STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365510	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Care Center	600 N Brush St Fremont, OH 43420

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on review of electronic medical records, review of emergency medical squad report, review of hospital records, review of staff education, staff interviews, review of text message review of facility policies, and resident family interview, the facility failed to ensure Resident #76 received medications to prevent seizure activity and notify the physician of resident not receiving medications and having seizure activity. This resulted in Immediate Jeopardy and serious life-threatening harm on 11/14/24 when, as a result of not having his prescribed medications, Resident #76 subsequently experienced continual tonic-clonic seizures (also known as a grand mal seizure - a type of seizure characterized by a sudden stiffening of the body muscles [tonic phase] followed by rapid jerking movements [clonic phase], usually causing loss of consciousness and violent muscle contractions throughout the body), requiring emergency Intramuscular (IM) and Intravenous (IV) administration of Versed (a medication used to treat severe seizures), was transferred to the emergency room with critical laboratory values and subsequently transferred to a tertiary care facility where he was admitted to the neurological intensive care unit (ICU). This affected one (#76) of six residents reviewed for receiving medications and treatment for change in condition. This facility identified six current residents (#05, #17, #21, #30, #42, and #48) who have seizure and convulsant disorders. The facility census was 75. On 11/26/24 at 1:15 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 11/14/24 when Resident #76 was admitted to the facility with diagnoses including epilepsy with unspecified convulsions, did not receive his prescribed seizure medications as ordered and subsequently began having seizures, which ultimately resulted in Resident #76 having to be transported to the emergency roiagnom on [DATE] via emergency medical services (EMS), requiring 5 milligrams (mg) of IV Versed and 5 mg of IM Versed during this transportation. Upon arrival at the hospital, it was documented that Resident #76 had critically elevated laboratory (lab) test results from not receiving physician ordered medications and continually having untreated seizure activity. Review of the emergency department (ED) physician notes revealed the elevated lab values are due to Resident #76's persistent seizures. It is further documented that Resident #76's Valproic acid level (the laboratory test utilized to determine the therapeutic dosage range or blood, plasma, or serum concentration usually expected to achieve desired therapeutic effects) of Depakote (divalproex sodium) was 21 micrograms liters (mcg/l). The therapeutic level for Valproic acid is 50-100 mcg/l indicating that Resident #76's Depakote level was subtherapeutic (less than therapeutic). Upon evaluation of Resident 76's clinical presentation and laboratory findings, it was determined that Resident #76 needed to be transferred to another hospital where he would be admitted into the neurological ICU for further evaluation and treatment of his persistent tonic-clonic seizures. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediate Jeopardy was removed on 11/26/24 when the facility implemented the following corrective actions: On 11/16/24 at 1:40 A.M., Resident #76 was transferred to the hospital for seizure like activity. On 11/19/24, upon review of the medical record, the DON identified that Resident #76 did not receive his scheduled Lyrica, lacosamide and Risperdal. A self-imposed plan of correction (SIPOC) was completed on this date. SIPOC included review of resident charts who had been admitted within the last 30 days by the DON/Designee, to ensure all physician's orders were transcribed correctly and are administered per order, and all resident medications are available to be administered at the facility. Facility nurses were educated by the DON/designee regarding medication order transcription as well as documentation of medication administration, including medications not available and on order from pharmacy, physician notification, and alternate medication administration and representative (RP) notifications. On 11/19/24, the Medical Director was notified via AD Hoc Quality Assurance Review. Review of processes for medication transcription, medication administration and notification of medications not available to physicians and RP. The Medical Director found these items to be appropriate and to proceed with staff training. On 11/19/24, the DON completed education to all licensed nurses regarding admission order transcription and obtaining medications from the pharmacy. On 11/19/24, all residents admitted within the last 30 days were reviewed by the DON and/or the Assistant Director of Nursing (ADON), to ensure all orders were transcribed accurately and all medications were available for administration and no discrepancies were identified. Beginning 11/19/24, the DON/Designee will complete a comprehensive medication order review of all admissions/readmissions within 24 hours to verify accuracy of order transcription and availability of medication for administration. Since 11/19/24, the facility has had three admissions (Resident #40, Resident #72, and Resident #75), and all medication orders were audited to be accurate and ensure medication availability. New admissions and readmissions will continue to be reviewed for transcription accuracy and availability of medications for 4 weeks and reviewed with Quality Assurance and Performance Improvement (QAPI) for compliance. On 11/25/24, education was initiated by Staff Development Coordinator (SDC) #158 with licensed nurses on Seizures: Clinical Protocol, Assessment and Recognition. On 11/26/24, an Ad hoc Policy Review was held with the Administrator, DON, Regional Director of Clinical Services (RDCS) #103, and the Medical Director to confirm the systems implemented and reviewed on 11/19/24 to ensure that residents receive medications as ordered by the physician and to meet their total care needs. Policies reviewed were Admission Assessment and Follow Up: Role of the Nurse, Reconciliation of Medications on Admission, Administering Medications, Change in Resident's Condition or Status, and the procedure for obtaining medications from pharmacy if not available. No changes were made, and policies and processes remain appropriate. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/26/24, the DON and the ADON verified all prescribed medications for current residents have been transcribed accurately. Current orders were verified for all residents with no discrepancies identified. On 11/26/24, all residents were assessed by the DON, the ADON, and/or Infection Preventionist (IP) Registered Nurse (RN) # 176. Four residents were noted to have a change in condition and physicians/physician assistants were notified per policy and orders received as indicated. Seventy residents remained at their medical baselines. On 11/26/24, all licensed nurses were re-educated by the DON and/or SDC #158 on the policies and procedures for Admission Assessment and Follow Up: Role of the Nurse, Reconciliation of Medications on Admission, Administering Medications, Change in Resident's Condition or Status, and the procedure for obtaining medications from pharmacy if not available. Previously initiated seizure education was also completed at this time. Education to include 13 licensed nurses. Agency staff will be educated upon arrival for and prior to their scheduled shift. All newly hired licensed nurses will be educated at the time of orientation. On 11/26/24, an Ad hoc Resident Council meeting was held with Activities Director #115 and the DON to review the process for obtaining medications and change in resident condition notification. Residents #04, #13, #09, #71, and #74 were in attendance. There were no concerns verbalized during the resident council meeting regarding policies shared and information reviewed, and residents were appreciative of the information. Beginning on 11/26/24 the DON/Designee will complete a comprehensive medication order review of admission/readmission charts within 24 hours of admission/readmission. Medication orders will be verified for accurate transcription and implementation of medications, and proper medication administration of ordered medications. The DON/Designee will complete ongoing auditing of medical records to ensure changes in condition are reported per policy. Ad hoc education will be completed as indicated. Beginning on 11/26/24, admission and readmission orders will be reviewed for transcription and receipt of medications from pharmacy for 4 weeks and reviewed by QAPI for continued compliance. Review of all resident medication availability and administration will continue 5 times/week for 4 weeks with QAPI review for compliance. Interviews on 11/26/24 with Licensed Practical Nurse (LPN) #133 and LPN #143, revealed they had all been educated on medication borrowing, the procedure for new resident admissions, reconciling orders with the provider for new admissions, process and procedure for if a medication is not available, and medication misappropriation. Review of facility education, dated 11/26/24, revealed all 13 licensed nurses were re-educated by the DON and/or SDC #158 on the policies and procedures for seizure assessment, Admission Assessment and Follow Up: Role of the Nurse, Reconciliation of Medications on Admission, Administering Medications, Change in Resident's Condition or Status, and the procedure for obtaining medications from pharmacy if not available. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Although the Immediate Jeopardy was removed on 11/26/24, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the electronic medical record for Resident #76 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included epilepsy, athetoid cerebral palsy, thrombocytopenia, unspecified protein-calorie malnutrition, unspecified convulsions, hypothyroidism, obstructive sleep apnea (OSA), dysphagia, hypomagnesemia, personal history of other diseases of the nervous system and sense organs (eyes, ears, nose, tongue and skin), cervical idiopathic scoliosis, congenital non-neoplastic nevus, and constipation. Due to the short duration of admission for Resident #76, there was no Minimum Data Set (MDS) assessment data available. Review of the discharge paperwork from the hospital for Resident #76 dated 11/14/24 revealed discharge medications to treat seizure activity including: clobazam oral tablet 10 milligram (mg), 1 tablet by mouth two times a day, for seizures; carbamazepine extended release (ER) oral tablet 12-hour 100 mg, 3 tablets by mouth two times a day, for seizures; divalproex sodium ER oral tablet 24-hour 500 mg, give 1 tablet by mouth two times a day, for seizures; lacosamide oral tablet 200 mg, give 1 tablet by mouth two times a day, for seizures; levetiracetam oral tablet 500 mg, 3 tablets by mouth two times a day, for seizures; pregabalin oral capsule 200 mg, 1 capsule by mouth two times a day, for seizures; pregabalin oral capsule 300 mg, 1 capsule by mouth two times a day, for epilepsy and risperidone oral tablet 2 mg, 1 tablet by mouth in the morning, for personal history of other diseases of the nervous system and sense organs. Valtoco (diazepam) 15 mg dose nasal liquid therapy pack 7.5 mg/0.1 milliliter (ml) was discontinued upon discharge from the hospital. Review of the admitting physician orders dated 11/14/24 included medication orders for: lacosamide oral tablet 200 mg, give 1 tablet by mouth two times a day, for seizures; carbamazepine ER oral tablet extended release 12-hour 100 mg, give 1 tablet by mouth twice a day, for seizures; clobazam oral tablet 10 mg, give 1 tablet by mouth two times a day, for seizures; divalproex sodium ER oral tablet extended release 24-hour 500 mg, give 1 tablet by mouth two times a day, for seizures; levetiracetam oral tablet 500 mg, give 3 tablets by mouth two times a day; and lactulose solution 20 gram/30 milliliters gm/ml, give 30 ml by mouth before meals, for supplement. Review of physician orders dated 11/15/24 revealed medication orders for: Valtoco 15 mg dose nasal liquid therapy pack 7.5 mg/0.1 ml, 1 spray in each nostril as needed (PRN) for seizures; lacosamide oral tablet 200 mg, give 1 tablet by mouth two times a day, for seizures; carbamazepine ER oral tablet extended release 12-hour 100 mg, give 1 tablet by mouth twice a day, for seizures; risperidone oral tablet 2 mg, give 1 tablet by mouth in the morning, related to personal history of diseases of the nervous system and sense organs; pregabalin oral capsule 200 mg, give 1 capsule by mouth two times a day, related to epilepsy; pregabalin oral capsule 300 mg, give 1 capsule by mouth two times a day, related to epilepsy; valium oral tablet 5 mg, give 5 mg by mouth PRN for anxiety/agitation for 14 days at HS/PM (bedtime) daily. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the medication administration record (MAR) revealed the following medications were scheduled to be administered: risperidone was scheduled to start on 11/16/24 at 7:00 A.M., and was discontinued on 11/17/24 at 2:54 P.M. There were no doses recorded as being administered. lacosamide was scheduled to start on 11/14/24 at 3:00 P.M., and was discontinued on 11/15/24 at 6:59 A.M. , with no doses administered. Another order for lacosamide was scheduled to start on 11/15/24 at 7:00 A.M., and was discontinued on 11/17/24 at 2:54 P.M. There were no recorded doses administered. pregabalin 200 mg and the 300 mg doses were scheduled to start on 11/15/24 at 3:00 P.M., and were discontinued on 11/17/24 at 2:54 P.M. There were no recorded doses administered. Valtoco 15 mg, administer 1 spray in each nostril as needed (PRN) for seizure was scheduled to start on 11/15/24 at 5:45 A.M., and was discontinued on 11/17/24 at 2:54 P.M. There were no recorded doses administered. carbamazepine ER oral tablet extended release 12-hour 100 mg, 1 tablet by mouth two times a day, for seizures. Documented as being 100 mg being administered on 11/14/24 evening dose, and 11/15/24 morning and evening dose. diazepam oral tablet 5 mg, give 5 mg by mouth as needed (PRN) for anxiety/agitation for 14 days at HS (bedtime)/PM daily. This order began on 11/15/24 at 5:30 P.M., and was discontinued on 11/17/24 at 2:54 P. M. There were no recorded doses administered. Review of the discharge paperwork for Resident #76 revealed an order for carbamazepine ER oral tablet extended release 12-hour 100 mg for three tablets (300 mg) to be taken by mouth two times a day, for seizures. Review of the progress note for Resident #76 dated 11/14/24 at 8:39 P.M., revealed the lacosamide oral tablet 200 mg was not available. Review of the progress note for Resident #76 dated 11/15/24 at 7:52 A.M., revealed the ergocalciferol oral tablet was not available and pharmacy will send out. Review of the progress note for Resident #76 dated 11/15/24 at 7:53 A.M. revealed the lacosamide oral tablet 200 mg was not available, the pharmacy was notified and will send out. Review of the progress note for Resident #76 dated 11/15/24 at 6:30 P.M., revealed the pregabalin oral capsule 300 mg was on order. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note for Resident #76 dated 11/15/24 at 6:40 P.M., revealed the resident was up in the wheelchair 3 times this shift. Increased anxiety noted during the morning and afternoon. Co-nurse (unidentified nurse working in facility) called the resident's mother to inform her of the resident's increase in agitation and anxiety. The resident was moving and turning in the wheelchair and staff had to keep repositioning the resident several times this shift. The resident's mother brought in the resident's wheelchair from home which was better for the resident. The resident's mother stated the resident was having a seizure. The writer observed resident moving backward and forward in a slow but steady position. Review of a progress note dated 11/15/24 at 6:54 P.M., documented by LPN #100, revealed the nurse called the pharmacy to check on the resident's lacosamide, nasal spray for seizure and the spray has diazepam in it. The pharmacy stated they didn ' t have the order and needed a C2 form or prescription. The writer updated management of the resident's status and received the C2 form for Valtoco 7.5 mg/ 0.1 ml from the physician and also received a new order for diazepam 5 mg at HS or evening for agitation and anxiety for 14 days until he can be seen or evaluated by a neurologist. All forms were faxed to the pharmacy. Review of the progress note for Resident #76 dated 11/16/24 at 1:24 A.M., revealed a change of condition was noted with this resident and he was seizing. At this time the facility called the physician and received an order to send Resident #76 to the emergency room . Review of a progress note for Resident #76 dated 11/16/24 at 7:11 A.M., revealed Resident #76 was sent to the ER for seizure activity on the previous shift. Review a progress note dated 11/16/24 at 12:15 P.M., written by Registered Nurse (RN) #160, revealed Resident #76 was sent to the emergency room for seizure activity on the previous shift. Further review of the medical record revealed no evidence of the physician being notified of Resident #76 not receiving medications as ordered or seizure activity until 11/16/24 at 1:24 A.M. Review of the emergency medical squad (EMS) patient care record for Resident #76 dated 11/16/24, revealed the first contact documented between EMS and Resident #76 was at 12:51 A.M. At 12:52 A.M., oxygen 2 liters per minute (lpm) was applied to Resident #76 via a nasal cannula (a small, flexible tube that contains two open prongs intended to sit just inside the nostrils) and an intravenous (IV) was started in his right hand. At 12:54 A.M., 2.5 mgs of Versed (a medication used to stop a seizure that has gone too long or if many seizures occur in a short period of time) was administered intramuscular (IM). At 12:58 A.M., Resident #76 was secured to the stretcher for transport. At 1:01 A.M., 2.5 mg of Versed was administered IM. At 1:07 A.M., Resident #76 received 150 ml of normal saline (NS) through his IV. At 1:09 A.M., 2.5 mgs of Versed was administered IV to Resident #76. At 1:13 A.M., 2.5 mgs of Versed was administered IV to Resident #76. At 1:20 A.M., Resident #76 arrived at the emergency room via ambulance and was transferred from the ambulance to the hospital cot. Review of the emergency department (ED) physician notes dated 11/16/24 at 1:40 A.M., revealed Resident #76 continued to have tonic-clonic seizures upon arrival to the ED, despite the interventions provided by EMS. The facility indicated Resident #76 did not have his medications since arrival to the facility as they did not have access to his medications. Due to the condition of Resident #76, the ED physician requested staff to prepare for possible intubation (inserting a tube into the airway to establish an airway for mechanical ventilation). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the ED physician notes dated 11/16/24 at 2:20 A.M., revealed Resident #76 had a critically elevated Myoglobin level (test for muscle damage) of 745.7 micrograms per liter (mcg/l), with a normal value range of 5-70 mcg/l; a critically elevated creatine kinase (CK) level (test to evaluate muscle damage) of 544 units per liter (U/l) with normal value range of 24-204 U/l; an elevated Troponin I (test of a protein found in cardiac and skeletal muscles that help regulate calcium-mediated muscle contractions and relaxation) of 10 nanogram per milliliter (ng/ml) with normal value range of 0.0-0.4 ng/ml; and a critically elevated Lactate level (by product of the body's normal metabolism and exercise. Blood lactate can increase during intense physical activity) of 5.5 millimoles per liter (mmol/l) with normal value range of 0.5-1 mmol/l. These elevated lab values are due to Resident #76's persistent seizure. Resident #76's Valproic acid level (the laboratory test utilized to determine the therapeutic level of Depakote (divalproex sodium) was 21 mcg/l. The therapeutic level for Valproic acid is 50-100 mcg/l indicating Resident #76's Depakote level was subtherapeutic. Upon evaluation of Resident 76's clinical presentation and laboratory findings, it was determined Resident #76 needed to be transferred to another hospital where he would be admitted into the neurological ICU for further evaluation and treatment of his persistent tonic-clonic seizures. Review of the ED Physician Notes date 11/16/24 at 2:53 A.M., revealed the ED physician initiated a transfer to a tertiary care facility for admission to the neurological ICU for further care and treatment. Interview on 11/25/24 at 11:50 A.M. with the DON revealed the order for lacosamide was changed and not obtained because the physician had not sent the order to the pharmacy. The DON verified no doses of lacosamide was administered during Resident #76's admission. The DON verified Resident #76 did not receive any of the ordered pregabalin due to the orders were not entered immediately upon admission as it was on the third page of medication orders the facility received from hospital. The facility staff did not see the third page of orders until the morning of 11/15/24 during the 24-hour admission check and were subsequently entered at 7:26 A.M., with the first scheduled administration to occur on 11/16/24 at 7:00 A.M. The DON verified the Valtoco nasal spray was ordered to be restarted by the facility physician on 11/15/24 at the request of Resident #76's mother. The DON stated the physician, or facility should have faxed a prescription for this medication to the pharmacy at this time, but there is no record of the physician or facility faxing a prescription to the pharmacy for this medication. The DON verified the physician was not notified of pregabalin was not administered as ordered and not scheduled to be administered until 11/16/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 11/25/24 at 1:32 P.M., with Resident #76's mother revealed she had been the primary care provided to Resident #76 for the entirety of his life, but his increasing care needs necessitated seeking a facility to provide the additional care he required. She stated on 11/14/24, upon his discharge from the hospital, she provided transportation to the facility via a private car. Upon arrival at the facility, she gave the admitting nurse a folder which contained a face sheet, Resident #76's discharge paperwork with orders, 12 tablets of clobazam 20 mg, and a bottle containing an unidentified quantity of carbamazepine 100 mg tablets. Resident #76's mother stated she spoke to the admitting nurse for approximately one hour to ensure that all items needed for admission were complete. Resident #76's mother stated she informed the facility she was willing to provide medication from home for Resident #76 to ensure that he had all necessary medications, but was assured by the facility that the pharmacy would have all of Resident #76's medications. Upon returning to the facility later in the evening on 11/14/24, Resident #76's mother asked the facility nurse if he had received all of his medication, and she was told he did. Resident #76's mother states that on the morning on 11/15/24, the facility called and asked her to provide Resident #76's personal wheelchair as he appeared to be uncomfortable in the facility wheelchair. Upon her arrival to the facility at approximately 1:30 P.M., she noted Resident #76 was seizing and appeared to have been up all night. At this time, Resident #76's mother notified facility staff. Upon noting Resident #76's seizure activity, his mother inquired from the nursing facility staff if he had received his seizure medications, and she was again assured that he had. At this time, she requested his PRN Valtoco nasal spray be administered. Per Resident #76's mother, the facility staff told her that the medication was not at the facility. Resident #76's mother stated she would go home and retrieve it from there and facility nursing staff replied that it would be faster if the facility pharmacy supplied it. Resident #76's mother stated she waited for the medication to arrive for one hour and at that time she left the facility and went home to obtain the medication. Upon returning to the facility with the Valtoco 15 mg Dose Nasal Liquid Therapy Pack 7.5 mg/0.1 ml, Resident #76's mother stated she administered it to him. Resident #76's mother stated she received a telephone call on 11/16/24 at approximately 1:10 A.M. from the facility and was told the facility had called 911 to transport Resident #76 to the emergency room (ER) due to Resident #76 seizing uncontrollably. She stated the facility told her they had administered two doses of Valium overnight on 11/15/24 into 11/16/24. She stated she arrived at the ER prior to the arrival of Resident #76 and was taken back to await his arrival. She stated that upon arrival to the ER, Resident #76 was seizing uncontrollably. Review of a text message dated 11/25/24 at 3:50 P.M. sent from LPN #100 to the DON stated: To whomever is concerned in regard to Resident #76's Valtoco, seizure medication was not available. This nurse called the pharmacy and inquired about medication. Pharmacy technician stated need C2 form. This nurse received a C2 form from the DON and faxed the order to the pharmacy. This nurse explained to the resident's mom that it would take a while before the pharmacy brings medication. Resident#76's mom stated that he had a dose or 2 at home and that she would bring it in. This nurse received a call from the receptionist stating that the resident's mom had returned with medication. This nurse spoke with Resident #76's mom, and she stated, this is Resident #76's last dose. Resident #76's mom gave resident the Valtoco medication, and resident was calm and up in his wheelchair for supper and no distress noted. The medication was effective. The pharmacy received an order, and the medication order was being prepared. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 11/25/24 at 4:16 P.M. with the DON revealed Resident #76 received no doses of Risperidone during his admission. Concurrent interview with the DON revealed this medication order was not entered immediately upon admission as it was on the third page of medication orders the facility received from the hospital upon Resident #76's admission and it was missed by the facility until the morning of 11/15/24 during the 24-hour admission check and entered at 7:26 A.M. with the first scheduled administration to occur on 11/16/24 at 7:00 A.M. Further interview with the DON revealed Resident #76 received no doses of Risperidone during his admission. The DON stated that LPN #100 stated to her that the mother of Resident #76 brought in his Valtoco and administered it herself. Interview on 11/26/24 at 10:45 A.M. with the DON revealed she was not aware of any communication between the facility and the physician between the afternoon hours on 11/15/24 and approximately 1:00 A.M. regarding the change in condition of Resident #76. Interview on 11/27/24 at 7:32 A.M. with the DON verified the dose discrepancy for carbamazepine between the facility order for 100 mg by mouth twice a day, for seizures, and the hospital discharge order for three 100 mg (300 mg) by mouth twice a day for seizures. The DON verified Resident #76 did not receive the physician ordered amount of carbamazepine. Interview on 11/27/24 at 9:25 A.M. with the DON verified Resident #76 received no doses of diazepam during his admission. Review of the policy titled, Seizures and Epilepsy - Clinical Protocol, with a revision date of September 2018, revealed the physician and staff will help identify individuals who have a history of seizure or epilepsy. Seizures and epilepsy are not identical. Review of the policy titled, Delivery and Receipt of Routine Deliveries, dated 12/01/07, revealed the pharmacy and facility should coordinate to determine delivery day(s) and time(s) as soon as possible. Review of the policy titled, Change in a Resident's Condition or Status, revised May 2017, revealed the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. Review of the policy titled, Admission Assessment and Follow Up: Role of the Nurse, revised September 2012, revealed the facility will reconcile the list of medications from the medication history, admitting orders, the previous MAR (if available), and the discharge summary from the previous institution, according to established procedures. Review of the policy titled, Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH001160040.