STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676440	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Round Rock, LLC	16219 Ranch Road 620 North Austin, TX 78717

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45937 Based on interviews and record reviews, the facility failed to inform the resident's Physician or Nurse Practitioner when there was a need to alter treatment significantly for 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure Resident #1's scheduled medications were acquired and administered. Resident #1 was not given ceftriaxone (antibiotic used to treat bacterial infections) for a total of 4 times within the dates of 07/09/2024 to 07/11/2024, staff did follow up with the pharmacy for the antibiotics, staff did not communicate with the NP of the lack of antibiotics and missed medications, and staff did not communicate the missed doses to the administration. This failure resulted in the Resident #1's being sent to the hospital to have consistent antibiotic treatment, and to treat Bacteremia (bacteria in the blood stream) and ventriculitis (inflammation of the ventricles in the brain). An IJ was identified on 07/18/2024. The IJ Template was provided to the facility on [DATE] at 06:35 p.m. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This failure could place residents at risk of not receiving their scheduled medications in an accurate and timely manner to promote healing and to meet the needs and care of resident. Findings Included: Review of Resident #1's face sheet, dated 07/18/2024, revealed a [AGE] year-old-female. admitted to the facility on [DATE] and discharged on [DATE]. Resident #1's face sheet further revealed diagnoses of other Encephalitis (An inflammation of the brain usually caused due to infection that causes flu like symptoms), Encephalomyelitis (term for inflammation of the brain and spinal cord), and Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Record review of Resident #1's orders, dated 07/18/2024, revealed two discontinued orders for: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024, start date: 07/09/2024 Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024, order date: 07/09/2024, start date: 07/09/2024, end date: 07/18/2024 Record review of Resident #1's July MAR (Medication Administration Record), dated 07/18/2024, revealed: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024 1038 (10:38 a.m.), D/C (Discontinued) Date: 07/10/2024 0608 (06:08 a.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Tuesday 07/09/24 a charting code of 09 at 2100 (09:00 p.m.) Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.), D/C (Discontinued) Date: 07/12/2024 at 1548 (03:48 p.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Wednesday 07/10/2024 a charting code of 09 at 0900 (09:00 a.m.), and 2100 (09:00 p.m.) Thursday 07/11/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of a check mark 2100 (09:00 p.m.) Friday 07/12/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of (x) at 2100 (09:00 p.m.) Further review of Resident #1 July MAR (Medication Administration Record) revealed a Chart Codes/Follow up table, a charting code of a check mark is listed as administered. Additional review of Resident #1's July MAR (Medication Administration Record), on page 30: Ceftriaxone Sodium Intravenous Solution Reconstituted, scheduled time: 07/11/2024 2100 (09:00 p.m.), administered time: 07/11/2024 2320 (11:20 p.m.), administered by LVN B, route intravenously, and location of Admin arm-right. Record review of Resident #1's July MAR revealed Resident #1 was administered Ceftriaxone Sodium Intravenous one time from the dates of 07/09/2024 to 07/12/2024. Record review of Resident #1's Progress Notes, dated 07/18/2024, revealed: Note, effective date: 07/09/2024 2022 (08:22 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) pending pharmacy delivery. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note, effective date: 07/10/2024 1007 (10:07 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) PT (patient) pulled IV (Intravenous) line out. Note, effective date: 07/10/2024 1600 (04:00 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) pending pharmacy delivery. Note, effective date: 07/10/2024 2253 (10:53 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Medication pending arrival to facility. Note, effective date: 07/11/2024 1810 (06:10 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Not Available. Note, effective date: 07/12/2024 0947 (09:47 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) med order pending, call pharmacy. Record review of Resident #1's NP Progress note, dated 07/12/2024, revealed an HPI (History of Present Illness) Related to this Visit, notified this AM (Morning) by nursing staff that pt (Patient) has not received IV (Intravenous) abx (Antibiotic) ceftriaxone since admission d/t (Determine that) Pharmacy carrier not delivering med to facility. No previous staff or nursing notified this NP (Nurse Practitioner) that med had not been delivered since pt's (Patient's) admission. This NP (Nurse Practitioner) called and notified attending MD (Medical Doctor) and notified her of the situation. pt (Patient) sent to ER (emergency room) to ensure pt restarted on abx (Antibiotic). Spoke to pt's Family #1 in pt's room and notified family that pt has not received her IV (Intravenous) abx and will be sending pt back to ER. MD stated his frustrations with facility and wanted pt immediately sent out, which this NP explained was already in the process. Record review of Resident #1's hospital records, dated 07/18/2024, revealed Resident #1 an admitted to the hospital on 07/12/2024, with no discharge date , with a chief complaint missed antibiotic. Further review of Resident #1's hospital records revealed an Assessment/Plan note: this 91-yeard-old female with past medical history of diabetes type 2 dementia, and haemophiles influenza (bacteria that can cause severe infection) on ceftriaxone was brought from skilled nursing facility. 1. Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Continue ceftriaxone 2 g (grams) every 12 hour till (until) 7/20 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 11:24 a.m., RN A stated that she worked the day shift when Resident #1 arrived on 07/09/2024, Resident #1 arrived between 3pm to 4pm. RN A stated that she remembered Resident #1 because of her antibiotics (Ceftriaxone) and she was scheduled to receive her medications twice, 9am and 9pm as that was how the orders was listed. RN A stated she admitted Resident #1, her antibiotics were not in house, RN A stated she ordered them from the pharmacy, as Resident #1's admitting records from the hospital revealed Resident #1 received her first dose of the antibiotic and Resident #1 next dose would be at 9pm. RN A stated she passed this information down to the next nurse on shift, as she would be off duty from 07/10/2024 to 07/12/2024. RN A returned to work on 07/12/2024 and reviewed Resident #1 medication administration and discovered that Resident #1 had missed doses of Ceftriaxone and had only received one dose on 07/11/2024 at 9pm. RN A stated when she inquired on the missed antibiotics, she was told the medications have not arrived in the facility. RN A stated she informed the ACNO, and NP of the missed doses. RN A stated that staff should have followed up with the pharmacy for the medications, inform the DON or ACNO, and notify the MD or NP of the missing antibiotics to look for alternatives. RN A stated that there we risk associated with the missed dosages as it could lead to an infection in Resident #'s blood. RN A stated Resident #1 was sent to the ER per the NP orders as the NP was seriously concerned of Resident #1 not receiving the antibiotics. Interview on 07/18/2024 at 12:27 p.m., LVN A stated she worked the floor as a charge nurse during Resident #1 stay on 07/11/2024. LVN A stated that Resident #1 antibiotics (Ceftriaxone) were not available that day. LVN A stated she checked the Ekit that day and there was no Ceftriaxone available. LVN A stated she marked it on the MAR as a 9, listed as other because the antibiotic was not available. LVN A stated that if there are missed doses, we contact the MD or NP, there is a procedure to follow up with the pharmacy and notify the DON or ACNO. LVN A stated, I screwed up, I admit it, I did not call the pharmacy because I thought it would be delivered later that day, and I did not call the NP. It was so busy that day, I'm sorry. LVN A stated the risks of Resident #1 not having her antibiotics would be the increased risk of infection. Interview on 07/18/2024 at 01:48 p.m., LVN B stated she worked during Resident #1's time at the facility and remembered her. LVN B confirmed that Resident #1 antibiotics are administered intravenously. LVN B stated that on Wednesday night (07/10/2024), she did not see Resident #1's Ceftriaxone in the cart, LVN B added she did not look in the Ekit that night. LVN B stated in Resident #1's MAR she coded it as 9 as she did not want to lie and say she administered the Ceftriaxone. LVN B stated on Thursday night (07/11/2024) Resident #1 did not have her Ceftriaxone in the cart, LVN B asked another nurse to look in the Ekit, and a dose of Ceftriaxone was available. LVN B stated she successfully administer Resident#1's antibiotic (Ceftriaxone), that is why she marked it with a checkmark. LVN B stated, I take full accountability, didn't check the ekit, and didn't call, I didn't call the pharmacy, I was thinking it (Ceftriaxone) was on its way here, I was thinking it was, that's why I put a medication pending arrival in the progress note, I didn't call the NP, the DON or ACNO, I should have but it was busy those nights. LVN B stated the risk of not Resident #1 not having her Ceftriaxone was, the risk of not getting better, of not healing, the risk of infection, and the risk of the resident (Resident #1) not going home as planned, I'm sorry. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 03:09 p.m., NP stated that she was only told that Resident #1 did not receive the scheduled antibiotic Ceftriaxone on 07/12/2024, the day I sent her to the ER. NP stated she was informed by RN A. NP stated she informed the MD, we were not happy, because staff did not give her Ceftriaxone, and we were not informed. NP added Resident #1 missed many doses, and when she was informed, I wanted to assure Resident #1 received her Ceftriaxone, that is the reason she had to send her to the ER. NP stated, the antibiotics (Ceftriaxone) was important for this patient, this was the main reason she was here to treat her infection, she had an infection in her brain that was treated at hospital, to assure that the infection won't come back and keep ravaging this patient, the antibiotics (Ceftriaxone) had to be consistent, and continued at the facility. the NP added, even with one dose she (Resident #1) received it could lead to serious harm, she (Resident #1) could have gone septic, sending to her hospital was ensuring she doesn't go septic and have drastic harm done to her (Resident #1). Interview on 07/18/2024 at 04:00 p.m., DON stated staff were required to look in the Ekit, if medications are not available staff are to notify the resident's providers, to look for alternative medications or treatments, or to make appropriate adjustments. The DON stated that the process and procedures are here to keep residents safe and to also offer options for our facility to treat residents. The DON confirmed she was not notified of Resident #1's missed doses (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. Interview on 07/18/2024 at 04:13 p.m., ACNO stated if no medications are available in the medication cart or the Ekit, staff should follow up with pharmacy, there two routes of delivery. If the medication does not come in from pharmacy, and there is no reason given from the pharmacy, staff are supposed to tell the DON, ADM, GM, ACNO. ACNO stated staff are supposed to follow up and call doctor or NP to see if there are alternatives. ACNO stated she recalled Resident #1 because she was on antibiotics (Ceftriaxone). ACNO stated she was informed on Friday (07/12/2024) approximately at 10:40 a.m., she informed the GM, and a pharmacy follow up would be completed. ACNO stated that she was informed that Resident #1 had missed two days without her (Resident #1) antibiotics. ACNO stated that staff should have notified, her, DON, GM that first day the Ceftriaxone had not come in and if Resident #1 did not receive the antibiotic. ACNO stated she verbally educated LVN A on the process of calling administration on 07/12/2024, but no in-services completed. ACNO stated, The antibiotic (Ceftriaxone), was important, if there were missed doses, it would interfere with her (Resident #1's) healing. Interview on 07/18/2024 at 05:39 p.m., GM stated staff are to contact the providers if there are no medications available for any reason, providers are to offer adjustments or alternatives for the missing medications, staff are to contact the pharmacy directly as well to work with them to have those medications delivered. GM added if the pharmacy is not able to deliver the medication, staff are to contact his or her supervisors and inform them of the situation. GM stated if the process is not followed, there are risk to residents not receiving the desired and appropriate treatments. GM stated she was not informed by staff of Resident #1 missed dosages of antibiotics (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. GM stated she was informed by the ACNO on 07/12/2024, and she immediately followed up with the pharmacy that day. Record Review of the Facility's Medication Ordering and Receiving from Pharmacy/Ordering and Receiving Non-Controlled Medications, dated 01/23, reflected the Policy: Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate reds of medication order and receipt. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedures: 1. Section E: New Medications, expect for emergency or stat medications, are ordered as follows: If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery. Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a non-controlled medication prior to pharmacy delivery. 1. Section F: Stat and emergency medications; except for Controlled Substances are ordered as follows: During regular pharmacy hours, the emergency or stat order is transmitted to the pharmacy immediately upon receipt. Such medications are delivered and administer in a timely manner. Emergency/STAT medication order then medication is not available in the emergency kit: An emergency/STAT order is placed with the provider pharmacy and the pharmacy is called by nursing staff to request the STAT. The requested medication(s) will be delivered in a timely manner. Subsequent doses are scheduled according to nursing care center policy on medication administration. Record Review of the Facility's Administration of Medications, dated 04/2023, revealed General statement, All medications are administered safely and appropriately to aid resident to and help overcome illness, relieve and prevent symptoms and help in diagnosis. The GM was notified on 07/18/2024 at 06:35 p.m., that an IJ situation was identified due to the above failures and the IJ template was provided. The POR (Plan of Removal) was accepted on 07/19/2024 at 03:37 p.m., and included: On 7/18/24 an abbreviated survey was initiated on 7/18/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy resident health and safety. The notification of Immediate Jeopardy states as follows: F755 - The facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of a resident, this resulted in Resident #1 missing dosages of ceftriaxone. 1. Corrective Action for residents affected by the deficient practice: a. Resident #1 had been discharged from the facility on 7/12/2024. 2. How other residents having the potential to be affected be identified and what corrective action(s) will be taken: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Residents admitted to the facility have the potential to be affected by the identified deficient practice. Education was given to DON and GM by Chief Clinical Officer on 7/18/2024. Inservice will start 7/18/2024 and be completed by all fulltime staff by 7/19/2024 and be conducted by director of nursing (DON), general manager (GM) to all Fulltime, part time, PRN nurses and certified medication aides (CMA). Training for all new hires, PRN and part time employees will be completed prior to start of shift. Post test will be conducted after Inservice. Topic will include: i. Proper ordering/reordering medications process - will review the pharmacy policy section 3.2 entitled Medication Ordering and Receiving From Pharmacy Provider ii. Proper Protocol for all Facility Nurses and medication aides for bullet points 1,2, and 3. when medication is unavailable - 1. Check Medication expensing machine and IV E-kit immediately. Nurses & CMAs. 2. Contact pharmacy immediately. Nurses & CMAs. 3. Notify DON and/or GM for escalation Within 1 hour of calling pharmacy. Nurses & CMAs. 4. Within 1 hour after notifying DON and/or GM, notify physician to request for alternative orders. ONLY for nurses 5. Document and carry out provider's instructions immediately. ONLY for nurses iii. Proper Protocol for all Facility Nurses and Medication aides of notification tree if medication is unavailable - 1. DON Contact information is posted in med room 2. Contact GM Contact information is posted in Med Room 3. Contact assigned provider ONLY for nurses iv. Contents of medication dispensing machine and IV E-kits - see Attachment A b. Inservices will be reinforced via the bulletin board of the electronic health records as well as live documents sent via text message. Inservice will be required to be completed prior to start of shift. There will be post test given and graded by CNO and/or GM c. Nursing staff initiated a MAR-to-Cart audit of all in-house residents on 7/18/2024 to ensure medications are available and to order/reorder medications that are not available in the medication carts. This will be completed by 7/19/2024. 3. Measures that will be put in place or systemic changes that will be made to ensure the deficient practice(s) does not recur: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The medication lists of all new admissions will be matched with actual medications the following day by DON and or designee starting 7/20/2024 and will be ongoing process. Medications should be available by next delivery period and/or within 24 hours of order entry. If a medication is scheduled prior to pharmacy scheduled delivery run, nurses or certified medication aides are to pull first dose from the IV-ekit or medication delivery machine. Then follow regular delivery for the next dose. If medications are not available on the medication dispensing machine, the nurses and certified medication aides are expected to call for STAT delivery. List of medications available on the medication dispensing machine was posted by DON on 7/18/2024 in the medication rooms. 4. Monitoring performance: a. DON and/or designee will complete a daily audit of medications for new admissions, starting 7/20/2024 until 8/1/2024. Then will be reduced to weekly x 2 weeks ending 8/15/2024. Then move to random new admit medication audits until 8/30/2024. b. If there is missing medication, DON and/or designee will ensure that the notification tree was activated beginning 7/18/2024 and will be ongoing process. c. Findings will be discussed weekly starting 7/19/2024 between GM, DON and/or designee and VP of clinical operations and will continue weekly until 8/15/2024. There was an ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, after the IJ was called. Findings will also be presented during monthly QAPI meeting x3 months. The Survey Team monitored the Plan of Removal on 07/19/2024 Observations on 07/19/2024 from 08:30 a.m. to 03:30 p.m., revealed nursing staff received in-service training from GM and DON on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Record review on 07/19/2024 revealed daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents. Record review on 07/19/2024 revealed ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical Record review on 07/19/2024 revealed in-services completed for 12 staff on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Further record review revealed graded post-test for staff, no failures. Interview on 07/19/2024 at 03:41 p.m., LVN C stated she has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN C stated she has taken the post-test and confirmed completion and passed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/2024 at 03:47 p.m., RN B stated he has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. RN B stated he has taken the post-test and confirmed completion and passed. Observation and interview on 07/19/2024 at 03:53 p.m., LVN D was observed calling the pharmacy on medications delivery. LVN D stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN D stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:09 p.m., CMA A stated she he has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, notifying nurses to follow process of provider notifications to seek immediate interventions and alternatives. CMA A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:36 p.m., ACNO stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. ACNO stated she has taken the post-test and confirmed completion and passed. ACNO stated daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents completed and will continue. Phone call Interview on 07/19/2024 at 04:39 p.m., LVN B stated she has taken in-services on 07/19/2024 over phone with DON, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN B stated she has taken the post-test and confirmed completion and passed. Phone call Interview on 07/19/2024 at 04:43 p.m., LVN A stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:49 p.m., the DON stated the Chief Clinical Officer educated her and the GM on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. (continued on next page)

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	676440	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Round Rock, LLC	16219 Ranch Road 620 North Austin, TX 78717

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/2024 at 04:59 p.m., GM stated Chief Clinical Officer educated her and DON on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. The GM was notified on 07/19/2024 at 05:27 p.m. that the Immediate Jeopardy was removed. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45937 Based on interviews and record reviews, the facility failed to provide pharmaceutical services, including accurate acquiring, and administering of all drugs and biologicals to meet the needs for 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure Resident #1's scheduled medications were acquired and administered. Resident #1 was not given ceftriaxone (antibiotic used to treat bacterial infections) for a total of 4 times within the dates of 07/09/2024 to 07/11/2024, staff did follow up with the pharmacy for the antibiotics, staff did not communicate with the NP of the lack of antibiotics and missed medications, and staff did not communicate the missed doses to the administration. This failure resulted in the Resident #1's being sent to the hospital to have consistent antibiotic treatment, and to treat Bacteremia (bacteria in the blood stream) and ventriculitis (inflammation of the ventricles in the brain). An IJ was identified on 07/18/2024. The IJ Template was provided to the facility on [DATE] at 06:35 p.m. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. This failure could place residents at risk of not receiving their scheduled medications in an accurate and timely manner to promote healing and to meet the needs and care of resident. Findings Included: Review of Resident #1's face sheet, dated 07/18/2024, revealed a [AGE] year-old-female. admitted to the facility on [DATE] and discharged on [DATE]. Resident #1's face sheet further revealed diagnoses of other Encephalitis (An inflammation of the brain usually caused due to infection that causes flu like symptoms), Encephalomyelitis (term for inflammation of the brain and spinal cord), and Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Record review of Resident #1's orders, dated 07/18/2024, revealed two discontinued orders for: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024, start date: 07/09/2024 Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024, order date: 07/09/2024, start date: 07/09/2024, end date: 07/18/2024 Record review of Resident #1's July MAR (Medication Administration Record), dated 07/18/2024, revealed: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024 1038 (10:38 a.m.), D/C (Discontinued) Date: 07/10/2024 0608 (06:08 a.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Tuesday 07/09/24 a charting code of 09 at 2100 (09:00 p.m.) Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.), D/C (Discontinued) Date: 07/12/2024 at 1548 (03:48 p.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Wednesday 07/10/2024 a charting code of 09 at 0900 (09:00 a.m.), and 2100 (09:00 p.m.) Thursday 07/11/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of a check mark 2100 (09:00 p.m.) Friday 07/12/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of (x) at 2100 (09:00 p.m.) Further review of Resident #1 July MAR (Medication Administration Record) revealed a Chart Codes/Follow up table, a charting code of a check mark is listed as administered. Additional review of Resident #1's July MAR (Medication Administration Record), on page 30: Ceftriaxone Sodium Intravenous Solution Reconstituted, scheduled time: 07/11/2024 2100 (09:00 p.m.), administered time: 07/11/2024 2320 (11:20 p.m.), administered by LVN B, route intravenously, and location of Admin arm-right. Record review of Resident #1's July MAR revealed Resident #1 was administered Ceftriaxone Sodium Intravenous one time from the dates of 07/09/2024 to 07/12/2024. Record review of Resident #1's Progress Notes, dated 07/18/2024, revealed: Note, effective date: 07/09/2024 2022 (08:22 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) pending pharmacy delivery. Note, effective date: 07/10/2024 1007 (10:07 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) PT (patient) pulled IV (Intravenous) line out. Note, effective date: 07/10/2024 1600 (04:00 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) pending pharmacy delivery. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note, effective date: 07/10/2024 2253 (10:53 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Medication pending arrival to facility. Note, effective date: 07/11/2024 1810 (06:10 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Not Available. Note, effective date: 07/12/2024 0947 (09:47 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) med order pending, call pharmacy. Record review of Resident #1's NP Progress note, dated 07/12/2024, revealed an HPI (History of Present Illness) Related to this Visit, notified this AM (Morning) by nursing staff that pt (Patient) has not received IV (Intravenous) abx (Antibiotic) ceftriaxone since admission d/t (Determine that) Pharmacy carrier not delivering med to facility. No previous staff or nursing notified this NP (Nurse Practitioner) that med had not been delivered since pt's (Patient's) admission. This NP (Nurse Practitioner) called and notified attending MD (Medical Doctor) and notified her of the situation. pt (Patient) sent to ER (emergency room) to ensure pt restarted on abx (Antibiotic). Spoke to pt's Family #1 in pt's room and notified family that pt has not received her IV (Intravenous) abx and will be sending pt back to ER. MD stated his frustrations with facility and wanted pt immediately sent out, which this NP explained was already in the process. Record review of Resident #1's hospital records, dated 07/18/2024, revealed Resident #1 an admitted to the hospital on 07/12/2024, with no discharge date , with a chief complaint missed antibiotic. Further review of Resident #1's hospital records revealed an Assessment/Plan note: this 91-yeard-old female with past medical history of diabetes type 2 dementia, and haemophiles influenza (bacteria that can cause severe infection) on ceftriaxone was brought from skilled nursing facility. 1. Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Continue ceftriaxone 2 g (grams) every 12 hour till (until) 7/20 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 11:24 a.m., RN A stated that she worked the day shift when Resident #1 arrived on 07/09/2024, Resident #1 arrived between 3pm to 4pm. RN A stated that she remembered Resident #1 because of her antibiotics (Ceftriaxone) and she was scheduled to receive her medications twice, 9am and 9pm as that was how the orders was listed. RN A stated she admitted Resident #1, her antibiotics were not in house, RN A stated she ordered them from the pharmacy, as Resident #1's admitting records from the hospital revealed Resident #1 received her first dose of the antibiotic and Resident #1 next dose would be at 9pm. RN A stated she passed this information down to the next nurse on shift, as she would be off duty from 07/10/2024 to 07/12/2024. RN A returned to work on 07/12/2024 and reviewed Resident #1 medication administration and discovered that Resident #1 had missed doses of Ceftriaxone and had only received one dose on 07/11/2024 at 9pm. RN A stated when she inquired on the missed antibiotics, she was told the medications have not arrived in the facility. RN A stated she informed the ACNO, and NP of the missed doses. RN A stated that staff should have followed up with the pharmacy for the medications, inform the DON or ACNO, and notify the MD or NP of the missing antibiotics to look for alternatives. RN A stated that there we risk associated with the missed dosages as it could lead to an infection in Resident #'s blood. RN A stated Resident #1 was sent to the ER per the NP orders as the NP was seriously concerned of Resident #1 not receiving the antibiotics. Interview on 07/18/2024 at 12:27 p.m., LVN A stated she worked the floor as a charge nurse during Resident #1 stay on 07/11/2024. LVN A stated that Resident #1 antibiotics (Ceftriaxone) were not available that day. LVN A stated she checked the Ekit that day and there was no Ceftriaxone available. LVN A stated she marked it on the MAR as a 9, listed as other because the antibiotic was not available. LVN A stated that if there are missed doses, we contact the MD or NP, there is a procedure to follow up with the pharmacy and notify the DON or ACNO. LVN A stated, I screwed up, I admit it, I did not call the pharmacy because I thought it would be delivered later that day, and I did not call the NP. It was so busy that day, I'm sorry. LVN A stated the risks of Resident #1 not having her antibiotics would be the increased risk of infection. Interview on 07/18/2024 at 01:48 p.m., LVN B stated she worked during Resident #1's time at the facility and remembered her. LVN B confirmed that Resident #1 antibiotics are administered intravenously. LVN B stated that on Wednesday night (07/10/2024), she did not see Resident #1's Ceftriaxone in the cart, LVN B added she did not look in the Ekit that night. LVN B stated in Resident #1's MAR she coded it as 9 as she did not want to lie and say she administered the Ceftriaxone. LVN B stated on Thursday night (07/11/2024) Resident #1 did not have her Ceftriaxone in the cart, LVN B asked another nurse to look in the Ekit, and a dose of Ceftriaxone was available. LVN B stated she successfully administer Resident#1's antibiotic (Ceftriaxone), that is why she marked it with a checkmark. LVN B stated, I take full accountability, didn't check the ekit, and didn't call, I didn't call the pharmacy, I was thinking it (Ceftriaxone) was on its way here, I was thinking it was, that's why I put a medication pending arrival in the progress note, I didn't call the NP, the DON or ACNO, I should have but it was busy those nights. LVN B stated the risk of not Resident #1 not having her Ceftriaxone was, the risk of not getting better, of not healing, the risk of infection, and the risk of the resident (Resident #1) not going home as planned, I'm sorry. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 03:09 p.m., NP stated that she was only told that Resident #1 did not receive the scheduled antibiotic Ceftriaxone on 07/12/2024, the day I sent her to the ER. NP stated she was informed by RN A. NP stated she informed the MD, we were not happy, because staff did not give her Ceftriaxone, and we were not informed. NP added Resident #1 missed many doses, and when she was informed, I wanted to assure Resident #1 received her Ceftriaxone, that is the reason she had to send her to the ER. NP stated, the antibiotics (Ceftriaxone) was important for this patient, this was the main reason she was here to treat her infection, she had an infection in her brain that was treated at hospital, to assure that the infection won't come back and keep ravaging this patient, the antibiotics (Ceftriaxone) had to be consistent, and continued at the facility. the NP added, even with one dose she (Resident #1) received it could lead to serious harm, she (Resident #1) could have gone septic, sending to her hospital was ensuring she doesn't go septic and have drastic harm done to her (Resident #1). Interview on 07/18/2024 at 04:00 p.m., DON stated staff were required to look in the Ekit, if medications are not available staff are to notify the resident's providers, to look for alternative medications or treatments, or to make appropriate adjustments. The DON stated that the process and procedures are here to keep residents safe and to also offer options for our facility to treat residents. The DON confirmed she was not notified of Resident #1's missed doses (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. Interview on 07/18/2024 at 04:13 p.m., ACNO stated if no medications are available in the medication cart or the Ekit, staff should follow up with pharmacy, there two routes of delivery. If the medication does not come in from pharmacy, and there is no reason given from the pharmacy, staff are supposed to tell the DON, ADM, GM, ACNO. ACNO stated staff are supposed to follow up and call doctor or NP to see if there are alternatives. ACNO stated she recalled Resident #1 because she was on antibiotics (Ceftriaxone). ACNO stated she was informed on Friday (07/12/2024) approximately at 10:40 a.m., she informed the GM, and a pharmacy follow up would be completed. ACNO stated that she was informed that Resident #1 had missed two days without her (Resident #1) antibiotics. ACNO stated that staff should have notified, her, DON, GM that first day the Ceftriaxone had not come in and if Resident #1 did not receive the antibiotic. ACNO stated she verbally educated LVN A on the process of calling administration on 07/12/2024, but no in-services completed. ACNO stated, The antibiotic (Ceftriaxone), was important, if there were missed doses, it would interfere with her (Resident #1's) healing. Interview on 07/18/2024 at 05:39 p.m., GM stated staff are to contact the providers if there are no medications available for any reason, providers are to offer adjustments or alternatives for the missing medications, staff are to contact the pharmacy directly as well to work with them to have those medications delivered. GM added if the pharmacy is not able to deliver the medication, staff are to contact his or her supervisors and inform them of the situation. GM stated if the process is not followed, there are risk to residents not receiving the desired and appropriate treatments. GM stated she was not informed by staff of Resident #1 missed dosages of antibiotics (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. GM stated she was informed by the ACNO on 07/12/2024, and she immediately followed up with the pharmacy that day. Record Review of the Facility's Medication Ordering and Receiving from Pharmacy/Ordering and Receiving Non-Controlled Medications, dated 01/23, reflected the Policy: Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate reds of medication order and receipt. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedures: 1. Section E: New Medications, expect for emergency or stat medications, are ordered as follows: If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery. Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a non-controlled medication prior to pharmacy delivery. 1. Section F: Stat and emergency medications; except for Controlled Substances are ordered as follows: During regular pharmacy hours, the emergency or stat order is transmitted to the pharmacy immediately upon receipt. Such medications are delivered and administer in a timely manner. Emergency/STAT medication order then medication is not available in the emergency kit: An emergency/STAT order is placed with the provider pharmacy and the pharmacy is called by nursing staff to request the STAT. The requested medication(s) will be delivered in a timely manner. Subsequent doses are scheduled according to nursing care center policy on medication administration. Record Review of the Facility's Administration of Medications, dated 04/2023, revealed General statement, All medications are administered safely and appropriately to aid resident to and help overcome illness, relieve and prevent symptoms and help in diagnosis. The GM was notified on 07/18/2024 at 06:35 p.m., that an IJ situation was identified due to the above failures and the IJ template was provided. The POR (Plan of Removal) was accepted on 07/19/2024 at 03:37 p.m., and included: On 7/18/24 an abbreviated survey was initiated on 7/18/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an Immediate Jeopardy resident health and safety. The notification of Immediate Jeopardy states as follows: F755 - The facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of a resident, this resulted in Resident #1 missing dosages of ceftriaxone. 1. Corrective Action for residents affected by the deficient practice: a. Resident #1 had been discharged from the facility on 7/12/2024. 2. How other residents having the potential to be affected be identified and what corrective action(s) will be taken: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Residents admitted to the facility have the potential to be affected by the identified deficient practice. Education was given to DON and GM by Chief Clinical Officer on 7/18/2024. Inservice will start 7/18/2024 and be completed by all fulltime staff by 7/19/2024 and be conducted by director of nursing (DON), general manager (GM) to all Fulltime, part time, PRN nurses and certified medication aides (CMA). Training for all new hires, PRN and part time employees will be completed prior to start of shift. Post test will be conducted after Inservice. Topic will include: i. Proper ordering/reordering medications process - will review the pharmacy policy section 3.2 entitled Medication Ordering and Receiving From Pharmacy Provider ii. Proper Protocol for all Facility Nurses and medication aides for bullet points 1,2, and 3. when medication is unavailable - 1. Check Medication expensing machine and IV E-kit immediately. Nurses & CMAs. 2. Contact pharmacy immediately. Nurses & CMAs. 3. Notify DON and/or GM for escalation Within 1 hour of calling pharmacy. Nurses & CMAs. 4. Within 1 hour after notifying DON and/or GM, notify physician to request for alternative orders. ONLY for nurses 5. Document and carry out provider's instructions immediately. ONLY for nurses iii. Proper Protocol for all Facility Nurses and Medication aides of notification tree if medication is unavailable - 1. DON Contact information is posted in med room 2. Contact GM Contact information is posted in Med Room 3. Contact assigned provider ONLY for nurses iv. Contents of medication dispensing machine and IV E-kits - see Attachment A b. Inservices will be reinforced via the bulletin board of the electronic health records as well as live documents sent via text message. Inservice will be required to be completed prior to start of shift. There will be post test given and graded by CNO and/or GM c. Nursing staff initiated a MAR-to-Cart audit of all in-house residents on 7/18/2024 to ensure medications are available and to order/reorder medications that are not available in the medication carts. This will be completed by 7/19/2024. 3. Measures that will be put in place or systemic changes that will be made to ensure the deficient practice(s) does not recur: (continued on next page)

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	676440	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Round Rock, LLC	16219 Ranch Road 620 North Austin, TX 78717

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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 - Few	a. The medication lists of all new admissions will be matched with actual medications the following day by DON and or designee starting 7/20/2024 and will be ongoing process. Medications should be available by next delivery period and/or within 24 hours of order entry. If a medication is scheduled prior to pharmacy scheduled delivery run, nurses or certified medication aides are to pull first dose from the IV-ekit or medication delivery machine. Then follow regular delivery for the next dose. If medications are not available on the medication dispensing machine, the nurses and certified medication aides are expected to call for STAT delivery. List of medications available on the medication dispensing machine was posted by DON on 7/18/2024 in the medication rooms. 4. Monitoring performance: a. DON and/or designee will complete a daily audit of medications for new admissions, starting 7/20/2024 until 8/1/2024. Then will be reduced to weekly x 2 weeks ending 8/15/2024. Then move to random new admit medication audits until 8/30/2024. b. If there is missing medication, DON and/or designee will ensure that the notification tree was activated beginning 7/18/2024 and will be ongoing process. c. Findings will be discussed weekly starting 7/19/2024 between GM, DON and/or designee and VP of clinical operations and will continue weekly until 8/15/2024. There was an ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, after the IJ was called. Findings will also be presented during monthly QAPI meeting x3 months. The Survey Team monitored the Plan of Removal on 07/19/2024 Observations on 07/19/2024 from 08:30 a.m. to 03:30 p.m., revealed nursing staff received in-service training from GM and DON on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Record review on 07/19/2024 revealed daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents. Record review on 07/19/2024 revealed ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical Record review on 07/19/2024 revealed in-services completed for 12 staff on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Further record review revealed graded post-test for staff, no failures. Interview on 07/19/2024 at 03:41 p.m., LVN C stated she has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN C stated she has taken the post-test and confirmed completion and passed. (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 - Few	Interview on 07/19/2024 at 03:47 p.m., RN B stated he has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. RN B stated he has taken the post-test and confirmed completion and passed. Observation and interview on 07/19/2024 at 03:53 p.m., LVN D was observed calling the pharmacy on medications delivery. LVN D stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN D stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:09 p.m., CMA A stated she he has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, notifying nurses to follow process of provider notifications to seek immediate interventions and alternatives. CMA A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:36 p.m., ACNO stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. ACNO stated she has taken the post-test and confirmed completion and passed. ACNO stated daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents completed and will continue. Phone call Interview on 07/19/2024 at 04:39 p.m., LVN B stated she has taken in-services on 07/19/2024 over phone with DON, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN B stated she has taken the post-test and confirmed completion and passed. Phone call Interview on 07/19/2024 at 04:43 p.m., LVN A stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:49 p.m., the DON stated the Chief Clinical Officer educated her and the GM on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/2024 at 04:59 p.m., GM stated Chief Clinical Officer educated her and DON on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. The GM was notified on 07/19/2024 at 05:27 p.m. that the Immediate Jeopardy was removed. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45937 Based on interviews and record reviews, the facility failed to ensure a resident was free of any significant medication errors for 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure Resident #1's scheduled medications were acquired and administered. Resident #1 was not given ceftriaxone (antibiotic used to treat bacterial infections) for a total of 4 times within the dates of 07/09/2024 to 07/11/2024, staff did follow up with the pharmacy for the antibiotics, staff did not communicate with the NP of the lack of antibiotics and missed medications, and staff did not communicate the missed doses to the administration. This failure resulted in the Resident #1's being sent to the hospital to have consistent antibiotic treatment, and to treat Bacteremia (bacteria in the blood stream) and ventriculitis (inflammation of the ventricles in the brain). An IJ was identified on 07/18/2024. The IJ Template was provided to the facility on [DATE] at 06:35 p.m. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This failure could place residents at risk of not receiving their scheduled medications in an accurate and timely manner to promote healing and to meet the needs and care of resident. Findings Included: Review of Resident #1's face sheet, dated 07/18/2024, revealed a [AGE] year-old-female. admitted to the facility on [DATE] and discharged on [DATE]. Resident #1's face sheet further revealed diagnoses of other Encephalitis (An inflammation of the brain usually caused due to infection that causes flu like symptoms), Encephalomyelitis (term for inflammation of the brain and spinal cord), and Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Record review of Resident #1's orders, dated 07/18/2024, revealed two discontinued orders for: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024, start date: 07/09/2024 Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024, order date: 07/09/2024, start date: 07/09/2024, end date: 07/18/2024 Record review of Resident #1's July MAR (Medication Administration Record), dated 07/18/2024, revealed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy), order date: 07/09/2024 1038 (10:38 a.m.), D/C (Discontinued) Date: 07/10/2024 0608 (06:08 a.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Tuesday 07/09/24 a charting code of 09 at 2100 (09:00 p.m.) Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.), D/C (Discontinued) Date: 07/12/2024 at 1548 (03:48 p.m.). With administer times at 0900 (09:00 a.m.) and 2100 (09:00 p.m.). Further review revealed: Wednesday 07/10/2024 a charting code of 09 at 0900 (09:00 a.m.), and 2100 (09:00 p.m.) Thursday 07/11/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of a check mark 2100 (09:00 p.m.) Friday 07/12/2024 a charting code of (x) at 0900 (09:00 a.m.), and a charting code of (x) at 2100 (09:00 p.m.) Further review of Resident #1 July MAR (Medication Administration Record) revealed a Chart Codes/Follow up table, a charting code of a check mark is listed as administered. Additional review of Resident #1's July MAR (Medication Administration Record), on page 30: Ceftriaxone Sodium Intravenous Solution Reconstituted, scheduled time: 07/11/2024 2100 (09:00 p.m.), administered time: 07/11/2024 2320 (11:20 p.m.), administered by LVN B, route intravenously, and location of Admin arm-right. Record review of Resident #1's July MAR revealed Resident #1 was administered Ceftriaxone Sodium Intravenous one time from the dates of 07/09/2024 to 07/12/2024. Record review of Resident #1's Progress Notes, dated 07/18/2024, revealed: Note, effective date: 07/09/2024 2022 (08:22 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) pending pharmacy delivery. Note, effective date: 07/10/2024 1007 (10:07 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) PT (patient) pulled IV (Intravenous) line out. Note, effective date: 07/10/2024 1600 (04:00 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) pending pharmacy delivery. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note, effective date: 07/10/2024 2253 (10:53 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Medication pending arrival to facility. Note, effective date: 07/11/2024 1810 (06:10 p.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) Not Available. Note, effective date: 07/12/2024 0947 (09:47 a.m.), type: Emar (electronic medication administration), note text: Ceftriaxone Sodium Intravenous Solution Reconstituted (Ceftriaxone Sodium) Use 2000 mg (milligrams) intravenously every 12 hours for abt (Antibiotic Therapy) until 07/18/2024 23:59 (11:59 p.m.) med order pending, call pharmacy. Record review of Resident #1's NP Progress note, dated 07/12/2024, revealed an HPI (History of Present Illness) Related to this Visit, notified this AM (Morning) by nursing staff that pt (Patient) has not received IV (Intravenous) abx (Antibiotic) ceftriaxone since admission d/t (Determine that) Pharmacy carrier not delivering med to facility. No previous staff or nursing notified this NP (Nurse Practitioner) that med had not been delivered since pt's (Patient's) admission. This NP (Nurse Practitioner) called and notified attending MD (Medical Doctor) and notified her of the situation. pt (Patient) sent to ER (emergency room) to ensure pt restarted on abx (Antibiotic). Spoke to pt's Family #1 in pt's room and notified family that pt has not received her IV (Intravenous) abx and will be sending pt back to ER. MD stated his frustrations with facility and wanted pt immediately sent out, which this NP explained was already in the process. Record review of Resident #1's hospital records, dated 07/18/2024, revealed Resident #1 an admitted to the hospital on 07/12/2024, with no discharge date , with a chief complaint missed antibiotic. Further review of Resident #1's hospital records revealed an Assessment/Plan note: this 91-yeard-old female with past medical history of diabetes type 2 dementia, and haemophiles influenza (bacteria that can cause severe infection) on ceftriaxone was brought from skilled nursing facility. 1. Bacteremia (the presence of bacteria in the bloodstream)/ventriculitis inflammation of ventricles in the brain). Continue ceftriaxone 2 g (grams) every 12 hour till (until) 7/20 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 11:24 a.m., RN A stated that she worked the day shift when Resident #1 arrived on 07/09/2024, Resident #1 arrived between 3pm to 4pm. RN A stated that she remembered Resident #1 because of her antibiotics (Ceftriaxone) and she was scheduled to receive her medications twice, 9am and 9pm as that was how the orders was listed. RN A stated she admitted Resident #1, her antibiotics were not in house, RN A stated she ordered them from the pharmacy, as Resident #1's admitting records from the hospital revealed Resident #1 received her first dose of the antibiotic and Resident #1 next dose would be at 9pm. RN A stated she passed this information down to the next nurse on shift, as she would be off duty from 07/10/2024 to 07/12/2024. RN A returned to work on 07/12/2024 and reviewed Resident #1 medication administration and discovered that Resident #1 had missed doses of Ceftriaxone and had only received one dose on 07/11/2024 at 9pm. RN A stated when she inquired on the missed antibiotics, she was told the medications have not arrived in the facility. RN A stated she informed the ACNO, and NP of the missed doses. RN A stated that staff should have followed up with the pharmacy for the medications, inform the DON or ACNO, and notify the MD or NP of the missing antibiotics to look for alternatives. RN A stated that there we risk associated with the missed dosages as it could lead to an infection in Resident #'s blood. RN A stated Resident #1 was sent to the ER per the NP orders as the NP was seriously concerned of Resident #1 not receiving the antibiotics. Interview on 07/18/2024 at 12:27 p.m., LVN A stated she worked the floor as a charge nurse during Resident #1 stay on 07/11/2024. LVN A stated that Resident #1 antibiotics (Ceftriaxone) were not available that day. LVN A stated she checked the Ekit that day and there was no Ceftriaxone available. LVN A stated she marked it on the MAR as a 9, listed as other because the antibiotic was not available. LVN A stated that if there are missed doses, we contact the MD or NP, there is a procedure to follow up with the pharmacy and notify the DON or ACNO. LVN A stated, I screwed up, I admit it, I did not call the pharmacy because I thought it would be delivered later that day, and I did not call the NP. It was so busy that day, I'm sorry. LVN A stated the risks of Resident #1 not having her antibiotics would be the increased risk of infection. Interview on 07/18/2024 at 01:48 p.m., LVN B stated she worked during Resident #1's time at the facility and remembered her. LVN B confirmed that Resident #1 antibiotics are administered intravenously. LVN B stated that on Wednesday night (07/10/2024), she did not see Resident #1's Ceftriaxone in the cart, LVN B added she did not look in the Ekit that night. LVN B stated in Resident #1's MAR she coded it as 9 as she did not want to lie and say she administered the Ceftriaxone. LVN B stated on Thursday night (07/11/2024) Resident #1 did not have her Ceftriaxone in the cart, LVN B asked another nurse to look in the Ekit, and a dose of Ceftriaxone was available. LVN B stated she successfully administer Resident#1's antibiotic (Ceftriaxone), that is why she marked it with a checkmark. LVN B stated, I take full accountability, didn't check the ekit, and didn't call, I didn't call the pharmacy, I was thinking it (Ceftriaxone) was on its way here, I was thinking it was, that's why I put a medication pending arrival in the progress note, I didn't call the NP, the DON or ACNO, I should have but it was busy those nights. LVN B stated the risk of not Resident #1 not having her Ceftriaxone was, the risk of not getting better, of not healing, the risk of infection, and the risk of the resident (Resident #1) not going home as planned, I'm sorry. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/18/2024 at 03:09 p.m., NP stated that she was only told that Resident #1 did not receive the scheduled antibiotic Ceftriaxone on 07/12/2024, the day I sent her to the ER. NP stated she was informed by RN A. NP stated she informed the MD, we were not happy, because staff did not give her Ceftriaxone, and we were not informed. NP added Resident #1 missed many doses, and when she was informed, I wanted to assure Resident #1 received her Ceftriaxone, that is the reason she had to send her to the ER. NP stated, the antibiotics (Ceftriaxone) was important for this patient, this was the main reason she was here to treat her infection, she had an infection in her brain that was treated at hospital, to assure that the infection won't come back and keep ravaging this patient, the antibiotics (Ceftriaxone) had to be consistent, and continued at the facility. the NP added, even with one dose she (Resident #1) received it could lead to serious harm, she (Resident #1) could have gone septic, sending to her hospital was ensuring she doesn't go septic and have drastic harm done to her (Resident #1). Interview on 07/18/2024 at 04:00 p.m., DON stated staff were required to look in the Ekit, if medications are not available staff are to notify the resident's providers, to look for alternative medications or treatments, or to make appropriate adjustments. The DON stated that the process and procedures are here to keep residents safe and to also offer options for our facility to treat residents. The DON confirmed she was not notified of Resident #1's missed doses (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. Interview on 07/18/2024 at 04:13 p.m., ACNO stated if no medications are available in the medication cart or the Ekit, staff should follow up with pharmacy, there two routes of delivery. If the medication does not come in from pharmacy, and there is no reason given from the pharmacy, staff are supposed to tell the DON, ADM, GM, ACNO. ACNO stated staff are supposed to follow up and call doctor or NP to see if there are alternatives. ACNO stated she recalled Resident #1 because she was on antibiotics (Ceftriaxone). ACNO stated she was informed on Friday (07/12/2024) approximately at 10:40 a.m., she informed the GM, and a pharmacy follow up would be completed. ACNO stated that she was informed that Resident #1 had missed two days without her (Resident #1) antibiotics. ACNO stated that staff should have notified, her, DON, GM that first day the Ceftriaxone had not come in and if Resident #1 did not receive the antibiotic. ACNO stated she verbally educated LVN A on the process of calling administration on 07/12/2024, but no in-services completed. ACNO stated, The antibiotic (Ceftriaxone), was important, if there were missed doses, it would interfere with her (Resident #1's) healing. Interview on 07/18/2024 at 05:39 p.m., GM stated staff are to contact the providers if there are no medications available for any reason, providers are to offer adjustments or alternatives for the missing medications, staff are to contact the pharmacy directly as well to work with them to have those medications delivered. GM added if the pharmacy is not able to deliver the medication, staff are to contact his or her supervisors and inform them of the situation. GM stated if the process is not followed, there are risk to residents not receiving the desired and appropriate treatments. GM stated she was not informed by staff of Resident #1 missed dosages of antibiotics (Ceftriaxone) within the dates of 07/09/2024 to 07/11/2024. GM stated she was informed by the ACNO on 07/12/2024, and she immediately followed up with the pharmacy that day. Record Review of the Facility's Medication Ordering and Receiving from Pharmacy/Ordering and Receiving Non-Controlled Medications, dated 01/23, reflected the Policy: Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate reds of medication order and receipt. (continued on next page)

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	676440	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Round Rock, LLC	16219 Ranch Road 620 North Austin, TX 78717

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedures: 1. Section E: New Medications, expect for emergency or stat medications, are ordered as follows: If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery. Timely delivery of new orders is required so that medication administration is not delayed. If available, the emergency kit is used when the resident needs a non-controlled medication prior to pharmacy delivery. 1. Section F: Stat and emergency medications; except for Controlled Substances are ordered as follows: During regular pharmacy hours, the emergency or stat order is transmitted to the pharmacy immediately upon receipt. Such medications are delivered and administer in a timely manner. Emergency/STAT medication order then medication is not available in the emergency kit: An emergency/STAT order is placed with the provider pharmacy and the pharmacy is called by nursing staff to request the STAT. The requested medication(s) will be delivered in a timely manner. Subsequent doses are scheduled according to nursing care center policy on medication administration. Record Review of the Facility's Administration of Medications, dated 04/2023, revealed General statement, All medications are administered safely and appropriately to aid resident to and help overcome illness, relieve and prevent symptoms and help in diagnosis. The GM was notified on 07/18/2024 at 06:35 p.m., that an IJ situation was identified due to the above failures and the IJ template was provided. The POR (Plan of Removal) was accepted on 07/19/2024 at 03:37 p.m., and included: On 7/18/24 an abbreviated survey was initiated on 7/18/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate Jeopardy resident health and safety. The notification of Immediate Jeopardy states as follows: F755 - The facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of a resident, this resulted in Resident #1 missing dosages of ceftriaxone. 1. Corrective Action for residents affected by the deficient practice: a. Resident #1 had been discharged from the facility on 7/12/2024. 2. How other residents having the potential to be affected be identified and what corrective action(s) will be taken: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Residents admitted to the facility have the potential to be affected by the identified deficient practice. Education was given to DON and GM by Chief Clinical Officer on 7/18/2024. Inservice will start 7/18/2024 and be completed by all fulltime staff by 7/19/2024 and be conducted by director of nursing (DON), general manager (GM) to all Fulltime, part time, PRN nurses and certified medication aides (CMA). Training for all new hires, PRN and part time employees will be completed prior to start of shift. Post test will be conducted after Inservice. Topic will include: i. Proper ordering/reordering medications process - will review the pharmacy policy section 3.2 entitled Medication Ordering and Receiving From Pharmacy Provider ii. Proper Protocol for all Facility Nurses and medication aides for bullet points 1,2, and 3. when medication is unavailable - 1. Check Medication expensing machine and IV E-kit immediately. Nurses & CMAs. 2. Contact pharmacy immediately. Nurses & CMAs. 3. Notify DON and/or GM for escalation Within 1 hour of calling pharmacy. Nurses & CMAs. 4. Within 1 hour after notifying DON and/or GM, notify physician to request for alternative orders. ONLY for nurses 5. Document and carry out provider's instructions immediately. ONLY for nurses iii. Proper Protocol for all Facility Nurses and Medication aides of notification tree if medication is unavailable - 1. DON Contact information is posted in med room 2. Contact GM Contact information is posted in Med Room 3. Contact assigned provider ONLY for nurses iv. Contents of medication dispensing machine and IV E-kits - see Attachment A b. Inservices will be reinforced via the bulletin board of the electronic health records as well as live documents sent via text message. Inservice will be required to be completed prior to start of shift. There will be post test given and graded by CNO and/or GM c. Nursing staff initiated a MAR-to-Cart audit of all in-house residents on 7/18/2024 to ensure medications are available and to order/reorder medications that are not available in the medication carts. This will be completed by 7/19/2024. 3. Measures that will be put in place or systemic changes that will be made to ensure the deficient practice(s) does not recur: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The medication lists of all new admissions will be matched with actual medications the following day by DON and or designee starting 7/20/2024 and will be ongoing process. Medications should be available by next delivery period and/or within 24 hours of order entry. If a medication is scheduled prior to pharmacy scheduled delivery run, nurses or certified medication aides are to pull first dose from the IV-ekit or medication delivery machine. Then follow regular delivery for the next dose. If medications are not available on the medication dispensing machine, the nurses and certified medication aides are expected to call for STAT delivery. List of medications available on the medication dispensing machine was posted by DON on 7/18/2024 in the medication rooms. 4. Monitoring performance: a. DON and/or designee will complete a daily audit of medications for new admissions, starting 7/20/2024 until 8/1/2024. Then will be reduced to weekly x 2 weeks ending 8/15/2024. Then move to random new admit medication audits until 8/30/2024. b. If there is missing medication, DON and/or designee will ensure that the notification tree was activated beginning 7/18/2024 and will be ongoing process. c. Findings will be discussed weekly starting 7/19/2024 between GM, DON and/or designee and VP of clinical operations and will continue weekly until 8/15/2024. There was an ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, after the IJ was called. Findings will also be presented during monthly QAPI meeting x3 months. The Survey Team monitored the Plan of Removal on 07/19/2024 Observations on 07/19/2024 from 08:30 a.m. to 03:30 p.m., revealed nursing staff received in-service training from GM and DON on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Record review on 07/19/2024 revealed daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents. Record review on 07/19/2024 revealed ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical Record review on 07/19/2024 revealed in-services completed for 12 staff on topics of Proper ordering/reordering medications process, contacting administration, and systematic changes to assure accuracy of orders and medications. Further record review revealed graded post-test for staff, no failures. Interview on 07/19/2024 at 03:41 p.m., LVN C stated she has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN C stated she has taken the post-test and confirmed completion and passed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/2024 at 03:47 p.m., RN B stated he has taken in-services on 07/18/2024 at PM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. RN B stated he has taken the post-test and confirmed completion and passed. Observation and interview on 07/19/2024 at 03:53 p.m., LVN D was observed calling the pharmacy on medications delivery. LVN D stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN D stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:09 p.m., CMA A stated she he has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, notifying nurses to follow process of provider notifications to seek immediate interventions and alternatives. CMA A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:36 p.m., ACNO stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. ACNO stated she has taken the post-test and confirmed completion and passed. ACNO stated daily audit of medications for new admissions, and MAR-to-Cart audit of all in-house residents completed and will continue. Phone call Interview on 07/19/2024 at 04:39 p.m., LVN B stated she has taken in-services on 07/19/2024 over phone with DON, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN B stated she has taken the post-test and confirmed completion and passed. Phone call Interview on 07/19/2024 at 04:43 p.m., LVN A stated she has taken in-services on 07/19/2024 at AM shift, on topics of Proper ordering/reordering medications process, contacting administration, providers to inform of any missing medications to seek immediate interventions and alternatives, and systematic changes to assure medications and orders accuracy. LVN A stated she has taken the post-test and confirmed completion and passed. Interview on 07/19/2024 at 04:49 p.m., the DON stated the Chief Clinical Officer educated her and the GM on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/19/2024 at 04:59 p.m., GM stated Chief Clinical Officer educated her and DON on topics of Proper ordering/reordering medications process on 7/18/2024, ADHOC QAPI meeting held on 7/18/2024 with the General Manager, Administrator, Director of Nursing, Medical Director, Pharmacy Director, Chief Clinical Officer, and Regional VP of Clinical, and in-service started 07/18/2024 after IJ identified on topics of [NAME] ordering/reordering medications process, for all Fulltime, part time, PRN nurses and certified medication aides (CMA), as needed for all new hires, PRN and part time employees will be completed prior to start of shift. DON stated daily and random audits will continue to assure compliance. The GM was notified on 07/19/2024 at 05:27 p.m. that the Immediate Jeopardy was removed. While the IJ was removed on 07/19/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy.