Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005722	A. BUILDING: ______ B. WING ______	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

(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
S 000	Initial Comments Annual Health Survey Complaint Investigation: 2425599/IL175640	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE OF FOUR 300.615e) 300.615f)) 300.615g) 300.615i) 300.615j) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search	S9999		

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page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

g) If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.

i) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.

j) The facility shall be responsible for taking all steps necessary to ensure the safety of

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residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.

This requirement in not met, as evidence by:

Based on interview and record review, the facility failed to complete background checks for five of six residents (R19,R51,R60,R217,R315) reviewed for Criminal Background Checks out of a sample of 37 residents.

Findings Include:

On 8/01/24, at 4:00 PM, V1, Administrator in Training, stated, "We do not have a policy for Criminal Background Checks. We just go by the regulations."

R19's electronic medical record states, "Admission Date 6/04/24." A Criminal History Investigation Report Process (CHIRP) is dated 6/12/24." "The Illinois State of Illinois Sex Offenders and the Department of Corrections Sex Offenders checks are dated 7/31/24."

R51's electronic medical record states, "Admission Date 6/18/24." "A Criminal History Investigation Report Process (CHIRP) is dated 6/29/24." "The Illinois State Police Sex Offenders and The Department of Corrections Sex Offenders checks are dated 7/31/24."

R60's electronic medical record states, "Admission Date 6/21/24." "The Illinois State Police Sex Offenders and The Department of

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Corrections Sex Offenders checks are dated 7/29/24."

R217's electronic medical record states, "Admission Date 7/17/24." "The Illinois State Police Sex Offenders and The Department of Corrections Sex Offenders checks are dated 7/29/24."

R315's electronic medical record states, "Admission Date 7/22/24." "A Criminal History Investigation Report Process (CHIRP) is dated 7/24/24." "The Illinois State Police Sex Offender and The Department of Corrections Sex Offenders checks are dated 7/29/24."

On 8/01/24, at 4:00 PM, V1, Administrator in Training, stated, "I am not sure why these background checks were not done as required."

The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24, signed by V1, Administrator in training, documents 64 residents currently reside within the facility.

(C)

TWO of FOUR
300.661

Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

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This requirement in not met, as evidence by:

Based on interview and record review, the facility failed to complete four employee's background checks prior to hire date (V12,V31,V32,V33) and failed to update a background check for one employee prior to hire date (V30) out of the 10 employees reviewed for Healthcare Worker Background Checks. This has the potential to affect all 64 residents living in the facility.

Findings Include:

On 8/01/24, at 4:00 PM, V1, Administrator in Training, stated, "We do not have a specific policy for Healthcare Worker Background Checks. We just go by the regulations."

The document, Abuse, Neglect and Exploitation, dated 12/05/22, states, "Background or reference and credentials checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations."

V12's, Licensed Practical Nurse, Charge Nurse, Date of Hire is 11/21/22, Healthcare Worker Background Checks completed over two months later on 1/31/23.

V30"s, Certified Nursing Assistant, Date of Hire is 5/12/21. Healthcare Worker Background Checks completed 13 months prior to hire on 4/21/20.

V31's, Certified Nursing Assistant, Date of Hire is 9/27/16. Healthcare Worker Background Checks completed four years later on 9/24/20.

V32's, Cook, Date of Hire, is 5/03/18. Healthcare

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Continued From page 5

Worker Background Checks completed 19 months later on 1/16/20.

V33's, Housekeeper, Date of Hire, is 2/26/19. Healthcare Worker Background Checks completed 13 months later on 1/17/20.

On 8/01/24, at 4:00 PM, V1 confirmed the Hire dates and Healthcare Background Checks dates, stating, "I wasn't the Administrator when these employees were hired and cannot say why the Healthcare Worker Background Checks were not completed prior to their hire date."

The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24, signed by V1, Administrator in Training, documents 64 residents currently reside within the facility.

(C)

THREE OF FOUR
300.610a)
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 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

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by this committee, documented by written, signed and dated minutes of the meeting.

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 met as evidenced by:

Based on Observation, Interview and Record Review, the facility failed protect a resident from staff-to-resident verbal and mental abuse for one of three residents (R315) reviewed for abuse in the sample of 39. This failure resulted in R315 experiencing extreme fear and mental anguish.

Findings include:

The facility's Abuse, Neglect and Exploitation Policy, dated 12/5/2022 documents " Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friend, or other individuals. Definitions: 2. Abuse means the willful infliction injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, Abuse also includes the deprivation by an individual, including a caretaker,

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of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual acted deliberately, not that the individual must have intended to inflict injury or harm. 3. Verbal Abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. 6. Mental abuse also includes abuse that is facilitated or caused by nursing home staff or using photographs or recording in any manner that would demean or humiliate a resident(s)."

R315's Admission Record documents R315 is an 83-year-old female who admitted to the facility on 7/22/24. This same form documents R315 has the following diagnoses: Dementia without behavioral disturbance, Major Depressive Disorder, Hypothyroidism, Type Two Diabetes Mellitus, Hypertension, and Gastro-esophageal Reflux Disease.

R315's BIMS (Brief Interview of Mental Status), dated 7/24/24, documents R315 has moderately impaired cognition.

R315's State Final Report, dated 7/28/24, documents "Conducted an interview on 7/28/24 at approximately 1:35 AM with Certified Nursing Assistant (CNA) 2 (identified as V10/CNA), who witnessed CNA 1 (identified as V17/Agency CNA) shoving her phone in (R315's) face and telling her

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to call the jail to come get her. (V10) intervened and (V17) then walked back to the nurse's station, while (V10) tried comforting resident. Conducted an interview on 7/28/24 at approximately 1:45 AM, with CNA 3 (identified as V8/CNA) and she stated (V17) was screaming and walking up to (R315) aggressive and yelling at (R315) and just very aggressive." (V8) walked over to resident sitting in her wheelchair and offered water, as (V17) walked away." This same Final Report documents allegations against (V17) are substantiated based on two CNA witnesses (V8 and V10). (V17) worked for an outside agency. Agency is aware and that (V17) will not be allowed to return to work at this facility.

On 7/30/24 at 9:45 AM R315 was lying in her bed and was dressed appropriately. A large purplish/black bruise was observed to R315's posterior right wrist. R315 looked terrified and tearfully stated, "I am afraid of some of the staff here. I was screamed at and threatened multiple times the other night and I was scared. I am not sure who the person was. They told me I was going to go to jail. I don't feel safe."

On 7/30/24 at 1:40 PM V10/CNA stated, "On 7/28/24 around 12:30 AM (R315) started screaming "help me" from her room. (V8/CNA) and I went to (R315's room) to see what was going on. When we entered her room (R315's) voice was hoarse and she was saying "I can't breathe." I took her vital signs, and they were within normal limits. (V8) and I went to the nurse and reported that (R315) stated she couldn't breathe. (V8), (V17/Agency CNA), and I were all by the nurse's station when we heard (R315) keep screaming from her room. (V17) then said, "Oh no we aren't doing this tonight." (V17) then starting aggressively walking towards (R315's)

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S9999	Continued From page 9 room. (V8) and I started walking towards (R315's) room and beat (V17) to (R315). (V8) and I were trying to calm (R315) down from yelling, but she was agitated. (V8) and I decided to give (R315) some space in the lobby area and started walking down a different hallway to provide care to other residents. (V17) was near the nurse's station at that time charting. (V8) and I then could hear (R315) start screaming again. (V8) and I saw (V17) walk over to (R315) and she started screaming in (R315's) face telling her to shut up, you're nothing but a nuisance, and that she needed to sit down. When (V17) started yelling at (R315), (R315) looked scared, started screaming louder, and was crying. (R315) went over to the couch in the lobby area and sat down. As I started walking down the hallway, I heard what sounded like a slap. I immediately went back to the lobby area and asked what happened. (R315) was screaming "help me" "I want to leave" at that time. (V17) stated as she was walking towards (R315) when she tripped over the couch and the couch moved. (V17) stated the sound I heard was from the couch sliding. During this time (R315) was still screaming for help. (V17) then aggressively went over to (R315) pulled out her cellphone and dialed 911 on the screen. (V17) then shoved the cell phone in (R315's) face and said "Call the cops because you are going to jail. The jail is right down the street and that is where you are going for acting like this. Come on call them." (R315) was really screaming and crying then. I then intervened and told (V17) she could not act like that to a resident and notified (V18/Agency Licensed Practical Nurse) of (V17's) behavior." On 7/31/24 at 9:55 AM V8/CNA stated, "I witnessed (V17/Agency CNA) be verbally and mentally abusive to (R315). (R315) was walking	S9999		

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down the hallway screaming in the middle of the night. (V17) was at the desk and said something like we are not doing this tonight. (V10) and I tried to comfort (R315) but she was agitated. We left (R315) in the lobby area to calm down and give her space. (V17) was at the nurse's station charting during this time. When I was walking down a different hallway with (V10) I heard (R315) start yelling again asking for help and screaming she wanted to leave. I then heard and saw (R315) walk over towards (R315) and started screaming at her and pointing fingers in her face. (V17) was screaming "You are being a nuisance, I told you we aren't doing this tonight, you do this every night I work, and I am done." I couldn't hear everything (V17) was saying because (R315) was screaming and crying. I then witnessed (V17) pull out her cellphone, dial 911, and shove it in (R315's) face telling (R135) to call the cops because she was going to send her (R315) to jail and kept screaming in (R315's) face that the jail was right down the street and that's where she (R315) is going to live. I was scared of (V17's) behavior and scared for (R315). (R315) was very scared and crying. (V10) and I walked up to (R315) to comfort her. (V10) told (V17) to stop and (V17) walked way. I reported it to (V18/Agency Licensed Practical Nurse) with (V10) and was told by (V18/Agency Licensed Practical Nurse) to call (V1/Administrator in Training) so I did."

On 7/31/24 at 2:45 PM V1/Administrator in Training stated, "(V8/CNA) and (V10/CNA) called and reported to me alleged verbal and mental abuse from (V17/Agency CNA) to (R315). (V8) and (V10) both stated they witnessed the abuse. (V17) will not be allowed to come back to work here. I have not spoken with (R315) yet regarding the incident and wasn't aware that she stated she

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was scared. We don't have a Social Service Director, so no one has been able to provide psychosocial support for her after the alleged incident on 7/28/24." V1/Administrator in Training also verified that she had no record of Abuse Training for (V17) from the facility. V1 stated she has a binder at the nurse's desk that the agency staff reads and signs off on but verified that the abuse policy was not in the binder.

(B)

FOUR OF FOUR
300.610a)
300.1210b)
300.1210d)1)

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 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

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S9999	Continued From page 12 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. These requirements were not met as evidenced by: Based on Observation, Interview and Record Review, the facility failed to monitor blood sugar glucose levels and administer physician ordered sliding scale insulin timely, hold subsequent doses of insulin after a medication error, ensure a physician prescribed medication for Parkinson's (Sinemet) was dose adjusted and reordered to prevent withdrawal of therapeutic medication levels and complete medication error reports after errors were identified for two of five residents (R5, R52) reviewed for medications in the sample of 39. This failure resulted in R5 eating breakfast without scheduled insulin, suffering fatigue, drowsiness, confusion, and an elevated blood sugar level of 487 and resulted in R52 not receiving Sinemet for 25 days, resulting in increased tiredness, unsteady gait, increased tremors and decreasing the therapeutic blood level of R52's Sinemet from the prescribed	S9999		

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dosage increase plan.

Finding include:

The Facility Medication Administration Policy, dated 1/4/2023, documents "Medications administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection." This policy also documents for medication administration "Administer within 60 minutes prior or after scheduled time unless otherwise ordered by physician."

The Facility Medication Error Policy, dated 9/28/2023, documents "It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents care and services safely in an environment free of significant medication errors. "Medication Error" means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principals which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety." This policy also documents "The facility must ensure that it is free of medication error rates of five percent or greater as well as significant medication error events. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication

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administered not in accordance with the prescriber's order. Examples include but not limited to incorrect dose, route of administration, dosage form, time of administration, medication omission, and incorrect medication." This policy also documents "If a medication error occurs, the following procedure will be initiated. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. Document actions taken in the medical record. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report."

The Facility Timely Administration of Insulin Policy Dated 5/10/2024 documents "It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition." This same policy documents "All insulin will be administered in accordance with physician's orders. Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order."

The facility's Medication Reordering Policy, dated 12/21/22, documents, "Policy: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. Definitions: Acquiring medication is the process by which the facility requests and obtains a medication. Policy Explanation and Compliance Guidelines: 1.

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Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting."

1. R5's current Medication Administration Record (MAR), dated 7/1/24-7/31/24, documents R5 has an order for blood glucose monitoring followed by a sliding scale "Insulin Aspart Injection Solution 100 units/milliliter. Inject as per sliding scale: if 110 - 140 = 5; 141 - 169 = 6; 170 - 199 = 7; 200 - 229 = 8; 230 - 259 = 9; 260 - 289 = 10; 290 - 319 = 11; 320 - 349 = 12; 350 - 399 = 13 call provider for above 400, subcutaneously before meals related to Type Two Diabetes Mellitus." This (MAR) documents administration times are 7:30 AM, 11:30 AM and 5:30 PM, before meals.

R5's current Care Plan, dated 8/2024, documents "(R5) has Type 2 Diabetes Mellitus. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Fasting Serum Blood Sugar as ordered by doctor. Monitor/document/report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (abnormal rapid breathing) breathing, acetone breath (smells fruity), stupor, coma."

On 7/29/2024 at 10:30 AM, R5 was sitting in his room in a wheelchair. R5 appeared to be tired and had difficulty keeping his eyes open when spoken to. R5 did not give verbal response when questioned and required assistance with taking morning medications. At this time V14 (Registered Nurse) confirmed that R5 did not

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have a 7:30 AM blood glucose check or insulin and that R5 has already eaten breakfast. V14 stated she is new and just hadn't got to R5 yet during her morning medication pass. At 10:40 AM, V14 checked R5's blood sugar and the result was 487. V14 then left R5 in his room and went to the nurse's station.

On 7/29/2024 at 11:28 AM, V13 (R5's Nurse Practitioner) called V14 (Registered Nurse) and gave a verbal telephone order for R5 to be given 14 units of Insulin Aspart subcutaneously and recheck blood sugar in 15 minutes.

On 7/29/2024 at 11:42 AM, V14 administered 14 units of Insulin Aspart to R5. R5's MAR dated 7/1/24-7/31/24 documents on 7/29/2024 at 12:24 PM R5's blood sugar was 356 and V14 administered another 13 units of scheduled Insulin Aspart. This same MAR documents on 7/29/24 at 5:30 PM, R5's blood glucose level was 91 and no sliding scale Insulin Aspart was indicated to be administered.

On 7/31/2024 at 1:49 PM, V13 (R5's Nurse Practitioner) confirmed she gave a one-time order for R5's insulin on 7/29/24 when his blood sugar was elevated. V13 stated she was not made aware that R5 missed his 7:30 AM blood glucose monitoring and sliding scale insulin that morning. V13 stated "I was not aware that (R5) had eaten without insulin. Knowing that may have changed my treatment. I would not expect the high dose of insulin to be given and then administer another large amount of insulin less than an hour later. The additional 13 units of sliding scale insulin should have been held. (R5's) blood sugar should have just been monitored at that point since the one-time dose was given so close to the next scheduled sliding scale dose. (R5) is not

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typically sleepy or lethargic when I see him in the facility. That was likely from eating and missing the morning insulin which resulted in his blood sugar elevating. Nurses should be letting me know all the facts. I depend on them to alert me of changes since they see the residents every day and can recognize what is and isn't normal."

R5's current electronic medical record does not document a medication error report was completed for R5's insulin medication error on 7/29/24.

On 7/31/24 at 10:30 AM, V1 (Administrator in Training) stated she does not have a medication error report for R5.

2. R52's Neurology After Summary Visit, dated 5/9/24 and signed by V15 (R52's Neurology Nurse Practitioner), documents "Read the attached information 1. Carbidopa; Levodopa Tablets 2. Parkinson's Disease. Start Sinemet 25-l00 mg (milligram) tablets. Week l: 0.5 tablet in AM, Week 2: 0.5 tablet twice a day. Week 3 and 4: 0.5mg TID (three times a day). (The Facility) staff is to update this office weekly while titration. Will send refills if tolerating." This same Summary Visit had attached information as follows: Carbidopa; Levodopa Tablets- treats the symptoms of Parkinson disease. It works by increasing the amount of dopamine in your brain, a substance which helps manage body movements and coordination. This reduces the symptoms of Parkinson, such as body stiffness and tremors. Do not stop taking except on your care team's advice. You may develop a severe reaction. Parkinson's Disease- causes problems with movements. It makes it harder for you to walk or control your body. It is a long-term condition that gets worse over time. Symptoms of

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S9999	Continued From page 18 this condition can vary. The main symptoms can be seen in your movement. These include shaking or tremors that you cannot control. This happens while you are resting. Stiffness in your neck, arms, and legs. Trouble making small movements that are needed to button your clothing or brush your teeth. Losing facial expressions. Walking in a way that is not normal. You may walk with short, shuffling steps. Loss of balance when standing. You may sway, fall backward, or have trouble making turns." R52's MAR (Medication Administration Record), dated June 2024, documents no administration of Sinemet from 6/8/24 to 6/26/24 or a new physician order to give Sinemet for a total of 19 missed days. R52's Fax Sheet, dated 6/26/24 and signed by V15/R5's Neurology Nurse Practitioner, documents "Resume Sinemet 25-100 titration as attached on this prescription. Nursing to contact once beginning of Week 4 with an update of medication (or sooner if needed). Will determine new dose adjustment after update is received. Do not allow medication to expire." R52's MAR, dated July 2024, documents no administration of Sentiment from 7/25/24 to 7/30/24 or a new physician order to give Sinemet for a total of five missed days. On 07/29/24 at 9:54 AM, R52 had a (electronic wandering monitor bracelet) located on her left wrist. Resident was sitting on the couch sleeping in the activity room on the memory care unit. On 7/30/24 at 10:11AM, R52 was sitting hunched over on the couch sleeping in the activity room on the memory care unit. R52 was non-responsive to	S9999		

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S9999	Continued From page 19 verbal stimuli. V9 (Licensed Practical Nurse) stated, "(R52) has been sleeping all day recently. That is not like (R52). When (R52) does wake up she has been shaky and has an unsteady gait. I am not sure what is going on with her." V9 confirmed that (R52's) Sinemet order had expired on July 24th and no new order was received from V15's (R52's Neurology Nurse Practitioner) office before it expired. On 7/30/24 at 1:41 PM, V16/Neurology Office Nurse stated she was unaware that R52's Sinemet order had expired and that this is not the first time (the facility) has allowed this to happen. V16 stated, "(R52) came to our office in May 2024 due to the family having concerns with (R52's) gait, balance, increased tremors, and sleepiness. (V15/R52's Neurology Nurse Practitioner) wrote a new order to start Sinemet for Parkinson's Disease. (V15) wrote the order to titrate the dose over four weeks. Before the four weeks were up the facility was supposed to update us with how (R52) was tolerating the new medication and to not allow the medication prescription to expire. We (Neurology) did not receive an update and did not know the facility allowed the Sinemet order to expire. (The facility) did not call our office until 6/26/24 letting us know they had allowed the Sinemet order to expire and forgot to call and give us an update. (The facility) reported (R52) had not received the Sinemet since 6/8/24. (The facility) reported at that time they noticed a difference when (R52) was on the Sinemet and that she was more awake, and alert and her balance was much better. (V16) wrote a new order on 6/26/24 to start the Sinemet titration over again and for the facility to call our office to update how (R52) is tolerating the mediation. It was instructed to call us before week four was up and to not allow the medication order to expire.	S9999		

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S9999	Continued From page 20 (The facility) has not called us to give us an update and I was unaware (R52) has not received her Sinemet since 7/24/24. (R52) could experience increased fatigue, unsteady gait, and tremors for stopping the medication once again." On 7/30/24 at 2:30 PM, V2 (Regional Nurse Consultant/Interim Director of Nursing) stated she was unaware that R52 has not been receiving her Sinemet or that the facility did not call to give Neurology an update and allowed the medication order to expire and that this is the second time it has happened. V2 stated, "I am unsure what the nurses are supposed to do when a medication has been missed or a medication error has been made. They should have caught it before hand and called the ordering physician. I would have to look at the Medication Policy to see what the nurses should have done. No medication error report was filled out for the missed doses of Sinemet in June or July 2024." On 8/1/24 at 10:30 AM, V28/R52's Primary Physician stated the facility did not notify him of needing an updated order for R52's Sinemet in June or July 2024 or that R52 had missed doses of her Sinemet. V28 stated, "(R52) could experience increased tremors and excessive tiredness when stopping Sinemet. It's not good (R52) missed her doses. It doesn't cause a long-term effect, but It can cause a short-term effect for (R52)." (B)	S9999		