STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Gtc	2950 Lafranier Rd Traverse City, MI 49686

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49302 This deficiency pertains to Facility Reported Incident (FRI) #MI00144562. Based on observation, interview, and record review, the facility failed to provide adequate supervision per the plan of care for three residents (Residents #508, #509, and #510) during mealtimes. This deficient practice resulted in two choking/aspiration events for Resident #509 which resulted in hospitalization and subsequent death. Findings Include: The Immediate Jeopardy began on [DATE] at 2:40 PM when the facility failed to provide supervision during a mealtime for a resident (Resident #508) with a known history of choking/aspiration. This resulted in R508 experiencing a choking event in his room. R508 experienced a subsequent choking event on [DATE] at 6:24 PM when R508 was left unsupervised on two different occasions in the dining room during a dinner time meal and was found unresponsive. R508 required life-saving efforts and was ultimately transported to a local hospital where he later expired. The Nursing Home Administrator (NHA), Senior Regional NHA, and Director of Nursing (DON) were notified of the immediate jeopardy on [DATE] at 12:10 PM. At that time, a written removal plan was requested from the facility. This surveyor confirmed by interview and record review that the immediacy was removed on [DATE] at 3:35 PM, however, noncompliance remains at the potential for more than minimal harm due to sustained compliance which has not been verified by the State Agency (SA). Resident #508 (R508): Review of R508's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including history of traumatic brain injury (TBI), dysphagia (difficulty or inability to swallow), and chronic obstructive pulmonary disease (COPD). Review of R508's Brief Interview for Mental Status (BIMS) assessment revealed a score of 00, indicative of severe cognitive impairment. Review of R508's discharge summary from the acute care hospital revealed the following: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Dysphagia: it was noted last week that he is impulsive with eating, and this may in part cause him to choke/cough when eating . Review of R508's Speech Therapy Clinical Swallowing Evaluation at the acute care hospital on [DATE] revealed the following recommendations: .he [R508] is noted to be an impulsive/fast eater per many recent ST [speech therapy] swallowing evaluations .if speed of intake is an ongoing issue, recommend direct supervision/assist w/ [with] pacing during meals. This has been recommended during each swallow assessment in the past . Review of R508's Nursing Admission Evaluation dated [DATE], indicated the following: 1. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Supervision or touching assistance, was selected by the evaluator. 2. Most support needed for eating. Supervision/cueing needed, was selected by the evaluator. Review of a Nursing to Dietary diet order form dated [DATE] completed by Registered Nurse (RN) E revealed the following: .[R508] is a feed. On [DATE] at 11:25 AM, a phone interview was conducted with RN E who verified she completed R508's Nursing Admission Evaluation and Nursing to Dietary diet order form on [DATE]. RN E stated she indicated R508 required supervision and cueing with eating on the Nursing Admission Evaluation because, the hospital told me that he stuffs his mouth and doesn't swallow and just keeps putting more and more in [his mouth]. RN E stated she talked with R508's sister/guardian [Guardian F] who stated R508 needed frequent cues to slow down when eating due to his impulsivity. RN E was asked for clarification behind the meaning of, [R508] is a feed on the Nursing to Dietary diet order form. RN E said, he [R508] has to have supervision to eat, he can't eat by himself . I meant that somebody has to be in his direct presence, they can't leave him alone in the room with his tray . On [DATE] at 8:20 AM, an interview was conducted with Occupational Therapist (OT) O who verified Guardian F was present at the time of her evaluation. OT O stated Guardian F revealed R508 needed supervision whenever he was eating. OT O recalled Guardian F was feeding R508 peanuts at the time of her evaluation and continued to repeat, chew, chew, chew! to cue R508 and reduce the risk of choking. Review of OT Evaluation and Plan of Treatment signed [DATE] read, in part: .Medial hx (history): .impulsive and eats to [sic] fast . Prior Level(s) of Function: .Eating = Supervision or touching assistance (Patient is impulsive and eats very fast. 'Tries to shove whole piece of toast in his mouth' per sister [Guardian F]) . Review of R508's progress notes revealed the following entry on [DATE] at 2:40 PM, written by Licensed Practical Nurse (LPN) D: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident left unsupervised for meal. Resident observed coughing up hot dog during lunch. Checked O2 [oxygen saturation] mid 80s [percent saturation] and pulse [heart rate] in 120s .nurse called on-call provider and got [an] order for 2 liters O2 to maintain O2 sat [saturation] 92% and above . On [DATE] at 12:36 PM, a phone interview was conducted with Certified Nursing Assistant (CNA) C who verified she passed lunch trays on R508's hallway on [DATE]. CNA C stated she attempted to locate R508's diet order and level of supervision in the EMR system but was unable to find the orders. CNA C indicated she asked the floor nurse, LPN D, of R508's diet orders and eating assistance requirements. CNA C indicated LPN D stated R508 was on a regular diet, therefore she subsequently placed the meal tray, which consisted of a hot dog, in front R508 and left him unattended in his private room. CNA C stated she went on a break soon after delivering R508's lunch tray, and it wasn't until after she returned from break that she learned R508 experienced a choking event. Upon return CNA C stated CNA B informed her R508 required supervision when eating. CNA C stated, I felt like an idiot, because I didn't know that [R508 required supervision during meals]. It wasn't in his chart or in the computer . You feel dumb and helpless when things like this happen. There's a lack of communication in the facility, especially regarding newly admitted patients and their diet orders. A lot of times we're [nursing assistants] scrambling around trying to figure out what they [residents] can eat or how they transfer . On [DATE] at 10:00 AM, an interview was conducted with CNA B who verified she worked with CNA C on [DATE]. CNA B stated she passed R508's room and noticed [R508] was rigid in his chair and his whole body was shaking like he was having a seizure. CNA B stated R508 was positioned in his wheelchair with his tray table in front of him, his chin was down toward his chest, his feet were sticking straight out, and his arms were out to his sides. CNA B indicated, his jaw was open a little bit and the hot dog was partially chewed and falling out of his mouth. CNA B stated she immediately grabbed a napkin off the lunch tray and began removing partially masticated hot dog from R508's mouth. CNA B stated, I held him so he wouldn't fall out of his chair because he was rigid .I called his name, and he didn't respond. I kept trying to get food to come out of his mouth . CNA B indicated R508 snapped out of it after approximately ,d+[DATE] seconds and she then yelled for LPN D for assistance. CNA B recalled, When I first went in the room, I noticed his lips were a blue or purplish color. CNA B stated she was unsure why R508 did not receive supervision during the lunch time meal. On [DATE] at 10:20 AM, an interview was conducted with LPN D who verified he responded to R508's choking incident on [DATE] after CNA B reported R508 had food coming out of his mouth, was shaking, and his lips were turning blue. LPN D stated he entered R508's room and noticed he was shaking a bit because, he had a lot of coughs backed up and was trying to breathe. LPN D stated R508's oxygen saturation would not exceed 85% following the choking event, when previously they had been around 95% on room air. LPN D indicated he called the on-call provider for an order of supplemental oxygen and chest x-rays but did not report the seizure-like activity, the discoloration of R508's lips, nor did he request a diet texture downgrade. When LPN D was asked why the change in R508's condition was not disclosed to the on-call provider, he stated R508 did not have a history of seizures and LPN D was most concerned about his low oxygen saturation. LPN D stated no changes to R508's diet order were made following the choking incident on [DATE] and admitted , I didn't let [the DON] know [about the choking incident] which was my bad .she probably would have told me to downgrade the diet but I didn't know I could do that as a nurse . LPN D verified R508 was supposed to be supervised during meal times, but CNA C had not heard him report it. LPN D stated after he notified Guardian F of the choking event she disclosed R508 was so impulsive that he attempted to consume the plastic cracker sleeve when eating a snack on the day of his admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:53 PM, a telephone interview was conducted with Nurse Practitioner (NP) P who verified she was on-call on [DATE]. NP P stated she was not notified R508 experienced seizure-activity during the choking incident on [DATE]. NP P indicated based on standards of practice she would have likely sent R508 to the hospital for further evaluation if he did not have a history of seizures. Review of R508's medical history did not reveal a history of seizures. Review of the Nursing to Physician communication binder located at the nursing station revealed the following entry on [DATE]: .[R508] had aspiration on food. Diet may need to be downgraded . Review of R508's EMR revealed a diet order change on [DATE] at 9:42 AM that read, Level 3 texture, regular fluid, thin consistency. Review of R508's Plan of Care revealed a revised intervention on [DATE] that read, EATING: Supervision - offer assistance with meal setup as needed. To eat in the dining room, with staff supervision. Review of a Diet Order/Change Form signed by Unit Manager/RN H on [DATE] revealed a checked box that read Feeding Assistance needed for R508. On [DATE] at 11:02 AM, an interview was conducted with Unit Manager/RN H who stated she downgraded R508's diet due to the report of the choking incident that occurred over the weekend. RN H stated, [LPN D] is a new employee and did not know how to put a diet change order in or notify the physician of a diet change which was why the change was delayed. On [DATE] at 11:45 PM, an interview was conducted with Speech Language Pathologist (SLP), G who stated he was made aware of R508's choking incident on the morning of [DATE] during a managerial meeting. SLP G evaluated R508 after the breakfast meal on [DATE]. SLP G stated he evaluated R508 eating a cakey textured food which he was able to physically chew but, .he wanted to eat the whole thing. He had poor safety awareness. SLP G stated he then had a discussion with Unit Manager/RN H about the diet downgrade. SLP G said, I told the nurse [Unit Manager/RN H] that [R508] needed supervision . the diet downgrade was safe, but it wasn't necessarily the intervention I would have placed. [R508]'s risk of choking wasn't due to his inability to chew a regular diet; it was his impulsivity. SLP G was asked his expectation for the meaning of supervision who stated, Eyes-on the resident and being able to provide cues or assistance. SLP G was asked if R508 could safely be left alone while consuming a meal to which he replied, No. During a follow up interview on [DATE] at 2:49 PM, SLP G reiterated, Downgrading his diet was a safe option, it did not harm him in anyway. But it's the impulsivity that's the root cause [of R508's choking risk]. Review of SLP Evaluation and Plan of Treatment for R508, signed [DATE] read, in part: 1.poor carryover with swallow precautions. Benefits from close supervision with all PO [by mouth] intake to promote safety and overall tolerance . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:48 AM, an interview was conducted with the Senior Regional NHA, the NHA, the DON, and regional RN N. The DON verified that based on R508's medical history and acute care discharge summary, R508 required oversight, cueing, and supervision with eating due to his well-documented history of impulsivity which resulted in a choking/aspiration risk. The DON confirmed she was unaware of R508's initial choking event that occurred on [DATE] until she was informed during report upon arriving to work on [DATE]. The DON confirmed LPN D was unaware of the protocol following a choking incident, including downgrading the diet and notifying the DON and/or physician. The DON stated, I would have probably downgraded the diet [on [DATE]] if I would have known about the choking incident. The Senior Regional NHA, the NHA, and the DON all confirmed R508 should have been supervised during the lunch meal on [DATE]. When the DON was asked if LPN D should have reported R508's seizure-like activity and discoloration of his lips to the on-call provider she stated, He [LPN D] didn't witness any seizure activity and there was nothing to alert him [of the seizure activity]. The Senior Regional NHA added, [LPN D] didn't think he [R508] had a seizure. Both LPN D and CNA B's witness statements were reviewed which stated, .food coming out of his mouth, he was shaking, and his lips were turning blue, and, he was not talking or responding ., respectively. The Senior Regional NHA stated, It's not the CNA's place to say if he had a seizure. When asked who the appropriate person would be to make that determination, the DON stated, The physician. CNA I witness statements and interviews were reviewed with the Senior Regional NHA, the NHA, the DON, and regional RN N which confirmed CNA I left R508 unattended twice during the [DATE] dinner meal. The Senior Regional NHA stated, I don't know what to say to you, that's not what I heard . I was told he [R508] was never left unattended with his food. When CNA I's witness statement was reviewed which read, he ate about half if [sic] the sandwich and half his drink. [CNA L] and I went to look at the binder, he had half his sandwich left . he fed the last half sandwich to himself .not even a minute was I looking at the book with [CNA L] the NHA replied, She [CNA I] never told us she left [R508 unattended]. All parties confirmed R508 was care planned for direct supervision in the dining room at mealtimes at the time of the incident on [DATE]. Resident #509 (R509): Review of R509's EMR revealed admission to the facility on [DATE] with diagnoses including cerebral infarction (stroke), dysarthria (difficulty speaking), and dysphagia. Review of R509's Brief Interview for Mental Status (BIMS) assessment revealed a score of 9, indicative of moderate cognitive impairment. Review of R509's Plan of Care read, in part: .EATING: 1 person assist, 1:1 supervision, initiated [DATE]. On [DATE] at approximately 1:40 PM, R509 was observed eating lunch in the A-side dining room. Two facility staff members, Resident Voice/Staff Member Q and Registered Dietitian (RD) R were in the dining room. R509 was observed with a meal tray placed in front of her with no staff supervision. R509 was observed eating for the duration of her meal without receiving cueing or assistance from staff. On [DATE] at 1:50 PM, an interview was conducted with the DON regarding facility personnel expectations in the dining rooms during mealtimes. The DON indicated there should be two staff members in the dining room as, a rule of thumb. When asked if the staff members should be a CNA she replied, Yes. The DON was asked if a non-CNA could assist in the dining and stated, As long as they're not providing direct care or feeding. (continued on next page)

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Medilodge of Gtc	2950 Lafranier Rd Traverse City, MI 49686

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:46 PM, a follow up interview was conducted with the DON and Resident Voice/Staff Member Q. The DON was asked her expectations for a resident who required 1 person assist or 1:1 supervision during mealtimes. The DON stated she considered 1:1 supervision to be, sitting next to the resident, providing cues and assistance, and being able to visualize the resident. Resident Voice/Staff Member Q was asked if she was aware of any residents in the dining room who required 1:1 supervision during mealtime to which she replied, No. Review of R509's meal tray card read, Alerts: 1:1 feeding assistance, supervision with meals. On [DATE] at 2:49 PM, an interview was conducted with SLP G who verified R509 required 1:1 supervision during mealtimes. When asked why R509 required 1:1 supervision, SLP G stated, Because she has zero motivation to feed herself . she's a failure to thrive. If she has one-on-one assistance, she'll accept that assistance [and eat]. When asked his definition of 1:1 assistance, SLP G replied, Eyes-on the resident, cueing, helping her feed herself. Resident #510 (R510): Review of R510's EMR revealed initial admission to the facility on [DATE] with diagnoses including dysphagia, cognitive communication deficit, and schizophrenia. Review of R510's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderate cognitive impairment. Review of R510's Plan of Care read, in part: .EATING: 1 person assist, initiated on [DATE]. On [DATE] at 7:35 AM, R510 was observed in the East-side dining room in a high back wheelchair in the rear left corner with his back facing the dining room entrance. At 7:39 AM, the Assistant Director of Nursing (ADON) was observed placing R510's tray in front of him then walking away and leaving him unsupervised. R510 was observed eating the entirety of his breakfast meal without assistance from staff. Review of discharge instructions from an acute care hospital, dated [DATE], read, in part: .Diet after discharge: dysphagia diet . Will need 1:1 assist. Hx [history] of choking on solids . Review of a Progress Note written by written by NP S on [DATE] read, in part: .He [R510] is on a modified diet and recommended to have one-to-one feeding assist . Dysphagia, unspecified type: history of aspiration pneumonia .recommend to have 1:1 feed assist . Review of R510's progress notes revealed the following entries: 1. [DATE]: .requires assist and supervision with meals-recent aspiration pneumonia . 2. [DATE]: .resident drinks very fast and requires staff to assist with eating and drinking . 3. [DATE]: .low safety awareness, impulsive ,d+[DATE] assist/sup [supervision] for feeding . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. [DATE]: .recommend 1:1 feeding assistance with all intake. 5. [DATE]: .resident drinks very fast if left unattended during meals . Review of R510's most recent SLP Evaluated, dated [DATE], read, in part: .Patient referred to ST following change in payer source and continued concern with intake of modified diet texture . high risk of aspiration . .How often does patient require supervision/assistance at mealtime d/t swallow safety = ,d+[DATE]% of the time. Review of R510's most recent quarterly Nutrition Data Collection/Evaluation dated [DATE] read, in part: .Resident's ability to feed self: supervision/cueing needed . On [DATE] at 9:48 AM, an interview was conducted with the Senior Regional NHA, the NHA, the DON, and regional RN N who were made aware of the ongoing concerns regarding lack of implementation of interventions for residents care planned to receive supervision/assistance while eating as evidenced by observations of both R509 and R510 not receiving their care-planned level of supervision during mealtimes. The DON stated R509's level of assistance for eating was downgraded the morning of [DATE] to, supervision as needed for cueing and encouragement to eat, but confirmed R509 was care planned for 1:1 supervision at the time the lunch observation was made on [DATE]. The DON confirmed R510 was care-planned for 1 person assist. The NHA stated there was ongoing confusion between the nursing staff, the MDS staff, and the speech therapist regarding verbiage for level for assistance. The regional NHA admitted , We [managerial staff] need to educate all staff that someone needs to be in the dining room if a resident requires supervision . if they are 1:1 then someone has to be with them and cannot leave them. Review of facility policy, Accidents and Supervision revised [DATE] read, in part: .Each resident will be assessed for accident risk and will receive care and services in accordance with their individualized care plan . .Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49302 This deficiency pertains to Intake #MI00144052 and Facility Reported Incident (FRI) #MI00144263. Based on interview and record review, the facility failed to provide pharmaceuticals for one resident (Resident #502) of three residents reviewed for pharmacy services. This deficient practice resulted in Resident #502 going without administration of a prescribed medication for an extended period of time resulting in increased likelihood of exacerbation of symptoms. Findings include: Resident #502 (R502): Review of R502's Electronic Medical Record (EMR) revealed a most recent admission to the facility on [DATE] with diagnoses including achondroplasia (a genetic bone growth disorder that leads to short-limbed dwarfism), post-traumatic stress disorder (PTSD), recurrent depressive disorder, adjustment disorder, anxiety disorder, and Raynaud's syndrome (a condition that causes the blood vessels in the extremities to narrow, restricting blood flow). Review of R502's Brief Interview for Mental Status (BIMS) assessment revealed a score of 15, indicative of intact cognition. Review of Intake #MI00144052 read, in part: .Complainant [Guardian T] states [R502] didn't get her heart medication for four days. From Sunday, 4/14/24-4/18/24 . complainant states she wasn't notified of the medication issues . Guardian T was called on 5/13/24 at 2:06 PM and again on 5/14/24 at 8:37 AM to verify the allegation details. Guardian T did not return this surveyor's phone calls by the time of survey exit. On 5/24/24 at 9:32 AM, an interview was conducted with R502 who stated she went four days without the prescribed medication Nifedipine. R502 reported when she asked the nursing staff about her missing prescription, they continued to report it was due to, pharmacy issues. R502 confirmed she is prescribed Nifedipine due to her diagnosis of Raynaud's syndrome. When asked if R502 experienced any negative consequences from going without the medication, she stated, I had anxiety from going without the medication . I had some chest pain, but I'm unsure if that was from the lack of medication or from anxiety. R502 also endorsed feelings of fatigue. Review of R502's physician orders revealed: NIFEdipine Capsule 10 MG (milligrams); Give 1 capsule by mouth two times a day for Raynaud's. Review of R502's Medication Administration Regimen (MAR) for the month of April 2024 revealed missed administrations of Nifedipine (indicated by 9 - other/see progress note in the MAR) on the following days: 1. 4/14/24: 8:00 PM dose. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. 4/15/24: 8:00 AM and 8:00 PM doses. 3. 4/16/24: 8:00 AM and 8:00 PM doses. 4. 4/17/24: 8:00 AM and 8:00 PM doses. 5. 4/18/24: 8:00 AM dose. Review of R502's EMR revealed the following progress notes: 1. 4/14/24 at 19:07 [7:07 PM]: NIFEdipine Capsule 10 MG .waiting for delivery. 2. 4/15/24 at 7:52 AM: NIFEdipine Capsule 10 MG .not available. 3. 4/15/24 at 19:00 [7:00 PM]: NIFEdipine Capsule 10 MG .waiting for delivery. 4. 4/16/24 at 8:39 AM: NIFEdipine Capsule 10 MG .not available. 5. 4/16/24 at 20:13 [8:13 PM]: NIFEdipine Capsule 10 MG .on order. 6. 4/17/24 at 8:07 AM: NIFEdipine Capsule 10 MG .not available. 7. 4/17/24 at 19:00 [7:00 PM]: NIFEdipine Capsule 10 MG .waiting for delivery. 8. 4/18/24 at 7:38 AM: NIFEdipine Capsule 10 MG .medication is unavailable, on order from pharmacy. Review of the facility's correspondence history with the pharmacy supplier revealed Unit Manager/Registered Nurse (RN) V first called to inquire about the missing prescription on 4/17/24 at 6:38 PM, 3 days after the initial missed administration. Review of a progress note written by the Nursing Home Administrator (NHA) dated 4/18/24 at 16:24 [4:24 PM] read, in part: This writer received a phone call from resident's [R502's] guardian [Guardian T] in regards to medication that resident has not yet received for Raynaud syndrome . NP [nurse practitioner] to follow up . Review of a progress note written by NP S dated 4/19/24 read, in part: .she [R502] is being seen today for reports of chest pressure .it is being reported that Nifedipine doses had not been delivered, resulting in a few missed doses. Patient reports potentially having some anxiety that contributed to the chest pressure . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 11:52 AM, a phone interview was conducted with Registered Pharmacist (RPh) W at [pharmacy supplier]. RPh W confirmed R502's Nifedipine prescription was delivered to the facility on [DATE] at 8:33 AM. When asked about potential side effects from the sudden cessation of the medication, RPh W stated, There's potential for exacerbation of Raynaud's itself, including a tingling, coldness, or numbness in the affected extremities . On 5/14/24 at 1:40 PM, an interview was conducted with the Director of Nursing (DON) regarding missed administrations of the prescribed Nifedipine for R502. The DON stated she was unaware of the pharmacy issue regarding R502 until Guardian T contacted the NHA with concerns on 4/18/24. The DON admitted a system failure as evidenced by: 1. Delayed communication with the pharmacy supplier (the first call to the pharmacy occurred on 4/17/24 at 6:47 PM, after 6 missed doses of the prescribed medication). 2. Delayed communication with the facility physician regarding medication dosage omissions (the NP evaluated R502 on 4/19/24, the day after Nifedipine was reinstated) and subsequent potential improper monitoring for adverse reactions. 3. The lack of staff education regarding: a. Escalation protocol for missed prescriptions. b. Nursing supervisor, responsible party, and physician notification for medication omissions. c. Adequate documentation of medication omissions in the EMR. d. Completion of a medication error incident report. Review of facility policy titled, Medication Administration, Missing Medications, and Medication Errors, undated, read, in part: All medications are to be given as ordered, every resident should get the medications that are ordered, as ordered, without delay. If a resident has a medication that is not available: First check the backup supply (Cubex) if it [sic] available, use it, and then follow-up with pharmacy to see when the remaining supply is coming in . You need to determine why it's unavailable, length of time it will be unavailable, and what efforts have been attempted by the facility or pharmacy or provider to obtain the medication . Notify physician of inability to obtain medication upon notification or awareness that medication is not available and when the medication is expected to arrive. Obtain alternative treatment orders and/or specific orders for monitoring resident while the medication is being held, and document this in the medical record . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is not acceptable to document on order, waiting for pharmacy, N/A If you do not have the medication, there should be a detailed noted as to what you did to rectify the issue, including calling the physician for additional orders whether that is a different medication, or an order to hold this dose . .Escalation protocol - posted at the nurse's station and on medication carts, call the 1800 number first, keep calling until you talk to someone to get the answer you need . .The facility maintains a contract with the pharmacy to supply routine, prn [as needed], and emergency medications. [Pharmacy supplier] can send most medication from a Local Retail Pharmacy so they get here sooner. You must request a Local Retail Pharmacy shipment, if you say STAT it will come from [pharmacy supplier], approx. [approximate] 4-hour delivery time, requesting a local retail pharmacy drop delivers it from a local retail pharmacy in town and its quicker . .If a resident misses a scheduled dose of medication, staff shall follow procedures for medication errors, including physician and family notification, completion of a medication error report, and monitoring the resident for adverse reactions to [sic] omission of the medication . .Medication errors: .Types of errors: Incorrect dose, incorrect route, incorrect dosage, incorrect time of administration, medication omissions . .If a medication error occurs, the following must be initiated: .The nurse must assess and examine the resident's condition and notify the prescriber of the medication error as soon as possible. .Monitor and document the resident's condition, including response to any provider orders or interventions. .Document actions taken in the medical record. .Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident report . During an interview on 5/14/24 at 9:45 AM, this Surveyor reviewed concerns related to R502's missed administrations of a prescribed medication. The DON understood the concerns and presented a Past Noncompliance (PNC) document. During the onsite survey, PNC was cited after the facility implemented actions to correct the noncompliance which included: 1. Medications-Unavailable Policy, Medication Administration Policy, and Medication Errors policy reviewed by DON and NHA and deemed appropriate. 2. All licensed staff reeducated on Medications-Unavailable Policy, Medication Administration Policy, and Medication Errors policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. An ad-hoc QAPI committee meeting was held on 4.19.24 to review plan and to make recommendations as indicated. 4. Facility will audit 5x per week of residents identified with a medications unavailable, medication errors, medication administration audit. 5. Findings will be brought to QAPI [Quality Assurance and Performance Improvement] monthly and followed until QAPI Committee deems substantial compliance. 6. Results of the audits will be provided to the QAPI committee for further recommendations. The facility successfully demonstrated monitoring of the corrective action and maintained compliance by completing weekly audits of residents identified with unavailable medications or medication errors to ensure established protocol was followed. The PNC was granted with a Plan of Corrections (POC) date of 4/19/24.