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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS#23616 and CI MS#24271 at the facility on 02/14/24-02/27/24. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements. The SA cited M700 related to CI MS #24271 for medication administration at past non-compliance and the facility had corrected all deficient practice on 02/23/24 prior to the SA entrance into the facility on 02/26/24. There were no deficiencies related to CI MS #23616. The facility held a license for 60 beds at the time of the survey, and the facility census was 43.	M 000		
M 700	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Level III Based on interview, record review, and facility policy review the facility failed to ensure that an antiarrhythmic medication was available for a resident which resulted in the resident being transported to the hospital emergency department for one (1) of three (3) residents reviewed. Resident #4. Based on the facility's implementation of corrective actions completed on 2/23/24, the State Agency determined that the deficiency was	M 700	Past Non-Compliance, No POC needed.	3/12/24

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M 700	Continued From page 1 Past Non-Compliance. Cross reference F760 Findings Include: Record review of the facility policy, "Medication Shortages/Unavailable Medications" with revision date of 01/01/13 revealed under "Procedure:...3. If a medication shortage is discovered after normal Pharmacy hours: If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: Emergency delivery; or, Use of an emergency (back-up) Third Party Pharmacy... 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions..." Record review of the facility "Reportable Incident Form" revealed that Resident #4 was admitted to the facility for skilled services on Friday, 02/16/24 following hospitalization for diagnosis of Congestive Heart Failure (CHF). Resident #4 was admitted with orders for Multaq 400 milligram (mg) tablet to be administered nightly related to diagnosis of atrial fibrillation. The local hospital provided the facility with one dose of Multaq 400 mg tablet to be administered on the night of 02/16/24. The resident's medication orders were electronically sent to the pharmacy by the facility on 02/16/24. The pharmacy was unable to provide Multaq 400 mg tablets on 02/16/24, due to backorder of the medication. Resident #4 did not receive Multaq on Saturday 02/17/24, or on Sunday 02/18/24. Multaq 400 mg tablets were delivered to the facility on 02/20/24 at 1:16 AM.	M 700		

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M 700	Continued From page 2 On Monday, 02/19/24, Resident #4 displayed elevated heart rate, decreased blood pressure with dizziness and nausea while attending therapy and was sent out to the hospital for evaluation. Resident #4 was evaluated and returned to the facility on 02/19/24 with new orders to increase Multaq 400 mg to twice daily for one week and if tachycardia greater than 110 persist Wednesday morning to return to the emergency room. While reviewing facility records, the Administrator discovered that Licensed Practical Nurse (LPN) #2, documented Multaq 400 mg as administered on Saturday, 02/17/24. The medication was not available in the facility on this date to be administered. LPN #2 did not administer Multaq 400 mg nightly on 02/18/24 and did not attempt to obtain the medication from the pharmacy or notify administration of medication not being available. LPN #2 was terminated from facility related to incorrect documentation of medication administration and failure to administer prescribed medication. In-Services initiated with nursing staff on documentation of medication administration and pharmacy protocols. This reportable incident form was signed by the Administrator and dated 02/23/24. On 02/26/24 at 9:45 AM, an interview with Administrator (ADM), revealed that Resident #4 was sent out to the hospital on 02/19/24 with symptoms of nausea, tachycardia, dizziness, and hypotension. ADM stated that she did not realize that Resident #4 had missed two doses of medication until she began her investigation after the resident had reported it to the Director of Nursing (DON). ADM revealed that she contacted the pharmacy who told her that they had sent a slip to the facility with the delivered medications on 02/16/24 with documentation that Resident	M 700		

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#4's Multaq was on backorder. ADM stated that LPN #2 did not give it on two (2) days, 02/17/24 and 02/18/24. The ADM revealed that LPN #2 had signed out that she gave it on 02/17/24. The ADM revealed that LPN #2 did not notify anyone of the medication being on back order, and stated, "She did nothing." ADM revealed that Resident #4 was sent out to the Emergency Room (ER) on 02/19/24, they treated him for Atrial Fibrillation (A-Fib) and he returned to the facility with an order to increase Multaq from once a day to twice a day to attempt to get his heart out of A-Fib. ADM stated that on 02/20/24, the Director of Nursing (DON) went in to check on Resident #4 and he told her that he had not received his heart medication for several days prior to the ER visit. The ADM revealed the DON reported this to her and they immediately started investigating. ADM stated she called LPN #2 by phone and she told the ADM that she did not call or report that Resident #4's medication was not in the medication cart to anyone. ADM revealed that she asked LPN #2 about the medications being signed off as given on the MAR on 02/17/24 and LPN #2 said that she accidentally clicked it off as administered. LPN #2 told her that she didn't have the medication to give Resident #4 on 02/17/24 or 02/18/24. ADM revealed that LPN #2 should have called the pharmacy and had the medication sent to another local pharmacy, or she could have called the doctor to see what to do next. ADM stated, "That's common sense and she didn't do it." ADM revealed that LPN #2 didn't tell anyone the medication wasn't available and stated, "She could have killed him." ADM revealed that LPN #2 would not come into the facility when she called her, so she terminated her over the phone. ADM agreed that Resident #4's medication needs were not met and revealed that he went into A-fib as a

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result of missing the two doses of Multaq. ADM stated, "I hate it happened, but I'm glad it wasn't any worse." She revealed that they already had plans in place to correct the issue with medication storage and administration and were working diligently to make things better to prevent anything like this from happening again.

On 02/26/24 at 10:50 AM, an interview with Nurse Practitioner (NP), revealed that she was not aware that Resident #4 had missed two doses of his medication on 02/17/24 and 02/18/24 until after it happened. She (NP) revealed that she was not in the facility those days and that LPN #2 had not contacted her about it. Nurse Practitioner revealed that Resident #4 should not have missed two doses of his heart medication, and that this could have been detrimental. She revealed that Multaq or any heart medication should not be skipped.

On 02/26/24 at 11:20 AM, an interview with DON, revealed that on 02/19/24, Resident #4 went out to the ER for tachycardia and hypotension, and he was given medication to try to get his heart back into rhythm. She revealed that the hospital sent an order to the facility with Resident #4 to hold the Multaq on 02/19/24 because he had received it in the hospital. DON revealed that on 02/20/24, at around 8:30 AM, she went into Resident #4's room to check on him and he told her that he hadn't been given his Multaq since he had been here. DON revealed that she reported this to the Administrator, and they immediately investigated the situation and found that resident had received the one dose of Multaq on 02/16/24. The DON revealed that on 02/17/24, the Multaq had been signed out on the Medication Administration Record (MAR) as given by LPN #2 and on 02/18/24, it was documented that the

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Multaq wasn't there by the same LPN. DON revealed that they investigated the situation and found that Resident #4 had received the one dose of Multaq that was sent with him from the hospital on 02/16/24 and that he had missed the doses on 02/17/24 and 02/18/24. DON revealed that when LPN #2 found that the Multaq was missing, she should have contacted the pharmacy to find out about the medication and called the doctor to see what to do from there. DON agreed that Resident #4's medication needs were not met and resulted in him having to go to the ER.

Record review of Pharmacy "Delivery Receipt" revealed that on 02/16/24, Resident #4's Multaq 400 mg tablet had the following documented status: "Backorder-remaining to follow"

Record review of "Monthly Schedule February 2024" and Timecards revealed that LPN #2 was working on the 7P-7A shift on 02/17/24 and 02/18/24.

Record review of "Disciplinary Report" on LPN #2 revealed she was terminated on 02/21/24 with the following offenses: Carelessness, Dishonesty, Falsification of Records, Medication Errors, Poor Performance, Breaking Nursing Home Rules, and Non-Compliance of Policy and Procedures. Details of Offense: "Employee falsified documentation of medication administration on 02/17/24 and failed to administer a physician ordered medication on 02/17/24 and 02/18/24. On 02/17/24 LPN #2 documented she administered Multaq 400 mg and the medication was not delivered by the pharmacy until 02/20/24 and not available. On 02/18/24 LPN #2 documented the same medication was not given because it was not available. She stated she did

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not mean to click that she gave the medication on 02/17/24. On 02/17/24 or 2/18/24 she did not contact the Registered Nurse (RN) SPV (supervisor), Assistant Director of Nursing (ADON), or Administrator, or MD to notify the medication was unavailable. She also failed to contact the pharmacy to check on this medication. When asked if she contacted anyone to notify the medication was not available or the pharmacy to get an update on the medication, she stated she did not and did not know why. Employee refused to come to the facility ..."

Record review of Resident #4's "eMAR (electronic Medication Administration Record) for the month of February of 2024 revealed that Multaq 400 mg tablet was administered on 02/17/24. On 02/18/24, the Multaq 400 mg was marked "N" for Not Administered by (Proper Name) LPN #2.

Record review of Resident #4's "ED (Emergency Department) Provider Notes" revealed that he was seen in the emergency room on 02/19/24 for tachycardia, dizziness, fatigue, and shortness of breath. Under "History" was documented, "70 year old male presents to the ED with the complaint of tachycardia x (times) 2 (two) days ago. The patient suffers from Afib (Atrial Fibrillation) that he normally treats with Multaq and Midodrine. He did have an unsuccessful ablation and has been using the medications instead. He has been out of Multaq since leaving the hospital Friday. He reports that he began having an underlying attack and began having labored breathing ...."

Record review of "Procedure Results" revealed that Resident #4 had two, 12 (twelve) lead EKGs

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(Electrocardiograms) completed during the time he was in the emergency department on 02/19/24 and was given Multaq 400 mg and Cardizem 30 mg by mouth. The results of both EKGs were abnormal, his heart rate was tachycardic and the clinical impression stated, "Atrial Fibrillation with rapid ventricular response." The EKGs were completed at 3:12 PM and at 4:36 PM on 02/19/24.

Record review of Resident #4's "Facesheet" revealed an admission date of 02/16/2024 and that he had diagnoses which included Acute systolic (congestive) heart failure, Anemia, Ascites, Acute kidney failure, Unspecified Atrial Fibrillation, Chronic Kidney Disease and Localized Edema.

Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date of 02/22/2024 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he was cognitively intact.

Record review of Resident #4's "Physician Orders List" revealed an order dated 02/16/24 for Multaq 400 mg tablet - one tablet by mouth nightly and an order dated 02/19/24 to transfer to ER related to tachycardia.

The State Agency (SA) validated through interview with the Administrator and record review that the facility reported incident related to a resident not receiving two doses of heart medication was immediately investigated by the facility Administrator on 02/20/24.

The SA validated through interview with the Administrator and record review that a Quality Assurance Meeting was held on 02/23/24

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M 700	Continued From page 8 concerning the resident not receiving two doses of heart medications. The Plan to improve performance included 1. In-Services on medication deliveries 100% nursing, 2. Match backs will be performed on third shift each night. 100% on both carts. 3. Mandatory Meeting with pharmacist 100% nursing. 4. In-Service on pharmacy policy and procedures. 5. Mandatory meeting with nursing staff with Administrator/Director of Nursing and 6. Nurse Consultant from pharmacy will do a match back audit on March 4th and 5th for 100% match back on both carts. The SA validated through interview with Administrator and record review of the sign in sheets that inservices were conducted with all nursing staff on proper medication administration on 02/20/24. The SA determined that the facility was in compliance on 02/23/24 when LPN #2 was formerly terminated, inservices and investigation was concluded.	M 700		