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| S 000 | Initial Comments<br><br>Annual Health Licensure Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1 of 3<br><br>300.610a)<br>300.1210b)<br>3001210d)6<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. | S9999 | Attachment A<br>Statement of Licensure Violations | |

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d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met as evidenced by:

Based on interview and record review the facility failed to safely transfer a resident (R69) via wheelchair. This failure resulted in R69 sustaining a fall with injury which included a laceration to her forehead that required sutures. The facility failed to ensure a resident was safely transferred from wheelchair to bed. These failures apply to 2 of 31 residents (R69, R37) reviewed for resident safety/supervision in the sample of 31.

The findings include:

1. R69's care plan dated February 2022, showed R69 was cognitively impaired with poor judgement and poor safety awareness related to her diagnosis of dementia. The care plan showed R69 also had a diagnosis of Parkinson's disease which put her at risk for falls due to her "impulsive behavior movements while sitting in her wheelchair." The care plan showed "staff will continue to monitor how resident is sitting in her wheelchair ..."

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R69's Nurses Notes dated August 13, 2023, showed a certified nursing assistant (CNA) was pushing R69 in her wheelchair. The CNA suddenly stopped pushing R69 in her wheelchair which caused R69 to fall forward out of her wheelchair, onto the floor. The note showed R69 sustained a "2.5 cm (centimeter) laceration on her left forehead with bleeding" due to the fall. 911 was called. R69 was sent to the hospital, via ambulance, for an evaluation. R69 returned to the facility, from the hospital, on August 13, 2023, after receiving five sutures to repair her forehead laceration.

On August 29, 2023, at 11:51 AM, V10 CNA stated, "An agency CNA was pushing (R69) down the hall in her wheelchair. I was walking next to them. (R69) was in her wheelchair. I had taken the leg rests off her wheelchair earlier that day. A resident that was walking in front of (R69) stopped suddenly so the CNA, pushing (R69), had to stop. When he stopped, (R69) went forward out of her wheelchair. She hit her head on the floor. She had a cut on her head. She was not scooted back in the seat of her wheelchair before she fell. I kept telling her to scoot back in her wheelchair, but she didn't listen."

On August 29, 2023, at 12:29 PM, V12 Restorative Nurse stated, "(R69) has dementia and is very confused. She has no safety awareness. She has a high-back, reclining wheelchair because she tends to lean forward in her chair. She has poor trunk control. When she is up in her wheelchair, the leg rests should be on the chair, with her legs on the rests, to help position her back in the seat of the chair. If she is leaning forward in her chair, staff need to direct her to sit back. Staff should make sure she is not

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leaning forward in her wheelchair when transporting her. If she is not positioned correctly in her chair, she could fall forward out of the chair."

On August 29, 2023, at 1:01 PM, V13 Nurse Practitioner stated R69 has a high-back, reclining wheelchair because "she has a tendency to lean forward and has slid out of her wheelchair before." V13 stated, "(R69) is very confused and has poor safety awareness. If she is scooted forward in her wheelchair or leaning forward in her chair, staff should reposition her towards the back of the wheelchair to make sure she's safe when transporting her."

2. R37's assessment dated May 25, 2023, showed R37 was severely cognitively impaired. The assessment showed R37 required the extensive assistant of 2 staff for transfers.

On August 28, 2023, at 12:15 PM, R37 was seated in a wheelchair next to her bed as V3 CNA stood next to her. V3 CNA transferred R37, from her wheelchair to the bed, by holding onto R37's pants with her right hand. No gait belt was used during the transfer. V3 CNA was the only staff in the room.

On August 29, 2023, at 12:38 PM, V12 Restorative Nurse stated R37 should be transferred by 1-2 staff, with the use of a gait belt. V12 stated gait belts should be used when transferring all residents.

The facility's Manual Gait Belt and Mechanical Lifts policy dated January 19, 2018, showed, "Use of gait belt for all physical assist transfers is mandatory."

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| S9999 | Continued From page 4<br>(B)<br><br>2 of 3 Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)3<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following | S9999 | | |

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| S9999 | Continued From page 5<br>and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to complete quarterly and significant change dietary assessments on residents. The facility failed to ensure dietary assessments were completed by the Registered Dietician. The facility failed to identify resident weight loss prior to the weight loss becoming significant. The facility failed to ensure weight loss treatment interventions were initiated in a timely manner, once resident weight loss was identified. These failures resulted in R37, R69, R144, R9, and R79 sustaining a significant weight loss. These failures apply to 5 of 10 (R37, R69, R144, R9, R79) residents reviewed for weight loss in the sample of 31.<br><br>The findings include:<br><br>1. R37's Admission Record dated 3/27/23, showed R37 was admitted to the facility with | S9999 | | |

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diagnoses of dementia and a left hip wound related to recent hip surgery.

An admission dietary profile for R37, dated 4/13/23, showed the profile was completed by V7, a non-certified Dietary Manager. R37's electronic medical records dated 3/27/28-4/25/23 were reviewed and showed no admission dietary assessment was completed by V6 Registered Dietician (RD).

R37's Weight Report dated 8/29/23 showed R37 weighed 119.4 pound (lbs) upon admission to the facility. The record showed R37 weighed 118 lbs on 4/4/23 and 89 lbs on 4/25/23 which resulted in a significant weight loss of 24.5 % (29 lbs) in 21 days.

R37's dietary note date 4/26/23, showed V6 RD's first visit/assessment of R37. The note showed R37 was not assessed by V6 RD until 28 days after admission and not until after R37 had sustained significant weight loss.

A Dietary Note for R37, dated 5/15/23, showed R37 was assessed by V6 RD. The note showed, "unintended weight loss ..." The note showed R37 was started on a diuretic on 4/21/23 but R37 had only been on the medication three days prior to the significant weight loss being discovered.

On 8/29/23 at 10:00 AM, V6 RD stated, "I am not full time or part time in the facility. I work in the facility on a consulting basis. I don't complete the admission, quarterly (every 3 months), or annual dietary assessments on the residents. The CDM (certified dietary manager) does those assessments. I don't routinely see residents unless they have significant weight loss, pressure wounds, are on dialysis, or require tube feeding.

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A resident could potentially be in the facility for months to years before I would need to see them. I don't see residents with dementia or with surgical wounds unless they have significant weight loss. Dementia and surgical wounds can put residents at risk for weight loss but those are not reasons or triggers for me to see a resident. The goal is to intervene before weight loss becomes significant. I did not see (R37) until after she had already had significant weight loss. I don't know why her admission dietary assessment was not completed until 4/13/23. I don't know exactly why she had such a significant weight loss." V6 RD stated she was aware V7 was not a certified Dietary Manager.

On 8/29/23 at 1:12 PM, V7 Dietary Manager stated he was not certified in dietary management but, he was currently enrolled in school for dietary management. V7 stated he had no certifications in food service management, did not have an associate's degree, and had no past work experience in long term care facilities. V7 stated, "I do the admission, quarterly, and annual dietary assessments on residents. The admission assessment should be done within 48 hours of admission. I am not sure why I did (R37's) admission assessment so late. I must have overlooked it. Nursing should be monitoring residents for weight loss. I only look at weights when I am doing a residents' quarterly assessments..." V7 stated he did not routinely complete residents' dietary assessments collaboratively with V6 RD, despite him not being a certified dietary manager. V7 stated he had never completed a dietary assessment on a resident prior to him being hired by the facility.

On 8/31/23 at 8:23 AM, V13 Nurse Practitioner (NP) stated the expectation is that the Registered

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Dietician assesses residents upon admission and quarterly to monitor residents for weight loss, weight gain, or any changes in nutritional needs. V13 stated any changes need to be reported to the physician or nurse practitioner immediately. V13 stated, "If a Registered Dietician is not assessing residents at least quarterly, changes in a resident's condition could get missed which includes not catching a resident's weight loss. If weight loss is not caught in time, residents could develop malnutrition and/or wounds."

On 8/31/23 at 8:23 AM, V1 Administrator stated V6 RD should be completing admission, quarterly, annual, and significant change dietary assessments on all residents. V1 stated she was notified on 8/30/23, that V6 RD was not completing the necessary dietary assessments on all residents. V1 stated, "I didn't know, until yesterday, that (V6 RD) was not doing all the assessments. Nursing is responsible for monitoring residents for weight loss. (V6 RD) is responsible for running the weekly weights to see who triggers for significant weight loss or is losing weight. We want to stop the weight loss before it become significant. The Registered Dietician is also responsible for making sure the residents get the proper nutrition, proper diet, and for noticing any changes in weight." V1 stated because V7 (Dietary Manager) was not certified, he was not to be completing any resident dietary assessments, on his own.

On 8/30/23 at 10:55 AM, V32 Regional Director of Operations stated, "We have some concerns about (V6 RD's) job performance. We are in the process of letting her go. All resident admission, quarterly, annual, and significant change dietary assessments should be completed by the Registered Dietician." V32 stated he was aware

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| S9999 | Continued From page 9<br>V7 Dietary Manager was not certified.<br><br>2. R69's Admission Record dated 2/11/22 showed R69 had diagnoses including Parkinson's disease, dementia, dysphagia, and muscle wasting/atrophy.<br><br>R69's electronic medical records dated 8/1/22-8/27/23 were reviewed. The records showed the last dietary profile/assessment completed on R69 was 2/21/23, done by the previous CDM. No quarterly dietary assessment dated on or around 5/21/23 was noted for R69.<br><br>R69's Weight Report printed 8/29/23 showed R69 weighed 143.2 lbs in May 2023 and 129.9 lbs in August 2023. This showed R69 sustained a significant weight loss of 9.3% (13.3 lbs) in three months.<br><br>A Dietician Evaluation for R69, was completed by V6 Registered Dietician on 8/28/23, after R69 had sustained significant weight loss. The note showed, "Unintended weight loss ..." V6 RD started R69 on nutritional supplements/weight loss treatment interventions on 8/28/23.<br><br>On 8/29/23 at 10:00 AM, V6 RD stated, "I didn't see (R69) until yesterday (8/28/23). Her last dietary assessment was completed on 2/21/23. I am not sure why she did not have as assessment done in May 2023. No one called me from the facility to tell me she was losing weight. I ran the facility's weight reports sometime during the middle of July (2023). I knew about (R69's) weight loss in July (2023) but did not put any interventions or supplements in place until yesterday. It was an oversight on my part. It got overlooked. That was my responsibility." | S9999 | | |

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On 8/29/23 at 1:01 PM, V13 Nurse Practitioner (NP) stated she was not aware of R69's significant weight loss from May 2023-August 2023. V13 stated, "We should have been notified of (R69's) weight loss as soon as it was discovered so we could have implemented interventions. If (V6 RD) was aware of (R69's) weight loss in July (2023), she should have implemented interventions immediately."

3. R144's Admission Record dated 4/5/23 showed R144 was admitted to the facility with diagnoses of a stroke (CVA/cerebral infarction), dementia, aphasia (inability to verbally communicate), and subdural hemorrhage (brain bleed).

An admission dietary profile for R144, dated 4/16/23, showed the profile was completed by V7, the non-certified Dietary Manager. R144's electronic medical records dated 4/5/23-7/27/23 were reviewed and showed no admission dietary assessment completed by V6 RD.

R144's Weight Report dated 8/31/23 showed R144 weighed 135 lbs in June 2023 and 120 lbs in July 2023. This showed R144 sustained a significant weight loss of 11.1 % (15 lbs) in one month.

A Dietician Evaluation for R144, was completed by V6 RD on 7/28/23, after R144 had sustained significant weight loss. The note showed, "Unintended weight loss related to decreased PO (oral) intakes as evidenced by chart review ..."

On 8/31/23 at 9:18 AM, V6 RD stated she was unaware R144's oral intake had decreased until after R144 had sustained significant weight loss. V6 stated, "I didn't assess her until after she had

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significant weight loss. I did not see her upon admission because she wasn't on dialysis, tube fed, and didn't have any pressure wounds."

4.) R9's face sheet shows she was admitted to the facility on 10/25/22 and has diagnoses including: Type 2 diabetes with diabetic neuropathy, depression, anxiety, adjustment disorder with depressed mood, vascular dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.

R9's electronic medical record shows she had a dietary assessment completed on 10/27/23 on admission, a quarterly dietary evaluation/assessment was completed on 2/1/23 (both completed by a former dietary manager). The next dietary evaluation was not completed until 8/29/23 after V6 Registered Dieitican (RD) was made aware of R9's significant weight loss by the surveyor.
R9's weight and vitals summary shows she weighed 245 lbs. on 6/8/23 and weighed 220.5 lbs. on 7/19/23 a 10% - 24.5 lb weight loss in one month. R9's 8/11/23 weight was 223 lbs.
R9's electronic medical records dated 5/1/23-8/29/23 were reviewed. These records showed no documentation R9 was ever assessed by V6 (RD) even after R9 sustained a significant weight loss.

8/29/23 1:07 PM, V7 (non-certified Dietary Manager)- said he is responsible for the quarterly dietary assessments and then gets the RD involved after he sees the resident. He said he was not aware of R9's significant weight loss and that there really is no process in place for notifying him of significant weight loss for residents. V7 said now that he is aware of R9's

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significant weight loss he will notify V6 and let her know because she would be the person to recommend interventions.

On 8/29/23 at 1:41 PM, V6 (RD) said R9's weight loss should have triggered in the computer for a significant weight loss. She said it was towards the end of the month when she got the resident weights for July so she decided to wait to see Augusts weights. She said she can't speak for the programmers, but this is pretty concerning that PCC (electronic medical record/EMR) is not triggering significant weight loss. V6 said she does not believe she has done any assessment on R9, the last quarterly assessment was last done in 2/1/2023. (No quarterly assessment was done in May or August of 2023 no significant weight loss assessment has been done as of today). V6 said the computer should have also triggered for a quarterly assessment and then V7 should completed those, but if the computer does not trigger it then he would not know to do one and quarterly assessments are being missed.

On 8/29/23 at 2:01 PM, V1 (Administrator) said V6 (RD) is responsible to be reviewing weights to see who triggers for significant weight loss.

5.) R79's face sheet shows he was admitted to the facility on 3/10/23 and has diagnoses including: end stage renal disease, type 2 diabetes, congestive heart failure and acquired absence of below the knee amputation.

R79 had a dietary evaluation completed on admission on 3/13/23, and again on 3/20/23. R79's 3/20/23 assessment completed by V6 (RD) shows he had a recent unplanned weight loss a current pressure injury. R79 went to the hospital for a medical procedure and a dietary

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re-assessment was completed on 5/1/23 upon his return. R79's EMR shows There are no additional quarterly or significant change dietary assessments or evaluations done on R79 after 5/1/23.

R79's weights and vitals summary showed on 4/1/23 he weighed 366.3 pounds. On 8/6/23 he weighed 324 pounds. A total weight loss of 42.3 pounds (11.55%) in 4 months.

On 8/28/23 at 10:53 AM, R79 said he has lot a lot of weight loss, over 85 lbs. and no one from dietary is seeing him that he is aware of.

On 8/28/23 at 1:14 PM, V7 (non-certified Dietary Manager) said he is unaware if the facility follows the 3 month weight loss if it is 7.5%, he thinks the facility just follows the 5% and 10% weight loss to determine significant weight loss. V7 said R79 was last seen by him on 4/24/23 and he was not aware of significant weight loss for R79.

On 8/8/23 at 1:35 PM, V6 (RD) said she was not aware of significant weight loss for R79 and she last saw him on 5/1/23. V6 said he also should have triggered in the computer for significant weight loss and a quarterly assessment but for some reason did not.

The facility's Weight Assessment and Intervention policy dated 2020 showed, "The goal is to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight loss ... Any weight change of 5% of more since the previous weight assessment shall be re-taken the next day to confirm. If the weight is verified, nursing will notify the appropriate designated individuals such as the physician, Registered Dietician, Dining Services Manager, or other

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members of the interdisciplinary team within 24 hours. Verbal notification must be writing ..." The policy defined significant weight loss as a loss of 5% of a resident's weight in one month, 7.5% in three months, or 10% in six months.

The facility's Registered Dietician Roles and Responsibilities policy dated 2020 showed, "The Registered Dietician will provide routine scheduled consultations to monitor compliance with state and federal regulations and plan nutritional care for residents." The policy showed the Registered Dietician (RD) will assess/monitor the nutritional needs of residents and keep the physician and appropriate staff informed of the nutritional status of residents. The policy showed the RD will "provide nutrition documentation for residents according to established schedules and guidelines including assessment and changes in resident nutritional plans ..."

(B)

3 of 3 Violations

300.610a)
300.1210b)
300.1210d)1
300.1210d)2
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives

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of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were not et as evidenced by:

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Based on interview and record review the facility failed to ensure a residents medication was given as prescribed and failed to ensure medication orders were transcribed correctly to avoid a significant medication error. This failure resulted in six of R9's medications being mistakenly discontinued without a physicians order. As a result of this failure R9 developed worsening psychiatric symptoms (paranoia) and was sent to the emergency room for evaluation. This applies to 1 of 7 residents (R9) reviewed for physician orders in the sample of 31.

The findings include:

R9's face sheet shows she was admitted to the facility on 10/25/22 and has diagnoses including: Type 2 diabetes with diabetic neuropathy, migraine without migrainosus, depression, adjustment disorder with depressed mood, vascular dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.

R9's 8/3/23 minimum data set shows she has on going pain and depression. R9's active care plan initiated on 11/30/22 shows R9 has a severe mental illness and has symptoms of delusions, paranoia and poor insight and judgement. R9's care plan also shows she has potential for pain due to migraines and a history of a fracture.

R9's physician order summary (p.o.s) show the following medication orders were all discontinued on 8/1/23 :

Effexor XR (Venlafaxine HCl ER-extended release) (Anti-depression and anxiety medication) 150 milligrams (MG.) 1 tablet per day start date

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10/26/22, bupropion HCL ER (SR) 150 MG. (Anti-depressant) 1 time per day start date 10/26/22, lamotrigine 25 MG. 3 times per day, (anti-seizure medication and also mood stabilizer) start date 10/26/22, Topiramate 25 MG./ Topamax 1 time per day, (medication to treat epilepsy and migraines) start date 10/25/22. Duloxetine (Anti-depressant/anti-anxiety) 60 MG. 1 time per day start date 6/9/23, and Gabapentin 400 MG. (used for neuropathy pain) 1 capsule 3 times a day start date 6/8/23.
There are no notes in R9's electronic medical record indicating who discontinued the medications or why.

A consultation report completed by V26 (Psychiatric Nurse Practitioner) on 6/30/23, shows he saw R9 and made no medication adjustments. The report identifies R9 is on the following psychotropic medications: Venlafaxine for depression and anxiety, Bupropion and duloxetine for depression, Lamictal and Topamax for mood stabilizers. The consultation report also says a gradual dose reduction of those medications are contraindicated and R9 is not a candidate at that time due to on going symptoms.

R9's 8/1/23 9:13 PM, nursing progress note shows R9 had returned from a doctor appointment and the doctor will fax a consultation report to the nurses station.

The consultation report from a pain doctor on 8/1/23 at 3:16 PM, shows a prescription to increase R9's Gabapentin order to 600 MG. 3 times a day for neuropathy pain, and to change/ add Cymbalta 30 MG every 12 hours or two times a day. R9's MAR and pos show those ordered were not carried out.

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| S9999 | Continued From page 18<br><br>A consultation report completed by V26 (Psych NP) on 8/29/23 states the following: "Patient was last seen by writer on 6/30/23 and no medication changes were made. Cymbalta, Wellbutrin, Effexor, Lamictal, Topamax and Melatonin were discontinued on 8/1/23 for unknown reason. The report shows that R9 is having depression an increased episodes of inappropriate behaviors, insomnia, anxiety and agitation.<br><br>R9's Medication Administration Summary (MAR) from 8/1/23 to 8/31/23 show she received 1 dose of Effexor, bupropion, Duloxetine, and Topiramate on 8/1/23 and then it was discontinued and no further doses were received in August. R9 missed 30 doses of each of those medications in the month of August. The MAR also shows R9 received 3 doses of each of Gabapentin and lamotrigine on 8/1/23 (ordered to be given 3 times a day) and then it was discontinued and no further doses were given in August. In total R9 missed 90 doses of each of those medications.<br><br>R9's Nurse Practitioner Progress Note completed by V27 (Nurse Practitioner/NP) on 8/8/23 at 9:47 AM, shows R9 is having an increase in paranoid symptoms.<br><br>Nursing progress notes for 8/29-8/30/23 show R9 was increasingly paranoid and was calling 911 to report feeling unsafe and seeing people with a knife hidden being their ear. Police arrived at the facility and R9 made an allegation of an assault occurring. R9 was sent to the Emergency Room for evaluation. Medication orders were obtained for R9 to be started on a mood stabilizer (Depakote) and a anti psychotic medication (Seroquel) due to her psychotic symptoms. R9 returned from the Emergency room on 8/30/23. | S9999 | | |

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| S9999 | Continued From page 19<br><br>On 8/30/23 at 9:05 AM, V2 (Director of Nursing) said she was not aware why R9's psychotropic and pain medications were stopped abruptly but she will investigate it. At 9:56 AM, V2 said what happened with R9's medication was R9 had went out for a doctor appointment to the pain clinic on 8/1/23 and then returned to the facility. The nurse on duty ( V22-Nurse Supervisor) mistakingly thought R9 had went to the hospital so she discontinued all of R9's medications. When R9 returned to the facility later that evening V22 tried to add the medications back and "missed a few." V2 said V22 should not have discontinued R9's medications and she also did not call the physician to verify any of the pain doctors new orders.<br><br>On 8/30/23 at 9:33 AM, V26 (Psych NP) said he was called to see R9 on 8/29/23. He said he could not figure out who stopped and why her psychiatric medications were stopped. He verified he was not the one who had given orders to discontinue those medications. V26 said he would say that R9 was having an increase in her paranoia from the last time he saw her until yesterday. At 12:56 PM, V26 said the obvious effect of R9 being off her medications would be an increase in psychiatric symptoms including mood, paranoia, and hallucinations.<br><br>On 8/30/23 at 10:22 AM, (V22) said she made a huge mistake with R9's medication orders. She said "she was told by another nurse that R9 was in the hospital so automatically I discontinued the medication orders and then when R9 returned and I learned she only went to a medical appointment I tried to reinstate her orders and I thought I had gotten everything but I missed a few. No one ever questioned it until now why all of R9's psychotropic medications and some of her | S9999 | | |

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pain medications were stopped." V22 said she did not call any physicians to verify any of the orders after R9 returned from the pain appointment. V22 said she should not have discontinued the medications, and it is protocol that after appointments or hospital stays the medication orders are verified with the physician and carried out but she missed the new orders also.

On 08/30/23 11:56 AM - V27 (NP) said her office was not called to discontinue R9's psychiatric or pain medications and she believes R9's topamax and lamotrigine medications were being used more for migraines. She said she would be even more concerned if R9 had a active seizure disorder and if the medications were for seizures then missing them would put her at risk for an increase in seizures. V27 said by R9 missing her other medications there could be changes in mood and behaviors and increased pain. V27 said the facility should contact their office if a resident goes out and comes back to verify medication orders.

On 8/31/23 at 9:11 AM, R9 said she does not recall making any accusations to anyone. She was paranoid about talking with this surveyor and stated, "Maybe I need my family here I don't know what you are up too." R9 said she has diabetic neuropathy and has pain all the time.

On 8/31/23 9:08 AM, V31 (Licensed Practical Nurse/LPN) said R9 been asking for increased amounts of PRN (as needed) norco (pain medication) this past week and has an increase in paranoia. He said he was there on 8/29/23 in the evening when R9 called 911 and was later sent to the hospital. R9 was seeing people with pocket knives, and saying she doesn't feel safe in

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| S9999 | Continued From page 21<br>facility.<br><br>On 8/31/23 9:13 AM- V24 (Certified Nursing Assistant/CNA) said R9 has had increase in paranoia over this past month and has been hallucinating seeing children, cats, and monkeys.<br><br>The facility provided Transcription of Physician Orders- Procedure effective date 11-3-22 says nurses should review the discharge summaries or records from other facilities and verify withthe residents physician of any new or changes in medication orders. All orders should be checked to verify they were entered into the electronic medical record correctly.<br><br>(A) | S9999 | | |