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	IL6012165	A. BUILDING: _____ B. WING _____	C 05/11/2024

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S 000	Initial Comments Facility Reported Incident of March 16, 2024 IL172114 Complaint Investigations: 2423173/IL172236 2423218/IL172332 2423338/IL172500	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.2900 d)2) 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	S9999		

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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.

Section 300.2900 General Building Requirements
d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide adequate supervision, failed to develop a care plan and implement interventions for residents at risk for wandering/elopement, and failed to ensure the front door was alarmed for one of three residents (R1) reviewed for elopement risk in the sample of 17. These failures resulted in a cognitively impaired resident (R1) with a known history of wandering, exiting the facility without staff knowledge for 40 minutes until the resident tried to reenter the facility, falling in the mud, and complaining of head and back pain. The facility is located close to a four-lane road that has high activity of traffic.

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Findings include:

The Elopements and Wandering Residents policy, dated 3/1/2020, documents, "This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk." Policy Explanation and Compliance Guidelines "1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and managing residents at risk for elopement or unsafe wandering a. residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person centered care plan. c. Interventions to increase staff awareness of the residence risk, modify their residence behavior, or to minimize risks associated with hazards will be added to the residence care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or

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elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff."

R1's Face Sheet documents R1 was admitted to the facility on 10/10/23, with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Chronic Respiratory Failure with Hypoxia, Other Sequel of Cerebral Infarction, Hypertensive Heart and Chronic Kidney Disease without Heart Failure, with Stage One Through Stage Four Chronic Kidney Disease, or Unspecified Chronic Kidney Disease, Localization- Related (Focal) (Partial) Symptomatic Epilepsy and Epileptic Syndrome with Complex Partial Seizures, not Intractable, With Status Epileptics, Vascular Dementia, Mild, with Agitation, and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris.

R1's MDS (Minimum Data Set), dated 2/15/24, documents a BIMS (Brief Interview for Mental Status) Score of 7/15, indicating (severe cognitive impairment). R1 uses a wheelchair. R1 does not wear an alarm to prevent elopement.

R1's Care Plan, dated 10/11/23, documents, "(R1) is an elopement risk/wanderer. Disoriented to place."

R1's Care Plan, dated 10/11/23, documents R1 has a behavior problem related to disrobing in public places around others, combative with cares, yelling profanities and additional co-morbidities. The intervention dated 10/12/23 documents R1 was placed on 1:1 observation for

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safety and exit seeking behaviors. Please monitor at a safe distance. If R1 pushes past staff and out a door, stay with R1 and call for help.

R1's Care Plan, dated 10/16/23, documents, "(R1) is an elopement risk/wanderer. Disoriented to place."

R1's Care Plan, dated 3/26/24, documents, "(R1) is an elopement risk and a wanderer. (R1) has impaired cognition and requires assistance with decision making. (R1) is frequently noted to make statements wanting to go home and is not always easily redirected. The facility is working on safer placement in a different facility to reduce risk of elopement."

The Final Incident Report for R1 sent to the State Agency (not dated) documents nursing staff last saw R1 a little before 8:00 PM,on 3/16/24. During the investigation, it was determined R1 went out the facility front door at approximately 7:50 PM. R1 was assisted back into the facility at approximately 8:39 PM. R1 expressed he fell while he was outside, R1 was sent to the Emergency Room for evaluation and treatment. Due to R1's impaired cognition, R1 was not able to express why he decided to go outside. However, when R1 was assisted back into the facility, it was noted his jeans were undone and had fallen around R1's ankles. It is plausible R1 was outside looking for a restroom due to his cognitive needs.

R1's Emergency Room Notes, dated 3/16/24 at 10:11 PM, documents, "(R1) presents from (the facility) where he had an unwitnessed fall outside. EMS (Emergency Medical Staff) states (R1) was complaining of some back pain but otherwise no other concerns or further information. (R1) states

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he had some chest pain and shortness of breath as well as lightheadedness prior to falling. Unsure if (R1) lost consciousness but thinks he may have hit his head. Denies any neck pain, vomiting, abdominal pain. Does have some pain in his bilateral knees." Skin assessment, "Abrasions, swelling, and mild TTP (thrombotic thrombocytopenic purpura) bilateral knees."

The facility is located with a busy road in front of the facility and within a quarter mile of a high traffic four-lane intersection.

R1's Nursing Note, dated 3/12/24 at 5:57 AM, documents R1 appears to be confused throughout the night. Appears to be aggressive and very restless throughout the night. Stayed up all night asking staff about keys to his car and wanting to go home. Continued to call family throughout the night attempting to see if anyone can pick him up. Assisted resident to his room to rest at this time.

R1's Nursing Note written by V15, Licensed Practical Nurse/LPN, dated 3/15/24 at 1:30 AM, documents V15 observed R1 exiting out of 100 hall doors at this time. R1 stated he was trying to go home and was going outside to find his car. 15 min checks were initiated at this time. V15 attempted to call R1's Power of Attorney and no response. R1 was redirected into bed and R1 is resting at this time.

R1's Nursing Note, dated 3/15/24 at 5:41 AM, documents R1 is resting in bed at this time. Displaying behaviors throughout the entire night. R1 continued to come up with reasons to leave the facility so he can go outside. Redirected R1 back to his bedroom to get some rest. 15 min checks continue at this time.

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R1's Nursing Note written by V1, Administrator in Training/AIT, as a "Late Entry", dated 3/16/24 at 9:00 PM,documents R1 went out the facility front door at approximately 8:00 PM, and walked to the left of the facility, staying on facility grounds. Resident was assisted back into the facility at approximately 8:39 PM. Resident was dressed appropriately for the weather, and was wearing shoes, socks, jeans, sweatshirt, jacket, and a hat. Resident was unable to express why he went outside. Upon assessment, R1 complained of head and back pain, R1 was able to move all extremities per usual, however, R1 was sent to the Emergency Room/ER for evaluation based on head and back pain.

R1's Nursing Note written by V1, AIT, as a "Late Entry", dated 3/16/24 at 9:05 PM, documents, "Upon assessment, it is plausible that the patient went outside to use the restroom evidenced by his pants down at his ankles."

R1's Nursing Note written by V15, LPN, dated 3/16/24 at 9:00 PM, documents, "It was reported to this nurse that (R1) was outside of the facility knocking on 400 hall door. This nurse observed (R1) in a wheelchair coming up the hallway with a staff member. Upon assessment, (R1) appeared to be covered with mud to the front and back of his clothing and shoes. Last seen (R1) around 8:00 PM when his medications were administered to him. Resident stated he was trying to go home, so he left the facility and he fell so he came back. Also, (R1) stated he hit his head and hurt his back."

R1's Wandering/Elopement Risk Assessment, dated 3/15/24 at 1:39 AM, documents R1 is a High Risk for Wandering. R1 is disoriented, has

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had recent medication changes, has dementia with psychosis, positions self at exit doors, and states "I want to go home." R1 last elopement attempt was 3/15/24.

R1's Fall Assessment, dated 4/5/24 at 3:00 PM, documents R1 is a high risk for fall scoring a 50 on the assessment. R1 has an impaired gait and overestimates or forgets limits.

On 5/2/24 at 10:00 AM, V18, Certified Nursing Assistant/CNA, was sitting in R1's room providing 1:1 supervision. V18 stated she was not here the day that R1 fell but she heard he had come back from a home visit. "I know he does get more worked up when he's been out with family. He doesn't remember how he fell when he was out there." V19 stated she knows he went to the ER, but he does not have any fractures. "The resident is receiving 1:1 supervision 24/7 and that it has been that way for a while. He had a 1:1 before, but he started doing a lot better and was ambulating and conversating with staff. I was off a few days and then when I came back, he was a 1:1. I work the 6-2:30 PM shift and I work all over the facility." V18 stated he does not have an ankle band/electronic monitoring device, and thinks they don't use those here. V18 stated she tries to keep an eye on him even when he is sleeping. "I may go out and help answer a light or go to the bathroom real quick, but I head back. He is mostly using a 1:1 for falls, elopement, and aggression. He would say he wants to go where he used to live or wants to go to his car and exit-seek."

On 5/2/24 at 10:25 AM, V15/ Licensed Practical Nurse/LPN, stated, "I was there the day that (R1) eloped. My nurses note on that day are correct. My main goal once I saw (R1) was to be sure he

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was ok and get (R1) sent out to the hospital. I then notified (V1/AIT). I don't remember (V1) coming in; I didn't see (V1) that night. (R1) is confused and (R1) does this a lot. It's normal for (R1) to be so confused and want to leave the building all the time. The nurse on the other side was the one who was pushing (R1) up the hallway. That might've been (V16, LPN) but I can't remember. I initiated the 15-minute checks and I think that stays in place for 72 hours. I am not sure what exact facility policy is, but I initiated them the day before the elopement happened. When I have (R1) and am his nurse, then I am the one who is responsible for (R1's) 15-minute checks. I was (R1's) nurse that night (3/16/24 elopement), but I was the only nurse on 100 and 200 hall due to a call off, so I would've required a CNA to be completing those checks, and I am not sure who I was working with. I know I was very busy with all the residents I had that night. I think that night it would have been a CNA doing the 15-minute checks. Those would be charted on a paper form."

On 5/2/24 at 1:00 PM, V17/Regional Nurse Consultant, stated, "(R1) was on one-on-one monitoring, but after a while that starts to make him more agitated, so we have to try other things. I know after this last incident of elopement, they decided that the 15-minute checks would not be enough, and he needed one on one supervision at all times. That's what he has now."

On 5/2/24 at 1:05 PM, V1/Administrator in Training/AIT, stated "I will look to see if we have any 15-minute checks documented on (R1). They should be documented. The front doors are supposed to lock at night. I am not sure how (R1) actually got out of the building." Interviews were conducted with the nurse working. (No other

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documentation was provided to show other staff were interviewed or the origin of exiting was ever discovered by V1)

On 5/2/24 at 1:50 PM, V1/AIT, stated, "Prior to (3/16/24), we were all (all staff) completing close observations of (R1) and making sure he was safe. There was no formal sheet or area that they had to document these checks. We know based on the video surveillance that he exited the front doors at 7:50 PM. Normally, we should have a receptionist at the front door until 8:00 PM and the doors lock/alarm after 8:00 PM. I don't know if the receptionist was not there/ left early, or why there wasn't anyone at the front to keep him from going out."

On 5/3/24 at 11:46 AM, V20/Nurse Practitioner, stated R1 was being treated by Psychiatry for his behaviors. V20 was notified when R1 eloped from the facility, and R1 was sent to the Emergency Room due to complaints of head and back pain.

On 5/3/24 at 2:55 PM, V1/AIT, stated the day R1 left the building (3/16/24) he went out the front door at 7:50 PM. V1 knows this from watching the video of R1 leaving. "There is usually staff at the front desk until 8:00 PM, but that day (V26/Receptionist) left at 7:00 PM. V26 should have locked the door when she left the building. If the door is locked and opened it will set off an alarm. R1 did not have an alarm on his ankle. The facility does not put alarms on residents."

On 5/4/24 at 9:39 PM, V22, LPN, stated she knows of one resident being an elopement risk and that is R1. V22 is not aware of there being a list of residents that are an elopement risk. V22 was asked how she knows if a resident is an elopement risk, and V22 stated the information is

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relayed in shift report.

On 5/4/24 at 7:20 PM, V26, Receptionist, stated when she leaves in the evening, she is supposed to lock both of the front doors and set the alarm. V26 doesn't know where to find the policy about locking and alarming the doors. When V26 was trained for her job, she was just told to do it. V26 also stated she heard from staff that R1 eloped, but was not at the facility when it happened. V26 is not aware of any other residents that are elopement risks, and does not know where to find that information.

On 5/5/24 at 11:58 AM, V1/AIT, stated, "(V26) left at 7:00 PM on 3/16/24, and did not lock or alarm the front doors. Had (V26) locked the door, (R1) would not have got out." V1 does not know if there is a policy about locking the door or if it is in the job description. V1 did not ask V26 why the door was not locked when V26 left on 3/16/24.

(B)

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300.610 a)
300.1210 b)
300.1210 c)
300.1210 d)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

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

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to obtain scheduled medications from the pharmacy for two of three residents (R2 and R9) reviewed for pharmacy services in the sample of 17. This failure resulted in R9 abruptly stopping and missing his scheduled seizure medication for

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a minimum of two days resulting in R9 experiencing weakness, seizure, and a fall breaking three ribs.

Findings include:

The facility's Medication Errors policy, dated 9/28/23, documents, "It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Significant Medication Error means one which causes the resident discomfort or jeopardizes his/her health and safety. The facility shall ensure medications will be administered according to the physician's orders."

The facility's Medication Reordering policy, dated 12/21/22, documents, "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. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner."

1. R9's MDS (Minimum Data Set), dated 4/11/24, documents a BIMS (Brief Interview for Mental Status) Score of 8/15, indicating (moderate cognitive impairment).

R9's Care Plan, dated 3/20/22, documents R9 is at risk for seizure activity and/or injury related to seizures as well as for complications associated with psychotropic medication used for treatment

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management of seizure disorder. Care Plan update documents R9 has a risk for limited mobility related to a recent fall on 4/10/24, with three left posterior rib fractures.

The Final Report for R9 sent to the State Agency (not dated) documents, "(R9) informed staff that he fell multiple times in his room on 4/10/24. (R9) sent to hospital due to complaints of pain related to self-reported fall. (R9) returned from hospital ED (Emergency Department) on 4/10/24 with unremarkable X-ray. Informed 4/19/24 that (R9) had minimal displaced fracture of 8th, 9th, 10th posterior left ribs." R9 is a 64-year-old who admitted on 11/12/22 with diagnosis of Generalized Idiopathic Epilepsy, Disorders of Psychological Development, Frontal Lobe and Executive Function Deficit, Muscle Weakness/Abnormalities of Gait and Mobility. Bims (Brief Interview for Mental Status)-8. R9 self-reported multiple falls in his room due to seizure activity. R9 is ambulatory without assistive devices and can get self-up off the floor. On 4/10/24 (R9) notified staff that he wanted to go to the hospital. R9 stated, "I fell five times and I need to go to ED (Emergency Department)."

R9's Medication Administration Record, dated 4/1/24 - 4/30/24, documents R9 has an order for Keppra (Seizure medication) 1000 milligrams, two tablets to be given at 8:00 AM and 8:00 PM daily for seizures. This same record does not document R9 was given any Keppra on 4/9/24 or 4/10/24. Those dates are coded to see the Progress Notes for why Keppra 1000 mg (give 2 tablets twice a day) was not given to R9 on 4/9/24 at 8:00 AM, 8:00 PM, and 4/10/24 at 8:00 AM. On 4/10/24 at 8:00 PM, it is documented R9 was in the hospital.

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R9's Progress Note written by V21/LPN, dated 4/9/24 at 7:10 AM, documents to give Keppra 1000 mg/milligram tablet. Give 2 (two) tablet by mouth two times a day related to Epilepsy, Unspecified Intractable, Without Status Epilepticus. "The medication is on order."

R9's Progress Note written by V22/LPN, dated 4/9/24 at 9:29 PM, documents to give Keppra 1000 mg/milligram tablet. Give 2 (two) tablet by mouth two times a day related to Epilepsy, Unspecified Intractable, Without Status Epilepticus. "The medication is on order."

R9's Progress Note written by V12/LPN, dated 4/10/24 at 3:16 PM, documents to give Keppra 1000 mg/milligram tablet. Give 2 (two) tablet by mouth two times a day related to Epilepsy, Unspecified Intractable, Without Status Epilepticus. "The medication is not available."

R9's Nursing Note, dated 4/10/24 at 5:46 PM, documents R9 put on his call light and stated, "I keep falling and I need to go to the Emergency Room." The Certified Nursing Assistant/CNA notified V12/Licensed Practical Nurse. V12 asked R9 what he needed. R9 stated, "I need to go to the Emergency Room. I have fallen multiple times." All falls were unwitnessed by staff. R9 insisted on going to the ER. R9 denies hitting his head and no pain reported.

R9's Emergency Department/ED note, dated 4/10/24 at 6:33 PM, documents, "(R9) came from the facility for evaluation of right wrist and left hip pain status post two unwitnessed ground level falls. Emergency Medical Staff/EMS reports (R9) has not had Keppra in four to five days. EMS reports (R9) reported believing he had seizures with each fall. EMS reports a 30 second

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tonic-clonic seizure in route to the ED. (R9) reports back pain currently. (R9) is alert to place and situation, disoriented to time and self. EMS reports (R9) is disoriented to self at baseline."

R9's Emergency Department Note, dated 4/10/24 at 7:23 PM, documents, "(R9) presents with Seizure and a Fall. The history is provided by the patient. The patient is a 64-year-old male with a past medical history of seizures on Keppra, moderate developmental delay, presenting with a chief complaint of seizure and fall. (R9) reports he was living at the facility, and he has not received his anti-epileptic medication for an unknown amount of time. He states they have not been able to fill it due to issues with the pharmacy. (R9) states he did receive his medication today. States he had two seizure episodes without bowel or bladder incontinence or tongue biting. He does not remember the episodes. He knows he did fall but is unsure if he hit his head. Currently his only pain is in his right wrist, left hip, and left ribs. Otherwise, he has no complaints chest pain, shortness of breath, numbness, weakness, tingling, headaches, vision changes and no recent illnesses."

R9's Emergency Department/ED Report, dated 4/10/24, documents R9's Keppra level as expected was low. R9's Keppra level was less than 2.0 per lab report. R9 was given a loading dose of 2 Grams intravenous Keppra.

R9's Emergency Department/ED Report, dated 4/10/24, documents R9 arrived by ambulance to the ED on 4/10/24 at 6:20 PM. Labs were done at 7:01 PM. Keppra 1000 milligrams was given at 8:27 PM. At 8:28 PM an X-ray of R9's left hip, left ribs, and right wrist were done. At 8:37 PM R9 received 1000 milligrams of Keppra. R9 was

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discharged at 11:30 PM back to the facility.

R9's Nursing Note, dated 4/10/24 at 11:50 PM, documents R9 is back to the facility from ER visit. R9 is alert and oriented with complaint of left lower back pain.

R9's X-ray Impression, dated 4/11/24 at 1:20 PM, documents, "Acute Left Rib Fractures."

R9's Left Rib X-ray Report, dated 4/11/24, documents, "Left Ribs: Acute, mildly displaced fractures of the 8th, 9th, and 10th posterior left ribs."

R9's Fall Interdisciplinary Team Note, dated 4/11/24 at 8:31 AM, documents R9 self-reported that he fell multiple times on 4/10/24. R9 was ambulating without assistance and fell hitting a garbage can. R9 stated, "I fell multiple times in my room because I can't concentrate." R9 was sent to the Emergency Department.

R9's Nursing Note, dated 4/19/23 at 3:37 AM, documents R9 has been restless and in pain. R9 stated he has two cracked ribs keeping him from sleeping and causing him pain.

R9's Nursing Note, dated 4/19/24 at 2:13 PM, documents V20, Nurse Practitioner, was notified of R9's rib fractures.

The Pharmacy Records, dated 5/4/24 at 12:19 PM, documents Keppra was removed from the E-box for R9 by V5/LPN on 4/6/24 at 8:15 AM, and V22/LPN on 4/8/24 at 10:49 PM. The E-box did not have any more Keppra available.

According to the Epilepsy Foundation typically anti-epileptic drugs take up to a couple of days to

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be completely out of your body. Drugs.com says the half-life for Keppra is 44 hours.

On 5/2/24 at 10:14 AM, R9 confirmed he had a recent fall and broke ribs. R9 states before the fall, he was not getting his Keppra because they (the facility) were out for 5 days and "I kept telling them this was going to happen. I fell forward in my room and got myself up and then I went over by my bed and fell backwards. That was a fall over my trash can, and I broke two ribs. I was alert but I know I had a seizure. That's what happens when I don't get my medicine."

On 5/2/24 at 10:20 AM, R10 (R9's roommate) stated he witnessed R9's fall in their room. R9 fell and then got up and went over by his bed then fell again backwards.

On 5/3/24 at 11:52 AM, V20/Nurse Practitioner, stated, "I think (R9) did have a seizure that caused him to fall ,or (R9) was weak from withdrawals of not getting the Keppra. I believe the labs done at the hospital (R9's) level was close to zero in his system when (R9) fell." V20 also stated from the x-ray, it was determined R9 had a minimal fracture of the 8th, 9th, and 10th rib.

On 5/3/24 at 3:30 PM, V1, Administrator in Training/AIT, stated, "We (the facility) get notified when medications are delivered. There were problems with the change over from one pharmacy to the other delaying some of the medication."

On 5/3/24 at 3:15 PM, V2, Director of Nursing/DON, stated 4/8/24 was her first day working at the facility. The facility had changed pharmacy's on 4/1/24 and there were issues. V2

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stated, "(R9) told me on the 9th (4/9/24) that he was not getting his Keppra. (R9) was upset and I told (R9) to calm down, and I would take care of it. I did the best I could." V2 called the pharmacy about R9's Keppra, and was told the refill was too soon. V2 requested the medication be sent, but the pharmacy did not send it. On 4/9/24, V2 talked to V11, Pharmacy Customer Service, explaining the facility needed medication for R9. V2 was asked if the doctor could have been contacted to write a script to get the medication at the local pharmacy. V2 stated, "I suppose I could have. Who would think the pharmacy would not send the medication. I don't know if they did not believe me or what. (V17/Regional Nurse Consultant) called the pharmacy, and it (Keppra) was finally sent to the facility on 4/10/24." V2 confirmed R9 missed at least three doses of his seizure medication on 4/9 and 4/10//24.

On 5/3/24 at 6:43 PM, V11, Pharmacy Customer Service, stated R9 had an order for Keppra 1000 mg tablets. On 3/19/24, the order was filled by another pharmacy for a 30-day supply. On 4/1/24, a new pharmacy was the supplier. On 4/5 and 4/7/24, there was a request from the facility to refill R9's Keppra. The facility was told it was too soon to refill. The facility should have had plenty of medication on hand. On 4/8/24, the pharmacy got a call for the Keppra and sent a notice by Electronic mail/Email that it was too soon to refill the order. The pharmacy did not get a response to the Email. On 4/10/24, V2/DON called that they (the facility) needed the medication STAT (immediately). The Keppra was delivered to the facility at 3:52 PM on 4/10/24. V11 also stated the E-box had eight 250 mg tabs of Keppra. There were four tabs removed on 4/6 for R9 and four tabs removed on 4/8/24 for R9.

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On 5/4/24 at 6:52 AM, V21, Licensed Practical Nurse/LPN stated there was a day (4/9/24) R9 did not have Keppra available, and there was none in the E-box. V21 reordered the medication through the computer.

On 5/4/24 at 9:39 PM, V22, LPN, stated she remembers running out of Keppra for R9 and needing to take it from the E-box, but there was none in the E-box.

2. R2's current computerized medical record, documents R2 was admitted to the facility on 5/30/23 with a diagnosis of Opioid Dependency, Essential (Primary) Hypertension, Suicidal Ideation's, Major Depressive Disorder, Cerebral Infarction due to Embolism of Right Middle Cerebral Artery, Other Specified Disorders of Brain, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, and Vascular Dementia with Other Behavioral Disturbance.

R2's MDS (Minimum Data Set), dated 3/12/24, documents a BIMS (Brief Interview for Mental Status) Score of 12/15, indicating (mild cognitive impairment).

R2's Medication Administration Record, dated 4/1/24-4/30/24, documents R2 was to get Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. R2 did not get the Norco as scheduled on 4/1 and 4/2/24.

R2's Orders Administration Note, dated 4/1/24 at 8:58 AM, documents an order for Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. "Awaiting signed script."

R2's Orders Administration Note, dated 4/1/24 at 12:09 PM, documents an order for Norco 5-325

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mg tablet, give 1 tablet by mouth three times a day for pain. "Need signed script."

R2's Orders Administration Note, dated 4/1/24 at 8:52 PM, documents an order for Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. "Not available on order."

R2's Orders Administration Note, dated 4/2/24 at 7:29 AM, documents an order for Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. "Awaiting signed script."

R2's Orders Administration Note, dated 4/2/24 at 12:39 AM, documents an order for Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. "New pharmacy new script needed."

R2's Orders Administration Note, dated 4/2/24 at 8:21 PM, documents an order for Norco 5-325 mg tablet, give 1 tablet by mouth three times a day for pain. "Not available on order."

On 5/3/24 at 11:38 AM, V20, Nurse Practitioner, stated, "I would believe that (R2) did not get her pain medication for a couple of days. There has been a terrible problem with the new pharmacy not getting the medications filled like they should. The facility does have a backup box that the medication should have been pulled from.

(A)