STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006860	A. BUILDING: _____ B. WING _____	10/08/2024

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ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

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S 000	Initial Comments Annual Licensure and Certification Complaint Investigation #2468111/IL178960	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3) 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999		

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the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on interview and record review the facility failed to develop post fall interventions and treatment for a resident on anticoagulant therapy with head injury (R171), failed to implement careplan interventions for a resident (R171) post fall, failed to complete fall risk assessments and failed to thoroughly investigate falls for a resident (R67). These failure affects two (R171, R67) out of five residents reviewed for falls in a sample list of 75 residents. These failures resulted in R171, who was receiving anticoagulants, falling and sustaining a subdural hematoma.

Findings include:

The facility policy titled Fall Assessment and Management Policy revised June 2024 documents the facility will assess each resident's fall risk on admission, quarterly and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. A licensed nurse will document for 72 hours after the incident regarding the resident's status and note any changes in the resident's condition.

1.) R171's undated Face Sheet documents R171's medical diagnoses as Dementia, Unsteadiness on Feet, Abnormalities of Gait and Mobility, Long Term Use of Anticoagulants, Osteoporosis without current Pathological Fracture and History of Venous Thrombosis and Embolism. R171's Minimum Data Set (MDS) dated 7/10/24 documents R171 as severely cognitively impaired. This same MDS documents R171 as requiring maximum assistance with

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toileting and moderate assistance with bathing, dressing, personal hygiene and bed mobility.

R171's Physician Order Sheet (POS) dated September 2024 documents a physician order starting 3/19/24 for Aspirin 81 milligrams (mg) daily for Chronic Atherosclerosis Disease. This same POS documents Rivaroxaban 10 mg daily starting 7/3/24 for blood clot prevention.

R171's Careplan intervention dated 2/23/24 documents (R171) may transfer and ambulate with one assist, assistive device and gait belt. R171's Fall Risk Assessment dated 8/1/24 documents R171 as a high fall risk. This same careplan documents a fall intervention dated 9/15/24 to place R171 on a restorative ambulation program.

R171's medical record documents R171 fell on 9/15 at 12:45 PM resulting in a left eye laceration. There was no documentation that the physician was notified of this fall. There were no policies regarding residents on anticoagulant therapy urgent treatment post head injury needs. R171 fell on 9/15/24 at 7:00 PM, R171 complained of hip pain, R171 was sent to the emergency room (ER) for hip pain. ER documented closed head injury.

R171's Electronic Medical Record (EMR) does not document R171's restorative evaluation or program notes. This same EMR does not document R171 as being in the restorative ambulation program nor receiving any assistance for the restorative ambulation program.

R171's Nurse Progress Note dated 9/20/24 at 3:14 PM documents "(R171) was observed on the floor in the hallway. (R171) was on her left

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side. A reopened laceration to her Left Temple was noted. On assessment (R171) was not able to move her left leg due to excruciating pain. (R171) stated "I'm going to pass out!" Ambulance was called. Emergency Medical Technicians (EMT'S) left with the resident at 3:04 PM."

R171's Emergency Room Progress Notes dated 9/20/24 document R171 was seen in the emergency room after having an unwitnessed fall at facility on 9/20/24. This same progress note documents "(R171) has fallen twice in the last week. Today, after falling (R171) became increasingly altered. (R171) is oriented x0 and obtunded. (R171) is obviously unwell. (R171) does not follow commands and is having some occasional sonorous respirations. Spontaneous eye opening, no verbal or motor response. (R171's) head is laid over to the Left, does not track to the Right. "

R171's Computerized Tomography (CT) of her brain without contrast dated 9/20/24 documents "Findings: Large Left Frontal and Temporal mixed density Subdural Hematoma measuring 3.2 centimeters (cm) in maximum diameter. The majority of this hemorrhage appears acute. Considerable mass effect on the underlying brain parenchyma resulting in 1.8 cm of rightward midline shift. Left Frontal Scalp soft tissue swelling." R171's Death Certificate documents R171's date of death as 9/21/24 with a Primary Cause of Death as "Subdural Hematoma" with an approximate interval between onset and death as one day.

On 10/8/24 at 9:05 AM, V36 CNA stated R171 was severely cognitively impaired and had very poor safety awareness. V36 stated "I don't know that (R171) was ever on a restorative ambulation

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program. It never came up in our charting. I worked with (R171) all the time and no one ever said anything about that. (R171) was impulsive and quick. (R171) would be laying down one minute and up the next. (R171) was very unsteady when she walked and needed one person to help her. (R171) was on 15 minute monitoring for months. I had last checked on (R171) 15-20 minutes prior to her falling on 9/20/24. It was awful. I found her in the hallway outside her room. (R171) was bleeding. I sat there with her. (R171) bled all over my pants. I'll never forget that. I felt so bad for (R171) but I don't know what else we could have done besides putting her on a one to one. (R171) needed constant supervision and we (facility) just couldn't keep up with her."

At this time V36 CNA also stated, the fifteen minute rounders means the call lights are activated every 15 minutes in the resident's room. V36 CNA stated the rounder lights can be deactivated in the resident room or at the nurses station. V36 stated when the 15 minute rounders go off the staff are supposed to visually see the resident to make sure they are safe.

On 10/8/24 at 10:50 AM, V7 Assistant Director of Nurses (ADON)/Restorative Nurse stated restorative programming is completed by the floor CNA assigned to the resident in a program. V7 stated V7 was on leave from 8/2/24-9/29/24 and V42 Restorative CNA was on leave from 9/19/24-10/9/24. V7 stated V7 is not able to find any documentation that R171 was ever evaluated or started on the restorative ambulation program. V7 stated "It shouldn't matter if I was gone or not. (R171's) careplan intervention was added for her 9/15/24 fall and was never done. (R171) could have benefited from that program. It may have

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not prevented her fall on 9/20/24 but we really don't know because (R171) never received the services."

On 10/8/24 at 12:30 PM, V2 Director of Nurses (DON) stated the facility has a system that activates a call light in the residents room every 15 minutes for any resident placed on 15 minute rounders. V2 stated there is a button at the nurses station and also in the resident rooms to deactivate the 15 minute rounders. V2 stated the staff are supposed to visualize the resident every 15 minutes and then deactivate the call system. V2 stated the call system will automatically come back on every 15 minutes. V2 DON stated "Normally, I am able to pull a report of what exact time the 15 minute reminder was activated and deactivated but our system is down today and I am not able to provide any documentation that (R171) was being checked on every 15 minutes." V2 DON stated the facility does not have a policy on restorative programming or 15 minute rounders/call light policy.

On 10/8/24 at 3:00 PM, V22 Physician/Medical Director stated R171 should have been sent to the emergency room after her 9/15/24 12:45 PM fall due to being severely cognitively impaired, having a fall with a head injury and on anticoagulants (ASA, Rivaroxaban). V22 stated after R171's falls on 9/15, she should have been on 'very close' monitoring. V22 stated "(R171) did not have a strength deficit. I don't know why they (facility) would have placed her on a restorative ambulation program. (R171) was too ambitious with movements. Along with her cognitive impairments, (R171) could not foresee any dangers due to her poor cognition. (R171) relied solely on the staff to ensure her safety. I don't normally recommend the personal alarms or

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one to one's (continual observation) but (R171) would have been a great candidate due to her poor awareness of instability. (R171's) falls were missed opportunities resulting in her major injuries."

2.) R67's diagnoses sheet dated 7/9/24 documents the following diagnoses: Muscle Weakness (Generalized) Repeated Falls, Spinal Stenosis, Cervical Region, Non-Surgical Orthopedic/Musculoskeletal, Spinal Stenosis, Lumbar Region Without Neurogenic, Claudication, Radiculopathy, Cervical Region, Non-Surgical Orthopedic/Musculoskeletal, Muscle Wasting Andatrophy, Not Otherwise Classified, Unspecified Site, Personal History Of Transient Ischemic Attack, and Cerebral Infarction Without Residual Effect Deficits.

R67's Unwitnessed "Fall" investigation dated 8/25/24 at 5:14 pm documents the following (the same as the corresponding nurses note): "Resident told CNA this morning while getting him up that he was just on the floor and 2 (two) girls came in and picked him up and put him back into bed. Resident was assessed no injury's were noted, no pain on range of motion, neuros (neurological assessment) were started because self reported fall."

There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning. There is no post-fall 8/25/24 risk assessment as policy directs.

R67's Unwitnessed "Fall" investigation dated 9/21/24 at 3:37 am documents the following (the

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same as the corresponding nurses note):"Resident was yelling, "help me." When nurse walked into resident's room resident was observed sitting on knees next to bed. Resident's top half of body was still in bed and the lower half of body hanging out of the bed. Nurse notified CNA (unidentified) to help assist resident back into bed per 2 (two) assist (unidentified). CNA assisted resident to be cleaned up. Urine was observed on the floor. Resident Description: Resident stated he was trying to roll to his other side."

There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning. There is no post- fall 9/21/24 risk assessment as policy directs.

R67's Unwitnessed "Fall" investigation dated 9/22/24 at 11:20 am documents the following (the same as the corresponding nurses note)": "Patient found sitting on floor on knees next to bed facing head of bed. CNA stated pt. head was caught on bedside rail. Resident Description: Patient stated he was unsure how he got on floor."

There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning.

On 10/8/24 at 11:25 am, V2, Director of Nursing (DON) reviewed R67's fall investigations 8/25/24, 9/21/24 and 9/22/24 and stated he did not interview anyone, does not know the last time that R67 was seen by staff and only has the details he obtained from R67's nurses notes that document

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R67 slid out of bed on each of those falls. V2, DON stated he is working on a better electronic medical record system to complete a more thorough fall investigation. "At this time I have not implemented a new system to ensure the investigations are completed thoroughly." V2, DON also stated he does not have fall risk assessment for R67's falls on 8/25/24 or 9/21/24. He expects the nurses to complete them when a fall occurs.

(A)

Statement of Licensure Violations (2 of 3)

300.610a)
300.1210a)
300.1210b)4)
300.1210d)3)

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

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a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living

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shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

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.

These Requirements were not met as evidenced by:

Based on interview and record review the facility failed to maintain a resident's nutritional status and prevent significant weight loss by failing to implement nutritional supplements recommended by the dietician, and failing to notify the physician and dietician when significant weight loss continued. This failure resulted in R36 continuing to lose a significant amount of weight over one months time. This failure affected one of two residents (R36) reviewed for nutrition on the sample list of 75.

Findings Include:

The facility's Weight Management Policy and Procedure dated 2023 documents all residents will be monitored for significant weight changes to assure maintenance of acceptable parameters of body weight. Any resident with a significant weight change will be referred to the dietitian for assessment of the resident's condition. The

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dietician will implement any necessary clinical interventions or make recommendations regarding diet and supplementation to the physician. The physician will be notified of any significant weight change and be made aware of any recommendations made by the dietitian.

R36's Medical Diagnoses sheet dated October 2024 documents R36 is diagnosed with Protein Calorie Malnutrition and Muscle Wasting and Atrophy.

R36's Physician Order Sheet dated October 2024 documents R36 is prescribed a regular diet with thin liquids.

R36's Care Plan dated 8/9/24 documents R36 is at risk for altered nutrition. Interventions include to provide supplements as ordered, monitor intakes, report weight changes to physician, and refer to dietician as needed.

R36's Weights Record document on 8/9/24 R36's weight upon admission was 130.6 pounds. On 8/28/24 R36's weight was 120.1 pounds.

R36's Dietician Assessment dated 8/13/24 documents R36 was admitted on 8/9/24 and weighed 129.3 pounds on 8/12/24. The same assessment documented R36 had a weight loss of 12 pounds or nine percent of her weight over the last thirty days according to (pre-admission) hospital and facility records. A recommendation was made for R36 to begin to receive 60 cubic centimeters of a liquid nutritional supplement three times per day in order to prevent further weight loss.

There is no documentation in R36's medical record that the recommended nutritional

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S9999	Continued From page 13 supplement was implemented or that the physician was ever notified of R36's continued weight loss of 9.2 pounds. On 10/4/24 at 12:57 PM, V2 Director of Nurses (DON) confirmed R36's recommended nutritional supplements were not implemented and R36 continued to lose weight. R36 had a significant weight loss of 10.5 pounds (7.69%) from admission on 8/9/24 to 8/28/24. V2 DON confirmed the facility should have notified the physician of and then implemented the nutritional supplement recommendation and monitored R36's weight closely. Staff should have notified the physician of R36's continued weight loss which ended up being significant. On 10/4/24 at 1:49 PM, V32 Registered Dietician confirmed she assessed R36 on 8/13/24 for nutritional risk and significant weight loss prior to admission. In order to assist in further weight loss, V32 recommended R36 be given a nutritional supplement three times a day. V32 confirmed her recommendation should have been sent to the physician and added to R36's plan of care. V32 confirmed if the nutritional supplement would have been implemented, potentially R36's weight loss could have been lessened. (B) Statement of Licensure Violations (3 of 3) 300.610a) 300.1210b) 300.1610a)1) 300.1620a) 300.1630b)	S9999		

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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 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.

Section 300.1610 Medication Policies and Procedures

a) Development of Medication Policies

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with

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the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication

b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

These Requirements were not met as evidenced

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S9999	Continued From page 16 by: Based on observation, interview and record review the facility failed to administer physician prescribed medications to one (R321) resident out of five residents reviewed for significant medication errors in a sample list of 75 residents. R321 experienced Gastrointestinal (GI) upset, malaise and was hospitalized as a result of R321 missing multiple doses of medications for blood glucose control and Gastroesophageal Reflux Disease (GERD). Findings include: R321's undated Face Sheet documents R321's medical diagnoses as Encephalopathy, Ischemic Cardiomyopathy, Heart Disease, Muscle Wasting and Atrophy, Acute Kidney Failure, Esophageal Obstruction, Diabetes Mellitus Type II, Other Specified Disease of the Pancreas, Pneumonia, Pleural Effusion, Peritoneal Abscess, Pneumonitis due to Inhalation of Food and Vomit, Chronic Diastolic Congestive Heart Failure, Cardiac Vascular Implant and Graft, Gastroesophageal Reflux Disease (GERD), Implanted Cardiac Defibrillator, Colostomy Status, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant side and Transischemic Attack (TIA). R321's Physician Order Sheet (POS) dated October 2024 documents a physician order starting 9/24/24 and discontinued 10/3/24 to administer Dapagliflozin Propanediol (Farxiga) Oral Tablet 5 milligrams (mg) daily for Diabetes Mellitus. This same POS documents a physician order for Lansoprazole Suspension 3 milligrams (mg)/milliliter (ml) starting 9/24/24 with no end date listed. Give 10 ml via Gastrostomy Tube	S9999		

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(G-Tube) in the morning for 30 days.

R321's Minimum Data Set (MDS) dated 9/27/24 documents R321 as cognitively intact. This same MDS documents R321 requires moderate assistance with toileting, maximum assistance with dressing, personal hygiene, bed mobility and is dependent on staff for transfers.

R321's Care Plan intervention dated 6/18/24 instructs staff to administer Gastrointestinal (GI) medications/laxatives/stool softeners as ordered. Assess for symptoms such as pain, bloating reflux, abnormal bowel function, nausea/vomiting, discomfort/pain upon defecation, blood in stool, black stools, hard/dry stools, mucous, signs of hemorrhoids. This same care plan instructs staff to administer diabetic medication/insulin as ordered.

R321's Medication Administration Record (MAR) dated September 2024 documents R321 was administered Farxiga 5 milligrams (mg) on 9/24-9/27, 9/29 and 9/30. This same MAR documents R321's Farxiga was not administered on 9/28/24. This same MAR documents R321's Lansoprazole 3 milligrams (mg)/milliliter (ml) was not administered on 9/24, 9/27, 9/28 and 9/29. This same MAR documents R321's Lansoprazole was administered on 9/25, 9/26 and 9/30.

R321's Medication Administration Record (MAR) dated October 2024 documents R321 was administered Farxiga 5 milligrams (mg) on 10/1/24 and not on 10/2/24. This same MAR documents R321 was not administered Lansoprazole 3 milligrams (mg)/milliliter (ml) give 10 ml 10/1/24-10/3/24.

R321' Nurse Progress Note dated:

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S9999	Continued From page 18 -10/2/24 at 8:00 AM documents "Late Entry: 10/4/24 at 7:34 AM (R321's) Lansoprazole and Farxiga not administered by nurse. Lansoprazole had not been sent yet because of waiting on pharmacy to complete insurance authorization. Farxiga was in process of being re-ordered and was sent on the night of 10/2/2024. (R321) unsure exactly what meds he didn't take. (V22) Physician notified and no new orders given for Farxiga. Instructed to consult Gastrointestinal Physician regarding Lansoprazole which was changed to Omeprazole by mouth." -10/2/24 at 1:18 PM documents "Faxed (V22) Physician and made aware that Farxiga 5 mg was not given this am, and also noted that his insurance will not cover his Lansoprazole oral suspension 3 mg/ml, that his cost out of pocket is plus $600. Spoke with pharmacy, included this information with fax to (V22) Physician, awaiting any new order, Farxiga will be sent out this evening." -10/2/24 at 5:16 PM documents "Received fax from pharmacy at this time, (R321) insurance prefers the brand name Dapagliflozin (Farxiga) they will be sending the Brand name Farxiga moving forward." -10/3/24 at 1:45 PM documents "New order for Omeprazole 20 mg by mouth daily." -10/3/24 at 11:54 PM documents "(R321) complained of malaise and stomach ache. First attempt via automatic blood pressure (BP) wrist cuff 87/39, second attempt manual BP 87/38. (R321) stated, "I just feel blah." (V22) Physician paged via telephone. Nurse waiting for return call."	S9999		

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-10/4/24 at 1:04 AM documents "(R321) continued to complain of stomach pain and malaise. Ambulance notified via telephone for transfer to emergency room for evaluation and treatment."

On 10/2/24 at 8:15 AM V8 Licensed Practical Nurse (LPN) searched through the medication cart and medication storage room looking for R321's Lansoprazole and Farxiga. V8 LPN did not find those two medications.

On 10/2/24 at 8:28 AM, R321 was laying in his bed with head of bed flat. R321's enteral feeding was running. R321's skin was pale. R321's voice was soft and raspy. R321's hand was rubbing his abdomen area. R321 stated "I don't feel good. I feel blah. My stomach hurts." as V8 Licensed Practical Nurse (LPN) was assessing R321.

On 10/2/24 at 8:20 AM V8 Licensed Practical Nurse (LPN) stated R321 does not have any Lansoprazole or Farxiga. V8 LPN stated "(R321) is the only resident who gets Lansoprazole in suspension form. The other nurses couldn't borrow it from someone because no one else has that order. (R321's) Farxiga and Lansoprazole has been signed out. I will have to investigate with pharmacy."

On 10/2/24 at 4:00 PM, V8 Licensed Practical Nurse (LPN) stated "I spoke with pharmacy. (R321's) Lansoprazole was waiting on insurance and so the pharmacy never did even send it. (R321's) Farxiga was never re-ordered when he came back from the hospital on 9/23/24. I don't know why other nurses have been signing those two medications out because they weren't here to

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give."

On 10/3/24 at 2:00 PM, V2 Director of Nurses (DON) stated R321 had missed doses of his Lansoprazole and Farxiga. V2 DON stated V2 called the pharmacy and verified the number of doses sent to the facility and when. V2 DON stated through V2's investigation, R321 did miss multiple doses of his Farxiga and Lansoprazole. V2 DON state nurses should only sign off that a medications been given if the resident actually got the medication. V2 DON stated if a resident misses a dose of any medications, there should be documentation as to why and that the proper people should be notified with multiple missed doses. V2 DON stated V2 was not certain why R321's Farxiga and Lansoprazole were signed out as given when they were not. V2 DON stated V2 would investigate this further and educate staff on medication administration and documentation. V2 DON stated the facility does not have a medication error rate policy but would assume that it is a standard of care to investigate and document why a resident would miss multiple doses of medications including notifications and any effect on the resident. V2 DON stated the facility does not have a policy for medication errors. V2 stated the expectation is for the nurses to self-report to V2 who would then do an investigation. V2 DON stated "I was not aware (R321) not receiving his medications until yesterday (10/2/24)."

On 10/4/24 at 2:55 PM, V33 Pharmacy Technician Data Entry Specialist stated R321's Farxiga was delivered to the facility on 8/16/24. V33 stated that would be a 14 day supply (14 doses). V33 stated R321's Farxiga should have lasted until 8/30/24. V33 stated R321 would have missed nine consecutive doses from

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S9999	Continued From page 21 9/24/24-10/2/24. V33 stated Farxiga was not sent any other times. V33 stated R321's Lansoprazole required authorization from his insurance company which was never obtained. V33 stated R321's Lansoprazole was never sent to the facility. V33 stated R321 would have missed eight consecutive doses from 9/25/24-10/2/24. On 10/4/24 at 3:10 PM, V34 Pharmacist stated Lansoprazole and Pantoprazole have similar effects on the body. V34 stated "If someone like (R321) with severe Gastrointestinal (GI) disease did not get these medications it could certainly contribute to GI distress and put him at a higher risk of having GI complications. (R321's) hospitalization in part could be caused by him not receiving his prescribed medications." V34 Pharmacist stated R321 should have his blood glucose monitored regularly due to R321 is receiving enteral feedings as his main nutritional source. On 10/8/24 at 3:00 PM, V22 Physician/Medical Director stated R321 has a long standing history of Gastrointestinal Disease. V22 stated R321 was recently hospitalized for GI issues. V22 stated R321 needs his Lansoprazole for his Gastroesophageal Reflux Disorder (GERD) or he will become symptomatic. V22 stated symptoms may include GI upset, malaise, nausea, vomiting or a feeling of fullness. V22 stated it is important for R321 to receive his prescription medications including the Lansoprazole to avoid being re-hospitalized. V22 stated R321 has a medical diagnosis of Diabetes Mellitus Type II and also requires his medication (Farxiga) to help to lower his blood glucose levels. V22 stated R321 missing so many doses of his Lansoprazole and Farxiga with no notification to V22 is	S9999		

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S9999	Continued From page 22 unacceptable. V22 stated R321 was re-hospitalized on 10/4/24 due to GERD symptoms. V22 stated the facility failing to administer R321's prescribed medications attributed to the fact that R321 has been hospitalized twice in the recent past for the same symptoms related to his Diabetes and GERD. (B)	S9999		