trilogy non-invasive ventilator (an all-in-one ventilation device capable of delivering both invasive and non-invasive ventilation that can be more finely calibrated and adjusted to meet individual needs) to Resident (R) 1. The facility did not have orders from the primary care physician regarding how to run the Trilogy non-invasive ventilator, what settings the non-invasive ventilator needed to be set at, or how and when to clean the Trilogy non-invasive ventilator. This deficient practice placed R1 at risk for respiratory failure. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), polyneuropathy (the simultaneous malfunction of peripheral nerves throughout the body), chronic pain, hypokalemia (low level of potassium in the blood), and edema (swelling). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 required oxygen and a non-invasive ventilator (a machine that provides ventilatory support without using an artificial airway). The MDS documented R1 had received diuretics (medication to promote the formation and excretion of urine), opioids (a class of medications derived from the poppy plant to relieve pain), and anti-depressants (a class of medications used to treat mood disorders) medications. The Activities of Daily Living/Rehabilitation Potential Care Area Assessment (CAA), dated 06/27/23, documented R1 reported having frequent pain in her bilateral hips. R1 was generally independent with bed mobility, but required limited assistance for transfer, supervision for ambulation and locomotion, and required assistance with dressing and toileting. The Pain CAA, dated 06/27/23, documented R1 had diagnoses of COPD, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and myalgia (muscle pain). R1 reported she had an increase in pain when sitting too long in one position and had improvement in pain with pain medication and repositioning. R1's Care Plan, dated 02/27/24, documented R1 received Lasix (diuretic), duloxetine (anti-depressant, used for pain control), and Norco (an opioid pain medication) and staff were directed to administer the medications as ordered. The care plan directed staff R1 required limited staff assistance for her activities of daily living. The care plan lacked any documentation or direction regarding R1's Trilogy non-invasive ventilator. The January Order Summary Report, signed by R1's primary care physician on 01/24/24, documented R1 was receiving hydrocodone/acetaminophen 10/325 mg four times a day and duloxetine 60 mg twice a day. The order report lacked any orders regarding R1's Trilogy non-invasive ventilator. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/24 at 10:30 AM, observation revealed R1 sat in her wheelchair and visited with her daughter in her room. R1 had on oxygen via nasal cannula. R1 had two-to-three-word dyspnea (shortness of air). A Trilogy non-invasive ventilator sat on a table behind R1's recliner to the right of her bed. On 03/04/24 at 10:30 AM, R1 stated she had missed medication multiple times in February. R1 stated that her pain had been uncontrollable in the middle of February, she could hardly move or sleep. R1 stated she felt it was the facility's responsibility to make sure that she had all her medications available for her to take and she felt it showed irresponsibility on the facility's part in not making sure she had those medications. R1 stated she had difficulty at night getting staff to hook up the Trilogy and make sure the oxygen settings were moved up to seven liters because the nurse was not always on the unit. R1 stated she often fell asleep sitting in her chair waiting for someone to come and assist her with the Trilogy. R1 stated she felt like staff would then yell at her about why she did not call somebody to put it on or have the Certified Nurse's Aides (CNA) put it on. R1 stated she was told the CNAs could not touch her Trilogy or titrate oxygen and she just could not understand why the nurses were not taking responsibility for it. On 03/04/24 at 10:15 AM, Licensed Nurse (LN) G verified there were no orders for R1's Trilogy non-invasive ventilator and nothing in R1's care plan regarding R1's Trilogy non-invasive ventilator. On 03/04/24 at 01:00 PM, Administrative Staff A was unaware there were no orders for R1's Trilogy non-invasive ventilator or that R1's care plan did not reflect R1's usage of the Trilogy. The CPAP (Continuous Positive Airway Pressure - a machine that uses mild air pressure to keep breathing airways open while sleeping)/BIPAP (a Bilevel Positive Airway Pressure - is a form of a non-invasive ventilator used if a person can breathe on their own but cannot get enough oxygen or get rid of carbon dioxide), policy revised March 2015, documented the purpose of the policy was to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen, to improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease, and to promote resident comfort and safety. Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask. Review the resident's medical record to determine his or her baseline oxygen saturation or arterial blood gases (ABGs), respiratory, circulatory, and gastrointestinal status. Review the physician's order to determine the oxygen concentration and flow and the PEEP pressure. Review and follow the manufacturer's instructions for machine setup and oxygen delivery. The facility failed to provide appropriate care and services to provide respiratory care with the Trilogy non-invasive ventilator for R1. This deficient practice placed R1 at risk for respiratory failure.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 44 residents with three residents reviewed for pain. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 received her pain medication as ordered to help alleviate her pain. This deficient practice placed R1 at risk of pain and emotional distress from being in pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), polyneuropathy (the simultaneous malfunction of peripheral nerves throughout the body), chronic pain, hypokalemia (low level of potassium in the blood), and edema (swelling). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 required oxygen and a non-invasive ventilator (a machine that provides ventilatory support without using an artificial airway). The MDS documented R1 had received diuretics (medication to promote the formation and excretion of urine), opioids (a class of medications derived from the poppy plant to relieve pain), and anti-depressants (a class of medications used to treat mood disorders) medications. The Activities of Daily Living/Rehabilitation Potential Care Area Assessment (CAA), dated 06/27/23, documented R1 reported having frequent pain in her bilateral hips. R1 was generally independent with bed mobility, but required limited assistance for transfer, supervision for ambulation and locomotion, and required assistance with dressing and toileting. The Pain CAA, dated 06/27/23, documented R1 had diagnoses of COPD, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and myalgia (muscle pain). R1 reported she had an increase in pain when sitting too long in one position and had improvement in pain with pain medication and repositioning. R1's Care Plan, dated 02/27/24, documented R1 received Lasix (diuretic), duloxetine (anti-depressant, used for pain control), and Norco (an opioid pain medication) and staff were directed to administer the medications as ordered. The care plan directed staff R1 required limited staff assistance for her activities of daily living. The care plan lacked any documentation or direction regarding R1's Trilogy non-invasive ventilator. R1's EMR documented an order from her primary care physician on 08/16/23 to give hydrocodone/acetaminophen (Norco-pain medication) 10/325 milligrams (mg) by mouth four times a day for pain. R1's EMR documented an order received from her primary care physician on 11/25/23 to give duloxetine 30 mg two capsules by mouth (total of 60 mg) twice a day for fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Gradual Dose Reduction Request, dated 12/05/23, documented the pharmacist requested R1's primary care physician to do a dose reduction on R1's duloxetine. R1's primary care physician responded, Duloxetine is for fibromyalgia. Continue the same dose. The January Order Summary Report, signed by R1's primary care physician on 01/24/24, documented R1 was receiving hydrocodone/acetaminophen 10/325 mg four times a day and duloxetine 60 mg twice a day. The February MAR, documented R1 had not received her hydrocodone/acetaminophen 10/325 mg at all on 02/12/24 due to the medication being unavailable. The February MAR, documented R1 had not received her duloxetine 60 mg for a total of three days February 14th, 15th, and 16th due to the medication being unavailable. R1's clinical record lacked evidence staff notified R1's physician that the pain medications were not given to R1. On 03/04/24 at 10:30 AM, observation revealed R1 sat in her wheelchair and visited with her daughter in her room. R1 had on oxygen via nasal cannula. R1 had two-to-three-word dyspnea (shortness of air). A Trilogy non-invasive ventilator sat on a table behind R1's recliner to the right of her bed. On 03/04/24 at 10:30 AM, R1 stated she had missed medication multiple times in February. R1 stated that her pain had been uncontrollable in the middle of February, she could hardly move or sleep. R1 stated she felt it was the facility's responsibility to make sure that she had all her medications available for her to take and she felt it showed irresponsibility on the facility's part in not making sure she had those medications. On 03/04/24 at 10:15 AM, Licensed Nurse (LN) G stated one of the Certified Medication Aides (CMA) M got all the medications that needed to be re-ordered and wrote them down from the tabs the other CMAs pulled off the medication cards. After CMA G wrote all the medications down, she would give the re-order sheet to either the charge nurse on duty that day, the Assistant Director of Nursing (ADON), or the Director of Nursing (DON), and then they would ensure the medications were ordered from whatever pharmacy the residents used. LN G was uncertain regarding the dates R1 missed her medications and stated she would have to check on it. LN G stated she was not sure about why R1 had not received her duloxetine for fibromyalgia for three days. LN G stated the facility had to buy R1's hydrocodone/acetaminophen because when R1 changed pharmacy, the prescription could not be refilled. On 03/04/24 at 11:00 AM, CMA M stated she wrote down all the medications that needed to be re-ordered on all three units of medication carts. CMA M stated the CMAs pulled the tabs off the medication cards and placed them in a plastic basket to be re-ordered, and then she would write all the medications down and give them to the administrative nurses for them to order. CMA M stated the nurses used to run a report on what medications needed to be ordered but she did not know how to do that. On 03/04/24 at 11:15 AM, CMA N stated she did not know why R1 had not received her pain medication in mid-February. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/24 at 01:00 PM, Administrative Staff A acknowledged that R1 not receiving her medications as ordered was a problem. Administrative Staff A stated the processes for re-ordering medication needed to be reviewed. The Pain Clinical Protocol Policy, revised October 2022, documented the physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing diagnoses and conditions that commonly cause pain. It also includes a review of any treatments the resident currently is receiving for pain, including complimentary and non-pharmacologic treatments. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. Staff will provide the elements of a comforting and appropriate physical and complementary intervention. The facility failed to ensure R1 had her pain medication administered as ordered to help alleviate her pain. This deficient practice placed R1 at risk of pain and emotional distress from being in pain.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 44 residents with three residents reviewed for medication errors. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 was free from medication errors. This deficient practice placed R1 at risk of medical complications from not receiving her medications as they were ordered by her physician. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), polyneuropathy (the simultaneous malfunction of peripheral nerves throughout the body), chronic pain, hypokalemia (low level of potassium in the blood), and edema (swelling). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 required oxygen and a non-invasive ventilator (a machine that provides ventilatory support without using an artificial airway). The MDS documented R1 had received diuretics (medication to promote the formation and excretion of urine), opioids (a class of medications derived from the poppy plant to relieve pain), and anti-depressants (a class of medications used to treat mood disorders) medications. The Activities of Daily Living/Rehabilitation Potential Care Area Assessment (CAA), dated 06/27/23, documented R1 reported having frequent pain in her bilateral hips. R1 was generally independent with bed mobility, but required limited assistance for transfer, supervision for ambulation and locomotion, and required assistance with dressing and toileting. The Pain CAA, dated 06/27/23, documented R1 had diagnoses of COPD, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), and myalgia (muscle pain). R1 reported she had an increase in pain when sitting too long in one position and had improvement in pain with pain medication and repositioning. R1's Care Plan, dated 02/27/24, documented R1 received Lasix (diuretic), duloxetine (anti-depressant, used for pain control), and Norco (an opioid pain medication) and staff were directed to administer the medications as ordered. The care plan directed staff R1 required limited staff assistance for her activities of daily living. The care plan lacked any documentation or direction regarding R1's Trilogy non-invasive ventilator. R1's EMR documented an order from her primary care physician on 08/16/23 to give hydrocodone/acetaminophen (Norco-pain medication) 10/325 milligrams (mg) by mouth four times a day for pain. R1's EMR documented an order received from her primary care physician on 11/02/23 to give potassium chloride (electrolyte supplement) 10 milliequivalents (meq) by mouth daily for hypokalemia. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's EMR documented an order received from her primary care physician on 11/25/23 to give duloxetine 30 mg two capsules by mouth (total of 60 mg) twice a day for fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance). The Pharmacy Gradual Dose Reduction Request, dated 12/05/23, documented the pharmacist requested R1's primary care physician to do a dose reduction on R1's duloxetine. R1's primary care physician responded, Duloxetine is for fibromyalgia. Continue the same dose. The January Order Summary Report, signed by R1's primary care physician on 01/24/24, documented R1 was receiving hydrocodone/acetaminophen 10/325 mg four times a day, potassium chloride 10 meq daily, and duloxetine 60 mg twice a day. The January Medication Administration Record (MAR), documented R1 had not received her potassium chloride 10 meq for twenty-four days in January due to the medication being unavailable. The February MAR, documented R1 had not received her hydrocodone/acetaminophen 10/325 mg at all on 02/12/24 due to the medication being unavailable. The February MAR, documented R1 had not received her duloxetine 60 mg for a total of three days February 14th, 15th, and 16th due to the medication being unavailable. The February MAR, documented R1 had not received her potassium chloride 10 meq for twenty-five days in February due to the medication being unavailable. The facility failed to notify R1's physician that the medications were not given to R1. On 03/04/24 at 10:30 AM, observation revealed R1 sat in her wheelchair and visited with her daughter in her room. R1 had on oxygen via nasal cannula. R1 had two-to-three-word dyspnea (shortness of air). A Trilogy non-invasive ventilator sat on a table behind R1's recliner to the right of her bed. On 03/04/24 at 10:30 AM, R1 stated she had missed medication multiple times in February. R1 stated that her pain had been uncontrollable in the middle of February, she could hardly move or sleep. R1 stated she felt it was the facility's responsibility to make sure that she had all her medications available for her to take and she felt it showed irresponsibility on the facility's part in not making sure she had those medications. On 03/04/24 at 10:15 AM, Licensed Nurse (LN) G stated one of the Certified Medication Aides (CMA) M got all the medications that needed to be re-ordered and wrote them down from the tabs the other CMAs pulled off the medication cards. After CMA G wrote all the medications down, she would give the re-order sheet to either the charge nurse on duty that day, the Assistant Director of Nursing (ADON), or the Director of Nursing (DON), and then they would ensure the medications were ordered from whatever pharmacy the residents used. LN G was uncertain regarding the dates R1 missed her medications and stated she would have to check on it. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/24 at 11:00 AM, CMA M stated she wrote down all the medications that needed to be re-ordered on all three units medication carts. CMA M stated the CMAs pulled the tabs off the medication cards and placed them in a plastic basket to be re-ordered, and then she would write all the medications down and give them to the administrative nurses for them to order. CMA M stated the nurses used to run a report on what medications needed to be ordered but she did not know how to do that. CMA M stated she had no idea R1 was out of her potassium chloride because if she did not get a tag in the basket, she did not know something needed re-ordered. CMA M stated she searched the medication cart for R1's hall and there was no potassium chloride for R1 in the cart. On 03/04/24 at 11:15 AM, CMA N stated that she had documented R1's potassium that morning before she realized the medication was not available and she went back and struck out the administration. CMA N stated she had not let anyone know the potassium was unavailable. On 03/04/24 at 01:00 PM, Administrative Staff A acknowledged that R1 not receiving her medications as ordered was a problem. Administrative Staff A stated the processes for re-ordering medication needed to be reviewed. The Administering Medications Policy, dated April 2019, documented that medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with the prescriber's orders. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff. The facility failed to ensure R1 was free from medication errors. This deficient practice placed R1 at risk of medical complications from not receiving her medications as they were ordered by her physician.