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F 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024016211, 2025000660, 2025002535, and 2025003100 was conducted on - and - at Highland Pines Rehabilitation Center. The facility was not in compliance with Code for Federal Regulations (CFR), Part 483, Requirements for Long-Term Care Facilities. Findings of Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, , , or to a resident) related to complaint number 2025002535 were identified at: F600, F710, F726, F773, and F867 Scope and Severity of "K" (Immediate Jeopardy to resident health or safety which is a pattern). Substandard Quality of Care was identified at F600. A partial extended survey was completed on . The Immediate Jeopardy started on . The facility resident census at the beginning of the survey was 111. The facility was informed of, and provided the templates for, the Immediate Jeopardy on . It was determined that the Immediate Jeopardy	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 000	Continued From page 1 was removed on and the Scope and Severity for F600, F710, F726, F773, and F867 was reduced to a "E" after verification of removal of immediacy of harm.	F 000		
F 600 SS=K	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and , . The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , , , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to protect the residents' right to be free from neglect for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) out of eleven residents sampled related to medication management and follow-up laboratory orders for medication therapeutic levels. Serious harm occurred when Resident #1's medication levels were not monitored, and consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level	F 600	F600 Free from & Neglect/N204 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Residents # 5 and #10 no longer reside in the facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. consult was for	

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F 600	Continued From page 2 of care as a result of the suffered on . This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or to Resident #1 and resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the scope and severity was reduced to an "E" after verification of removal of immediacy of harm. Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , , and , , , , not , without status , , , status as of , with loss of , , , , , , adult , protein-calorie , , , major , , lack of coordination, communication , and , . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on .	F 600	resident #1 as requested by physician. 2.How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and that consultation orders for were completed as indicated. Any residents identified without lab monitoring orders or fully executed consults were reported to physician and new orders transcribed as indicated. 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur. Director of Nursing/Designee will educate licensed nursing staff on the lab monitoring process to include ensuring that residents on medication receive proper lab monitoring, physician notification of abnormal lab values or refused labs, documentation of physician notification and new orders is recorded in the resident clinical record, and consultation orders for are properly executed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Ie. What quality assurance program will be put into place. Director of Nursing/Designee will randomly	

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F 600	Continued From page 3 Review of Resident #1's Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her , levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER {] , consult, check medication levels ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was	F 600	audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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and shaking the full time of the .
Resident is currently lying in bed. Dr. notified and waiting for a call ."

Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician.

Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results."

Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on .

Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week.

Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today"

Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m.

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F 600	Continued From page 5 Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on . Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician. Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... ر Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general." ...Assessment and Plan ... ر consult, check medications levels ..."	F 600		

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Review of Resident #1's medical record revealed no evidence she received services.

Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or noted. No injuries. MD [Medical Doctor] notified. New order placed for labs."

Review of Resident #1's physician orders revealed, an order with an order date of for level, Ammonia Level, ( ), and level. There was no start date or end date on the physician order.

Review of Resident #1's MAR revealed the physician order for level, Ammonia level, ( ), and level was not documented as completed.

Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for level, Ammonia Level, ( ), or a level.

Review of Resident #1's progress note, dated at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2

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minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air].

Review of the medical record did not reveal the resident's physician was notified of the .

Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on .

Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day.

Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values:
: Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL
: High (24 mg/dL) with a reference range of mg/dL
/ Ratio: High (38.6 mg/dL) with a reference range of 6.0-25.0 mg/dL
: Low (3.4 mg/dL) with a reference range of

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8. .2 mg/dL
: Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL
: Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL
: Low (35.9%) with a reference range of 37.0-47.0%
, (,): low (25 ug/mL) with a reference range of 50-100 ug/mL

Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date.

Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected.

An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn.

Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and

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is nonverbal at this time. Resident has history of activity. Family and MD aware."

Review of Resident #1's change in condition, dated , revealed
"The change in condition ...:
The was: New onset activity, OR
persistent in someone with known
intermittent activity.
Provider Notification and Feedback: ...send to Er [emergency room]"

Review of Resident #1's hospital record revealed a physician note, dated , as:
"Impressions and Plan
Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive .
Low , , level
Low , level but her dose of this medication may not be therapeutic.
...Plan
Prescribe telemetry
Neurochecks every hours
precautions
. 2mg [ ] for convulsive activity lasting more than 100 seconds
, ,
,
, .
She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear

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how her refusal to take p.o. [by] AEDs will get resolved. She may need a [.
, ˘ ˛].”

Review of Resident #1's hospital Physician note, dated , revealed:
"The patient presents with ˛ [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , ˘ . denies , , n/v [/ ˛] and ˛ , ˘ . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , ˛ issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , , d/c [discomfort]. She has no ˘ [˘]
complaints.
...plan
Npo[nothing by] after mn [midnight]
Egd [, ˘ ˘ , ˛/, ˘
tomorrow."

Review Resident #1's through ˛ Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug

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refused". The , MAR review revealed Resident #1 received , , 125 mg three times a day for every day for the month of , until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug.

Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal."

Review of Resident #1's nutrition note, dated at 9:59 a.m. revealed, "Res [Resident] readmitted to facility s/p [status/post] 7d [day] hospitalization. New [, , tube] inserted however res eats 75-100% of meals by and requests snacks frequently. Will d/c [discontinue] feed as res is able to meet needs via po [by] at this time. Flush tube w/ [with] 150cc H20 [water] q [every] shift to maintain patency."

Review of Resident #1's progress note, dated at 10:21 a.m., written by Staff A, Licensed Practical Nurse (LPN), revealed, "This writer received order from NP [Nurse Practitioner] stating resident able to take medication by if

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resident refuses then we may use for medications; resident is currently eating meals w/o [without] issues or concerns."

An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a ,, consultation while in the hospital, but the facility did not follow up to schedule a ,, ,, for Resident #1. The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's ,, consultation was followed up on. She stated there

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was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation.

An interview was conducted on at 3:50 p.m. with Resident #1's , Physician Assistant (PA). The , PA said he does not manage Resident #1's levels. If a resident is on , for , would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP).

An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents , because it is managed by , . He stated , is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in , and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been managing her lab results and followed up with . He stated residents who are on , , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the

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provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.

An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is

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still herself but not quite the same, "we definitely fried some cells with that ."

An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication

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labs are abnormal the nursing staff should be notifying the ˬ because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a ˬˬ consultation then the facility should coordinate so the resident sees a ˬ . The Medical Director said the residents had to go out to see a ˬ because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients."

An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.

An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has

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been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications.

An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure.

A phone interview was conducted on at

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1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the .

A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses don not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisitions form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse

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re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that's the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility.

2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified .

Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #2's order showed the following:
-Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated .
-Fasting CMP, Lipids, , , level,

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F 600	Continued From page 20 Ammonia level. Every night shift for 1 day. Dated . - , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified . Dated . - , level. Dated . -Ammonia level. Dated . Review of lab results for Resident #2 showed , level and Ammonia level, dated . The , level was low at 23 ug/ml with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml. Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on . Review of Resident #2's Lab Order History on the lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level. Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT	F 600		

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, ."

An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until .

A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed.

3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , .

Review of Resident #8's physician orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , . Dated .
-Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated .

Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L

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(micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m.

Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m., showing labs were sent to the Advanced Registered Nurse Practitioner.

Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes."
Review of progress notes revealed no nurses' note showing why the lab was not drawn.

Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL.

An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not.

4. Review of Admission Records showed Resident

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F 600	Continued From page 23 #4 was admitted on with diagnoses including other . Review of Resident #4's care plan showed a focus area of , dated . Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #4's orders revealed the following active orders: - , , Oral Capsule Delayed Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated . - , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , , . Dated . Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels." Review of Resident #4's lab results showed the last , level result was on . 5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following , , , , , and . Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg . Give 1 tablet by at bedtime related to	F		

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and of unspecified .
Dated .
- /INR. Every night shift every 7 days related to unspecified . Dated .
- , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated .

Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds.

Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results.

Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL.

Review of Resident #3's MAR showed 4mg continued to be administered on
- .

An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the

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results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , , consultation. When asked why a , , consultation was being ordered she said , , is who manages the dosing for , , even for residents on the medication for .

6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , , .

Review of Resident #7's orders revealed the following orders:
- , { , } Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , , . Dated .
- , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued .
- Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated .

Review of Resident #7's TAR showed the order for labs on was signed off as completed.

Review of Resident #7's medical record showed no labs had been drawn.

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Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until .

Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL.

7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , , of front and .

Review of Resident #5's provider orders revealed the following:
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated .
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued .

Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

8. Review of Admission Records showed Resident #6 was admitted on with diagnoses including other .

Review of Resident #6's provider orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated .

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Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs.

9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other .

Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated .

Review of Resident #9's provider orders revealed the following:
- , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued .
- , , oral tablet 750 mg. Give one tablet by

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two times a day for . Dated . Discontinued .
, , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated .

Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn.

An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the doctor increased his , , and took him off , .

10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified .

Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated .

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F 600	Continued From page 29 Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL. An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again."	F 600		

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Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels ordered, and both scheduled to be collected . Awaiting psych response for low , levels."

11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified .

Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #11's provider orders revealed the following:
- , oral tablet delayed release 250 mg. Give 250 mg by two times a day for . Dated .
- , level. Every night shift every 3 months starting on the 16th for 1 day. Dated ,

Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL.

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F 600	Continued From page 31 Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order. Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in . Review of the facility's policy titled " Prevention Program", dated , revealed the following: "Policy: The facility has designated and implemented processes, which strive to reduce the risk of , neglect, , , mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, , neglect, mistreatment, and , . It is expected that these policies will assist the facility with reducing the risk of , neglect, , , and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burnout, or resident behavior which may increase the likelihood of such events. DEFINITIONS: ...Neglect " Failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical	F 600		

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F 600	Continued From page 32 harm, , , mental anguish or emotional distress. ...Mistreatment " Inappropriate treatment or 、 of a resident. ...Serious Bodily Injury An injury involving extreme physical , ; involving substantial risk of ; involving protracted loss of , of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal . ... Procedure The facility has implemented the following processes in an effort to provide resident's, visitors and staff with a safe and comfortable environment. " The administrator is responsible for designating an Coordinator. " The designated shift supervisor is identified as responsible for immediate initiation of the reporting process. " The administrator, DON and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, , neglect, and 、 and misappropriation. " The administrator, DON and/or designated individual are also ultimately responsible for the following: o Implementation o Ongoing monitoring o Investigation o Reporting o Tracking and trending TRAINING Facility orientation program and ongoing training programs will include, but may not be limited to: " 483.95(c): Freedom from , neglect, &	F 600		

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F 600	Continued From page 33 , requirements in 483.13. " 483.95(c): Activities that constitute , neglect, , , & misappropriation of resident property as set forth in 483.12. " 483.95(c): Procedures for reporting incidents of , neglect, , , or the misappropriation of resident property. " 483.95(c): management & resident prevention. " ...Identification of , neglect, mistreatment, , , and misappropriation. " ...How staff should report their knowledge related to allegations without fear of reprisal. " How to provide protection for residents. " Components of a compete and thorough investigation. " Methods to reduce the risk of , neglect, mistreatment, misappropriation, and , that may include, but may not be limited to, recognizing signs of burnout, frustration and stress, stress management and relaxation techniques .... PREVENTION " ... staff are instructed to report concerns, incidents, and grievances without fear of retaliation. " ... Facility leadership will identify situations in which , neglect, this treatment, , , misappropriation may be more likely to occur such as " Residents with needs/behaviors which might lead to conflict or /neglect. " Staff burnout " analyze the occurrences to determine what changes are needed, if any, to policies and procedures and education to prevent further occurrences.	F 600		

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F 600	Continued From page 34 " ... event reports and resident concern/Grievance Reports are reviewed, tracked, and trended for indicators suspicious for , neglect, mistreatment, , , and/or misappropriation. ...TRACKING AND TRENDING " A monthly report of reportable events is prepared and provided to the Quality Assurance, Assessment, and Compliance Committee for review. " Events are tracked and trended to identify similarities, causative factors and any other area that may increase the risk of repeat occurrences of the same or similar nature. Review of the facility's policy titled "Physician Notification," dated , showed: Policy The facility strives to ensure that each resident's health is supervised by a qualified attending Physician. The attending Physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient. Procedure 1. Licensed Nurses will ensure that physicians are notified of changes or diagnostic results that occur between visits. Changes may include but are not limited to: " A change in condition, mental or physical " A change in the status of a " The development of a new " Laboratory Results " Diagnostic Results " Abnormal or those outside the " Successful treatment of " Consultant reports & recommendations	F 600		

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" Family concerns related to medical care
" Events
" Resident's refusal to take medication
" Any time a medication is not administered as ordered
2. It is not sufficient to document Faxed to the physician without verbal follow up.
3. If there has been no verbal contact within a reasonable time frame (Based on Nursing judgment & the acuity of the situation).
o Notify the DON or designee
o Notify the Medical Director
4. Emergent situations do not require a physician order to dial 911.

The facility's immediate actions to correct the deficient practice and remove the Immediate Jeopardy included:
" On the Regional Nurse Consultant educated the Administrator and Director of Nursing on , neglect, and , as they relate to ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification of abnormal labs, and follow-up procedures and resident condition change related to laboratory results. Education is 100% complete.
" On the Consultant Physician provided education to facility Medical Director and physician extender on , neglect, and , as they relate to ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, and follow-up procedures related to laboratory results.
" On the Director of Nursing or designee educated 100% of staff on , neglect, and

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, as they relate to ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification of abnormal lab values, and follow-up procedures related to laboratory results.

" Process Change: Effective , the Director of Nursing is responsible for reviewing consultation log(s) and making sure that consultation orders were executed, monitoring the laboratory monitoring processes for medications that require lab levels, reviewing progress notes to ensure physician notification has taken place, and ensuring complete follow-through with relation to laboratory results.

On all education and in-service sign-in sheets were reviewed and validated 53 out of 93 employees had received , neglect, and , training as they relate to ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification of abnormal labs, and follow-up procedures and resident condition change related to laboratory results.

On interviews were conducted with 53 staff members across various shifts, the Nursing Home Administrator, the Assistant Director of Nursing, the DON, and the Medical Director. The staff members were able to verbalize they had been trained and were knowledgeable about the new policies.

Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy

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F 600	Continued From page 37 was determined to be removed on , and the non-compliance was reduced to a scope and severity of E.	F 600		
F 710 SS=K	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse , must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide competent physician services for the treatment and monitoring of diagnoses for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) out of eleven sampled residents. Serious harm occurred when Resident #1's medication levels were not monitored, and , consultation was not obtained per the provider's request. Resident #1 experienced a	F 710	F710 Resident s Care Supervised by a Physician. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #5 and #10 no longer reside in facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11.	

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F 710	Continued From page 38 on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or to residents and resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the scope and severity was reduced to an "E" after verification of removal of immediacy of harm. Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , , and , , , not , without status , , , status as of , with loss of , , , , , , adult , protein-calorie , , major , , lack of coordination, communication , and , . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a	F 710	Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. consult was for resident #1 as requested by physician. 2. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and consults have been completed as indicated. Any residents identified without lab monitoring orders were reported to physician and new orders transcribed as indicated. Any prior consultation orders not properly executed were scheduled. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur. Director of Nursing/Designee will educate licensed nursing staff on ensuring appropriate physician oversight of resident care related to the lab monitoring process, ensuring that residents on medication receive proper lab monitoring, physicians are notified of abnormal lab values or refused labs, outside or providers are consulted as indicated,	

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F 710	Continued From page 39 day for , start date and discontinued on . Review of Resident #1's Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with	F 710	and documentation of physician notification and new orders is recorded in the resident clinical record. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. Director of Nursing/Designee will randomly audit residents on medications to ensure that the results of lab orders for monitoring medication levels have been reported to the physician, new orders are transcribed as indicated, and consultation orders for or outside providers are completed as indicated. Audits will be performed weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ."

Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician.

Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results."

Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on .

Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week.

Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today"

Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked

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F 710	Continued From page 41 today" was signed off as completed on at 3:06 a.m. Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on . Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician. Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general." ...Assessment and Plan ...	F 710		

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F 710	Continued From page 42 consult, check medications levels ..." Review of Resident #1's medical record revealed no evidence she received services. Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or noted. No injuries. MD [Medical Doctor] notified. New order placed for labs." Review of Resident #1's physician orders revealed, an order with an order date of ,for , level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order. Review of Resident #1's MAR revealed the physician order for , level, Ammonia level, (, ,), and level was not documented as completed. Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level, Ammonia Level, (, ,), or a level. Review of Resident #1's progress note, dated at 7:30AM, revealed " activity	F 710		

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noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air].

Review of the medical record did not reveal the resident's physician was notified of the .

Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on .

Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day.

Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values:
: Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL
: High (24 mg/dL) with a reference range of mg/dL
/ Ratio: High (38.6 mg/dL) with a

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reference range of 6.0-25.0 mg/dL
: Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL
: Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL
: Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL
: Low (35.9%) with a reference range of 37.0-47.0%
, (,): low (25 ug/mL) with a reference range of 50-100 ug/mL

Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date.

Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected.

An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn.

Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved

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F 710	Continued From page 45 to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware." Review of Resident #1's change in condition, dated , revealed "The change in condition ...: The was: New onset activity, OR persistent in someone with known intermittent activity. Provider Notification and Feedback: ...send to Er [emergency room]" Review of Resident #1's hospital record revealed a physician note, dated , as: "Impressions and Plan Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a posticta state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive . Low , , level Low , level but her dose of this medication may not be therapeutic. ...Plan Prescribe telemetry Neurochecks every hours precautions , 2mg [ ] for convulsive activity lasting more than 100 seconds , , , , . She is also on , that is not available	F 710		

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in form, but the other 's [, , drugs] should be adequate. There is not yet clear how her refusal to take p.o. [by] AEDs will get resolved. She may need a [, ,]."

Review of Resident #1's hospital Physician note, dated , revealed: "The patient presents with [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , . denies , , n/v [/] and , , . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , , d/c [discomfort]. She has no [,] complaints.
...plan
Npo[nothing by] after mn [midnight]
Egd [, , , ,]/, , tomorrow."

Review Resident #1's through Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On

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F 710	Continued From page 47 at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The , MAR review revealed Resident #1 received , , 125 mg three times a day for every day for the month of , until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug. Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal." An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , , nurse practitioner. The DON stated she was aware that this was a	F 710		

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system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a ,, consultation while in the hospital, but the facility did not follow up to schedule a ,, ,, for Resident #1. The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's ,, consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation.

An interview was conducted on at 3:50 p.m. with Resident #1's , , Physician Assistant (PA). The , , PA said he does not manage Resident #1's , levels. If a resident is on , for , , would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP).

An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice

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Registered Nurse (APRN). The APRN said he does not monitor residents , because it is managed by , . He stated , is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in , and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been managing her lab results and followed up with . He stated residents who are on , , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.

An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost

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control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ."

An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director

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reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a consultation then the facility should coordinate so the resident sees a . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients."

An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big "

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( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.

An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , and they were able to

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upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications.

An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure.

A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the *. The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the .

A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide

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F 710	Continued From page 54 a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisition form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that's the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility. 2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified .	F 710		

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Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #2's order showed the following:
-Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated .
-Fasting CMP, Lipids, , , level, Ammonia level. Every night shift for 1 day. Dated .
- , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified , Dated .
- , level. Dated .
-Ammonia level. Dated ,

Review of lab results for Resident #2 showed , level and Ammonia level, dated . The , level was low at 23 ug/ml with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and

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drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml.

Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on .

Review of Resident #2's Lab Order History on the lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level.

Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT , ."

An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until .

A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the

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lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed.

3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , ,.

Review of Resident #8's physician orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , ,. Dated ,
-Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated .

Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m.

Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m.,. showing labs were sent to the Advanced Registered Nurse Practitioner.

Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes."
Review of progress notes revealed no nurses' note

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showing why the lab was not drawn.

Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL.

An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not.

4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other .

Review of Resident #4's care plan showed a focus area of , dated .
Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow
up as indicated.

Review of Resident #4's orders revealed the following active orders:
- , , Oral Capsule Delayed Release Sprinkle 125 mg (,).
Give 2 capsule by every 8 hours related to other . Dated .
- , CMP, , , , Ammonia Level.
One time a day every 90 day(s) for , ,

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F 710	Continued From page 59 , , , . Dated . Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels." Review of Resident #4's lab results showed the last , level result was on . 5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following , , , , and . Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg , Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to unspecified . Dated . - , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds.	F 710		

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Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results.

Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL.

Review of Resident #3's MAR showed 4mg continued to be administered on - .

An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , , consultation. When asked why a , , consultation was being ordered she said , , is who manages the dosing for , , even for residents on the medication for .

6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , , .

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F 710	Continued From page 61 Review of Resident #7's orders revealed the following orders: - , (,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , . Dated . - , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued . - Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated . Review of Resident #7's TAR showed the order for labs on was signed off as completed. Review of Resident #7's medical record showed no labs had been drawn. Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until . Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL. 7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , of front and . Review of Resident #5's provider orders revealed the following: - (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for .	F 710		

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F 710	Continued From page 62 Dated . - (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued . Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . 8. Review of Admission Records showed Resident #6 was admitted on with diagnoses including other . Review of Resident #6's provider orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated . Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs. 9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other .	F 710		

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F 710	Continued From page 63 Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #9's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued . - , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued . , , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated . Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn. An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the	F 710		

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F 710	Continued From page 64 doctor increased his , , and took him off , . 10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified . Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of	F 710		

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50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL.

An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again."

Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels."

11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified .

Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #11's care plan showed a focus

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F 710	Continued From page 66 area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated . Review of Resident #11's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 250 mg by two times a day for , Dated . - , level. Every night shift every 3 months starting on the 16th for 1 day. Dated . Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL. Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order. Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in . Review of a facility policy titled "Physician Services," effective , showed: Policy	F 710		

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The facility strives to ensure that each resident's health is supervised by a qualified attending Physician. The attending Physician in the facility is ultimately responsible for supervision and management of the care of the resident.
Procedure Physician Direction of Resident Care
1. Assure the medical care of each resident is supervised by a Physician. Physician supervision includes, but is not limited to, the following:
a. Approves admission to the facility as demonstrated by Physician admission orders for the resident's immediate care.
b. Provides orders consistent with the resident's physical and medical status upon admission.
c. Verified admission orders at the time of admission.
If the attending Physician at the transferring institution is the attending Physician at the receiving facility, the Physician's signature on the transfer orders serves as the admission orders.
d. Participates in the resident's assessment and care planning, monitoring changes in the medical status.
e. Provides consultation or treatment when called by the facility
Designating the Personal Physician
2. Honor resident rights by permitting each resident to designate their personal Physician.
3. Offer information about alternative Physicians to those residents who's attending Physician at the previous institution does not follow residents at this facility.
4. Explain alternative Physician choices to the resident and family preadmission, when possible, and at the time of admission. The attending Physician at the time of admission is agreed upon with the family and documented on the admission

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F 710	Continued From page 68 sheet. 5. Explain to the resident/resident representative that another Physician will be designated when their attending Physician is unavailable. Physician Visits 6. Schedule Physician visits according to the resident's Level of Care & State & Federal regulations. Review of a National Library of Medicine article titled " , , updated , , showed: " , (VPA) ia [sic] as a highly prevalent medication with multifaceted therapeutic applications in various and , . The therapeutic uses of VPA include , , treatment across different types, , management, and prophylaxis. The mechanism of action for VPA involves the enhancement of inhibitory neurotransmission and the modulation of voltage-gated ion channels. Coordination among interprofessional healthcare professionals, including , psychiatrists, pharmacists, and nurses, is crucial for appropriate patient selection, dosage adjustment, and monitoring of VPA . This activity analyzes and assesses the indications, , , potential drug interactions, and adverse effects of VPA , encompassing its effectiveness across various clinical scenarios. Furthermore, this activity also critically reviews the evidence supporting VPA's application in specific populations, including , patients, , women, and older individuals. The assessment also delves into the effectiveness of communication among healthcare providers, patients, and caregivers, regarding the	F 710		

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F 710	Continued From page 69 advantages, potential risks, and adherence to VPA treatment." Monitoring " [ ] should be monitored at baseline and then at regular intervals, , within the first 6 months of VPA treatment or if , mitochondrial is present. with differential, tests, and ammonia levels should be assessed at baseline, periodically, before planned surgical procedures, and throughout , . Screening procedures should be conducted for patients to detect signs of , , alterations in behavior, and , . drug levels should be monitored, with therapeutic ranges set at 50 to 100 mcg/mL for , , , and 50 to 125 mcg/mL for . The toxic levels are indicated as >175 mcg/mL before the morning dose of VPA. When , , is present, assessing , 's free levels is essential due to its protein-binding nature, as the total concentration measurements may be inaccurate." (https://www.ncbi.nlm.nih.gov/books/NBK559112/ accessed on). Review of a National Library of Medicine article titled " , [, ,]" updated , showed: " is a novel , , drug used to treat partial, myoclonic, and tonic-clonic . In 2000, the FDA approved the use of the oral formulation as adjunctive , , for the treatment of focal , myoclonic , and primary generalized . In addition, the FDA approved in 2006 for use in patients older than 15 years as adjunctive	F 710		

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F 710	Continued From page 70 , , when the oral formulation is not tolerated. This activity covers , including mechanism of action, , , adverse event profiles, eligible patient populations, and monitoring. In addition, it highlights the interprofessional team's role in managing conditions where , , is helpful." Monitoring "Baseline should be checked before initiating , , . Clinicians should closely monitor signs and symptoms of , , , , and , , ... Routine therapeutic drug monitoring (TDM) of is not recommended for all patients. However, pharmacokinetic parameters are altered in critically ill, , , or elderly patients. Hence, TDM may be recommended in this selected patient population as a dosing guide and monitor compliance ..." (https://www.ncbi.nlm.nih.gov/books/NBK499890/ accessed). Facility immediate actions to correct the deficient practice and remove the Immediate Jeopardy included: " On the Regional Nurse Consultant educated the Administrator and Director of Nursing on ensuring a competent physician process is in place for residents with diagnoses. " On at 1:30pm a consulting was credentialed with Point Click Care access and on site. " On the Consultant Physician provided education to facility Medical Director and physician extender on the process for monitoring therapeutic lab levels for residents with diagnoses and the medication prescribing	F 710		

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F 710	Continued From page 71 standards for such. " On the Director of Nursing or designee educated 100% of licensed nursing staff on the process for ensuring that consultation orders are completed, lab work is ordered for residents on medications, abnormal lab results are reported to physicians, and new orders are transcribed appropriately. " Process Change: Effective , the Director of Nursing is responsible for making sure that a competent physician process is in place for residents with diagnoses. On all education and in-service sign-in sheets were reviewed and validated with 12 out of 18 licensed nursing staff on the process for ensuring that consultation orders are completed, lab work is ordered for residents on medications, abnormal lab results are reported to physicians, and new orders are transcribed appropriately. On interviews were conducted with 10 licensed nurses across various shifts, the Assistant Director of Nursing, the DON, and the Medical Director. The staff members were able to verbalize they had been trained and were knowledgeable about the new policies. Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy was determined to be removed on , and the non-compliance was reduced to a scope and severity of E.	F 710		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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F 726	Continued From page 72 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and , , well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure nursing staff were competent in caring for residents with diagnoses to include laboratory monitoring process, following through with orders, processing consultations, and communications with physicians for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10,	F 726	F 726 Competent Nurse staffing 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Residents #5 and #10 no longer reside in	

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F 726	Continued From page 73 #11) out of eleven residents sampled. Serious harm occurred when Resident #1's medication levels were not monitored, and consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or to Resident #1 and resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the scope and severity was reduced to an "E" after verification of removal of immediacy of harm. Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , , and , , , , not , without status , , , status as of , with loss of , , , , , , adult , protein-calorie , , major , lack of coordination, communication , and , . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule	F	the facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. consult was for resident #1 as requested by physician. 2. How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and that any consults that were previously ordered were scheduled. Any residents identified without lab monitoring orders or fully executed consults were reported to physician and new orders transcribed as indicated. 3. What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur: Director of Nursing/Designee will educate licensed nursing staff on the care of residents with a diagnosis to include ensuring that lab orders are in place to monitor medication levels, physicians are notified of abnormal lab	

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F 726	Continued From page 74 delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on . Review of Resident #1's Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her , levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels	F 726	values or refused labs, documentation of physician notification of lab levels and new orders is recorded in the resident clinical record, and that consultation orders for or other outside providers are executed appropriately. 4. How the corrective action(s) will monitor to ensure the practice will not recur, i.e., what quality assurance program will be put in place(s); will be accomplished for those residents: Director of Nursing/Designee will randomly audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place and consultation orders for outside providers are completed weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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F 726	Continued From page 75 ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing] followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ." Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician. Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results." Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on . Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week. Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have	F 726		

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F 726	Continued From page 76 , level rechecked today" Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m. Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on . Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician. Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... , Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels	F 726		

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like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general."
...Assessment and Plan
...
ب consult, check medications levels ..."

Review of Resident #1's medical record revealed no evidence she received ب services.

Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or , noted. No injuries. MD [Medical Doctor] notified. New order placed for labs."

Review of Resident #1's physician orders revealed, an order with an order date of ,for . level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order.

Review of Resident #1's , MAR revealed the physician order for , level, Ammonia level, (, ,), and level was not documented as completed.

Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level,

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F 726	Continued From page 78 Ammonia Level, (,), or a level. Review of Resident #1's progress note, dated at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air]. Review of the medical record did not reveal the resident's physician was notified of the . Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on . Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day. Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values:	F 726		

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F 726	Continued From page 79 : Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL : High (24 mg/dL) with a reference range of mg/dL / Ratio: High (38.6 mg/dL) with a reference range of 6.0-25.0 mg/dL : Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL : Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL : Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL : Low (35.9%) with a reference range of 37.0-47.0% , (,): low (25 ug/mL) with a reference range of 50-100 ug/mL Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date. Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected. An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn.	F 726		

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Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware."

Review of Resident #1's change in condition, dated , revealed
"The change in condition ...:
The was: New onset activity, OR persistent in someone with known intermittent activity.
Provider Notification and Feedback: ...send to Er [emergency room]"

Review of Resident #1's hospital record revealed a physician note, dated , as:
"Impressions and Plan
Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive .
Low , , level
Low , level but her dose of this medication may not be therapeutic.
...Plan
Prescribe telemetry
Neurochecks every hours
precautions
, 2mg [ ] for convulsive

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F 726	Continued From page 81 activity lasting more than 100 seconds ' ` , , ` She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear how her refusal to take p.o. [by] AEDs will get resolved. She may need a [, , ⌣ ⌟]. " Review of Resident #1's hospital Physician note, dated , revealed: "The patient presents with ⌟ [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , ⌣ . denies , , n/v [/ ⌣] and ⌟ , ⌣ . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , ⌟ issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , , d/c [discomfort]. She has no ⌣ [⌣] complaints. ...plan Npo[nothing by] after mn [midnight] Egd [, ⌣ ⌣ , ⌟/, ⌣ tomorrow." Review Resident #1's through ⌟ Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for	F 726		

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except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The MAR review revealed Resident #1 received , , 125 mg three times a day for every day for the month of until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug.

Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal."

Review of Resident #1's nutrition note, dated at 9:59 a.m. revealed, "Res [Resident] readmitted to facility s/p [status/post] 7d [day] hospitalization. New [, tube] inserted however res eats 75-100% of meals by and requests snacks frequently. Will d/c [discontinue] feed as res is able to meet needs via po [by] at this time. Flush tube w/ [with] 150cc H20 [water] q [every] shift to maintain

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patency."

Review of Resident #1's progress note, dated at 10:21 a.m., written by Staff A, Licensed Practical Nurse (LPN), revealed, "This writer received order from NP [Nurse Practitioner] stating resident able to take medication by if resident refuses then we may use for medications; resident is currently eating meals w/o [without] issues or concerns."

An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a consultation while in the hospital, but the facility did not follow up to schedule a for Resident #1. The DON stated Resident #1's and Resident #2's

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labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation.

An interview was conducted on at 3:50 p.m. with Resident #1's Physician Assistant (PA). The PA said he does not manage Resident #1's levels. If a resident is on for would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP).

An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents because it is managed by . He stated is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been

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managing her lab results and followed up with [illegible]. He stated residents who are on [illegible], and [illegible] medications for [illegible] should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.

An interview was conducted on [illegible] at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a [illegible] for not eating, drinking, or taking her medications but she kept pulling the [illegible] out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal [illegible]", foaming at the [illegible], lost control of her [illegible] and [illegible], and then became post ictal (the period immediately following a [illegible] when the [illegible] recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including [illegible], drowsiness, [illegible], and [illegible] difficulties.) Staff B, LPN said Resident #1's normal [illegible] are focal [illegible], and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1

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returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ."

An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them"

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immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a consultation then the facility should coordinate so the resident sees a . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients."

An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by .

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Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.

An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a .a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications.

An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said

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she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure.

A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the .

A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the

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nurse has put the order into the lab portal, but they did not print the requisition form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that is the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility.

2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified .

Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #2's order showed the following:
-Fasting comprehensive panel (CMP),

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system for labs to be drawn on . There was an order put in on for a , level.

Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT , ."

An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until .

A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed.

3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , , .

Review of Resident #8's physician orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give

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F 726	Continued From page 93 3 tablet by two times a day related to , , . Dated , -Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated . Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m. Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m.,. showing labs were sent to the Advanced Registered Nurse Practitioner. Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes." Review of progress notes revealed no nurses' note showing why the lab was not drawn. Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL. An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the	F 726		

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provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not.

4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other .

Review of Resident #4's care plan showed a focus area of , dated .
Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow
up as indicated.

Review of Resident #4's orders revealed the following active orders:
- , , Oral Capsule Delayed Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated .
- , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , , . Dated .

Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels."

Review of Resident #4's lab results showed the last , level result was on .

5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following

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F 726	Continued From page 95 , , , , , and Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg . Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to unspecified . Dated . - , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds. Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results. Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL. Review of Resident #3's MAR showed 4mg continued to be administered on -	F 726		

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An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , consultation. When asked why a , consultation was being ordered she said , is who manages the dosing for , even for residents on the medication for .

6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , .

Review of Resident #7's orders revealed the following orders:
- , (,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , . Dated .
- , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued .
- Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated

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Review of Resident #7's TAR showed the order for labs on was signed off as completed.

Review of Resident #7's medical record showed no labs had been drawn.

Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until .

Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL.

7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , of front and .

Review of Resident #5's provider orders revealed the following:
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated .
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued .

Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

8. Review of Admission Records showed Resident #6 was admitted on with diagnoses

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Review of Resident #6's provider orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated .

Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs.

9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other .

Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated .

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Review of Resident #9's provider orders revealed the following:
- , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued .
- , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued .
, , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated .

Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn.

An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the doctor increased his , , and took him off , .

10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified .

Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

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F 726	Continued From page 100 Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for , Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL. An interview was conducted on at 11:34	F 726		

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a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again."

Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels."

11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified .

Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #11's provider orders revealed the following:
- , oral tablet delayed release 250 mg. Give 250 mg by two times a day for

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F 726	Continued From page 102 , Dated , - , level. Every night shift every 3 months starting on the 16th for 1 day. Dated . Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL. Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order. Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in , An interview was conducted on at 10:40 a.m. with Staff C, LPN. Staff C said she currently did not have access to the lab portal to enter labs. She said she had been locked out for a few days and did not know why. When asked if she had any education in the facility on the lab processes, she stated, "Honestly, no." Staff C said she would have another nurse print out a lab sheet for her if she needed it. She said there had been a problem with unit managers throwing the paper lab requisitions away because they wanted everything entered in the computer. Staff C said when a provider asks for a lab the nurse should put the order in the medical record timed to show up for the 11 p.m.-7 a.m. shift because that is when the	F 726		

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lab techs come in to draw labs. She said a requisition form should be filled out and put in the lab book under the date it is to be drawn. She said once the lab is drawn the 11 p.m.-7 a.m. nurse should check it off as complete in the medical record. Regarding reviewing lab results and ensuring labs are completed, Staff C said "That part I am not too sure. I hear it is the unit managers who do it, but I also hear the nurses are supposed to do it. I get conflicting information on that." Staff C said if a resident is on , they should have , levels checked and if they are on , , they should have , , levels checked.

An interview was conducted on at 10:57 a.m. with Staff A, LPN/UM. Staff A said when a provider requested a lab the nurse should place the order the in the resident's electronic medical record, night shift then puts the lab orders in the lab portal and fills out a lab requisition form, then the lab tech comes in the mornings to draw labs. Staff A said the lab tech came to the facility daily Monday-Saturday. She said after labs are drawn the results come in around p.m. She said the nurse assigned to the resident should call the provider and see if they have any new orders. Staff A said the lab faxes over results to the facility and the results are in the lab portal. She said a nurse should pass down in report if a resident had lab results pending. Staff A said the unit manager should check to ensure labs were done and the provider has been notified. She agreed there had been a breakdown in the lab process.

An interview was conducted on at 11:08 a.m. with the DON. She said the lab orders had

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not been put in the lab book as they were supposed to be. The Don said, "It was a breakdown because we weren't doing the right process." She said the way the labs had been handled there was no record of what lab results providers were aware of and what labs had not been reported.

An interview was conducted on at 5:20 p.m. with Staff E, LPN. He said when a physician orders a lab for a resident, he inputs the order into the EMR, so it triggers the 11:00p.m. to 7:00 a.m. staff to put the lab order into the lab portal. He stated he would tell the nurse taking over for him in report the resident has a lab ordered. He said the nurses should be following up and notifying the physician to make sure the labs were collected and resulted, and if the nurses did not do it then the Unit Managers make sure they are done. He said he just got access today to the lab portal. He said he was hired in and "maybe" in , he got education on the lab process. He said residents who are on medications should get medication labs every three to six months, but he "thinks" the Unit Managers are the ones make sure those orders are in the computer.

An interview was conducted on at 5:30 p.m. with Staff F, LPN she said she usually works the 7:00 a. m.-3:00p.m. shift and 3:00p.m.-11:00p.m. shift. She said for labs they have to put the physician order into the EMR and in the lab portal. She said then the nurse lets the oncoming nurse know the resident needs labs. Unless it is a STAT (emergent) order, then she said the nurse calls the lab company and lets

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them know there is a STAT order. She said she has access to the lab portal and has since she started but some nurses do not put the orders into the lab portal when they get lab orders, they just put the order into the EMR and have the 11:00p.m. to 7:00 a. m. nurse put the order into the lab portal. She said she is not sure if residents who are on medications should have medication lab levels routinely checked and if they do, she would have to ask how often they need them because she is not sure. She said she was familiar with the lab process from her previous employer, and it is not much different at this facility, but she has received training on the lab process throughout her employment with the facility.

An interview was conducted on at 3:17 p.m. with Staff G, LPN. Staff G said she felt if the nurses had communicated better during report, it would have helped with the lab problems. She said she had previously been taught the lab process at the facility.

An interview was conducted on at 3:20 p.m. with Staff H, LPN. She said she had worked at the facility since they changed to the new lab company, and she had no access to the lab portal.

An interview was conducted on at 3:48 p.m. with Staff I, LPN/UM and Staff A, LPN/UM. Staff I said the nurse working the cart assigned to a resident should get lab results and follow through with everything. He said they used to take the book into the morning clinical meetings and review the labs, but "It stopped for some reason." He said

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they would look at new orders and make sure labs were drawn, but with several NHA and DON changes "That process just kind of off." He said there had been a lot of turnovers at the facility. He said in clinical meetings they did review new orders but had not been looking at labs. He said clinical leadership should trust the nurse is doing the right thing, but still verify it is done. He said when the facility changed to the new lab company in 2024, the lab brought in books and did training during the day, then day shift trained the night shift nurses. Staff I said he sets up lab portal access for nurses. He said everyone gets access, but some do not use it very often, so the security features lock them out. Staff I said if a provider wanted a consult scheduled, they let the nurse know and the nurse should put an order in the computer. He said the UM sees the orders and tries to find a provider that takes the resident's insurance. He said if the UM cannot find a provider to take a resident's insurance, they let the NHA know. Staff A said they had not really noticed issues with the lab process, but did notice sometimes labs do not come quickly enough. Staff A said when she started at the facility another nurse trained her on the lab portal. She said for orders and consults the providers communicate to the nurse what is new.

An interview was conducted on at 4:20 p.m. with Staff J, LPN and Staff K, RN. Staff J said when she started at the facility she had three days of orientation, but "I got thrown in there." She said she never received formal training on the lab portal. She said when she had questions, she asked the supervisors or DON and got the answers she needed. Staff J said she had not noticed any

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issues with labs being completed, but it is everyone's responsibility to make sure they are done and to ensure labs are being monitored for the medications that require it. Staff J said she felt like the problem with the lab process was the amount of turnover with staff in the facility. She said they need continuity and regular staff caring for the residents. Staff J said there was not good communication with nurses when there was a lot of turnover and inconsistency. Staff K said when she started at the facility she did training and was told where to locate the lab portal instruction book. She said she had not noticed any lab or consultation issues. She said if a provider wants a consultation for a resident, they let the nurse know and the nurse should put in an order and let the UM know. The UM then followed up to set up , , and transportation. She said providers typically fill the nurses in on their plans and what they would like done. Staff K said medication labs should be drawn every 3 months and it is everyone's responsibility to make sure those routine labs get completed.

An interview was conducted on at 4:57 p.m. with the Assistant Director of Nursing (ADON). She said at morning clinical meetings she would look at labs related to control since she is the facility's preventionist, other labs were not reviewed. She said it is a team effort to ensure consultations , , and transportation were set up. The ADON said overall she believed so many nursing and administrative changes caused a breakdown in the system. She said from her understanding. a nurse got an order and put it in the electronic medical record, and the nurse who received the results through fax should

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F 726	Continued From page 108	F 726		

have followed up with the provider. She said when she started it was a work in progress to get the lab process in place; it would get started and then there was a turnover, and the process would go backwards. The ADON said "It is systemic" and there was not a solid process in place to ensure labs were completed.

Review of the facility's policy titled "Physician Notification," dated , showed: "Policy-The facility strives to ensure that each resident's health is supervised by a qualified attending Physician. The attending Physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient.
Procedure
1. Licensed Nurses will ensure that physicians are notified of changes or diagnostic results that occur between visits. Changes may include but are not limited to:
" A change in condition, mental or physical
" A change in the status of a
" The development of a new
" Laboratory Results
" Diagnostic Results
" Abnormal or those outside the
" Successful treatment of
" Consultant reports & recommendations
" Family concerns related to medical care
" Events
" Resident's refusal to take medication
" Any time a medication is not administered as ordered
2. It is not sufficient to document Faxed to the physician without verbal follow up.

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F 726	Continued From page 109 3. If there has been no verbal contact within a reasonable time frame (Based on Nursing judgment & the acuity of the situation). o Notify the DON or designee o Notify the Medical Director 4. Emergent situations do not require a physician order to dial 911." Review of an undated facility job description titled "Licensed Practical Nurse (LPN)" showed: "SUMMARY OF POSITION: The Licensed Practical Nurse is responsible for delivering care to residents/patients utilizing the nursing process of assessment, planning, intervention, implementation, and evaluation; and effectively interacts with residents/patients, family members, and other health team members while maintaining standards of professional nursing. ESSENTIAL DUTIES AND RESPONSIBILITIES (To be completed without harming or injuring resident/patient, co-worker, self, or others): Direct Care/ Patient Responsibilities " Assesses, plans, directs and evaluates total nursing care as determined by the resident's/patient's age related physical, , , , and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan. " Consults and coordinates with health care team members to assess, plan, implement and evaluate resident's/patient's care plans. " Maintains accurate, detailed reports and records. " Modifies resident's/patient's treatment plans, according to physician orders, indicated by residents'/patients' responses and conditions. " Monitors all aspects of residents/patients	F 726		

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F 726	Continued From page 110 care, including diet and physical activity. " Monitors, records and reports symptoms and changes in resident's/patient's conditions." Review of an undated facility job description titled "Registered Nurse (RN,)" showed: "SUMMARY OF POSITION: The Registered Nurse (RN) is responsible for delivering care to residents/patients utilizing the nursing process of assessment, planning, intervention, implementation, and evaluation; effectively interacts with residents/patients, family members, and other health team members while maintaining the standards of professional nursing. ESSENTIAL DUTIES AND RESPONSIBILITIES (To be completed without harming or injuring the resident/patient, co-worker, self, or others): Direct Care/ Patient Responsibilities " Assesses, plans, directs and evaluates total nursing care as determined by the resident's/patient's age related physical, , , , and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan. " Consults and coordinates with health care team members to assess, plan, implement and evaluate resident's/patient's care plans. " Maintains accurate, detailed reports and records. " Modifies resident's/patient's treatment plans, according to physician orders, indicated by residents'/patients' responses and conditions. " Monitors all aspects of residents/patients care, including diet and physical activity. " Monitors, records and reports symptoms and changes in resident's/patients conditions.	F 726		

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F 726	Continued From page 111 " Visits residents/patients to ensure proper nursing care. " Orders and evaluates diagnostic tests to identify and assess resident's/patient's condition. Performs physical examinations to determine the residents/patient's status and develop a treatment plan. " Recommends forms of treatment, such as , , , , inhalation , , , or related therapeutic procedures. " Records resident's/patient's medical information and vital signs. " Reports all changes in resident's/patient's condition to supervisor timely." Facility immediate actions to correct the deficient practice and remove the Immediate Jeopardy included: " On the Regional Nurse Consultant educated the Administrator and Director of Nursing on ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification abnormal lab values, and follow-up procedures and resident condition change related to laboratory results. " Current resident audit conducted by Director of nursing/designee on for review of residents taking medications with no concerns identified. " On the Consultant Physician provided education to facility Medical Director and physician extender regarding standards of practice for monitoring and treating residents with -related diagnoses. " From through the Director of Nursing or designee educated 100% of licensed	F 726		

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F 726	Continued From page 112 nursing staff on ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification of abnormal lab values, and follow-up procedures related to laboratory results. " Process Change: Effective , the Director of Nursing is responsible for ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification, and follow-up procedures related to laboratory results. On all education and in-service sign-in sheets were reviewed and validated 10 out of 18 licensed nursing staff on ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels for medications, physician notification of abnormal lab values, and follow-up procedures related to laboratory results. On interviews were conducted with 10 licensed nurses across various shifts, the Assistant Director of Nursing, the DON, and the Medical Director. The staff members were able to verbalize they had been trained and were knowledgeable about the new policies. Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy was determined to be removed on , and the non-compliance was reduced to a scope and severity of E.	F 726		
F 773 SS=K	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must-	F 773		

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F 773	Continued From page 113 (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse , in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse , of laboratory results that outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure laboratory orders were entered in the electronic medical record and electronic laboratory (lab) portal, labs were completed as ordered, and abnormal results were reported to providers in a timely manner for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) out of eleven residents sampled. Serious harm occurred when Resident #1's medication levels were not monitored, and ␣ consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or to residents and resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and	F 773	F773 lab services 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Resident #5 and #10 no longer reside in facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. ␣ consult was for resident #1 as requested by physician. 2.How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken Facility-wide audit of current residents on medications was conducted by	

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F 773	Continued From page 114 the scope and severity was reduced to an "E" after verification of removal of immediacy of harm. Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , and , , , not , without status , , , status as of , with loss of , , , , , , adult , protein-calorie , , major , lack of coordination, communication , and , . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on . Review of Resident #1's , Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her , levels were low at 10 microgram per milliliter (ug/ml). with	F 773	Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and that any consults that were previously ordered were scheduled. Any residents identified without lab monitoring orders or fully executed consults were reported to physician and new orders transcribed as indicated. 3.What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur Director of Nursing/Designee will educate licensed nursing staff on the lab process to include ensuring that lab orders are in place to monitor medication abnormal levels, physicians are notified of abnormal lab values or refused labs, and documentation of physician notification of lab levels and new orders is recorded in the resident clinical record. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. Director of Nursing/Designee will randomly audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality	

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F 773	Continued From page 115 a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ." Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician.	F 773	Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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F 773	Continued From page 116	F 773		

Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results."

Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on .

Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week.

Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today"

Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m.

Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on .

Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician.

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F 773	Continued From page 117 Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... ب Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general." ...Assessment and Plan ... ب consult, check medications levels ..." Review of Resident #1's medical record revealed no evidence she received ب services. Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety.	F 773		

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F 773	Continued From page 118 was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or , noted. No injuries. MD [Medical Doctor] notified. New order placed for labs." Review of Resident #1's physician orders revealed, an order with an order date of ,for , level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order. Review of Resident #1's , MAR revealed the physician order for , level, Ammonia level, (, ,), and level was not documented as completed. Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level, Ammonia Level, (, ,), or a level. Review of Resident #1's progress note, dated at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air]. Review of the medical record did not reveal the resident's physician was notified of the .	F 773		

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F 773	Continued From page 119 Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on . Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day. Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values: : Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL : High (24 mg/dL) with a reference range of mg/dL / Ratio: High (38.6 mg/dL) with a reference range of 6.0-25.0 mg/dL : Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL : Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL : Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL : Low (35.9%) with a reference range of 37.0-47.0% , (,): low (25 ug/mL) with a reference range of 50-100 ug/mL	F 773		

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F 773	Continued From page 120	F 773		

Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date.

Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected.

An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn.

Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware."

Review of Resident #1's change in condition, dated , revealed
"The change in condition ...:
The was: New onset activity, OR persistent in someone with known intermittent activity.

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F 773	Continued From page 121 Provider Notification and Feedback: ...send to Er [emergency room]" Review of Resident #1's hospital record revealed a physician note, dated , as: "Impressions and Plan Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive . Low , , level Low , level but her dose of this medication may not be therapeutic. ...Plan Prescribe telemetry Neurochecks every hours precautions , 2mg [ ] for convulsive activity lasting more than 100 seconds ' ' , , , She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear how her refusal to take p.o. [by] AEDs will get resolved. She may need a [, , ,]. Review of Resident #1's hospital Physician note, dated , revealed: "The patient presents with , [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed	F 773		

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F 773	Continued From page 122 . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , . denies , , n/v [/] and , , . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , d/c [discomfort]. She has no [ ] complaints. ...plan Npo[nothing by] after mn [midnight] Egd [.] tomorrow." Review Resident #1's through Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The MAR review revealed Resident #1 received , , 125 mg three times a day for every day for the month of until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug.	F 773		

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Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal."

An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's levels were being monitored by the , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a consultation while in the hospital, but the facility did not follow up to schedule a for Resident #1.

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The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation.

An interview was conducted on at 3:50 p.m. with Resident #1's Physician Assistant (PA). The PA said he does not manage Resident #1's levels. If a resident is on for would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP).

An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents because it is managed by . He stated is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the

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resident had her if the facility had been managing her lab results and followed up with . He stated residents who are on , , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.

An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the

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hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ."

An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they

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have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a consultation then the facility should coordinate so the resident sees a . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients."

An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if

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she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.

An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications.

An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just

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a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure.

A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the .

A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition

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form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisition form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that is the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility.

2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified .

Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #2's order showed the following:

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F 773	Continued From page 131 -Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated . -Fasting CMP, Lipids, , , level, Ammonia level. Every night shift for 1 day. Dated . - , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified . Dated . - , level. Dated . -Ammonia level. Dated . Review of lab results for Resident #2 showed , level and Ammonia level, dated . The , level was low at 23 ug/ml with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml. Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on . Review of Resident #2's Lab Order History on the	F 773		

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lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level.

Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT , ."

An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until .

A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed.

3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , .

Review of Resident #8's physician orders revealed the following:

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F 773	Continued From page 133 - (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , , . Dated , -Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated . Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m. Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m., showing labs were sent to the Advanced Registered Nurse Practitioner. Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes." Review of progress notes revealed no nurses' note showing why the lab was not drawn. Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL. An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were	F 773		

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received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not.

4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other .

Review of Resident #4's care plan showed a focus area of , dated .
Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow
up as indicated.

Review of Resident #4's orders revealed the following active orders:
- , , Oral Capsule Delayed Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated .
- , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , . Dated .

Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels."

Review of Resident #4's lab results showed the last , level result was on .

5. Review of Admission Records showed Resident #3 was admitted on with diagnoses

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F 773	Continued From page 135 including , and , following , , , , and Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg . Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to unspecified . Dated . - , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds. Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results. Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL. Review of Resident #3's MAR showed 4mg continued to be administered on	F 773		

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F 773	Continued From page 136 - . An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , , consultation. When asked why a , , consultation was being ordered she said , , is who manages the dosing for , , even for residents on the medication for . 6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , , . Review of Resident #7's orders revealed the following orders: - , (,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , , . Dated . - , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued . - Lipid Panel, A1C, , CMP, , ,	F 773		

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F 773	Continued From page 137 Ammonia Level. Every night shift for 1 Day. Dated . Review of Resident #7's TAR showed the order for labs on was signed off as completed. Review of Resident #7's medical record showed no labs had been drawn. Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until . Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL. 7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , of front and . Review of Resident #5's provider orders revealed the following: - (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated . - (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued . Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . 8. Review of Admission Records showed Resident	F 773		

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F 773	Continued From page 138 #6 was admitted on with diagnoses including other . Review of Resident #6's provider orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated . Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs. 9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other . Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as	F		

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F 773	Continued From page 139 indicated. Dated . Review of Resident #9's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued . - , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued . , , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated . Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn. An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the doctor increased his , , and took him off , . 10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified . Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.	F 773		

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F 773	Continued From page 140 Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated , - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified , Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL.	F 773		

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An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again."

Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels."

11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified .

Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #11's provider orders revealed the following:
- , oral tablet delayed release 250 mg.

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F 773	Continued From page 142 Give 250 mg by two times a day for . Dated . - , level. Every night shift every 3 months starting on the 16th for 1 day. Dated . Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL. Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order. Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in . An interview was conducted on at 3:02 p.m. with the facility's Regional Nurse Consultant. She stated the facility did not have a policy for the laboratory process or for a resident change of condition. The facility's immediate actions to correct the deficient practice and remove the Immediate Jeopardy included: " On the Regional Nurse Consultant educate the Administrator and Director of Nursing on ensuring proper follow-through with consultation orders, laboratory monitoring of therapeutic levels	F 773		

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F 773	Continued From page 143 for medications, lab process with morning meeting process review compared to lab binder by clinical leadership, physician notification of abnormal labs, and follow-up procedures related to laboratory results. " On the Consultant Physician provide education to facility Medical Director and physician extender on ensuring proper and timely monitoring and treating of residents with -related diagnoses. " On the Director of Nursing or designee educated 100% of licensed nursing staff on making sure that consultation orders are properly executed, labs are in place to monitor therapeutic levels for medications, physicians are notified of abnormal lab results, and lab monitoring guidelines are followed related to laboratory results. " Process Change: Effective , the Director of Nursing is responsible for making sure that consultation orders are properly executed, labs are in place to monitor therapeutic levels for medications, physicians are notified of abnormal lab results, and lab monitoring guidelines are followed related to laboratory results. On all education and in-service sign-in sheets were reviewed and validated with 12 out of 18 licensed nursing staff on making sure that consultation orders are properly executed, labs are in place to monitor therapeutic levels for medications, physicians are notified of abnormal lab results, and lab monitoring guidelines are followed related to laboratory results.	F 773		

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F 773	Continued From page 144 On interviews were conducted with 10 licensed nurses across various shifts, the Assistant Director of Nursing, the DON, and the Medical Director. The staff members were able to verbalize they had been trained and were knowledgeable about the new policies. Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy was determined to be removed on , and the non-compliance was reduced to a scope and severity of E.	F 773		
F 867 SS=K	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be	F 867		

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F 867	Continued From page 145 used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the ⎵ and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies ⎵: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 146 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 147 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure they effectively monitored adverse events to systematically identify, report, track, and analyze the data to prevent potential or serious harm to residents for ineffective management of health care services, and treatment for medication management for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) out of eleven residents sampled. Serious harm occurred when Resident #1's medication levels were not monitored, and ,, consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or to residents and resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the scope and severity was reduced to an "E" after verification of removal of immediacy of harm.	F 867	F 867 QAPI/ N 901 QA Program 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Residents # 5 and #10 no longer reside in the facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. ,, consult was for resident #1 as requested by physician. 2.How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and that any ,, consults that	

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F 867	Continued From page 148 Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , and , , , , not , without status , , , status as of , with loss of , , , , , , , adult , protein-calorie , , major , , lack of coordination, communication , and . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on . Review of Resident #1's Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated	F 867	were previously ordered were scheduled. Any residents identified without lab monitoring orders or fully executed consults were reported to physician and new orders transcribed as indicated. 3.What measures will be put into place or what systematic changes will you make to ensure that the practice does not recur: The Regional Nurse Consultant educated the Nursing Home Administrator and Director of Nursing on ensuring that an effective Quality Assurance program is in place as it pertains to the care of residents with a diagnosis, ensuring that lab orders are in place to monitor medication levels, physicians are notified of abnormal lab values or refused labs, documentation of physician notification of lab levels and new orders is recorded in the resident clinical record, and that consultation orders for or other outside providers are executed appropriately. 4. How the corrective action(s) will monitor to ensure the practice will not recur, i.e., what quality assurance program will be put in place(s); will be accomplished for those residents: Director of Nursing/Designee will randomly audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place and consultation orders for outside providers are completed weekly for four	

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F 867	Continued From page 149 at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ." Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician. Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels	F 867	weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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one time only for 1 day notify MD [Medical Doctor] of results."

Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on .

Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week.

Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today"

Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m.

Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on .

Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician.

Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated ,

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F 867	Continued From page 151 revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... ␣␣ Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general." ...Assessment and Plan ... ␣␣ consult, check medications levels ..." Review of Resident #1's medical record revealed no evidence she received ␣␣ services. Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or noted. No injuries. MD	F 867		

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[Medical Doctor] notified. New order placed for labs."

Review of Resident #1's physician orders revealed, an order with an order date of ,for , level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order.

Review of Resident #1's , MAR revealed the physician order for , level, Ammonia level, (, ,), and level was not documented as completed.

Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level, Ammonia Level, (, ,), or a level.

Review of Resident #1's progress note, dated at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air].

Review of the medical record did not reveal the resident's physician was notified of the .

Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of

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50-100 ug/ml.

Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on .

Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day.

Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values:
: Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL
: High (24 mg/dL) with a reference range of mg/dL
/ Ratio: High (38.6 mg/dL) with a reference range of 6.0-25.0 mg/dL
: Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL
: Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL
: Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL
: Low (35.9%) with a reference range of 37.0-47.0%
, (,): low (25 ug/mL) with a reference range of 50-100 ug/mL

Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order,

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dated , had a status of "collection pending, no results" and there was no sample collection date.

Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected.

An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn.

Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware."

Review of Resident #1's change in condition, dated , revealed
"The change in condition ...:
The was: New onset activity, OR persistent in someone with known intermittent activity.
Provider Notification and Feedback: ...send to Er [emergency room]"

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Review of Resident #1's hospital record revealed a physician note, dated , as:
"Impressions and Plan
Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive .
Low , , level
Low , level but her dose of this medication may not be therapeutic.
...Plan
Prescribe telemetry
Neurochecks every hours
precautions
, 2mg [ ] for convulsive activity lasting more than 100 seconds
, ,
,
, .
She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear how her refusal to take p.o. [by] AEDs will get resolved. She may need a [
, ,]."

Review of Resident #1's hospital
Physician note, dated , revealed:
"The patient presents with , [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , . denies , , n/v

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F 867	Continued From page 156 [/] and . Apparently, she frequently refuses to eat and take her medications due to her neurologic and issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , d/c [discomfort]. She has no [ ] complaints. ...plan Npo[nothing by] after mn [midnight] Egd [, tomorrow." Review Resident #1's through Medication Administration Record (MAR) revealed she received 10 ml's of , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The MAR review revealed Resident #1 received 125 mg three times a day for every day for the month of until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug. Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to	F 867		

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facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal."

Review of Resident #1's nutrition note, dated at 9:59 a.m. revealed, "Res [Resident] readmitted to facility s/p [status/post] 7d [day] hospitalization. New [_ , tube] inserted however res eats 75-100% of meals by and requests snacks frequently. Will d/c [discontinue] feed as res is able to meet needs via po [by] at this time. Flush tube w/ [with] 150cc H20 [water] q [every] shift to maintain patency."

Review of Resident #1's progress note, dated at 10:21 a.m., written by Staff A, Licensed Practical Nurse (LPN), revealed, "This writer received order from NP [Nurse Practitioner] stating resident able to take medication by if resident refuses then we may use for medications; resident is currently eating meals w/o [without] issues or concerns."

An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for

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medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a ,, consultation while in the hospital, but the facility did not follow up to schedule a ,, , , for Resident #1. The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's ,, consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation.

An interview was conducted on at 3:50 p.m. with Resident #1's , , Physician Assistant (PA). The , , PA said he does not manage Resident #1's , levels. If a resident is on , for , ,

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would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP).

An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents , because it is managed by , . He stated , is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in , and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been managing her lab results and followed up with . He stated residents who are on , , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.

An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it,

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eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ."

An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were

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low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a consultation then the facility should coordinate so the resident sees a . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients."

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An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.

An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a

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few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications.

An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure.

A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the .

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F 867	Continued From page 164 A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisition form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that is the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility.	F 867		

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2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified .

Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #2's order showed the following:
-Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated .
-Fasting CMP, Lipids, , , level, Ammonia level. Every night shift for 1 day. Dated .
- , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified . Dated .
- , level. Dated .
-Ammonia level. Dated ,

Review of lab results for Resident #2 showed , level and Ammonia level, dated . The , level was low at 23 ug/ml

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with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml.

Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on .

Review of Resident #2's Lab Order History on the lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level.

Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT , ."

An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation

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sheets. She confirmed the resident had labs in
and not again until .

A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed.

3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , .

Review of Resident #8's physician orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , . Dated ,
-Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated .

Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m.

Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m.,. showing labs were sent to the Advanced Registered Nurse Practitioner.

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Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes."
Review of progress notes revealed no nurses' note showing why the lab was not drawn.

Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL.

An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not.

4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other .

Review of Resident #4's care plan showed a focus area of , dated .
Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow
up as indicated.

Review of Resident #4's orders revealed the following active orders:

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F 867	Continued From page 169 - , , Oral Capsule Delayed Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated . - , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , . Dated . Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels." Review of Resident #4's lab results showed the last , level result was on . 5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following , , , , , and . Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg . Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to unspecified . Dated . - , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab	F 867		

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results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds.

Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results.

Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL.

Review of Resident #3's MAR showed 4mg continued to be administered on - .

An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , , consultation. When asked why a , , consultation was being ordered she said , , , is who manages the dosing for

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F 867	Continued From page 171 , , even for residents on the medication for . 6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , . Review of Resident #7's orders revealed the following orders: - , (,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , . Dated . - , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued . - Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated . Review of Resident #7's TAR showed the order for labs on was signed off as completed. Review of Resident #7's medical record showed no labs had been drawn. Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until . Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL. 7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , of front and	F 867		

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Review of Resident #5's provider orders revealed the following:
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated .
- (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued .

Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

8. Review of Admission Records showed Resident #6 was admitted on with diagnoses including other .

Review of Resident #6's provider orders revealed the following:
- (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated .

Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .

An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than

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F 867	Continued From page 173 that due to a change in labs. 9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other . Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , under the section. Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #9's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued . - , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued . , , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated . Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn. An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident	F 867		

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F 867	Continued From page 174 #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the doctor increased his , , and took him off , . 10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified . Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day	F		

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F 867	Continued From page 175 every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL. An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again." Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels." 11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified .	F 867		

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Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section.

Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated .

Review of Resident #11's provider orders revealed the following:
- , oral tablet delayed release 250 mg. Give 250 mg by two times a day for . Dated .
- , level. Every night shift every 3 months starting on the 16th for 1 day. Dated ,

Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL.

Review of progress notes did not reveal any documentation a provider was notified of the low , levels on .

Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order.

Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the

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F 867	Continued From page 177 lab system for a , level in ` An interview was conducted on at 11:02 a.m. with the DON. She said she had a list of audits for processes she was responsible for completing to ensure there were no system breakdowns, and she was responsible for bringing those audits to the Quality Assurance and Performance Improvement (QAPI) committee for review, but the lab process had not been an audit on the list. She said all the clinical nurses did not have access to the lab portal because they changed to the current laboratory they use in . She said, "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered and it was not really looked at as a system failure. An interview was conducted on at 5:15 p.m. with the Nursing Home Administrator (NHA) and the DON. The NHA said the facility needed better communication with the providers. He said he is going to make sure staff are held accountable by completing audits and looking at data. The NHA said he felt like there were a lot of steps in the lab process and he would like to say the problem should have been caught. He then added, "I am not surprised" there were issues with labs. The NHA said with a good QAPI program the problem should have been looked at. The DON stated she had several audits that were done but that did not include labs or the lab process. She	F 867		

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said when conducting daily clinical meetings she assumed nurses were following up on labs. The DON said they did not know there was an issue with the labs and medication monitoring prior to the survey. The DON and NHA said there had been a lot of turnovers in staff and administration in the past year. They both stated they felt like this was a big part of the problem.

Review of a facility policy titled "Quality Assurance Performance Improvement (QAPI) Plan, effective , showed:

POLICY

The facility will develop a QAPI Plan to describe how the facility will track and measure performance; establish goals and thresholds for performance measurement; identify and prioritize deviations for performance and other problems and issues; systematically investigate and analyze to determine underlying causes of systemic problems and adverse events; develop and implement corrective actions or performance improvement activities; monitor/evaluate the effects of corrective actions/performance activities.

The QAPI Plan is reported to QA&A Compliance Committee with regular updates regarding progress with improvement activity, or corrective actions when there is unplanned or unexpected response to such activities.

It is the responsibility of the QA&A Compliance Committee to consider all data presented by the improvement team(s) and to direct the team(s) to continue, change or conclude the assignment.

PROCEDURE Track and Measure Performance

o Clinical areas are tracked through:

o Weekly reporting of specific clinical indicators to include , , , returns to hospital

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F 867	Continued From page 179 o Quality Measures to include overall, staffing and QMs o Incidents e.g. o Survey findings such as repeat citations, high severity citations, failure to clear at first revisit o Reports such as the Casper Report and PEPPER Report o Other areas that are tracked may include, but may not be limited to,: o Grievances o Reportable incident outcomes such as substantiated or neglect or elopement occurring that was within the facility's control. o Concierge round findings such as environmental concerns; Staffing concerns such as difficulty hiring staff; high turnover, use of agency staff, overtime over 6%; PBJ data with staff regularly working over 64 hours/week; any other area identified as a concern requiring investigation and corrective actions o Goals and thresholds o Goals will be set that are measurable, attainable and time specific. For example - are above benchmark for 6 weeks; goal is to reduce the number of to below benchmark within 30 days. This can be updated once the initial goal is achieved i.e. No repeat for the next 30 days or reduce by X% in 30 days. o Thresholds are set for clinical indicators and HR measures Identify and prioritize o Once issues are identified through tracking, trending and analysis, the QA&A Compliance Committee will assist with prioritizing the concerns in order that high risk areas are studied and corrected first. o Multi-voting may be used to assist with prioritizing areas of study e.g. each team member	F 867		

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gets 5 votes and may use them in any amount (all on one item; 4 on 1, 1 on another; 2 on one 3 on another etc.) to "vote" for specific area to be corrected first; item with the most votes is corrected first.
o Systematically investigate and analyze
o The facility uses specific processes in their performance improvement activities.
o -Failure Mode Effect and Criticality Analysis (FMECA)
o A process implemented prior to initiation of any high risk systems change. Involves identifying current process steps, process steps in planned change and areas of risk within the new process. Once identified controls or corrective actions are implemented to reduce the risk.
o -Root Cause Analysis (RCA)
o -RCA steps:
o Data collection e.g. number of per week/month, timing, site and cause of such
o 5 Whys
o -Team will ask why (and/or why not) until a root cause is identified
o Root causes are noted on either the fishbone or the "weed" to provide a visual reference

Develop and implement corrective actions
-Prioritization (Multi-Voting)
Multi-voting may also be used to assist with prioritizing corrective actions (process as above)
-Plan, Do, study, Act (PDSA)
o Once items are prioritized a specific plan is developed to address the issue, the plan is implemented and monitored to see the effect the action has on the area being studied. The PIP team will act on these findings by continuing the action if effective, changing the action if ineffective

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F 867	Continued From page 181 (after further planning), or discontinuing the action once the issue is resolved. Monitor and evaluate the effects o PDSA continues until the PI team is assured that the appropriate correction has occurred o PI team selects a team member to report activity to QA&A Compliance Committee for comment and recommendations. o The QA&A Compliance Committee will ensure the team(s) are provided with resources to review, inspect, validate and analyze concerns related to the assignment. Review of a facility policy titled "Essential Job Functions Nursing Home Administrator," undated, showed: Any individual who is working as the Nursing Home Administrator in a Skilled Nursing Facility (SNF) licensed by the state or certified as a Medicare/Medicaid provider should have the following job skills and perform the following functions. The identification of these jobs functions/skills is based on the assumptions that: 1. The patient/resident population is frail, , in nature and experiences many illnesses and . 2. It is imperative to identify the essential mix of administrative/management skills, knowledge of fiscal management, ethical principles and decision making skills, and the knowledge of local, state, federal and other regulatory requirements that the Nursing Home Administrator must possess or develop in order to lead, administer and manage a long-term care facility. FRAMEWORK The framework for the essential core functions are	F 867		

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contained in the facility's job description/position description for the Nursing Home Administrator. The five principles that form the organizing framework for the essential core functions include the following:
1. Knowledge and expertise in management of the frail ˬ and other long-term care patient/resident;
2. Experience and skill in:
a. Leadership and mentoring;
b. Development and implementation of a facility management system;
c. Administration, management, supervision and coordination of all departments to insure appropriate care;
d. Use of computers and other technological resources;
e. Oversight of a facility quality assurance process;
f. Financial management of a health care facility.
3. Knowledge of pertinent local, state, federal and other regulations and ability to implement and maintain compliance with these regulations governing the facility, patient/resident care, and reimbursement;
4. Experience in developing professional relationships and representing the facility in professional and community activities;
5. Participation in educational programs for continued professional development.
1. RESPONSIBILITIES
The Nursing Home Administrator's role under the following domains and associated tasks:*
A. RESIDENT CARE AND QUALITY OF LIFE
o Ensure that nursing services are planned, implemented, and evaluated to maximize resident quality of life and quality of care ...

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F 867	Continued From page 183 o Ensure that medical services are planned, implemented, and evaluated to meet resident medical care needs and preferences to maximize resident quality of life and quality of care ... Review of a facility job description titled "Essential Job Functions Director of Nursing," undated, showed: Any registered nurse who is working as the Director of Nursing of a Skilled Nursing Facility (SNF) licensed by the state and/or certified to be a Medicare/Medicaid provider should have the following job skills and perform the following functions. The identification of these job functions/skills is based on the assumptions that: 1) the patient/resident population is frail, , in nature and experiences many illnesses and 2) it is imperative to identify the essential mix of nursing clinical skills; management and leadership skills; and knowledge of fiscal management, ethical principles, state and federal regulatory requirements and standards of professional nursing practice that the Director of Nursing must possess in order to develop and implement a system of nursing care that meets the needs of the facility's patient/resident population. FRAMEWORK The framework for the essential core functions is contained in the facility's job description/position description for the Director of Nursing. The five principles that form the organizing framework for the essential core job functions include: 1. Knowledge and expertise in nursing management of the and other long-term care patient/resident. 2. Experience and skill in:	F 867		

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F 867	Continued From page 184 a. leadership and mentoring; b. development and implementation of a system of nursing that includes the ability to analyze and identify personnel resource needs and skills; c. administrative management and supervision of licensed and unlicensed personnel in the delivery of nursing care; and the identification and proper utilization of the skill mix of nursing personnel; d. coordination of nursing services with all other departments to ensure appropriate care; e. knowledge in basic computer skills and other technological resources; f. ability to develop and implement an ongoing quality assurance process. 3. Knowledge of state and federal regulations and ability to implement and maintain compliance with these regulations governing the facility, resident care, and reimbursement; 4. Development of professional relationships and representation of the facility and nursing service in professional and community activities; 5. Expansion of knowledge base and improvement of nursing skills by continued professional development, including attendance at educational programs, etc. I. RESPONSIBILITIES The Director of Nursing has functions and tasks associated with his or her role. These functions and tasks include: A. Responsible to the owner/governing body/licensed administrator for: 1) the overall coordination and execution of nursing services and 2) monitoring and evaluating the outcomes of nursing care. B. Providing nursing oversight. The Director of Nursing should:	F 867		

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F 867	Continued From page 185 1. oversee all staff who provide nursing care to the facility's residents/patients; 2. ensure that there is a procedure to collect and review nursing staff's licensure / certification/credentials; 3. establish rules governing the conduct of nursing staff; and, 4. ensure that all nursing staff are held accountable for the care they deliver to residents / patients in the nursing facility. C. Defining the scope of nursing services. The Director of Nursing should develop written policies and procedures which are approved by the owner/governing body/licensed administrator, related to the scope of nursing services and nursing care that should be provided to a facility's residents/patients, upon and after admission. D. Ensuring nursing accountability. The Director of Nursing should implement and enforce policies and procedures that cover essential nursing responsibilities to the residents/patients and the facility including: 1. accepting responsibility for the care of residents/patients; 2. supporting resident/patient discharges and transfers; and 3. providing adequate ongoing nursing coverage 4. providing appropriate, timely and pertinent documentation. E. Care quality assessment and improvement. The Director of Nursing should participate actively in the facility's quality improvement process. Such participation should include: 1. regular attendance at, and reporting to, the facility's quality improvement committee meetings; and 2. routine participation in ongoing facility efforts to	F 867		

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improve the overall quality of the nursing care, including facility efforts to evaluate and address the causes of various care related problems and deficiencies.
F. Clinical. The Director of Nursing ensures that nursing practice in the facility reflects the following nursing skills:
1. skill in resident assessment, critical thinking and nursing interventions;
2. oversight of the interdisciplinary care planning process to include initial planning (on admission to the unit); interim planning (to include clinical status changes); and the required Resident Assessment Instrument (RAI);
3. evaluation of whether the nursing care facility can meet each resident / patient's needs, which includes the potential new admission to the facility, a current resident of the facility, or the transfer of a resident from the facility.
G. Administration. The Director of Nursing should:
1. Develop and implement an organized nursing system for the delivery of care and services which may include but is not limited to:
a. coordination of nursing services with other services and departments; i.e. pharmacy, dietary, housekeeping, laundry, activities, social services, accounting, maintenance, medical records, medical services, etc;
b. work with other management personnel to facilitate delivery of nursing services and other services.
2. Utilize the expertise of other departments and services to address nursing issues in facilitating delivery of resident services;
3. Develop the nursing budget for the nursing department to include but not limited to:
a. Hours of care per day per patient;

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F 867	Continued From page 187 b. Staffing mix to deliver hours of care; c. Necessary supplies and technological resources. 4. Direct nursing preparation for review and response to federal, state and local surveys and inspections. H. Management and Nursing Oversight: The Director of Nursing should: 1. ensure that nursing practice complies with regulatory and legislative requirements; 2. help develop and implement immunization programs for patients and staff; 3. conduct clinical rounds on all nursing units; 4. promote, establish, and maintain customer relationships with residents, families, staff, community and other professionals; 5. identify and access available resources to develop and implement an ongoing educational plan appropriate for each level of nursing staff; 6. develop and implement policies, procedures and programs regarding communicable , control and isolation procedures; 7. develop and implement policies and procedures for , assessment and management; 8. develop and implement policies, procedures and programs regarding , neglect and violence prevention, in collaboration with the Nursing Home Administrator ..." Facility immediate actions to correct the deficient practice and remove the Immediate Jeopardy included: " On the Regional Nurse Consultant educated the Administrator and Director of Nursing on ensuring that an effective Quality Assurance and Performance Improvement Plan is in place to	F 867		

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F 867	Continued From page 188 ensure the safety of all residents. " On the Administrator educated 100% of the members of the Quality Assurance and Assessment Committee on ensuring that an effective Quality Assurance and Performance Improvement Plan is in place to ensure the safety of all residents. " Adhoc meeting held with interdisciplinary team and Medical director[sic] on related to lab process monitoring and MD notification. Another Adhoc meeting was held on on lab process/lab monitoring, following physician orders, clinical morning meeting process with review of lab binder, lab access availability audit, Neglect & , . " Daily audits were conducted on lab process beginning on and complete on with no new findings. " Process Change: Effective , the Administrator is responsible for ensuring that an effective Quality Assurance and Performance Improvement Plan is in place to ensure the safety of all residents. On all education and in-service sign in sheets were reviewed and validated for 13 out of 13 members of the Quality Assurance and Assessment Committee on ensuring that an effective Quality Assurance and Performance Improvement Plan is in place to ensure the safety of all residents. On interviews were conducted with the Nursing Home Administrator, members of the interdisciplinary team, the Assistant Director of Nursing, and the DON. The staff members were able to verbalize they had been trained and were knowledgeable about the new policies.	F 867		

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F 867	Continued From page 189 Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy was determined to be removed on , and the non-compliance was reduced to a scope and severity of E.	F 867		

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N 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024016211, 2025000660, 2025002535, and 2025003100 was conducted on - and - at Highland Pines Rehabilitation Center. Deficiencies were identified at the time of the survey. A Class I deficiency was identified at N201 and N204 related to complaint number 2025002535. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in the facilty. The facility resident census at the beginning of the survey was 111. The Class I started on . The facility administration was informed of the Class I deficiency on .	N 000		
N 201 SS=K	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.	N 201		

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N 201	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure nursing staff were competent in caring for residents with diagnoses to include laboratory monitoring process, following through with orders, processing consultations, and communications with physicians for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11) out of eleven residents sampled. Serious harm occurred when Resident #1's medication levels were not monitored, and consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , , and , , , not , without status , , , status as of , with loss of , , , , , , adult , protein-calorie , , , major , lack of coordination, communication , and , . Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule	N 201	F 726 Competent Nurse staffing 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Residents #5 and #10 no longer reside in the facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. consult was for resident #1 as requested by physician. 2. How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that residents on medications had appropriate lab monitoring orders in place and that any consults that were previously ordered were scheduled. Any residents identified without lab monitoring orders or fully executed consults were reported to physician and new orders transcribed as indicated. 3. What measures will be put into place or	

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N 201	Continued From page 2 delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - , , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on . Review of Resident #1's Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her , levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels ...increased dose, , leve[sic] ..."	N 201	what systematic changes will you make to ensure that the practice does not recur: Director of Nursing/Designee will educate licensed nursing staff on the care of residents with a diagnosis to include ensuring that lab orders are in place to monitor medication levels, physicians are notified of abnormal lab values or refused labs, documentation of physician notification of lab levels and new orders is recorded in the resident clinical record, and that consultation orders for or other outside providers are executed appropriately. 4. How the corrective action(s) will monitor to ensure the practice will not recur, i.e., what quality assurance program will be put in place(s); will be accomplished for those residents: Director of Nursing/Designee will randomly audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place and consultation orders for outside providers are completed weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance Committee monthly for three months for further recommendations and guidance.	

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N 201	Continued From page 3 Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ." Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician. Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results." Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , level on . Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week. Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today"	N 201		

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N 201	Continued From page 4 Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m. Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on . Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician. Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... Consult, check medications levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general."	N 201		

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N 201	Continued From page 5 ...Assessment and Plan ... ر consult, check medications levels ..." Review of Resident #1's medical record revealed no evidence she received ر services. Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or , noted. No injuries. MD [Medical Doctor] notified. New order placed for labs." Review of Resident #1's physician orders revealed, an order with an order date of ,for , level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order. Review of Resident #1's , MAR revealed the physician order for , level, Ammonia level, (, ,), and level was not documented as completed. Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level, Ammonia Level, (, ,), or a level. Review of Resident #1's progress note, dated	N 201		

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N 201	Continued From page 6 at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making , contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, , rate]- [,]-97% [, saturations] R/A [room air]. Review of the medical record did not reveal the resident's physician was notified of the . Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on . Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night shift for one day. Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values: : Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL : High (24 mg/dL) with a reference range of mg/dL / Ratio: High (38.6 mg/dL) with a	N 201		

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N 201	Continued From page 7 reference range of 6.0-25.0 mg/dL : Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL : Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL : Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL : Low (35.9%) with a reference range of 37.0-47.0% , (,): low (25 ug/mL) with a reference range of 50-100 ug/mL Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date. Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected. An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn. Review of Resident #1's progress note, dated at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased.	N 201		

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N 201	Continued From page 8 Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware." Review of Resident #1's change in condition, dated , revealed "The change in condition ...: The was: New onset activity, OR persistent in someone with known intermittent activity. Provider Notification and Feedback: ...send to Er [emergency room]" Review of Resident #1's hospital record revealed a physician note, dated , as: "Impressions and Plan Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive . Low , , level Low , level but her dose of this medication may not be therapeutic. ...Plan Prescribe telemetry Neurochecks every hours precautions , 2mg [ ] for convulsive activity lasting more than 100 seconds , , , , . She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear	N 201		

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N 201	Continued From page 9 how her refusal to take p.o. [by] AEDs will get resolved. She may need a [. , ˘ ˛]. Review of Resident #1's hospital Physician note, dated , revealed: "The patient presents with [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , ˘ . denies , , n/v [/ ˛] and ˛ , ˘ . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , ˛ issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , , d/c [discomfort]. She has no ˘ [˘] complaints. ...plan Npo[nothing by] after mn [midnight] Egd [, ˘ ˘ , ˛]/, ˘ tomorrow." Review Resident #1's through ˛ Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The ˛ MAR review revealed	N 201		

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N 201	Continued From page 10 Resident #1 received , , 125 mg three times a day for every day for the month of , until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug. Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1;[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal." Review of Resident #1's nutrition note, dated at 9:59 a.m. revealed, "Res [Resident] readmitted to facility s/p [status/post] 7d [day] hospitalization. New [, tube] inserted however res eats 75-100% of meals by and requests snacks frequently. Will d/c [discontinue] feed as res is able to meet needs via po [by] at this time. Flush tube w/ [with] 150cc H20 [water] q [every] shift to maintain patency." Review of Resident #1's progress note, dated at 10:21 a.m., written by Staff A, Licensed Practical Nurse (LPN), revealed, "This writer received order from NP [Nurse Practitioner] stating resident able to take medication by If resident refuses then we may use for medications; resident is currently eating meals	N 201		

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N 201	Continued From page 11 w/o [without] issues or concerns." An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a ,, consultation while in the hospital, but the facility did not follow up to schedule a ,, , for Resident #1. The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's ,, consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were	N 201		

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N 201	Continued From page 12 completed. The DON said their process was broken for following up with labs and completing documentation. An interview was conducted on at 3:50 p.m. with Resident #1's , Physician Assistant (PA). The , PA said he does not manage Resident #1's levels. If a resident is on , for , , would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP). An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents , because it is managed by , . He stated , is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in , and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been managing her lab results and followed up with . He stated residents who are on , , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him.	N 201		

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N 201	Continued From page 13 An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ." An interview was conducted with the Medical Director on at 3:11 p.m., she said she was	N 201		

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N 201	Continued From page 14 Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a , consultation then the facility should coordinate so the resident sees a	N 201		

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N 201	Continued From page 15 . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients." An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking. An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her	N 201		

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N 201	Continued From page 16 medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications. An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and did not question why. The DON said the labs were just reordered and it was not really looked at as a system failure. A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the	N 201		

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N 201	Continued From page 17 in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the . A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisition form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that is the only way the lab can print labels for the specimen. Once the test has	N 201		

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N 201	Continued From page 18 resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility. 2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified . Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated . Review of Resident #2's order showed the following: -Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated . -Fasting CMP, Lipids, , , level, Ammonia level. Every night shift for 1 day. Dated . - , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified . Dated . - , level. Dated . -Ammonia level. Dated . Review of lab results for Resident #2 showed	N 201		

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N 201	Continued From page 19 , level and Ammonia level, dated . The , level was low at 23 ug/ml with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml. Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on . Review of Resident #2's Lab Order History on the lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level. Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT , ." An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not	N 201		

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N 201	Continued From page 20 transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until . A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed. 3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , , . Review of Resident #8's physician orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , . Dated , -Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated . Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m. Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m., showing labs were sent to the Advanced Registered Nurse Practitioner.	N 201		

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N 201	Continued From page 21 Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes." Review of progress notes revealed no nurses' note showing why the lab was not drawn. Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL. An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not. 4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other . Review of Resident #4's care plan showed a focus area of , dated . Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #4's orders revealed the following active orders: - , , Oral Capsule Delayed	N 201		

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N 201	Continued From page 22 Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated . - , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , , Dated . Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels." Review of Resident #4's lab results showed the last , level result was on . 5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following , , , , , and . Review of Resident #3's physicianorders revealed the following: - Oral Tablet 4 mg . Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to unspecified . Dated . - , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3	N 201		

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N 201	Continued From page 23 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds. Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results. Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL. Review of Resident #3's MAR showed 4mg continued to be administered on An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified. She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , consultation. When asked why a , consultation was being ordered she said , is who manages the dosing for , even for residents on the medication for	N 201		

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N 201	Continued From page 24 6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , , . Review of Resident #7's orders revealed the following orders: - , { ,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , , . Dated . - , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued . - Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated . Review of Resident #7's TAR showed the order for labs on was signed off as completed. Review of Resident #7's medical record showed no labs had been drawn. Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until . Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL. 7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , of front and . Review of Resident #5's provider orders revealed the following:	N 201		

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N 201	Continued From page 25 - (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated . - (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued . Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . 8. Review of Admission Records showed Resident #6 was admitted on with diagnoses including other . Review of Resident #6's provider orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated . Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs. 9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other .	N 201		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 26 Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #9's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued . - , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued . , , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated . Review of Resident #9's lab results showed an Ammonia level had been drawn on , but there was no evidence of a , or , , level ever being drawn. An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the	N 201		

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	55227	A. BUILDING: _____ B. WING _____	C 04/17/2025

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N 201	Continued From page 27 doctor increased his , , and took him off , . 10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified . Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and	N 201		

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N 201	Continued From page 28 Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL. An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again." Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels." 11. Review of Admission Records showed Resident #11 was admitted on with diagnoses including unspecified . Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor.	N 201		

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N 201	Continued From page 29 Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated . Review of Resident #11's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 250 mg by two times a day for . Dated . - , level. Every night shift every 3 months starting on the 16th for 1 day. Dated , Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL. Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order. Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in . An interview was conducted on at 10:40 a.m. with Staff C, LPN. Staff C said she currently did not have access to the lab portal to enter labs. She said she had been locked out for a few days and did not know why. When asked if she had any education in the facility on the lab processes, she	N 201		

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N 201	Continued From page 30	N 201		

stated, "Honestly, no." Staff C said she would have another nurse print out a lab sheet for her if she needed it. She said there had been a problem with unit managers throwing the paper lab requisitions away because they wanted everything entered in the computer. Staff C said when a provider asks for a lab the nurse should put the order in the medical record timed to show up for the 11 p.m.-7 a.m. shift because that is when the lab techs come in to draw labs. She said a requisition form should be filled out and put in the lab book under the date it is to be drawn. She said once the lab is drawn the 11 p.m.-7 a.m. nurse should check it off as complete in the medical record. Regarding reviewing lab results and ensuring labs are completed, Staff C said "That part I am not too sure. I hear it is the unit managers who do it, but I hear the nurses are supposed to do it. I get conflicting information on that." Staff C said if a resident is on , they should have , levels checked and if they are on , , they should have , , levels checked.

An interview was conducted on at 10:57 a.m. with Staff A, LPN/UM. Staff A said when a provider requested a lab the nurse should place the order the in the resident's electronic medical record, night shift then puts the lab orders in the lab portal and fills out a lab requisition form, then the lab tech comes in the mornings to draw labs. Staff A said the lab tech came to the facility daily Monday-Saturday. She said after labs are drawn the results come in around p.m. She said the nurse assigned to the resident should call the provider and see if they have any new orders. Staff A said the lab faxes over results to the facility and the results are also in the lab portal. She said a

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N 201	Continued From page 31 nurse should pass down in report if a resident had lab results pending. Staff A said the unit manager should check to ensure labs were done and the provider has been notified. She agreed there had been a breakdown in the lab process. An interview was conducted on at 11:08 a.m. with the DON. She said the lab orders had not been put in the lab book as they were supposed to be. The Don said, "It was a breakdown because we weren't doing the right process." She said the way the labs had been handled there was no record of what lab results providers were aware of and what labs had not been reported. An interview was conducted on at 5:20 p.m. with Staff E, LPN. He said when a physician orders a lab for a resident, he inputs the order into the EMR, so it triggers the 11:00p.m. to 7:00 a.m. staff to put the lab order into the lab portal. He stated he would tell the nurse taking over for him in report the resident has a lab ordered. He said the nurses should be following up and notifying the physician to make sure the labs were collected and resulted, and if the nurses did not do it then the Unit Managers make sure they are done. He said he just got access today to the lab portal. He said he was hired in and "maybe" in , he got education on the lab process. He said residents who are on medications should get medication labs every three to six months, but he "thinks" the Unit Managers are the ones make sure those orders are in the computer. An interview was conducted on at 5:30 p.m. with Staff F, LPN she said she usually works	N 201		

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N 201	Continued From page 32 the 7:00 a. m.-3:00p.m. shift and 3:00p.m.-11:00p.m. shift. She said for labs they have to put the physician order into the EMR and in the lab portal. She said then the nurse lets the oncoming nurse know the resident needs labs. Unless it is a STAT (emergent) order, then she said the nurse also calls the lab company and lets them know there is a STAT order. She said she has access to the lab portal and has since she started but some nurses do not put the orders into the lab portal when they get lab orders, they just put the order into the EMR and have the 11:00p.m. to 7:00 a. m. nurse put the order into the lab portal. She said she is not sure if residents who are on medications should have medication lab levels routinely checked and if they do, she would have to ask how often they need them because she is not sure. She said she was familiar with the lab process from her previous employer, and it is not much different at this facility, but she has received training on the lab process throughout her employment with the facility. An interview was conducted on at 3:17 p.m. with Staff G, LPN. Staff G said she felt if the nurses had communicated better during report, it would have helped with the lab problems. She said she had previously been taught the lab process at the facility. An interview was conducted on at 3:20 p.m. with Staff H, LPN. She said she had worked at the facility since they changed to the new lab company, and she had no access to the lab portal. An interview was conducted on at 3:48	N 201		

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N 201	Continued From page 33 p.m. with Staff I, LPN/UM and Staff A, LPN/UM. Staff I said the nurse working the cart assigned to a resident should get lab results and follow through with everything. He said they used to take the book into the morning clinical meetings and review the labs, but "It stopped for some reason." He said they would look at new orders and make sure labs were drawn, but with several NHA and DON changes "That process just kind of off." He said there had been a lot of turnovers at the facility. He said in clinical meetings they did review new orders but had not been looking at labs. He said clinical leadership should trust the nurse is doing the right thing, but still verify it is done. He said when the facility changed to the new lab company in 2024, the lab brought in books and did training during the day, then day shift trained the night shift nurses. Staff I said he sets up lab portal access for nurses. He said everyone gets access, but some do not use it very often, so the security features lock them out. Staff I said if a provider wanted a consult scheduled, they let the nurse know and the nurse should put an order in the computer. He said the UM sees the orders and tries to find a provider that takes the resident's insurance. He said if the UM cannot find a provider to take a resident's insurance, they let the NHA know. Staff A said they had not really noticed issues with the lab process, but did notice sometimes labs do not come quickly enough. Staff A said when she started at the facility another nurse trained her on the lab portal. She said for orders and consults the providers communicate to the nurse what is new. An interview was conducted on at 4:20 p.m. with Staff J, LPN and Staff K, RN. Staff J said when she started at the facility she had three days	N 201		

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N 201	Continued From page 34 of orientation, but "I got thrown in there." She said she never received formal training on the lab portal. She said when she had questions, she asked the supervisors or DON and got the answers she needed. Staff J said she had not noticed any issues with labs being completed, but it is everyone's responsibility to make sure they are done and to ensure labs are being monitored for the medications that require it. Staff J said she felt like the problem with the lab process was the amount of turnover with staff in the facility. She said they need continuity and regular staff caring for the residents. Staff J said there was not good communication with nurses when there was a lot of turnover and inconsistency. Staff K said when she started at the facility she did training and was told where to locate the lab portal instruction book. She said she had not noticed any lab or consultation issues. She said if a provider wants a consultation for a resident, they let the nurse know and the nurse should put in an order and let the UM know. The UM then followed up to set up , , and transportation. She said providers typically fill the nurses in on their plans and what they would like done. Staff K said medication labs should be drawn every 3 months and it is everyone's responsibility to make sure those routine labs get completed. An interview was conducted on at 4:57 p.m. with the Assistant Director of Nursing (ADON). She said at morning clinical meetings she would look at labs related to control since she is the facility's preventionist, other labs were not reviewed. She said it is a team effort to ensure consultations , , and transportation were set up. The ADON said overall she believed so many nursing and administrative	N 201		

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N 201	Continued From page 35	N 201		

changes caused a breakdown in the system. She said from her understanding. a nurse got an order and put it in the electronic medical record, and the nurse who received the results through fax should have followed up with the provider. She said when she started it was a work in progress to get the lab process in place; it would get started and then there was a turnover, and the process would go backwards. The ADON said "It is systemic" and there was not a solid process in place to ensure labs were completed.

Review of the facility's policy titled "Physician Notification," dated , showed:
"Policy-The facility strives to ensure that each resident's health is supervised by a qualified attending Physician. The attending Physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient.
Procedure
1. Licensed Nurses will ensure that physicians are notified of changes or diagnostic results that occur between visits. Changes may include but are not limited to:
- A change in condition, mental or physical
- A change in the status of a
- The development of a new
- Laboratory Results
- Diagnostic Results
- Abnormal or those outside the
- Successful treatment of
- Consultant reports & recommendations
- Family concerns related to medical care
- Events
- Resident's refusal to take medication
- Any time a medication is not administered as

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N 201	Continued From page 36 ordered 2. It is not sufficient to document Faxed to the physician without verbal follow up. 3. If there has been no verbal contact within a reasonable time frame (Based on Nursing judgment & the acuity of the situation). o Notify the DON or designee o Notify the Medical Director 4. Emergent situations do not require a physician order to dial 911." Review of an undated facility job description titled "Licensed Practical Nurse (LPN)" showed: "SUMMARY OF POSITION: The Licensed Practical Nurse is responsible for delivering care to residents/patients utilizing the nursing process of assessment, planning, intervention, implementation, and evaluation; and effectively interacts with residents/patients, family members, and other health team members while maintaining standards of professional nursing. ESSENTIAL DUTIES AND RESPONSIBILITIES (To be completed without harming or injuring resident/patient, co-worker, self, or others): Direct Care/ Patient Responsibilities " Assesses, plans, directs and evaluates total nursing care as determined by the resident's/patient's age related physical, , , , and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan. " Consults and coordinates with health care team members to assess, plan, implement and evaluate resident's/patient's care plans. " Maintains accurate, detailed reports and records. " Modifies resident's/patient's treatment plans, according to physician orders, indicated by	N 201		

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N 201	Continued From page 37 residents'/patients' responses and conditions. " Monitors all aspects of residents/patients care, including diet and physical activity. " Monitors, records and reports symptoms and changes in resident's/patient's conditions." Review of an undated facility job description titled "Registered Nurse (RN,)" showed: "SUMMARY OF POSITION: The Registered Nurse (RN) is responsible for delivering care to residents/patients utilizing the nursing process of assessment, planning, intervention, implementation, and evaluation; effectively interacts with residents/patients, family members, and other health team members while maintaining the standards of professional nursing. ESSENTIAL DUTIES AND RESPONSIBILITIES (To be completed without harming or injuring the resident/patient, co-worker, self, or others): Direct Care/ Patient Responsibilities " Assesses, plans, directs and evaluates total nursing care as determined by the resident's/patient's age related physical, , , , and cultural needs in accordance with established standards, policies and procedures and residents/patients care plan. " Consults and coordinates with health care team members to assess, plan, implement and evaluate resident's/patient's care plans. " Maintains accurate, detailed reports and records. " Modifies resident's/patient's treatment plans, according to physician orders, indicated by residents'/patients' responses and conditions. " Monitors all aspects of residents/patients care, including diet and physical activity. " Monitors, records and reports symptoms and	N 201		

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N 201	Continued From page 38 changes in resident's/patients conditions. " Visits residents/patients to ensure proper nursing care. " Orders and evaluates diagnostic tests to identify and assess resident's/patient's condition. Performs physical examinations to determine the residents/patient's status and develop a treatment plan. " Recommends forms of treatment, such as , , , , inhalation , , , or related therapeutic procedures. " Records resident's/patient's medical information and vital signs. " Reports all changes in resident's/patient's condition to supervisor timely." Class I	N 201		
N 204 SS=K	400.022(1)(o), FS Right to be Free from , , etc 400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and , , , , neglect, , , corporal punishment, extended involuntary , and , , , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are	N 204		

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N 204	Continued From page 39 necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to protect the residents' right to be free from neglect for eleven residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) out of eleven residents sampled related to medication management and follow-up laboratory orders for medication therapeutic levels. Serious harm occurred when Resident #1's medication levels were not monitored, and consultation was not obtained per the provider's request. Resident #1 experienced a on , , , and . Resident #1 had to be transferred to a higher level of care as a result of the suffered on . Findings included: 1. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on from an acute care hospital with medical diagnoses of generalized idiopathic , , , and , , , not , without	N 204	F600 Free from & Neglect/N204 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices? Residents # 5 and #10 no longer reside in the facility. Laboratory orders for medication management were received for residents #1, #2, #3, #4, #6, #7, #8, #9, and #11. Results of labs were reported to resident physicians, documented in the clinical record, and new orders were transcribed as indicated. consult was for resident #1 as requested by physician. 2.How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective actions will be taken. Facility-wide audit of current residents on medications was conducted by Director of Nursing/designee to ensure that	

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N 204	Continued From page 40 status . , ' ˘ ˛ status as of ' ˘ with loss of ' ˛ , ' , ' , ˘ , adult , protein-calorie , ˛ , major , , lack of coordination, ˘ communication , and ' ˛ ' Review of Resident #1's physician orders revealed the following: - , (,) , Oral Capsule delayed release 125 mg (milligrams), give one capsule by two times a day for , start date and discontinued on . - . , Oral Capsule delayed release 125 mg, give one capsule by three times a day for , start date and discontinued on . Review of Resident #1's ˛ Medication Administration Record (MAR) revealed she received 125 mg of , three times a day starting on . Review of Resident #1's laboratory (lab) results, dated , revealed her , levels were low at 10 microgram per milliliter (ug/ml). with a reference range of 50-100 ug/mL. Review of Resident #1's progress note, dated at 8:13 p.m., revealed "Hard copy labs called to ARNP (Advanced Registered Nurse Practitioner) . No new orders. Review of Resident #1's ARNP note, dated , revealed: "CHIEF COMPLAINTS fu [follow up] Visit	N 204	residents on medications had appropriate lab monitoring orders in place and that consultation orders for ˘ were completed as indicated. Any residents identified without lab monitoring orders or fully executed ˘, consults were reported to physician and new orders transcribed as indicated. 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur. Director of Nursing/Designee will educate licensed nursing staff on the lab monitoring process to include ensuring that residents on medication receive proper lab monitoring, physician notification of abnormal lab values or refused labs, documentation of physician notification and new orders is recorded in the resident clinical record, and consultation orders for ˘, are properly executed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Ie. What quality assurance program will be put into place. Director of Nursing/Designee will randomly audit residents on medications to ensure that appropriate lab orders for monitoring medication levels are in place weekly for four weeks and then monthly for two months. Results of the audits will be submitted by the Director of Nursing/designee to the Quality Assessment, Assurance, and Compliance	

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N 204	Continued From page 41 She [Resident #1] has had some in the past and had the recent staff members reporting. Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ...ASSESSMENT AND PLAN ... D-DER [ ] , consult, check medication levels ...increased dose, , leve[sic] ..." Review of Resident #1's Progress note, dated at 8:19 a.m., revealed "Resident had a tonic-clonic [a type of with stiffing followed by rhythmic jerking with a loss of] for 2 minutes. Resident was and shaking the full time of the . Resident is currently lying in bed. Dr. notified and waiting for a call ." Review of Resident #1's medical record did not reveal evidence the physician called , or further attempts were made to contact the physician. Review of Resident #1's physician order revealed an order with a start date of , and an end date of for " , , levels one time only for 1 day notify MD [Medical Doctor] of results." Review of Resident #1's lab results, dated , revealed , results were low (12 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the	N 204	Committee monthly for three months for further recommendations and guidance.	

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N 204	Continued From page 42 low , level on . Review of Resident #1's physician orders revealed an order, with a revision date of , a start date of , and an end date of , to "recheck , level in one week. Review of Resident #1's progress note, dated at 3:06 a.m., revealed "Resident to have , level rechecked today" Review of Resident #1's Treatment Administration Record (TAR) revealed the physician order for "Resident to have , level rechecked today" was signed off as completed on at 3:06 a.m. Review of Resident #1's Lab Order History from the lab portal did not reveal a physician's order was in the lab portal for , to be drawn on . Review of Resident #1's medical record did not reveal evidence the , was drawn on and reported to the physician. Review of Resident #1's Advanced Practice Registered Nurse (APRN) note, dated , revealed "CHIEF COMPLAINTS -fu [follow up] Visit ...Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's [activities of daily living] and assist with feeding in general. ... ASSESSMENT AND PLAN ... .. Consult, check medications	N 204		

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N 204	Continued From page 43 levels ..." Review of Resident #1's Physician note, dated revealed "CHIEF COMPLAINTS fu Visit ... Recently she had the and medications were adjusted. Overall, she is very weak and feels like she is de-conditioned. She relies on staff to complete ADL's and assist with feeding in general." ...Assessment and Plan ... ب consult, check medications levels ..." Review of Resident #1's medical record revealed no evidence she received ب services. Review of Resident #1's progress note, dated at 5:36 PM, revealed "Resident had a while lying in bed at 1730 [5:30PM]. Resident was laying on her side while was occurring. Made sure of resident safety. was under 5 minutes long and not reoccurring. Resident is now alert and able to speak and move. No discomfort or , noted. No injuries. MD [Medical Doctor] notified. New order placed for labs." Review of Resident #1's physician orders revealed, an order with an order date of ,for , level, Ammonia Level, (, ,), and level. There was no start date or end date on the physician order. Review of Resident #1's , MAR revealed the physician order for , level,	N 204		

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N 204	Continued From page 44 Ammonia level, (, ,), and level was not documented as completed. Review of Resident #1's Lab Order History on the laboratory portal did not reveal a physician order was placed on for , level, Ammonia Level, (, ,), or a level. Review of Resident #1's progress note, dated at 7:30AM, revealed " activity noted this am [morning] lasting approximately 3.5 minutes s/p [status post] snoring lasting about 2 minutes then aroused making contact with staff alert and orientated to self-97.2 [temperature]-76 [,]-20 [, rate]- [,]-97% [saturations] R/A [room air]. Review of the medical record did not reveal the resident's physician was notified of the . Review of Resident #1's lab report with a collection date of at 5:09 p. m., revealed , was low (14 ug/mL) with a reference range of 50-100 ug/ml. Review of Resident #1's medical record did not reveal evidence the physician was notified of the low , (,) lab results collected on . Review of Resident #1's physicians' orders, revealed an order, with a start date of and an end date of , for a , ( ), Comprehensive Panel (CMP), , level, and Ammonia level, every night	N 204		

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N 204	Continued From page 45 shift for one day. Review of Resident #1's lab results with a collection date of , revealed abnormal , CMP and , Level results for the following lab values: : Low (67 milligrams per deciliter (mg/dL)) with a reference range of 70-99 mg/dL : High (24 mg/dL) with a reference range of mg/dL / Ratio: High (38.6 mg/dL) with a reference range of 6.0-25.0 mg/dL : Low (3.4 mg/dL) with a reference range of 8. .2 mg/dL : Low (3.93 million per microliter (M/uL)) with a reference range of 4. .9) M/uL : Low (11. grams per deciliter (8g/dL)) with a reference range of 12.0-16.0 g/dL : Low (35.9%) with a reference range of 37.0-47.0% , (,): low (25 ug/mL) with a reference range of 50-100 ug/mL Review of Resident #1's Lab Order History on the laboratory portal revealed the Ammonia order, dated , had a status of "collection pending, no results" and there was no sample collection date. Review of Resident #1's medical record revealed no evidence the physician was notified of the abnormal lab results collected on . The medical record revealed no Ammonia levels were collected or physician communication related to the Ammonia level lab not being collected. An interview was conducted on at 12:45 p.m. with the Director of Nursing (DON). She	N 204		

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N 204	Continued From page 46 reviewed Resident #1's Lab Order History on the laboratory portal, and she said "Collection pending, No Results" means the labs were not drawn. Review of Resident #1's progress note, dated , at 9:18 a.m., revealed "At approx. [approximately] 7:30am resident was having activity. foaming[sic] at and release of and feces noted. resident[sic] moved to[sic] onto her side until ceased. Resident cont [continued] to be slow to wake and is nonverbal at this time. Resident has history of activity. Family and MD aware." Review of Resident #1's change in condition, dated , revealed "The change in condition ...: The was: New onset activity, OR persistent in someone with known intermittent activity. Provider Notification and Feedback: ...send to Er [emergency room]" Review of Resident #1's hospital record revealed a physician note, dated , as: "Impressions and Plan Breakthrough due to noncompliance. The patient is currently unresponsive. This could be due to a postictal state, non-convulsive activity or , , , . I spoke to her [Resident #1's] nurse ... at the nursing home ... the patient has been refusing her medications. Yesterday she had a 4-minute convulsive . Low , , level Low , level but her dose of this medication may not be therapeutic. ...Plan	N 204		

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N 204	Continued From page 47 Prescribe telemetry Neurochecks every hours precautions , 2mg [ ] for convulsive activity lasting more than 100 seconds , , , , . She is also on , that is not available in form, but the other 's [, , drugs] should be adequate. There is not yet clear how her refusal to take p.o. [by] AEDs will get resolved. She may need a [, ,]." Review of Resident #1's hospital Physician note, dated , revealed: "The patient presents with , [year old] f [female] who presented to the ed [emergency department] from her facility after a witnessed . , [patient] was also in the ed 2 days ago for glf [ground level]. I was asked to see the , for a , . denies , , n/v [/] and , , . Apparently, she frequently refuses to eat and take her medications due to her neurologic and , issues. did not have issues swallowing during her vss [video swallow study]. per nursing if she is fed she will eat. She does pocket her food and requires verbal reminders. She has no , d/c [discomfort]. She has no [ ] complaints. ...plan Npo[nothing by] after mn [midnight] Egd [, ,]/, tomorrow." Review Resident #1's through	N 204		

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N 204	Continued From page 48 Medication Administration Record (MAR) revealed she received 10 ml's of , , (100 mg/ml) by twice a day every day for except on at 5:00 p.m. the documentation revealed "10". Review of the chart codes revealed "10=spit out meds". On at 9:00 a.m. the documentation revealed "6" review of the chart codes revealed 6= Hospitalized. On at 9:00 a.m. the documentation revealed "2". Review of the chart codes revealed "2=drug refused". The MAR review revealed Resident #1 received , , 125 mg three times a day for every day for the month of until she was discharged on , except on at 9:00 a.m. and 1:00 p.m., the documentation revealed Resident #1 was hospitalized. On at 9:00 a.m. and 1:00 p.m. the documentation revealed Resident #1 refused the drug. Review of Resident #1's progress note, dated at 2:12 p.m., revealed "Resident returned to facility at approx. [approximately] 1:[sic]55pm via stretcher/ [emergency medical services]. resident[sic] had no s/s [signs and symptoms] of distress noted ...Resident has in place and can eat by . Jevity 1.2 @ 60 FWF [free water flush] 200ml q6 [every 6]. Resident can eat by soft / bite sized. 1400 total in 24 hours. Two boxes a meal." Review of Resident #1's nutrition note, dated at 9:59 a.m. revealed, "Res [Resident] readmitted to facility s/p [status/post] 7d [day] hospitalization. New [tube] inserted however res eats 75-100% of meals by and requests snacks frequently. Will d/c [discontinue] feed as res is able to meet	N 204		

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N 204	Continued From page 49 needs via po [by] at this time. Flush tube w/ [with] 150cc H20 [water] q [every] shift to maintain patency." Review of Resident #1's progress note, dated at 10:21 a.m., written by Staff A, Licensed Practical Nurse (LPN), revealed, "This writer received order from NP [Nurse Practitioner] stating resident able to take medication by if resident refuses then we may use for medications; resident is currently eating meals w/o [without] issues or concerns." An interview was conducted on at 3:10 p.m. with the DON. The DON stated she did not assign a primary person to oversee the labs and review results. She said if labs were not critical staff would put the lab results in the providers' boxes for them to sign. If the labs were critical staff would call the provider to inform them about the critical lab results. The DON stated labs for medications should be drawn every three months, but she does not know why some resident's labs were not being checked. She stated Resident #1's , levels were being monitored by the , nurse practitioner. The DON stated she was aware that this was a system failure on the facility when it came to their lab process. She stated she would have expected her nurses to fax labs results to the doctor, put follow-up labs in to check the , levels, and monitor the process. The DON stated Resident #1's labs from and were not signed off by the provider to show they reviewed the resident's lab results. She stated she thought Resident #1 had a consultation while in the hospital, but the facility did not follow up to schedule a for Resident #1.	N 204		

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N 204	Continued From page 50 The DON stated Resident #1's and Resident #2's labs were not done because the nurses were not transcribing the information from the orders to the lab reconciliation sheet and putting them in the lab book, so the tech knows which labs to draw for which residents. The DON stated it was her responsibility to ensure the resident's consultation was followed up on. She stated there was a system failure because management did not have anyone assigned to pull labs, review lab results, and ensure all ordered labs were completed. The DON said their process was broken for following up with labs and completing documentation. An interview was conducted on at 3:50 p.m. with Resident #1's Physician Assistant (PA). The PA said he does not manage Resident #1's levels. If a resident is on for would not manage the medication; that would be managed by a resident's Primary Care Provider (PCP). An interview was conducted on at 4:20 p.m. with Resident #1's Advanced Practice Registered Nurse (APRN). The APRN said he does not monitor residents because it is managed by . He stated is not a medication he would prescribe a resident for . He stated that he made a referral to have Resident #1 seen by a in and then again when Resident #1 came from her most recent hospital stay ( ), but he is not sure if the facility had followed up on his referral. He stated it is possible the low medication labs could have been caught before the resident had her if the facility had been	N 204		

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N 204	Continued From page 51 managing her lab results and followed up with . He stated residents who are on , and , medications for should have labs drawn every three to six months to ensure the medication level are therapeutic for the resident's diagnosis. The APRN confirmed the facility should be doing the labs as ordered by the provider. For abnormal labs the facility should notify him the day the labs resulted and for critical labs the facility should get a hold of him. An interview was conducted on at 1:50 p.m. with Staff B, LPN, she said she has worked at the facility on and off for four years and is very familiar with Resident #1. She said, "Some years ago" Resident #1 had a for not eating, drinking, or taking her medications but she kept pulling the out, so her family decided to just leave it out. She was doing well without it, eating, drinking, and taking her medications without any concerns. Staff B, LPN said for "less than one day" Resident #1 was not eating, drinking, or taking her medications and when she came in the next morning she had a "huge gran-mal ", foaming at the , lost control of her and , and then became post ictal (the period immediately following a when the recovers, and the body returns to its normal state. During this phase, individuals may experience a range of symptoms, including , drowsiness, , and difficulties.) Staff B, LPN said Resident #1's normal are focal , and she just stares, and they do not last long but "this was a big one". Staff B, LPN said she called the physician and had Resident #1 sent to the hospital. Staff B, LPN said when Resident #1 returned the family must have agreed to a	N 204		

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N 204	Continued From page 52 tube again because she came with a but all "we" do is flush it in the morning with water. She said Resident #1 eats by and takes her medications by without any problems. She said since Resident #1 has returned from the hospital after her she is still herself but not quite the same, "we definitely fried some cells with that ." An interview was conducted with the Medical Director on at 3:11 p.m., she said she was Resident #1's primary physician and she was familiar with the resident. She said, typically Resident #1's are controlled, and she was on multiple medications but, she did go to the hospital for a . The Medical Director said when Resident #1 was admitted to the hospital for the , her , , levels were low and her , levels were not therapeutic, because she was not eating and was "pocketing her medications [storing medications in her cheek]". She needed ( ) , , and , because her levels were very low and "it was an emergency". The Medical Director reviewed Resident #1's hospital notes and said Resident #1 had a placed in the hospital because she was not eating or taking her medication, so it was life saving for her to have the . The Medical Director said she did not remember the staff at the nursing home notifying her Resident #1 was not eating, drinking, or taking her medications. She said the nursing notes will reflect if they notified her or her APRN. The Medical Director said when labs are ordered her expectation is they are collected and once they have resulted the nurses should notify "them" immediately if any labs are critical. If they aren't critical then the nurses are supposed to put the	N 204		

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N 204	Continued From page 53 results in the "folder" so she or her APRN can check them when they come in three to five times a week. The Medical Director said medication levels should be drawn upon admission and every six months and if the medication labs are abnormal the nursing staff should be notifying the because she is not the Physician for the medications, she is just "supporting." The Medical Director said if there is an order for a consultation then the facility should coordinate so the resident sees a . The Medical Director said the residents had to go out to see a because the facility did not have one coming to the facility. "But there are transportation problems for bed ridden patients." An interview was conducted on at 10:37 a.m. with Staff C, LPN she said she would get "floated" to take care of Resident #1. She said she works two double shifts a week the 3:00 p.m. to 11:00p.m. and 11:00 p.m. to 7:00 a.m. shift. She said before Resident #1 had her "big " ( ) she didn't have any problems giving her, her medications. She said the nurses knew you had to give her the medications in foods she liked, such as a milk shake. She said Resident #1 used to self-propel herself up and down the hallways yelling "cheeseburger" and asking for coffee. Staff C, LPN said now she is just not as "spunky" as she used to be before the . Staff C, LPN said when she returned from the hospital she came with a . She said Resident #1 does not use the , it's only there if she refuses to take her medications by . Staff C, LPN said she does not have any issues with Resident #1 taking her medications or eating and drinking.	N 204		

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N 204	Continued From page 54 An interview was conducted on at 10:56 AM with Staff A, LPN 200 hall Unit Manager (UM) and the DON. Staff A, LPN, UM, said she has been a UM since the end of , and did not take over the 200 hall until the end of . She said she knew Resident #1 for the most part, at the beginning, when Staff A, LPN, UM first started, she had only spit out her medications a couple of times and she was always eating so it was easy to give her medications. Only a day or two before her , she was refusing her medications, "But it wasn't long that she was refusing her meds before her ." The DON said it's their understanding she had a a few years ago for but she had pulled it out and it was left out because she was eating and taking her medications by without issues. The DON said when she came from the hospital with the , she worked with , , , and they were able to upgrade her diet right away and she continued to eat, drink, and take her medications without any problems. The DON said, "she uses it for nothing" and it is there just in case she does not take her medications. An interview was conducted on at 11:02 a.m. with the DON. She said all the clinical nurses did not have access to the lab portal because they changed to the current lab in , "We didn't push to get everyone access, there was just a push to get the system online." The DON said she had noticed for the past couple of months that lab orders had been cancelled. She said the facility just reordered the labs and didn't question why. The DON said the labs were just reordered	N 204		

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N 204	Continued From page 55 and it was not really looked at as a system failure. A phone interview was conducted on at 1:00 p.m. with Resident #1's Heath Care Proxy and family. They said they were informed Resident #1 went to the hospital in , for a and when she was at the hospital, the hospital had called them and told them Resident #1 was "pocketing her food," not drinking and not taking her medications "that's why she had the ". The family gave the approval to put the in and then they had a care plan meeting with the facility, and they were told Resident #1 was eating well and taking her medications by and they were not using the . A phone interview was conducted on at 2:27 p.m. with the Regional Lab Supervisor. She said the comes to the facility six days a week Monday through Saturday regardless if there are lab orders or not. She said they provide a for STAT (immediately or without delay) labs as they need it. The Lab Supervisor said the expectation is the facility puts the lab order into the lab portal, print out the reacquisition form, and put the reacquisition form in the lab book. She said if the nurses do not have access to the lab portal, they can write the order on a blank reacquisition form, that the lab company provides, and put that in the lab book. The will not know a lab needs to be drawn on a resident if there is not a reacquisition form in the lab book. The Lab Supervisor said if the nurse has put the order into the lab portal, but they did not print the requisitions form and put it in the lab book then the will not collect the lab and the order will sit in the portal and have a status of "collection pending, no results." If the	N 204		

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N 204	Continued From page 56 order is cancelled due to a collection error, then the lab will call the facility and have the nurse re-enter the order in the lab portal and print the reacquisition to put in the lab book so the can redraw the labs the next day. Once the has drawn the labs, they take the reacquisition forms with them and when they drop off the lab specimen someone from the lab makes sure the reacquisition was put into the portal because that is the only way the lab can print labels for the specimen. Once the test has resulted, then the result is uploaded into the lab portal and if there is a critical result the lab calls the facility. 2. Review of Admission Records showed Resident #2 was admitted on with diagnoses including unspecified injury of and unspecified . Review of Resident #2's care plan showed a focus area of . Interventions included: give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated . Review of Resident #2's order showed the following: -Fasting comprehensive panel (CMP), lipids, , ( ), , level, Ammonia level. One time a day every 4 months starting on the 1st for 1 day for hypertensive atherosclerotic (ASCVD), drug monitoring. Schedule routine weekday mornings. Dated .	N 204		

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N 204	Continued From page 57 -Fasting CMP, Lipids, , , level, Ammonia level. Every night shift for 1 day. Dated . - , capsule delayed release 250 mg (,). Give 250 mg by at bedtime for related to unspecified . Dated . - , level. Dated . -Ammonia level. Dated . Review of lab results for Resident #2 showed , level and Ammonia level, dated . The , level was low at 23 ug/ml with a reference range of 50-100 ug/ml and the ammonia level was high at 69 ug/ml with a reference range of 11.0-35.0 ug/ml. There were no results found for the labs ordered to be drawn on . The order for , level was not completed. The labs were reordered and drawn on with a low result of <13 ug/ml with a reference range of 50-100 ug/ml. The Ammonia level drawn on was high at 80 umoL/ml with a reference range of 18-72 umoL/ml. Review of Resident #2's progress notes showed no documentation a provider was notified of the abnormal , and Ammonia results on . Review of Resident #2's Lab Order History on the lab portal showed no orders were input in their system for labs to be drawn on . There was an order put in on for a , level. Review of Resident #2's progress notes, dated , showed "obtained orders to redraw , due to alb [ ] stating uncollected lab" and "Lab tech out to get STAT	N 204		

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N 204	Continued From page 58 , ." An interview was conducted on at 12:40 p.m. with the DON. She confirmed Resident #2 had a , level ordered on that was not completed. She said they did not realize it was not done until . At 1:56 p.m. the DON reviewed Resident #2's medical record and confirmed there was an active order for labs every 4 months. She said the lab order was one that had through the cracks and labs were not transcribed to the lab portal and lab reconciliation sheets. She confirmed the resident had labs in and not again until . A follow-up interview was conducted on at 5:15 p.m. with the DON. She said somehow Resident #2's lab was cancelled on by the lab or the nurse. She said the unit manager (UM) had been given this to check on the homework sheet and they should have caught the fact the lab was not completed. 3. Review of Admission Records showed Resident #8 was admitted on with diagnoses including , , . Review of Resident #8's physician orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 3 tablet by two times a day related to , , . Dated . -Ammonia Level. Every night shift every Wednesday for 4 weeks. Dated . Review of Resident #8's lab results, dated , showed an Ammonia Level results of 118 umol/L (micromole per liter) with a reference range of	N 204		

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N 204	Continued From page 59 18-72 umol/L. This was indicated as a critical result. The lab showed the result was reported on at 11:38 a.m. Review of Resident #8's progress notes showed no documentation a provider was notified on of the critically high ammonia level. There was a progress note, dated at 9:02 a.m.,. showing labs were sent to the Advanced Registered Nurse Practitioner. Review of Resident #8's Treatment Administration Record (TAR) showed the Ammonia level that was scheduled to be rechecked on was documented as "9" indicating "Other/See Nurse Notes." Review of progress notes revealed no nurses' note showing why the lab was not drawn. Review of Resident #8's lab results, dated , showed a , , level high at 49.5 ug/mL with a reference range of 6.0-46.0 ug/mL. An interview was conducted on at 2:35 p.m. with the DON. She reviewed Resident #8's medical record and confirmed documentation showed the provider was not notified of the critical high ammonia level until the day after the results were received. She said her expectation would be the provider to be notified immediately of critical results. The DON confirmed there was no documentation as to why the ammonia level scheduled for was not completed and said it should have been rescheduled but was not. 4. Review of Admission Records showed Resident #4 was admitted on with diagnoses including other .	N 204		

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N 204	Continued From page 60 Review of Resident #4's care plan showed a focus area of , dated . Interventions included obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #4's orders revealed the following active orders: - , , Oral Capsule Delayed Release Sprinkle 125 mg (,). Give 2 capsule by every 8 hours related to other . Dated . - , CMP, , , , Ammonia Level. One time a day every 90 day(s) for , , , , , . Dated . Review of Resident #4's provider note, dated , noted " , , check levels and ammonia levels." Review of Resident #4's lab results showed the last , level result was on . 5. Review of Admission Records showed Resident #3 was admitted on with diagnoses including , and , following , , , , , and . Review of Resident #3's physician orders revealed the following: - Oral Tablet 4 mg , Give 1 tablet by at bedtime related to and of unspecified . Dated . - /INR. Every night shift every 7 days related to	N 204		

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N 204	Continued From page 61 unspecified . Dated . - , , oral capsule, delayed release 125 mg. Give 2 capsules by two times a day for . Dated . Review of Resident #3's lab results showed a , (,) level was checked on resulting in a low , level of 47 ug/mL with a reference range 50-100 ug/mL. Lab results were checked again on resulting in a lower , level of 42 ug/mL. Resident #3 had a /INR lab checked on resulting in a high of 25.5 seconds with a reference range 9. .5 seconds and high INR with a reference range 0.93-1.15 seconds. Review of Resident #3's progress notes showed no documentation a provider had been notified of or reviewed the above lab results. Review of Resident #3's lab results dated showed the , level was even lower at 32 ug/mL with a reference range of 50-100 ug/mL. Review of Resident #3's MAR showed 4mg continued to be administered on - . An interview was conducted on at 12:52 p.m. with the DON. She reviewed Resident #3's medical record and confirmed there was no documentation the , level results had been sent to the provider on . As for the /INR, she said the provider was reviewing the results currently and confirmed they had not been notified of the abnormal /INR labs. The DON said it is not acceptable that four days had passed, and the provider had not been notified.	N 204		

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N 204	Continued From page 62 She said abnormal lab values should be reported to the provider with 24 hours and critical lab values should be reported to them immediately. The DON said the nurse practitioner was ordering an ammonia level to be drawn for Resident #3 and a , , consultation. When asked why a , , consultation was being ordered she said , , is who manages the dosing for , , even for residents on the medication for . 6. Review of Admission Records showed Resident #7 was admitted on with diagnoses including , , , . Review of Resident #7's orders revealed the following orders: - , (,) Oral Tablet Delayed Release 250 mg. Give 1 tablet by two times a day related to , , , . Dated . - , Oral Tablet Delayed Release 250 mg. Give 1 tablet by every 12 hours for . Dated . Discontinued . - Lipid Panel, A1C, , CMP, , , Ammonia Level. Every night shift for 1 Day. Dated . Review of Resident #7's TAR showed the order for labs on was signed off as completed. Review of Resident #7's medical record showed no labs had been drawn. Review of Resident #7's lab order history of the lab portal from - showed the resident had no , levels drawn until .	N 204		

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N 204	Continued From page 63 Review of Resident #7's lab results, dated showed her , level was low at 25 ug/mL with a reference range of 50-100 ug/mL. 7. Review of Admission Records showed Resident #5 was admitted on with diagnoses including , , of front and . Review of Resident #5's provider orders revealed the following: - (, ,) Oral Tablet 1000 mg. Give 1 tablet by two times a day for . Dated . - (, ,) Oral Tablet 1000 mg. Give 1 tablet by every 12 hours for activity. Dated . Discontinued . Review of lab results for Resident #5 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / . 8. Review of Admission Records showed Resident #6 was admitted on with diagnoses including other . Review of Resident #6's provider orders revealed the following: - (, ,) Oral Tablet 500 mg. Give 1 tablet every 12 hours for . Dated . Review of lab results for Resident #6 showed no , , levels had been checked for the resident as long as the facility had used their current lab, which was , / .	N 204		

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N 204	Continued From page 64 An interview was conducted on at 12:55 p.m. with the DON. She reviewed Residents #5, #6, and #7's medical record and the facility's lab portal and said no labs had been drawn for the three residents since at least the spring of 2024. She said she was unable to see further than that due to a change in labs. 9. Review of Admission Records showed Resident #9 was admitted on with diagnoses including anoxic damage and other . Review of Resident #9's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #9's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #9's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 1 tablet by one time a day for . Dated . Discontinued . - , , oral tablet 750 mg. Give one tablet by two times a day for . Dated . Discontinued . , , oral tablet 1000 mg. Give 1000 mg by two times a day for . Dated . Review of Resident #9's lab results showed an Ammonia level had been drawn on , but	N 204		

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N 204	Continued From page 65 there was no evidence of a , or , , level ever being drawn. An interview was conducted on at 12:40 p.m. with the DON. The DON confirmed Resident #9's , and , , level at not been checked as evidenced by the lab order history on the lab portal she provided. The DON confirmed current labs were drawn for Resident #9 on and his , level was low at 12 ug/mL with a reference range of 50-100 ug/mL. She said the doctor increased his , , and took him off , . 10. Review of Admission Record showed Resident #10 was admitted on with diagnoses including unspecified . Review of Resident #10's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #10's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Dated . Review of Resident #10's provider orders revealed the following: - , delayed release sprinkle 125 mg. Give 2 capsules by every 8 hours for . Dated . - , , Tablet 500 mg. Give 500 mg by one time a day for related to unspecified	N 204		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 204	Continued From page 66 . Dated . - , CMP, , , , , / , level. Dated . -Lipid level, A1C, Ammonia level one time a day every 3 months starting on the 23rd for labs. Dated . Review of Resident #10's lab results showed a lab, dated , for , (,) that resulted low at 45 ug/mL with a reference range of 50-100 ug/mL. There were no , , and Ammonia results for the labs ordered on . An Ammonia level lab ordered on to be completed on was not completed as ordered. It was reordered to be drawn on . The Ammonia level resulted as critically high at 123 umol/L with a reference range of 18-72 umol/L. A , (,) level was completed on showing a low result of <10 ug/mL with a reference range of 50-100 ug/mL. An interview was conducted on at 11:34 a.m. with the DON. She said Resident #10's labs were ordered on for some reason the , , and Ammonia labs were cancelled. She said the labs were reordered on but never completed. The DON said, "It's the follow through again." Review of Resident #10's Progress note, dated , showed "Resulted labs sent to appropriate providers this shift. Per MD [medical doctor] orders, , , labs reordered due to lab error. Ammonia levels also ordered, and both scheduled to be collected . Awaiting psych response for low , levels." 11. Review of Admission Records showed	N 204		

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	55227	A. BUILDING: _____ B. WING _____	C 04/17/2025

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N 204	Continued From page 67 Resident #11 was admitted on with diagnoses including unspecified . Review of Resident #11's Quarterly MDS, Section I, Active Diagnoses, showed or , , , under the section. Review of Resident #11's care plan showed a focus area of . Interventions included give medication as ordered by doctor. Monitor/document side effects and effectiveness and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated and monitor labs and report sub therapeutic or toxic results to MD. Dated . Review of Resident #11's provider orders revealed the following: - , oral tablet delayed release 250 mg. Give 250 mg by two times a day for . Dated . - , level. Every night shift every 3 months starting on the 16th for 1 day. Dated , Review of lab results showed a , level was drawn on with low , levels of 33 ug/mL with a reference range of 50-100 ug/mL. Review of progress notes did not reveal any documentation a provider was notified of the low , levels on . Review of lab results showed , levels were not checked again until . There were no results for the labs ordered for , 90 days from the original order.	N 204		

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N 204	Continued From page 68 Review of Resident #11's Lab order summary from the lab portal showed there was no order put in the lab system for a , level in . Review of the facility's policy titled " Prevention Program", dated , revealed the following: "Policy: The facility has designated and implemented processes, which strive to reduce the risk of , neglect, , , mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, , neglect, mistreatment, and , . It is expected that these policies will assist the facility with reducing the risk of , neglect, , , and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burnout, or resident behavior which may increase the likelihood of such events. DEFINITIONS: ...Neglect " Failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, , , mental anguish or emotional distress. ...Mistreatment " Inappropriate treatment or , of a resident. ...Serious Bodily Injury An injury involving extreme physical , ; involving substantial risk of ; involving protracted loss of , of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from	N 204		

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N 204	Continued From page 69 criminal . ... Procedure The facility has implemented the following processes in an effort to provide resident's, visitors and staff with a safe and comfortable environment. " The administrator is responsible for designating an Coordinator. " The designated shift supervisor is identified as responsible for immediate initiation of the reporting process. " The administrator, DON and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, , neglect, and , and misappropriation. " The administrator, DON and/or designated individual are also ultimately responsible for the following: o Implementation o Ongoing monitoring o Investigation o Reporting o Tracking and trending TRAINING Facility orientation program and ongoing training programs will include, but may not be limited to: " 483.95(c): Freedom from , neglect, & , requirements in 483.13. " 483.95(c): Activities that constitute , neglect, , , & misappropriation of resident property as set forth in 483.12. " 483.95(c): Procedures for reporting incidents of , neglect, , , or the misappropriation of resident property. " 483.95(c): management & resident prevention. " ...Identification of , neglect, mistreatment, , and misappropriation. " ...How staff should report their knowledge	N 204		

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N 204	Continued From page 70 related to allegations without fear of reprisal. " How to provide protection for residents. " Components of a compete and thorough investigation. " Methods to reduce the risk of , neglect, mistreatment, misappropriation, and , that may include, but may not be limited to, recognizing signs of burnout, frustration and stress, stress management and relaxation techniques .... PREVENTION " ... staff are instructed to report concerns, incidents, and grievances without fear of retaliation. " ... Facility leadership will identify situations in which , neglect, this treatment, , , misappropriation may be more likely to occur such as " Residents with needs/behaviors which might lead to conflict or /neglect. " Staff burnout " analyze the occurrences to determine what changes are needed, if any, to policies and procedures and education to prevent further occurrences. " ... event reports and resident concern/Grievance Reports are reviewed, tracked, and trended for indicators suspicious for , neglect, mistreatment, , , and/or misappropriation. ...TRACKING AND TRENDING " A monthly report of reportable events is prepared and provided to the Quality Assurance, Assessment, and Compliance Committee for review. " Events are tracked and trended to identify similarities, causative factors and any other area that may increase the risk of repeat occurrences	N 204		

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N 204	Continued From page 71 of the same or similar nature. Review of the facility's policy titled "Physician Notification," dated , showed: Policy The facility strives to ensure that each resident's health is supervised by a qualified attending Physician. The attending Physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient. Procedure 1. Licensed Nurses will ensure that physicians are notified of changes or diagnostic results that occur between visits. Changes may include but are not limited to: " A change in condition, mental or physical " A change in the status of a " The development of a new " Laboratory Results " Diagnostic Results " Abnormal or those outside the " Successful treatment of " Consultant reports & recommendations " Family concerns related to medical care " Events " Resident's refusal to take medication " Any time a medication is not administered as ordered 2. It is not sufficient to document Faxed to the physician without verbal follow up. 3. If there has been no verbal contact within a reasonable time frame (Based on Nursing judgment & the acuity of the situation). o Notify the DON or designee o Notify the Medical Director 4. Emergent situations do not require a physician order to dial 911.	N 204		

Agency for Health Care Administration

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N 204	Continued From page 72 Class I	N 204		