STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676167	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckner Westminster Place	2201 Horseshoe LN Longview, TX 75605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 2 of 3 residents reviewed for pharmacy services (Resident #'s 1 and 2). 1.The facility failed to provide 7 (daily) doses of Resident #1's physician ordered Enoxaparin/Lovenox (a blood thinner to prevent blood clots) between the dates of 2/15/24 - 2/21/24. 2.The facility failed to provide 11 (weekly) doses of Resident #2's physician ordered Bydureon (treats Type 2 Diabetes and controls blood sugar levels) between the dates of 12/11/23 - 2/13/24. 3.Staff falsified documentation indicating they had administered Lovenox for Resident #1 and Bydureon for Resident #2 when those medications were not available in the facility. An Immediate Jeopardy (IJ) situation was identified on 5/8/24 at 1:30 PM. While the IJ was removed on 5/9/24 at 1:21 PM, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of inaccurate drug administration, not receiving the intended therapeutic levels of MD ordered medication, and not having accurate records of medication administration which could result in diminished health and well-being. Findings included: 1.Record review of the undated face sheet for Resident #1 indicated she was an [AGE] year old female that admitted [DATE] with diagnoses that included: fracture of right femur (broken hip), venous insufficiency (improper functioning of the valve veins), chronic peripheral hypertension (abnormality in the capillaries within the leg tissues that make them more permeable-allowing fluid, proteins, and blood cells to leak into the tissues), and peripheral vascular disease (reduced blood flow to the limbs). Record review of physician's orders for Resident #1 indicated: (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

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1/31/24 Enoxaparin 30mg/0.3ml subcutaneous syringe (0.3 mls) syringe one time daily starting 2/1/24. Record review of a physician's note dated 1/25/24 indicated: Lovenox x 21 days, start 2/1/24. At increased risk of deep vein thrombosis . Record review of the Admission MDS assessment dated [DATE] indicated Resident #1 had clear speech, understood others, and was understood by others. She had a BIMS of 14 indicating she was cognitively intact. The MDS indicated she had 7 injections during the 7-day lookback period. Record review of the undated care plan indicated Resident #1 was at risk for bleeding due to Lovenox (generic name, Enoxaparin) use. The goal was Resident #1 not developing an embolism post operatively or having adverse consequences of treatment. Interventions included: Notify MD of concerns, monitor for signs of embolism, monitor for bruising or bleeding, administer Lovenox per MD orders. Resident #1 had PVD with the goals: skin on her feet/legs would remain intact over the next 90 days and interventions were to check her feet and legs for redness, skin tears, swelling, or pressure areas daily. Report any signs of skin breakdown. Record review of the Provider Investigation Report for Resident #1, dated 3/6/24 with an incident date of 2/26/24 indicated during a chart audit, the DON discovered Enoxaparin (Lovenox) had been documented as given to Resident #1 but Enoxaparin had not been refilled by the pharmacy. The DON assessed Resident #1 and indicated she had a negative Homan's Sign (no pain in the calf muscles on forced dorsiflexion (toes in the upward direction), of the foot with the knee straight), no bruising, no s/s of abnormal bleeding, no pain, no discomfort, or tenderness at calves. No swelling to bilateral lower extremities. The DON indicated there were no adverse effects to Resident #1. The DON indicated that LVN A, RN B, MA C, and MA D had been terminated and all staff would be in-serviced on documentation and falsifying documentation. The PIR indicated statements received from RN B indicated she had given the medication as ordered. MA C stated that when LVN A worked he told her to document the injection was given, but she had never seen him administer the medication. The MAR showed documentation Enoxaparin had been administered to Resident #1 2/15/24 - 2/26/24, but documentation from the pharmacy showed the medication was never refilled after the first 14-day supply. Record review of the MAR dated February 2024 indicated Resident #1 had received Enoxaparin 30mg/0.3 ml subcutaneous syringe (0.3 mls) one time daily starting 2/1/24. (Order date 1/31/24) 2/1/24 through 2/27/24. Record review of a pharmacy slip dated 1/31/24 indicated Resident #1 had received Enoxaparin injections 30/0.3 ml. The quantity indicated was 4.20 (no unit of measure was indicated). Record review of a pharmacy slip dated 2/27/24 indicated Resident #1 had received Enoxaparin injections 30/0.3 ml. The quantity was indicated to be 3.00 and 1.20 (no unit of measure was indicated). 2.Record review of the undated face sheet for Resident #2 indicated she admitted [DATE], was an [AGE] year-old female with diagnoses that included: Transient Cerebral Ischemic Attack (a brief stroke resolving within minutes to hours), Diabetes Mellitus Type 2 with hyperglycemia (the body has trouble controlling sugar and it builds in the bloodstream), hypertension (high blood pressure-when the pressure in your blood vessels is too high), old Myocardial infarction (heart attack), and peripheral vascular disease (reduced blood flow to the limbs). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the significant change MDS assessment dated [DATE] indicated Resident #2 had clear speech, understood others and was understood by others. The MDS indicated she had not received any injections in the 7-day look back period. Record review of the Annual MDS dated [DATE] indicated Resident #2 had a BIMS score of 13 indicating her cognition was intact. The annual MDS indicated she had received 1 injection (of any type) in the 7-day lookback period and 1 insulin injection in the 7-day lookback period. Record review of the care plan dated 3/23/24 indicated Resident #2 had diabetes and would receive labs and finger sticks per MD orders, monitor for signs or symptoms of hyperglycemia, and administer medications per MD orders. Record review Resident #2's MAR for December 2023 indicated she had received her Bydureon 12/11/23, 12/18/23, and 12/25/23. Record review of Resident #2's MAR for January 2024 indicated she had received her Bydureon 1/1/24, 1/8/24, 1/15/24, 1/22/24, and 1/29/24. Record review of Resident #2's Mar for February 2024 indicated she had received her Bydureon 2/5/24 and 2/12/24. Resident #2 was not available for interview. Record review of the physician's orders for Resident #2 indicated: 1/7/23 Bydureon BCise 2mg/0.85 ml subcutaneous auto-injector, 2 mg, SQ every Saturday. Shows a d/c date of 2/2/23 . 2/27/24 Completed order for Bydureon BCise 2mg/0.85 ml subcutaneous auto-injector, 2 mg, SQ every Saturday. Record review of pharmacy slips from Resident #2's personal pharmacy indicated Bydureon, BC injection 2mg/0.85 ml was filled 11/9/23. The next fill date for her Byuydureon was 2/26/24. Record review of the Provider Investigation Report for Resident #2, dated 3/6/24 indicated an incident date of 2/27/24 when Resident #2's family member stated she did not believe Resident #2 was receiving her Bydureon injection as prescribed. Physician notified, no negative effects to the resident. The DON indicated that LVN A, RN B, MA C, and MA D had been terminated and all staff would be in-serviced on documentation and falsifying documentation. On 2/27/24 Resident #2's family member indicated her Bydureon prescription had not been refilled since 11/9/23 from the pharmacy. The MAR indicated all doses had been administered. The DON called the pharmacy and found out the last fill date for the medication was 11/9/23 and four injections came in a box (28-day supply). LVN A and RN B gave statements that the medication was in the facility even though the last fill date was 11/9/23. The facility pharmacy was also contacted to see if they had filled the Bydureon for Resident #2 and they had not. Resident #2 got her medication from her personal pharmacy. Resident #2's lab work on 11/13/23 showed her hbgA1C to be within normal limits. Her blood sugar was taken 3 times per week and had been within normal limits 11/3/23 - 2/12/24. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an in-service dated 2/29/24 on Charting and Documentation indicated: Falsifying documentation is prohibited and will not be tolerated at [name of facility]. If a medication is given by you, please make sure you are documenting accordingly. Furthermore if you do not give a medication, you should never document that it has been given and always specify in your documentation the reason why medication was unable to be administered. Nurses should always be aware of what their scope of practice is regarding medication administration and know what should and should not be delegated to medication aides/CMAs to administer and document. Service Standard: All services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record is primarily electronic; however, there may be some manual documents that are uploaded into the record. 1.The following information is to be documented in the resident's medical record: a.Objective observations; b.Medications administered; c.Treatments or services performed; d.Changes in the resident's condition; e.Events, incidents, or accidents involving the resident; f.Progress toward or changes in the care plan goals and objectives. 2.Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. 3. Entries may only be recorded in the resident's clinical record by licenses personnel (e.g., RN, LVN, physician's, therapists, social workers, administrator, etc.) in accordance with state law and BRS service standards . 9.Documentation of procedures and treatments will include care-specific details, including: a.The date and time the procedure/treatment was provided; b. Name and title of the individual(s) who provided the care . g.Signature and title of the individual documenting. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 5/7/24 at 8:55 AM, Resident #1 was in EBP due to a wound on her heel. She was in her wheelchair in her room. She said it had been a while since she got shots in her tummy. She said she did not remember a man giving her shots in her tummy but said she did not remember anything when she had Covid. She said no one at the facility ever told her they were out of any of her medication. She said she did not remember how often she got shots in her tummy but did not think it was every day. She said she thought she got all her medication when she was supposed to. She said she did not get any type of shots now. During an interview on 5/7/24 at 9:07 AM, LVN E said she had worked at the facility 3-4 weeks. She said if a resident ran out of medication she would pull that medication from the e-kit. She said whatever nurse saw that a resident's medications were low was responsible to reorder the medications. She said that nurse did not need to tell the DON or ADON about it, just to reorder it. She said if a resident had missed a medication and she realized it she would notify the MD, ADON, and DON to report it. She said she gave injectable medications and the only resident that got injectable medication at this time was Resident #3. She said Resident #3 got Lovenox and Insulin daily. LVN E said when his medication got low, she would reorder it. She said the pharmacy would not refill a medication if it was more than 3 days so she waited until she had 3 days left of the medication to reorder. She said it was the nurse's responsibility to take care of that. She said there were no longer MA's in the building. She said she would never ask a MA to document what she had done/medication she had given. LVN E said she documented what she had administered. She said it was outside of the scope of a MA to document or give Lovenox or any injectable. She said she did not work at the facility when Resident #1 or Resident #2 missed their medications. During an interview on 5/7/24 at 9:21 AM, the Interim ADON said she used to worked Friday through Sunday. She said for the last week she had been the Interim ADON and now worked during the week, Monday through Friday. She said the nurse that ran out of medication or noticed it was low was responsible for reordering it and that nurse did not need to notify anyone. She said if that nurse did not reorder the medication and did not give the medication it would be that nurse's fault and her responsibility. She said they had to trust that their nurses were doing what they were supposed to do. She said she was not aware of Resident #1 and Resident #2 missing their medications. She said the only documentation of reordering medications was what they scanned to the pharmacy when the reorder sticker off of the label of the medication (from the pharmacy), was faxed to the pharmacy. She said after that paper was faxed she was not sure where it went or where it was kept. She said she had a few in her office. She said she thought there was a book for the pharmacy reorders, but she would have to ask where the book was located. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 5/7/24 at 10:12 AM, MA C said LVN A would tell her to document he had given the injectable medication, to Resident #1 and Resident #2. She said she told the ADON (at the time, currently the DON) and said the ADON told her it was alright to do that, as long as the nurse gave her the verbal okay that they (the nurse) had given the medication. She said the DON used to be the ADON and that was who she had talked to about it. She said RN B would document when she gave injections to Resident #1 and Resident #2 herself. She said RN B did not ask her to document for her. She said she would mark injections (on the MAR) that were given by RN B sometimes because she physically saw RN B give the medication. She said she never saw LVN A give an injection to Resident #1 or Resident #2. She said LVN A just told her he had given the injections and she had no reason to doubt him. She said Resident #1 never ran out of her Lovenox injections that she knew of. She said Resident #1's shots were in the locked top drawer of her dresser with her scheduled medications. She said the resident's medications were kept locked in their room in the dresser drawer. She said she never dealt with either Resident #1 or Resident #2's injections. She said she was not asked to reorder the medications for either Resident #1 or Resident #2. She said both LVN A and RN B were good to reorder medications if a resident ran out of medications. She said Resident #2's injection was given once a week and she thought they ordered those in bulk. She said sometimes she would accidentally mark off the injections were given by going down the medications due list because the injections were on the MAR. She said she and MA D had talked to the ADON (currently the DON) and told her they were accidentally marking off injections for Resident #1 and Resident #2. She said the ADON told them to try their best not to do that, but if they did to get with that nurse make sure the nurse had given the injection medications. She said neither Resident #1 nor Resident #2 ran out of their injections. She said she did not know why the nurses would document they had given medications that were not in the building. She said she guessed that was why she was fired. She said she wrote a statement for the facility and then she was fired. During an attempted phone interview on 5/7/24 at 10:26 AM, called MA D. Her voice mail was full. Sent a text message. No return call was received. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/7/24 at 10:58 AM, the DON said she was the ADON before she was the DON. She said she was ADON [DATE] to [DATE]. She said February 2024 she started as DON. She said MA's were documenting that they were giving injections when they were not. She said they were not supposed to do that. She said it was not in their scope of practice. She said according to the statements from the MA's the nurse or nurses were asking them to document that injectable medications were given. She said MA C told her at one time that the injections showed up on the MAR instead of the TAR, and it was easy for them to accidentally mark it off. She said she told MA C it was the nurse's responsibility, and MA's should not be checking off an injection given on the MAR. She said MA C only discussed that with her once. She said she never told MA C if a nurse told her to mark off an injection that she could. She said she would never tell an MA that. The DON said according to the statement MA C wrote, LVN A was asking her to check off that he had given the injections to Resident #1 and Resident #2. She said when she questioned LVN A during the investigation he told her he documented the injections he had given to Resident #1 and Resident #2 in the MAR. She said she had not asked him about documenting prior to the investigation because she had no reason to. She said she would not know if a medication was low or out, and not reordered unless the nurse brought it to her attention. She said she thought Resident #2 was on a cycle fill at her personal pharmacy which meant the Bydureon medication automatically came without a need to reorder. She said the pharmacy later apologized when they realized Resident #2's Bydureon was not on a cycle fill and the medication had not been refilled. She said when MA C was writing a statement regarding Resident #2 she said something about Resident #1's medication in her statement, so they began looking at Resident #1's Lovenox medication during their investigation. The DON said the process at that time (November 2023 - March 2024) for reordering injections was the nurse was responsible for it because they administered it. She said if it was a medication an MA administered, then the MA was responsible for reordering it. She said the ball was dropped but she was not sure where. She said as a nurse, the nurse was responsible for their MAR and TAR regarding medications they administered. She said she believed RN B and LVN A were giving all ordered the injections to Resident #1 and Resident #2, but were not always documenting that they did. She said she believed LVN A and RN B were lying about giving the injections to Resident #1 (Lovenox) and Resident #2 (Bydureon) at the times when the medications were not in the building. She said there was no way the medications could have been in the building on certain dates for both residents. She said she called the facility pharmacy for Resident #1 and she called Resident #2's personal pharmacy and neither pharmacy had filled the medications at the times they reported in their investigations. She said she had no idea why LVN A or RN B would have documented they gave an injection that they could not have given. She said the new process and changes they had made for ordering medications was the facility did not employ MA's anymore. LVN A, RN B, MA C, and MA D had been terminated. She said all injections/medications given by nurses only, had been moved to the TAR instead of MAR. She said in case they later brought MA's back they could not check off or document they had given something on the TAR. She said only the nurses could access the TAR. She said they brought the issue to QAPI and the Medical Director was at the QAPI meeting, was notified and aware of both incidents regarding Resident #1 and Resident #2. She said they did in-services on administering medications, documenting medications that were administered and falsifying documentation. The DON said that was their plan of action going forward to make sure nothing like this ever happened again. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/7/24 at 12:28 PM, the Interim ADM said these investigations (Resident #1 and Resident #2) were all about false documentation. She said staff was documenting they were giving medication that was not in the building. She said because of that no one reordered the medication and that was why everyone involved (LVN A, RN B, MA C, and MA D) was fired. She said staff either had documented they had given medications that were not in the facility or did not give them at the times they were in the facility. She said there were no more MA's in the building and the injections had been moved from the MAR's to the TAR's. During an observation and interview on 5/7/24 at 12:37 PM, LVN E unlocked the dresser in Resident #3's room. He had Enoxaparin 30 mg/0.3 ml. He had 1 box of 10 unopened and 1 pkt of 3. LVN E said he currently had enough medication and when it was time to reorder it she would. During an interview and record review on 5/7/24 at 1:15 PM, the DON and this surveyor reviewed nurses notes in their computer system that indicated Resident #2 went to the hospital 2/13/24 due to signs and symptoms of dehydration. The DON said the hospital admit was unrelated to her missing her Bydureon. She said when Resident #2 went to the hospital her family member came to the facility to pick up her Bydureon medication, realized the box was dated 11/9/23, and one injection was left unused in the box. The DON said Resident #2 had to have missed a dose of her medication sometime between 11/13/23 - 12/4/23 but it was documented she received it. She said there was no Bydureon in the facility 12/11/23 - 2/13/24 . She said she called Resident #2's pharmacy and the pharmacy said they had not refilled it since 11/9/23. The DON said Resident #1 had her Lovenox available in the facility 2/1/24 - 2/14/24. She said Resident #1 had no Lovenox available in the facility 2/15/24 - 2/26/24 . She said the stop date for the lovenox was 2/27/24 and showed this surveyor on the computer program. It was marked completed 2/27/24. She said they did not use discontinued, they used completed when a medication was discontinued or finished. She said initially it did not have a stop date but she called the NP and she had given her a stop date of 2/27/24, which she put in the orders in the computer. She said the MAR for Resident #1's Lovenox was initialed as given 2/15/24 - 2/27/24 but that medication was not available in the building to give. She said LVN A, RN B, MA C, and MA D had worked during that time. She said she did not know if LVN A had asked one of the MA's to mark the Lovenox given for him. She said the MA's did not give that medication but signed off they did sometimes. She said she assessed Resident #1 on 3/7/24 when she realized she had not had her Lovenox, called the MD, NP, and the family. She said the MD and NP did not order any labs but told her to monitor Resident #1 for any adverse effects. During an interview on 5/7/24 at 2:54 PM, The DON said she spot checked at least 4 times per week the initial TAR to make sure medication was documented, checked to see if the medication was in the room, interviewed nurses and residents making sure documentation was correct, and checked injection site(s) on residents. She said this was ongoing and she would be doing it indefinitely at this time or until they were convinced everything was working how it should. The DON provided an in-service dated 2/29/24 titled: Medication Documentation. Falsifying documentation if prohibited and will not be tolerated at [the facility]. If a medication given by you, please make sure you are documenting accordingly. Furthermore, if you do not give a medication, you should never document that it has been given and always specify in your documentation the reason why medication was unable to be administered. Nurses should always be aware of what their scope of practice is regarding medication administration and know what should and should not be delegated to medication aides/MA's to administer and document. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON provided an Action Plan dated 3/6/24 that indicated: Problem: Injections not being given by the nurses, and medication aides documenting that injections have been given. Intervention: Injections moved from the MAR to the TAR Medication Aides terminated, will no longer use medication aides. DON to monitor injections. 4/10/24 Outcome: No issues found with injections. Signed by the Interim ADM The DON provided a QAPI sign in sheet dated 4/10/24 signed by: Interim ADM Medical Director DON EVS (Environmental Services) LVN AL/MC nurse (Assisted Living/Memory Care) Director of Rehab Marketing/Admissions Business Office Manager Executive Director During an interview and observation on 5/7/24 at 3:49 PM, LVN E said she had given Resident #3 his Lovenox this morning. She said he got his insulin in the evening. Observation of his abdomen showed signs of Lovenox injections. (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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 5/8/24 at 7:42 AM, RN B said Resident #2 received Bydureon injections on Mondays. She said she usually would work 2 Mondays in a row then LVN A would work the other 2 Mondays. She said she always gave Resident #2 her Bydureon injection but she did not know if LVN A did, or if it was missed on days she did not work. RN B said Resident #2 did not miss any doses of her Bydureon when she worked. She said there were 2 boxes of Bydureon medication in the refrigerator and those boxes were stuck together. She did not know how many was in each box. She said she never documented she gave a medication that she did not give, and would not do that because that would have been false documentation. She said she never asked either MA C or MA D to document that she had given Resident #2 her injection. She said the MA's would sometimes accidentally mark the Bydureon medication as given when they checked or synced the medications in the computer. She said she did not know if LVN A was giving Resident #1 her Lovenox. She said LVN A was the other nurse that gave Resident #1 her Lovenox. She said she gave Resident #1 her Lovenox every time it was due and did not miss any doses. She said the Lovenox initially was a 30-day supply in a bag and the refill was a 14 day supply in a box. She said Resident #1 did not run out of the Lovenox and she never had to reorder or refill it because it was available. She said she did not look at the date it was filled because she always had the medication to give. During a phone interview on 5/8/24 at 8:09 AM, LVN A said Resident #2 always got her Bydureon injection on Mondays and she always got it when he worked because he gave it to her. He said it did not need to be refilled because it was on an auto-fill and automatically filled on time. He said he was not aware the last fill date on the prescription was 11/9/23. He said the medication was always on hand and he administered it. He said he would never document he gave a medication that he did not give because that would be a medication error. He said the process was the MA would let him know the Bydureon was due, and he would give it. He said that medication was on the MAR not the TAR. He said MA's had access to the MAR but not the TAR. He said he never asked an MA to document he had given an injection or to document anything for him. He said sometimes the MA's would accidentally click on the Bydureon on the computer and it would show they had given it when they had not. He said no one ever asked him if he was giving the medication to Resident #1 or Resident #2. He said it was not correct that there was no Bydureon in the building for Resident #2 12/11/23 - 2/13/24. He said the medication was in the building and he gave it. LVN A said he would have reordered it if it needed to be reordered but it did not because it was an auto-refill. He said he did not remember when he was suspended and did not remember when he was fired but he was not working at the facility the entire time when Resident #1 supposedly had no Lovenox in the building. He said Resident #1 always had Lovenox available in her locked drawer in her room. He said Resident #1 was never out of her Lovenox. He said he would know it if she had been out of that medication. He said it was possible, if the MA did not remind him the medication was due and she had marked it off as given, he may not have given it by mistake. He said he looked at the TAR, not the MAR because the TAR was for the nurses and the MAR was for the MA's. He said he would never have allowed an MA to document a medication he did not give. He said the orders for injections given by the nurses should have been on the TAR, not the MAR. He said that was the problem and the reason this happened. He said there was nothing written that indicated who was responsible to refill a medication. He said when a medication was low the MA usually reordered unless it was an auto-fill. He said there was a book that pharmacy reorders were put in when the MA's pulled a sticker off the medication and faxed it to the pharmacy. He said it was the Pharmacy Book. He said he never talked with the DON about either Resident #1 or Resident #2's medications because he did not see a problem. He said going without Lovenox could be a problem for Resident #1 in that she could get a blood clot. He said missing her Lovenox could cause a lot of health problems for her. He said the Lovenox was given to her to prevent her from getting a blood clot after hip surgery. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 5/8/24 at 9:24 AM, a representative from the facility pharmacy said Resident #1 had Lovenox (Enoxaparin) filled on 1/31/24 which contained 14 syringes, enough for 14 days. He said there were no refills for the Lovenox until 2/27/24. During an interview on 5/8/24 at 9:33 AM, a representative of Resident #2's pharmacy said on 11/9/23 Resident #2 got Bydureon, 4 syringes that would last 28 days. She said the next refill was 2/26/24 also with 4 syringes. During an interview on 5/8/24 at 10:13 AM, the DON said there was a basket at one time and now a drawer where the pharmacy refill sheets were put after they were faxed to the MD (at the nurse's station) but she was not aware of a pharmacy book. She said she checked the basket/drawer at the time of the investigations for Resident #1 and Resident #2 and did not find any refill requests for either of them. She said she did not document she was monitoring Resident #1 regarding missing her lovenox but she was checking her at least daily. She said the numerous orders and discontinue for Resident #2's bydureon was when she was having trouble with the computer and not doing it right. She said there was no written plan or policy/process for reordering medications at that time. During an observation and interview on 5/8/24 at 10:35 AM, the Interim ADON and LVN E were in the nurses' station in building 1. Observed a small shelf next to the computer with a clear plastic container that contained folded packing slips from the pharmacy when medications were delivered. The Interim ADON provided a copy of the packing slip from the facility pharmacy indicating a delivery on 1/31/24 for Resident #1's Enoxaparin, 30mg/0.3 ml, subcutaneous syringe (0.3 mls), one time daily starting 2/1/24 had been delivered on 1/31/2024. QTY 4.20 (no unit of measure indicated) noted on slip for Resident #1. The Interim ADON said they did not always use the pharmacy stickers to re-order medications. She said some nurses would call the pharmacy to reorder the medication. She said the nurses did not document in their clinical notes when they called [TRUNCATED]

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observation, interview, and record review, the facility failed to ensure residents remained free of any significant medication errors for 2 of 3 residents reviewed for medication errors (Resident #'s 1 and 2). 1.The facility failed to provide 7 doses of Resident #1's physician ordered Enoxaparin/Lovenox (a blood thinner to prevent blood clots) between the dates of 2/15/24 - 2/21/24. 2.The facility failed to provide 11 doses of Resident #2's physician ordered Bydureon (treats Type 2 Diabetes) between the dates of 12/11/23 - 2/13/24. The noncompliance was identified as PNC. The IJ began on 12/11/23 and ended on 2/29/24. The facility had corrected the noncompliance before the survey began. These failures placed all residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician, which could result in serious complications, decline in health, hospitalization , and death. Findings included: 1.Record review of the undated face sheet for Resident #1 indicated she was an [AGE] year old female that admitted [DATE] with diagnoses that included: fracture of right femur (broken hip), venous insufficiency (improper functioning of the valve veins), chronic peripheral hypertension (abnormality in the capillaries within the leg tissues that make them more permeable-allowing fluid, proteins, and blood cells to leak into the tissues), and peripheral vascular disease (reduced blood flow to the limbs). Record review of physician's orders for Resident #1 indicated: 1/31/24 Enoxaparin 30mg/0.3ml subcutaneous syringe (0.3 mls) syringe one time daily starting 2/1/24. Record review of a physician's note dated 1/25/24 indicated: Lovenox x 21 days, start 2/1/24. At increased risk of deep vein thrombosis. Record review of the Admission MDS dated [DATE] indicated Resident #1 had clear speech, understood others, and was understood by others. She had a BIMS of 14 indicating she was cognitively intact. The MDS indicated she had 7 injections during the 7-day lookback period. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the undated care plan indicated Resident #1 was at risk for bleeding due to Lovenox (generic name, Enoxaparin) use. The goal was Resident #1 not developing an embolism post operatively or have adverse consequences of treatment. Interventions included: Notify MD of concerns, monitor for signs of embolism, monitor for bruising or bleeding, administer Lovenox per MD orders. Resident #1 had PVD with the goals: skin on her feet/legs would remain intact over the next 90 days and interventions were to check her feet and legs for redness, skin tears, swelling, or pressure areas daily. Report any signs of skin breakdown. Record review of the Provider Investigation Report for Resident #1, dated 3/6/24 with an incident date of 2/26/24 indicated during a chart audit, the DON discovered Enoxpaparin (Lovenox) had been documented as given to Resident #1 but Enoxaparin had not been refilled by the pharmacy. The DON assessed Resident #1 and indicated she had a negative Homan's Sign (no pain in the calf muscles on forced dorsiflexion of the foot with the knee straight), no bruising, no s/s of abnormal bleeding, no pain, no discomfort, or tenderness at calves. No swelling to bilateral lower extremities. The DON indicated there were no adverse effects to Resident #1. The DON indicated that LVN A, RN B, MA C, and MA D had been terminated and all staff would be in-serviced on documentation and falsifying documentation. The PIR indicated statements received from RN B indicated she had given the medication as ordered. MA C stated that when LVN A worked he told her to document the injection was given, but she had never seen him administer the medication. The MAR showed documentation Enoxaparin had been administered to Resident #1 2/15/24 - 2/26/24, but documentation from the pharmacy showed the medication was never refilled after the first 14-day supply. Record review of the MAR dated February 2024 indicated Resident #1 had received Enoxaparin 30mg/0.3 ml subcutaneous syringe (0.3 mls) one time daily starting 2/1/24. (Order date 1/31/24) 2/1/24 through 2/27/24. Record review of a pharmacy slip dated 1/31/24 indicated Resident #1 had received Enoxaparin injections 30/0.3 ml. The quantity indicated was 4.20. Record review of a pharmacy slip dated 2/27/24 indicated Resident #1 had received Enoxaparin injections 30/0.3 ml. The quantity was indicated to be 3.00 and 1.20. 2.Record review of the undated face sheet for Resident #2 indicated she admitted [DATE], was an [AGE] year-old female with diagnoses that included: Transient Cerebral Ischemic Attack (a brief stroke resolving within minutes to hours), Diabetes Mellitis Type 2 with hyperglycemia (the body has trouble controlling sugar and it builds in the bloodstream), hypertension (high blood pressure-when the pressure in your blood vessels is too high), old Myocardial infarction (heart attack), and peripheral vascular disease (reduced blood flow to the limbs). Record review of the significant change MDS dated [DATE] indicated Resident #2 had clear speech, understood others and was understood by others. The MDS indicated she had not received any injections in the 7-day look back period. Record review of the Annual MDS dated [DATE] indicated Resident #2 had a BIMS score of 13 indicating her cognition was intact. The annual MDS indicated she had received 1 injection (of any type) in the 7-day lookback period and 1 insulin injection in the 7-day lookback period. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the care plan dated 3/23/24 indicated Resident #2 had diabetes and would receive labs and fingersticks per MD orders, monitor for signs or symptoms of hyperglycemia, and administer medications per MD orders. Record review of the physician's orders for Resident #2 indicated: 1/7/23 Bydureon BCise 2mg/0.85 ml subcutaneous auto-injector, 2 mg, SQ every Saturday. Shows a d/c date of 2/2/23. 2/27/24 Completed order for Bydureon BCise 2mg/0.85 ml subcutaneous auto-injector, 2 mg, SQ every Saturday. Record review of pharmacy slips from Resident #2's personal pharmacy indicated Bydureon, BC injection 2mg/0.85 ml was filled 11/9/23. The next fill date for her Budureon was 2/26/24. Record review of a lab dated 11/13/23 indicated Resident #2's HgA1c was 6.5. Record review of the Provider Investigation Report for Resident #2, dated 3/6/24 indicated an incident date of 2/27/24 when Resident #2's family member stated she did not believe Resident #2 was receiving her Bydureon injection as prescribed. Physician notified, no negative effects to the resident. The DON indicated that LVN A, RN B, MA C, and MA D had been terminated and all staff would be in-serviced on documentation and falsifying documentation. On 2/27/24 Resident #2's family member indicated her Bydureon prescription had not been refilled since 11/9/23 from the pharmacy. The MAR indicated all doses had been administered. The DON called the pharmacy and found out the last fill date for the medication was 11/9/23 and four injections came in a box (28-day supply). LVN A and RN B gave statements that the medication was in the facility even though the last fill date was 11/9/23. The facility pharmacy was also contacted to see if they had filled the Bydureon for Resident #2 and they had not. Resident #2 got her medication from her personal pharmacy. Resident #2's lab work on 11/13/23 showed her hgA1C to be within normal limits. Her blood sugar was taken 3 times per week and had been within normal limits 11/3/23 - 2/12/23. Record review of Resident #2's blood sugars were: 11/3/23 - 114 11/6/23 - 122 11/8/23 - 110 11/10/23 - 110 11/13/23 - 122 11/15/23 - 106 11/17/23 - 116 11/20/23 - 118 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11/22/23 - 126 11/24/23 - 121 11/27/23 - 120 11/29/23 - 98 12/1/23 - 105 12/4/23 - 117 12/8/23 - 126 12/11/23 - 125 12/13/23 - 138 12/15/23 - 126 12/18/23 - 120 12/20/23 - 224 12/22/23 - 117 12/25/23 - 123 12/27/23 - Resident Resting 12/29/23 - 115 1/1/24 - 122 1/3/24 - 105 1/5/24 - 117 1/8/24 - 133 1/10/24 - 121 1/12/24 - 129 1/15/24 - 120 1/17/24 - 171 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1/19/24 - 126 1/22/24 - Resident refused 1/24/24 - 188 1/26/24 - 254 1/29/24 - 127 1/31/24 - 130 2/2/24 - 133 2/5/24 - 200 2/7/24 - 145 2/9/24 - 141 2/12/24 - 136 Record review of an in-service dated 2/29/24 on Charting and Documentation indicated: Falsifying documentation is prohibited and will not be tolerated at [name of facility]. If a medication is given by you, please make sure you are documenting accordingly. Furthermore if you do not give a medication, you should never document that it has been given and always specify in your documentation the reason why medication was unable to be administered. Nurses should always be aware of what their scope of practice is regarding medication administration and know what should and should not be delegated to medication aides/CMAs to administer and document. Service Standard: All services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition shall be documented t=in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record is primarily electronic; however, there may be some manual documents that are uploaded into the record. 1.The following information is to be documented in the resident's medical record: a.Objective observations; b.Medications administered; c.Treatments or services performed; d.Changes in the resident's condition; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	e.Events, incidents, or accidents involving the resident; f.Progress toward or changes in the care plan goals and objectives. 2.Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. 3. Entries may only be recorded in the resident's clinical record by licenses personnel (e.g., RN, LVN, physician's, therapists, social workers, administrator, etc.) in accordance with state law and BRS service standards . 9.Documentation of procedures and treatments will include care-specific details, including: a.The date and time the procedure/treatment was provided; b. Name and title of the individual(s) who provided the care . g.Signature and title of the individual documenting. During an interview and observation on 5/7/24 at 8:55 AM, Resident #1 was in EBP(Enhanced Barrier Precautions) due to a wound on her heel. She was in her wheelchair in her room. She said it had been a while since she got shots in her tummy. She said she did not remember a man giving her shots in her tummy but said she did not remember anything when she had Covid. She said no one at the facility ever told her they were out of any of her medication. She said she did not remember how often she got shots in her tummy but did not think it was every day. She said she thought she got all her medication when she was supposed to. She said she did not get any type of shots now. During an interview on 5/7/24 at 9:07 AM, LVN E said she had worked at the facility 3-4 weeks. She said if a resident ran out of medication she would pull that medication from the e-kit. She said whatever nurse saw that a resident's medications were low was responsible to reorder the medications. She said that nurse did not need to tell the DON or ADON about it, just to reorder it. She said if a resident had missed a medication and she realized it she would notify the MD, ADON, and DON to report it. She said she gave injectable medications and the only resident that got injectable medication at this time was Resident #3. She said Resident #3 got Lovenox and Insulin daily. LVN E said when his medication got low, she would reorder it. She said the pharmacy would not refill a medication if it was more than 3 days so she waited until she had 3 days left of the medication to reorder. She said it was the nurse's responsibility to take care of that. She said there were no longer MA's in the building. She said she would never ask a MA to document what she had done/medication she had given, she documented what she had administered. She said it was outside of the scope of a MA to document or give Lovenox or any injectable. She said she did not work at the facility when Resident #1 or Resident #2 missed their medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/7/24 at 9:21 AM, the Interim ADON said she used to worked Friday through Sunday. She said for the last week she had been the Interim ADON and now worked during the week, Monday through Friday. She said the nurse that ran out of medication or noticed it was low was responsible for reordering it and that nurse did not need to notify anyone. She said if that nurse did not reorder the medication and did not give the medication it would be that nurses fault and her responsibility. She said they had to trust that their nurses were doing what they were supposed to do. She said she was not aware of Resident #1 and Resident #2 missing their medications. She said the only documentation of reordering medications was what they scanned to the pharmacy when the reorder sticker off of the label of the medication (from the pharmacy), that was faxed to the pharmacy. She said after that paper was faxed she was not sure where it went or where it was kept. She said she had a few in her office. She said she thought there was as book for the pharmacy reorders, but she would have to ask where the book was located. During a phone interview on 5/7/24 at 10:12 AM, MA C said LVN A would tell her to document he had given the injectable medication, to Resident #1 and Resident #2. She said she told the ADON (at the time, currently the DON) and said the ADON told her it was alright to do that, as long as the nurse gave her the verbal okay that they (the nurse) had given the medication. She said the DON used to be the ADON and that was who she had talked to about it. She said RN B would document when she gave injections to Resident #1 and Resident #2 herself. She said RN B did not ask her to document for her. She said she would mark injections (on the MAR) that were given by RN B sometimes because she physically saw RN B give the medication. She said she never saw LVN A give an injection to Resident #1 or Resident #2. She said LVN A just told her he had given the injections and she had no reason to doubt him. She said Resident #1 never ran out of her Lovenox injections that she knew of. She said Resident #1's shots were in the locked top drawer of her dresser with her scheduled medications. She said the resident's medications were kept locked in their room in the dresser drawer. She said she never dealt with either Resident #1 or Resident #2's injections. She said she was not asked to reorder the medications for either Resident #1 or Resident #2. She said both LVN A and RN B were good to reorder medications if a resident ran out of medications. She said Resident #2's injection was given once a week and she thought they ordered those in bulk. She said sometimes she would accidentally mark off the injections were given by going down the medications due list because the injections were on the MAR. She said she and the MA D had talked to the ADON (currently the DON) and told her they were accidentally marking off injections for Resident #1 and Resident #2. She said the ADON told them to try their best not to do that, but if they did to get with that nurse make sure the nurse had given the injection medications. She said neither Resident #1 or Resident #2 ran out of their injections. She said she did not know why the nurses would document they had given medications that were not in the building. She said she guessed that was why she was fired. She said she wrote a statement for the facility and then she was fired. During an attempted phone interview on 5/7/24 at 10:26 AM, called MA D. Her voice mail was full. Sent a text message. No return call was received. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/7/24 at 10:58 AM, the DON said she was the ADON before she was the DON. She said she was ADON [DATE] to [DATE]. She said February 2024 she started as DON. She said MA's were documenting that they were giving injections when they were not. She said they were not supposed to do that. She said it was not in their scope of practice. She said according to the statements from the MA's the nurse or nurses were asking them to document that injectable medications were given. She said MA C told her at one time that the injections showed up on the MAR instead of the TAR, it was easy for them to accidentally mark it off. She said she told MA C it was the nurse's responsibility, and MA's should not be checking off an injection given on the MAR. She said MA C only discussed that with her once. She said she never told MA C if a nurse told her to mark off an injection that she could. She said she would never tell a MA that. The DON said according to the statement MA C wrote, LVN A was asking her to check off that he had given the injections to Resident #1 and Resident #2. She said when she questioned LVN A during the investigation he told her he documented the injections he had given to Resident #1 and Resident #2 in the MAR. She said she had not asked him about documenting prior to the investigation because she had no reason to. She said she would not know if a medication was low or out, and not reordered unless the nurse brought it to her attention. She said Resident #2 was on a cycle fill at her personal pharmacy which meant the Bydureon medication automatically came without a need to reorder. She said the pharmacy later apologized when they realized Resident #2's Bydureon was not on a cycle fill and the medication had not been refilled. She said when MA C was writing a statement regarding Resident #2 she said something about Resident #1's medication in her statement, so they began looking at Resident #1's Lovenox medication during their investigation. The DON said the process at that time (November 2023 - March 2024) for reordering injections was the nurse was responsible for it because they administered it. She said if it was a medication an MA administered, then the MA was responsible for reordering it. She said the ball dropped but she was not sure where. She said as a nurse, the nurse was responsible for their MAR and TAR regarding medications they administered. She said she believed RN B and LVN A were giving the injections to Resident #1 and Resident #2, but were not always documenting that they did. She said she believed LVN A and RN B were lying about giving the injections to Resident #1 (Lovenox) and Resident #2 (Bydureon) at the times when the medications were not in the building. She said there was no way the medications could have been in the building on certain dates for both residents. She said she called the facility pharmacy for Resident #1 and she called Resident #2's personal pharmacy and neither pharmacy had filled the medications at the times they reported in their investigations. She said she had no idea why LVN A or RN B would have documented they gave an injection that they could not have given. She said the new process and changes they had made for ordering medications was the facility did not employ MA's anymore. LVN A, RN B, MA C, and MA D had been terminated. She said all injections/medications given by nurses only, had been moved to the TAR instead of MAR. She said in case they later brought MA's back they could not check off or document they had given something on the TAR. She said only the nurses could access the TAR. She said they brought the issue to QAPI and the Medical Director was at the QAPI meeting, was notified and aware of both incidents regarding Resident #1 and Resident #2. She said they did in-services on administering medications, documenting medications that were administered and falsifying documentation. The DON said that was their plan of action going forward to make sure nothing like this ever happened again. (continued on next page)

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	676167	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckner Westminster Place	2201 Horseshoe LN Longview, TX 75605

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/7/24 at 12:28 PM, the Interim ADM said these investigations (Resident #1 and Resident #2) were all about false documentation. She said staff was documenting they were giving medication that was not in the building. She said because of that no one reordered the medication and that was why everyone involved (LVN A, RN B, MA C, and MA D) was fired. She said staff either had documented they had given medications that were not in the facility or did not give them at the times they were in the facility. She said there were no more MA's in the building and the injections had been moved from the MAR's to the TAR's. During an observation and interview on 5/7/24 at 12:37 PM, LVN E unlocked the dresser in Resident #3's room. He had Enoxaparin 30 mg/0.3 ml. He had 1 box of 10 unopened and 1 pkt of 3. LVN E said he currently had enough medication and when it was time to reorder it she would. During an interview and record review on 5/7/24 at 1:15 PM, the DON and this surveyor reviewed nurses notes in their computer system that indicated Resident #2 went to the hospital 2/13/24 due to signs and symptoms of dehydration. The DON said the hospital admit was unrelated to her missing her Bydureon. She said when Resident #2 went to the hospital her family member came to the facility to pick up her Bydureon medication, realized the box was dated 11/9/23, and one injection was left unused in the box. The DON said Resident #2 had to have missed a dose of her medication sometime between 11/13/23 - 12/4/23 but it was documented she received it. She said there was no Bydureon in the facility 12/11/23 - 2/13/24. She said she called Resident #2's pharmacy and the pharmacy said they had not refilled it since 11/9/23. The DON said Resident #1 had her Lovenox available in the facility 2/1/24 - 2/14/24. She said Resident #1 had no Lovenox available in the facility 2/15/24 - 2/26/24. She said the stop date for the lovenox was 2/27/24 and showed this surveyor on the computer program. It was marked completed 2/27/24. She said they did not use discontinued, they used completed when a medication was discontinued or finished. She said initially it did not have a stop date but she called the NP and she had given her a stop date of 2/27/24, which she put in the orders in the computer. She said the MAR for Resident #1's Lovenox was initialed as given 2/15/24 - 2/27/24 but that medication was not available in the building to give. She said LVN A, RN B, MA C, and MA D had worked during that time. She said she did not know if LVN A had asked one of the MA's to mark the Lovenox given for him. She said the MA's did not give that medication but signed off they did sometimes. She said she assessed Resident #1 on 3/7/24 when she realized she had not had her Lovenox, called the MD, NP, and the family. She said the MD and NP did not order any labs but told her to monitor Resident #1 for any adverse effects. During an interview on 5/7/24 at 2:54 PM, The DON said she spot checked at least 4 times per week, the initial TAR to make sure medication was documented, checked to see if the medication was in the room, interviewed nurses and residents making sure documentation was correct, and checked injection site(s) on residents. She said this was ongoing and she would be doing it indefinitely at this time or until they were convinced everything was working how it should. The DON provided an in-service dated 2/29/24 titled: Medication Documentation. The in-service indicated: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Falsifying documentation if prohibited and will not be tolerated at [the facility]. If a medication is given by you, please make sure you are documenting accordingly. Furthermore, if you do not give a medication, you should never document that it has been given and always specify in your documentation the reason why medication was unable to be administered. Nurses should always be aware of what their scope of practice is regarding medication administration and know what should and should not be delegated to medication aides/MA's to administer and document. The DON provided an Action Plan dated 3/6/24 that indicated: Problem: Injections not being given by the nurses, and medication aides documenting that injections have been given. Intervention: Injections moved from the MAR to the TAR Medication Aides terminated, will no longer use medication aides. DON to monitor injections. 4/10/24 Outcome: No issues found with injections. Signed by the Interim ADM The DON provided a QAPI sign in sheet dated 4/10/24 signed by: Interim ADM Medical Director DON EVS (Environmental Services) LVN AL/MC nurse (Assisted Living/Memory Care) Director of Rehab Marketing/Admissions Business Office Manager Executive Director (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 5/7/24 at 3:49 PM, LVN E said she had given Resident #3 his Lovenox this morning. She said he got his insulin in the evening. Observation of his abdomen showed signs of Lovenox injections. During a phone interview on 5/8/24 at 7:42 AM, RN B said Resident #2 received Bydureon injections on Mondays. She said she usually she would work 2 Mondays in a row then LVN A would work the other 2 Mondays. She said she always gave Resident #2 her Bydureon injection but she did not know if LVN A did, or if it was missed on days she did not work. RN B said Resident #2 did not miss any doses of her Bydureon when she worked. She said there were 2 boxes of Bydureon medication in the refrigerator and those boxes were stuck together. She did not know how many was in each box. She said she never documented she gave a medication that she did not give, and would not do that because that would have been false documentation. She said she never asked either MA C or MA D to document that she had given Resident #2 her injection. She said the MA's would sometimes accidentally mark the Bydureon medication as given when they checked or synced the medications in the computer. She said she did not know if LVN A was giving Resident #1 her Lovenox. She said LVN A was the other nurse that gave Resident #1 her Lovenox. She said she gave Resident #1 her Lovenox everytime it was due and did not miss any doses. She said the Lovenox initially was a 30-day supply in a bag and the refill was a 14 day supply in a box. She said Resident #1 did not run out of the Lovenox and she never had to reorder or refill it because it was available. She said she did not look at the date it was filled because she always had the medication to give. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 5/8/24 at 8:09 AM, LVN A said Resident #2 always got her Bydureon injection on Mondays and she always got it when he worked because he gave it to her. He said it did not need to be refilled because it was on an auto-fill and automatically filled on time. He said he was not aware the last fill date on the prescription was 11/9/24. He said the medication was always on hand and he administered it. He said he would never document he gave a medication that he did not give because that would be a medication error. He said the process was the MA would let him know the Bydueron was due, and he would give it. He said that medication was on the MAR not the TAR. He said MA's had access to the MAR but not the TAR. He said he never asked an MA to document he had given an injection or to document anything for him. He said sometimes the MA's would accidentally click on the Bydureon on the computer and it would show they had given it when they had not. He said no one ever asked him if he was giving the medication to Resident #1 or Resident #2. He said it was not correct that there were no Bydureon in the building for Resident #2 12/11/23 - 2/13/24. He said the medication was in the building and he gave it. LVN A said he would have reordered it if it needed to be reordered but it did not because it was an auto-refill. He said he did not remember when he was suspended and did not remember when he was fired but he was not working at the facility the entire time when Resident #1 supposedly had no Lovenox in the building. He said Resident #1 always had Lovenox available in her locked drawer in her room. He said Resident #1 was never out of her Lovenox. He said he would know it if she had been out of that medication. He said it was possible, if the MA did not remind him the medication was due and she had marked it off as given, he may not have given it by mistake. He said he looked at the TAR, not the MAR because the TAR was for the nurses and the MAR was for the MA's. He said he would never have allowed a MA to document a medication he did not give. He said the orders for injections given by the nurses should have been on the TAR, not the MAR. He said that was the problem and the reason this happened. He said there was nothing written that indicated who was responsible to refill a medication. He said when a medication was low the MA usually reordered unless it was an auto-fill. He said there was a book that pharmacy reorders were put in when the MA's pulled a sticker off the medication and faxed it to the pharmacy. He said it was the Pharmacy Book. He said he never talked with the DON about either Resident #1 or Resident #2's medications because he did not see a problem. He said going without Lovenox could be a problem for Resident #1 in that she could get a blood clot. He said missing her Lovenox could cause a lot of health problems for her. He said the Lovenox was given to her to prevent her from getting a blood clot after hip surgery. During a phone interview on 5/8/24 at 9:24 AM, a representative from the facility pharmacy said Resident #1 had Lovenox (Enoxaparin) filled on 1/31/24 which contained 14 syringes, enough for 14 days. He said there were no refills for the Lovenox until 2/27/24. During an interview on 5/8/24 at 9:33 AM, a representative of Resident #2's pharmacy said on 11/9/23 Resident #2 got Bydureon, 4 syringes that would last 28 days. She said the next refill was 2/26/24 also with 4 syringes. During an interview on 5/8/24 at 10:13 AM, the DON said there was a basket at one time and now a drawer where the pharmacy refill sheets were put after they were faxed to the MD (at the nurse's station) but she was not aware of a pharmacy book. She said she checked the basket/drawer at the time of the investigations for Resident #1 and Resident #2 and did not find any refill requests for either of them. She said she did not document she was monitoring Resident #1 regarding missing her lovenox but she was checking her at least daily. She said the numerous orders and discontinue for Resident #2's bydureon was when she was having trouble with the computer and not doing it right. She said there was no written plan or policy/process for reordering medications at that time. (continued on next page)

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