STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

02/11/2025

Cascade Living Group - Cottage, LLC
The Cottage
3210 Rickey Rd NE
Bremerton, WA 98310

RE: The Cottage # 2246

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 54106 (Completion Date 02/11/2025) and 37830 (Completion Date 05/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/11/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

The Department staff who did the On Site verification:

Cathleen Davis, ALF Licensor
Melisa Moran, Assisted Living Facility Nursing Consultant Institutional

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: The Cottage
Provider Type: Assisted Living Facility
License/Cert.#: 2246
Compliance Determination #: 37830
Intake ID: 113907
Investigator: Regenia Coleman
Region/Unit #: RCS Region 3 / Unit D
Investigation Date(s): 03/04/2024 through 05/03/2024
Complainant Contact Date(s):

Allegation(s):

Quality of Care/Treatment- the facility failed to provide quality of care to the residents when they did not receive their scheduled medications as prescribed.

Investigation Methods:

Sample:
Total residents: 32
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Medication administration

Interviews:
Identified resident
Nursing staff
Residents
Family members
Former Staff
Collateral Contact (Pharmacy)
Nursing Leadership

Record Reviews:
Grievance log
State reporting log
Incident investigation
Facility policies
Staff training records
Pharmacy Records
Communication Records from Physician
Physician Orders

Investigation Summary:

Quality of Care/Treatment- Based on interview and record review the facility failed to administer the residents' medications as prescribed by their primary care providers.

The facility failed to ensure a resident received their medications as ordered and as documented in their negotiated service agreement. The facility failed to clarify orders that were not within the facility's routine dosage parameters, administered as needed pain medications outside of the prescribed time parameters, administered medications beyond the duration of an order, failed to ensure the electronic medication administration record contained accurate orders, and failed to administer scheduled medications as prescribed. The facility did not have systems in place to prevent, detect, and/or correct the medication errors. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 03/04/2024 and 05/03/2024 of:

The Cottage
3210 Rickey Rd NE
Bremerton, WA 98310

This document references the following complaint number(s): 113907

The following sample was selected for review during the unannounced on-site visit: 4 of 32 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Regenia Coleman, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interviews and records review, the facility failed to ensure 4 of 4 sampled residents' (Resident 1, Resident 2, Resident 3, and Resident 4 [R1, 2, 3, and 4]) were administered their medications as prescribed. The failure of the facility to ensure medications were administered as prescribed resulted in instability of R4's existing mental health condition and placed all sampled residents at risk for worsening of their medical conditions, risk for possible hospitalization, and a diminished quality of life.

Findings included…

According to an article published Nov. 4 2022 in the American Geriatrics Society, titled, "Make Your Voice Heard," medication errors in the elderly population are a "large contributor to poor outcomes, and hospitalizations (and readmissions) and appropriate reviews of total medication lists should be required in all care settings."

Record review of the facility's Disclosure of Services dated 03/2017 documented "The Cottage has a licensed nursing staff available to administer directly, or to supervise the administration of oral and topical medications, eye/ear/ nose drops, and injections including insulin (a medication used to lower the level of sugar in the blood)."

Record review of the Facility's Medication Assistance Policy, dated 04/2015 documented, "Standards of medication management will be consistently followed in all Cascade Living communities.
Procedures:
Match the resident's name, the medication name, dose, route, and instructions indicated on the MAR (Medication Administration Record) with the label of medication.

Medication delivery standards:
It is the responsibility of the licensed personnel to contact the resident's health care provider with any questions, concerns, or observations related to administered medications.
Document any communication regarding missed doses in the resident's record. It is the responsibility of the licensed personnel to contact the resident's health care provider with any questions, concerns, or observations related to administered medications."

Record review of the facility's Medication Errors Policy dated 09/2011 documented, "A medication error is: the wrong medication given, medication given to the wrong resident, the wrong dosage given, a messed dose of medication, medication given at the wrong time, medication given by the wrong route, medication mixed or prepared incorrectly, or missed documentation."

Resident 1
R1 was admitted to the facility on [redacted]/2020 with multiple diagnoses including [redacted] and [redacted].

Record review of R1's most recent Negotiated Service Agreement (NSA) updated Sep. 22 2023 documented medication services were to be provided to R1 by the community, and staff would order, store, and deliver R1's medications per "health care providers orders and Licensed Nurse (LN) instructions." R1's NSA addressed the order for alcohol and documented, "staff store and dispense alcohol related products per instructions; may have 4 ounces of wine per day; doctor approved."

Review of R1's December 2023 MAR documented the following medication error:
"Oseltamivir Phosphate (a medication used to stop the spread of flu virus), take 1 capsule by mouth every day for 10 days." The medication was placed on the eMAR (the facility's electronic medication administration record) as a medication for R1 to take PRN (only as needed). The date of the original order was Dec. 15, 2022. The order remained on R1's eMAR as a PRN order until Feb. 03 2024, when it was discontinued. The facility was unable to provide records which documented communication with the provider to clarify the order.

Review of R1's January 2024 MAR documented the following medication error:
"Oseltamivir Phosphate, take 1 capsule by mouth every day for 10 days." The medication was placed on the eMAR as a medication for R1 to take PRN. The date of the original order was Dec. 15 2022. The order remained on R1's eMAR as a PRN order until Feb. 03 2024, when it was discontinued. The facility was unable to provide records which documented communication with the provider to clarify the order.

Review of R1's February 2024 MAR documented the following medication errors:
"Oseltamivir Phosphate, take 1 capsule by mouth every day for 10 days." The medication was placed on the eMAR as a medication for R1 to take PRN. The date of the original order was Dec. 15 2022. The order remained on R1's eMAR as a PRN order until Feb. 03, 2024,

when it was discontinued. The facility was unable to provide records which documented communication with the provider to clarify the order.

Wine, 4 ounces prescribed to be taken by R1 once a day at bedtime. There were 12 missed doses of wine at bedtime between Feb. 0, 2024 and Feb. 17 2024. The documented reasons for the 12 missed doses of wine were “awaiting clarification.” The facility was unable to provide records which documented communication with the provider to clarify the order.

Resident 2

R2 was admitted to the facility on [redacted]/2021 with multiple diagnoses including [redacted] an [redacted]

Record review of R2’s most recent NSA updated Dec. 06 2023 documented medication services were to be provided to R2 by the community and staff would order, store and deliver R2’s medications per “health care providers orders and LN instructions.”

Review of R2’s December 2023 MAR documented the following medication errors:
“Propranolol, take 1 tablet by mouth two times a day, hold (do not give) for HR (heart rate) less than 55 [beats per minute].” Between Dec. 01 2023, through Dec. 27 2023, R2’s MAR documented 54 doses of Propranolol administered with no documented pulse. The facility was unable to provide documentation for the missing pulses at the time R2’s Propranolol was administered.

Hydrocodone (a medication used to read moderate to severe pain)-acetaminophen, take 1 tablet by mouth every six hours as needed for breakthrough pain (a sudden increase in pain that may occur in people who already have existing pain from some medical condition).” Review of R2’s MAR documented on Dec. 31 2023, Hydrocodone-Acetaminophen was administered to R2 at 11:30 AM. The next dose of Hydrocodone-Acetaminophen was administered to R2 at 3:19 PM, less than four hours after the first dose was administered.

Review of R2’s January 2024 MAR documented the following medication errors:
Hydrocodone-acetaminophen, take 1 tablet by mouth every six hours as needed for breakthrough pain.” Review of R2’s documented on MAR on Jan. 19 2024, Hydrocodone-Acetaminophen was administered to R2 at 11:53 AM. The next dose of Hydrocodone-Acetaminophen was administered to R2 at 4:37 PM, less than five hours after the first dose was administered.

Resident 3

R3 was admitted to the facility on [redacted]/2023, with multiple diagnoses including [redacted] and [redacted].

Review or R3's most recent NSA, updated Nov. 03 2023 documented medication services were to be provided to R3 by the community and staff would order, store, and deliver R3's medications per "health care providers orders and LN instructions."

Review of R3's February 2024 MAR documented the following medication errors:
"Risperidone (a medication used to treat certain mental health conditions), take 1 tablet by mouth two times a day for five days." The total number of doses encompassed by this order is ten doses. Review of R3's MAR documented a total of 11 doses given under this order.

"Risperidone, then take 1 tablet by mouth every day for three days, then discontinue." The total number of doses encompassed by this order are three doses. Review of R3's MAR documented a total of four doses given under this order. Combined, R3 should have received a Risperidone tapering (a slow reduction) dose of 13 tablets. R3's MAR documented 15 doses of Risperidone administered.

Resident 4

R4 was admitted to the facility on [redacted]/2024, with multiple diagnoses including [redacted] and [redacted].

Record review of R4's most recent NSA updated 01/26/2024 documented medication services were to be provided to R4 by the community and staff would order, store, and deliver R4's medications per "health care providers orders and LN (licensed nurse) instructions."

Review of R4's March 2024 MAR documented the following medication errors:
Daily Vite was prescribed to be taken by R4 once a day, was missed on Mar. 1 2024. There was no documented administration of Daily Vite on R4's MAR and no documented exception in the pass notes.

Eliquis was prescribed to be taken by R4 twice a day, was missed twice on Mar. 1 2024, once in the morning and once in the evening. There were no documented administrations

of Eliquis on R4's MAR and no documented exceptions in the pass notes.

Furosemide (a medication used to treat swelling in areas of the body such as ankles and feet) was prescribed to be taken by R4 twice a day. Furosemide was missed twice on Mar. 1 2024, once in the morning and once in the evening. There were no documented administrations of Furosemide on R4's MAR and no documented exceptions in the pass notes.

Healthy Eyes Supervision was prescribed to be taken by R4 taken once a day. Healthy Eyes Supervision was missed on Mar. 1 2024. There was no documented administration of Healthy Eyes Supervision on R4's MAR and no documented exception in the pass notes.

Levothyroxine Sodium was prescribed to be taken by R4 once a day. Levothyroxine Sodium was missed on Mar. 1 2024. There was no documented administration of Levothyroxine Sodium on R4's MAR and no documented exception in the pass notes.

Loratadine was prescribed to be taken by R4 once a day. Loratadine was missed on Mar. 1 2024. There was no documented administration of Loratadine on R4's MAR and no documented exception in the pass notes.

Magnesium Oxide was prescribed to be taken by R4 once a day. Magnesium Oxide was missed Mar. 1 2024. There was no documented administration of Magnesium Oxide on R4's MAR and no documented exception in the pass notes.

Meloxicam was prescribed to be taken by R4 once a day. Meloxicam was missed on Mar. 1 2024. There was no documented administration of Meloxicam on R4's MAR for that date and no documented exception in the pass notes.

Metoprolol Tartrate was prescribed to be taken by R4 twice a day. Metoprolol Tartrate was missed twice on Mar. 1 2024, once in the morning and once in the evening. There were no documented administrations of Metoprolol Tartrate on R4's MAR for that date and no documented exceptions in the pass notes.

Montelukast Sodium was prescribed to be taken by R4 once a day. Montelukast Sodium was missed on Mar. 1 2024. There was no documented administration of Montelukast Sodium on R4's MAR and no documented exception in the pass notes.

Risperidone (a medication used to treat mental health disorders) was prescribed to R4 to be taken twice a day. Risperidone was missed twice on Mar. 1 2024, once in the morning and once in the evening. There were no documented administrations of Risperidone on R4's MAR for that date and no documented exceptions in the pass notes.

Trazodone (a medication used to treat depression and/or to help someone fall asleep) was prescribed to R4 to be taken once a day. Trazadone was missed on Mar. 1 2024. There was no documented administration of Montelukast Sodium on R4's MAR and no documented exception in the pass notes.

Vitamin D3, a medication prescribed to be taken once a day, was missed on Mar. 1 2024. There was no documented administration of Montelukast Sodium on R4's MAR for that date and no documented exception in the pass notes.

In an interview with Staff D, Medication Aide (MA) on 03/08/2024 at 2:53 PM, they said it would be unusual to see an order on a resident's MAR to administer acetaminophen every hour as needed. Staff D stated, "PRN Tylenol [acetaminophen] is given every four hours as needed. That [every hour order for acetaminophen] was definitely a mistake and should have been caught."

In an interview with Staff E, MA, on 04/04/2024 at 10:22 AM, they said when a resident has an order to not administer a medication to a resident when the resident's pulse rate is less than 60 beats per minute (BPM), the process would be to measure and document the resident's pulse, if the pulse is above 60 BPM, administer the medication. If the pulse is below 60 BPM and the medication is not given, the initials of the person giving the medication would be circled and the reason it was not given would be documented in the exception log. Staff E said it would be unsafe to administer a medication prior to taking the pulse, if the order included a specific instruction pertaining to the pulse.

In an interview with Staff B, Bachelor of Science in Nursing, Registered Nurse, Wellness Director, on 05/03/2024 at 2:21 PM, Staff B described the process for orders being input into the QuickMAR (the facility's electronic medication administration record) when a new order for a resident is received: the order was first reviewed by a licensed person at the pharmacy (Costless Pharmacy), then the licensed person then inputs the order into the QuickMAR (at this point, the order is not available to be administered). Once placed on the QuickMAR, Staff C, Resident Care Coordinator (RCC) would compare the original order to the one placed on the QuickMAR by the pharmacy. Once the RCC ensured the order on the QuickMAR is complete, accurate, and does not need to be clarified, they release (make the medication available to be administered) the order on the QuickMAR to be seen and administered by the individual administering medications. Staff B said an order for acetaminophen to be administered to a resident every hour as needed would be "in our setting, an immediate call to the doctor for clarification."

In an interview with Staff A, Licensed Practical Nurse, Associate Executive Director, on 05/03/2024 at 02:21 PM, they said ultimately it was Staff C's job to ensure the correct orders were on the QuickMAR of the residents. Staff A stated all the resident's MARs are reviewed for accuracy weekly by Staff B and Staff C.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Cottage is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____
Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interviews and records review the facility failed to ensure 1 of 4 sampled resident's (Resident 4 [R4]) medications were available to be administered in a timely manner. This failure resulted in R4 not receiving their medications as ordered and placed the resident at risk for instability of existing medical conditions and for additional medical complications associated with not receiving medications as prescribed.

Findings included…

According to an article in the Best Practice Journal titled, "A Practical Guide to Stopping Medicines in Older People," published in 2010, medications, particularly in the elderly population, should not be stopped abruptly because it increases the risk of adverse consequences such as withdrawal symptoms or the return of the pre-existing disease/condition that was being treated. The article recommends a "stepwise approach to stopping medicines: reduce or stop one medicine at a time, consider if the medicine can be stopped abruptly or should be tapered, and check for benefit or harm after each medicine has been stopped."

Record review of the facility's Disclosure of Services dated 03/2017 documented, "The Cottage has a licensed nursing staff available to administer directly, or to supervise the administration of, oral and topical medications, eye/ear/ nose drops, and injections including insulin (a medication used to lower the level of sugar in the blood)."

Record review of the facility's Medication Assistance Policy dated 04/2015 documented, "Standards of medication management will be consistently followed in all Cascade Living communities.
Assisting with Medications:
Match the resident's name, the medication name, dose, route, and instructions indicated on the MAR (medication administration record) with the label of medication. Immediately

record the observed dosage taken on the MAR or note times when the resident refused or missed a medication. Medication associates will conduct a self-audit following each medication pass and at the conclusion of the shift to ensure that all appropriate documentation has occurred.
Documentation & Notification:
All refused or missed medications are documented and reported to licensed personnel or the wellness director. If a medication is missed or refused, the medication associate will circle the space on the front of the MAR and document the reason on the reverse side of the MAR or choose the appropriate designation for the medication on the eMAR (electronic medication administration record).
Medication Reordering:
All medications dispensed by the community will be reordered in accordance with pharmacy policies, with sufficient time so that the resident does not run out of a medication. Should there be a delay in obtaining the medication and a dose is messed, the resident's health care provider should be notified, as well as the resident's responsible party. All medication associates are responsible for keeping track of the need for medication refills when performing routine medication duties. A system of reporting medications that need refilling is kept by each community and overseen by licensed personnel."

Resident 4
R4 was admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted] and [redacted].

Record review of R4's most recent Negotiated Service Agreement (NSA) updated 01/26/2024 documented medication services were to be provided to R4 by the community and staff would order, store, and deliver R4's medications per "health care providers orders and LN (licensed nurse) instructions."

Review of R4's December 2023 MAR documented the following missed medications:
Combivent Inhaler (an inhaled medication used to treat a breathing disorder) was prescribed to be taken by R4 four times a day. There were 31 missed doses of Combivent between Dec. 14 2023, through Dec. 22 2023, when the medication was discontinued. The documented reason for 1 missed dose of Combivent was, "med on order." The documented reason for 30 missed Combivent doses was, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

QVAR inhaler (an inhaled medication used to treat a breathing disorder), was prescribed to be taken by R4 twice a day. There were 16 missed doses of QVAR Dec. 14 2023, through Dec. 22 2023, when the medication was discontinued. The documented reason for 1 missed dose of QVAR was "med on order." The documented reason for 15 missed QVAR doses was "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Eliquis (a medication used to treat and prevent blood clots), was prescribed to be taken by R4 twice a day. There were 10 missed doses of Eliquis between Dec. 14 2023 through Dec. 22 2023. Eight missed Eliquis doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of medication in the facility for those doses to be given. Two missed Eliquis doses were documented on R4's MAR as "awaiting clarification." Review of Costless Pharmacy delivery records indicated a sufficient quantity of Eliquis had been delivered to the facility for those documented doses. The facility was unable to provide records which documented communication with the provider to clarify the order.

Atorvastatin (a medication used to lower cholesterol), was prescribed to be taken by R4 once a day at bedtime. There were 18 missed doses of Atorvastatin between Dec. 14 2023 through Dec. 31 2023. Sixteen missed doses of Atorvastatin were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Atorvastatin had been delivered to the facility for those documented doses. Costless Pharmacy records documented the first delivery of Atorvastatin to the facility for R4 was on Jan. 5 2024. Two missed Atorvastatin doses were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Daily Vite (a dietary supplement) was prescribed to be taken by R4 once a day. There were 8 missed doses of Daily Vite between Dec. 14 2023, through Dec. 31 2023. Four missed Daily Vite doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Atorvastatin had been delivered to the facility for those documented doses. Four missed Daily Vite doses were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Healthy Eyes Supervision (a dietary supplement) was prescribed to be taken by R4 once a day. There were 7 missed doses of Healthy Eyes Supervision between Dec. 14 2023 through Dec. 31 2023. Four missed doses of Healthy Eyes Supervision were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Healthy Eyes Supervision had been delivered to the facility for those documented doses. Three missed doses of Healthy Eyes Supervision were documented on R4's MAR as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Levothyroxine Sodium (a medication used to treat an underactive thyroid gland) was prescribed to be taken by R4 once a day. There were 18 missed medication doses of Levothyroxine Sodium between Dec. 15 2023 through Dec. 31 2023. The missed Levothyroxine Sodium doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records documented the first delivery to the facility of Levothyroxine Sodium for R4 was on Jan. 12 2024.

Loratadine (a medication used to treat allergies), was prescribed to be taken by R4 once a day. There were 7 missed medication doses of Loratadine between Dec. 15 2023 through

Dec. 31 2023. Four missed Loratadine doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Loratadine had been delivered to the facility for those documented doses. Three missed Loratadine doses were documented on R4's MAR as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Magnesium Oxide (a dietary supplement) was prescribed to be taken by R4 once a day. There were 7 missed Magnesium Oxide doses between Dec. 15 2023, through Dec. 31 2023. Four missed Magnesium Oxide doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Magnesium Oxide had been delivered to the facility for those documented doses. Three missed doses of Magnesium Oxide were documented on R4's MAR as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Meloxicam (a medication used to decrease inflammation) was prescribed to be taken by R4 once a day. There were 17 missed Meloxicam doses between Dec. 15 2023 through Dec. 31 2023. Fourteen missed Meloxicam doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated the first delivery of Meloxicam for R4 was on Jan. 12 2024. Three missed doses or Meloxicam were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Metoprolol Tartrate (a medication usually used to treat high blood pressure or other heart-related conditions) was prescribed to be taken by R4 twice a day. There were 35 missed Metoprolol Tartrate doses between Dec. 15 2023 through Dec. 31 2023. Thirty-two missed Metoprolol Tartrate doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated the first delivery to the facility of Metoprolol Tartrate for R4 was on Jan. 12 2024. Three missed doses of Metoprolol Tartrate were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Montelukast Sodium (a medication used to treat allergies) was prescribed to be taken by R4 once a day. There were 17 missed doses of Montelukast Sodium between Dec. 15 2023, through Dec. 31 2023. Fourteen missed Montelukast Sodium doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Montelukast Sodium had been delivered to the facility for those documented doses. Three missed Montelukast Sodium doses were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Vitamin D3 (a dietary supplement) was prescribed to be taken by R4 once a day. There were 7 missed Vitamin D3 doses between Dec. 15 2023 through Dec. 31 2023. Two missed Vitamin D3 doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Vitamin D3 had been delivered to the facility for those documented doses. Four missed Vitamin D3 doses

were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

COVID (an easily transmitted disease that can cause severe illness and even death) Outbreak Monitoring, R4 was to have their oxygen level and temperature taken twice a day and to be monitored twice a day for cough, sore throat, and/or difficulty breathing. On Dec. 22 2023 the morning Covid Outbreak Monitoring documentation was not documented. The reason documented on R4's MAR was "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Review of R4's January 2024 MAR documented the following missed medications:
Atorvastatin was prescribed to be taken by R4 once a day at bedtime. There were 4 missed Atorvastatin doses of Atorvastatin from Jan. 1 2024 through Jan. 4 2024. Four missed doses of Atorvastatin were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records documented the first delivery to the facility of Atorvastatin for R4 was on Jan. 5 2024, at 8:24 PM.

Eliquis was prescribed to be taken by R4 twice a day. There were 18 missed doses of Eliquis between Jan. 4 2024 and Jan. 12 2024. Nine missed Eliquis doses were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Eliquis had been delivered to the facility for those documented doses. Nine missed Eliquis doses were documented on R4's MAR as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Levothyroxine Sodium was prescribed to be taken by R4 once a day. R4 missed 12 doses of Levothyroxine Sodium between Jan. 1 2024 and Jan. 12 2024. The missed Levothyroxine Sodium doses between Jan. 1 2024 and Jan. 8 2024, were documented as administered to R4. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Levothyroxine Sodium was on hand for those doses. R4's four missed Levothyroxine Sodium doses between Jan. 9 2024, and Jan. 12 2024, were documented as, "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Meloxicam was prescribed to be taken by R4 mouth once a day. R4 missed 12 doses of Meloxicam between Jan. 1 2024, and Jan. 12 2024. The missed Meloxicam doses between Jan. 1 2024, and Jan. 8 2024 were documented as administered to R4. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Meloxicam was in the facility for those doses. R4's four missed Meloxicam doses between Jan. 9 2024, and Jan. 12 2024 were documented as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Metoprolol Tartrate was prescribed to be taken by R4 twice a day, was missed 24 times from Jan. 1 2024 through Jan. 12 2024. The 15 missed Metoprolol Tartrate doses between the morning dose of Jan. 1 2024 and the morning dose of Jan. 8 2024 were documented

on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Metoprolol Tartrate was in the facility for those documented doses. The nine missed Metoprolol Tartrate doses between the evening dose of Jan. 8 2024 through Jan. 12 2024 were documented as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

Montelukast Sodium was prescribed to be taken by R4 once a day, was missed 12 times between Jan. 1 2024 and Jan. 12 2024. The eight missed Montelukast Sodium doses between Jan. 1 2024 through Jan. 8 2024 were documented on R4's MAR as administered. Review of Costless Pharmacy delivery records indicated an insufficient quantity of Montelukast Sodium was in the facility for those documented doses. The 4 missed Montelukast Sodium doses between Jan. 9 2024 through Jan. 12 2024 were documented as "awaiting clarification." The facility was unable to provide records which documented communication with the provider to clarify the order.

In an interview with Staff C, Resident Care Coordinator (RCC) on 03/04/2024 at 4:41 PM, they said a resident should never run out of medication while at the facility because there were processes in place to prevent that from happening. Staff C said if a resident did not receive their prescribed medication, staff were expected to initial the resident's MAR, circle their initials, and document the reason the medication was not given to the resident in the exception log.

In an interview with Staff I, Care Associate, 03/04/2024, at 5:01 PM, they said they were familiar with R4 and their care needs. Staff I said after R4 started missing their medications they began to act very restless at night and it was difficult for R4 to sit in one place for any length of time. Staff I said R4 told her they, "didn't feel quite right."

In an interview with Former Staff A (FS A), Medication Aide (MA), 04/04/2024, at 10:04 AM, they said staff initials on a resident's MAR indicated the medication had been given. If a resident had not been given a prescribed medication for any reason, the facility's policy was for staff to initial the MAR, circle their initials, and document the reason the medication was not given in the exception log or pass notes at the end of the resident's MAR for that month. FS A said when they saw "awaiting clarification" documented in a resident's chart it was hard to tell if the resident had run out of the medication or if they were waiting on a fax from the doctor. FS A stated, "It was well known in the building if the medication was not in from the pharmacy or it was on hold, we were told to document 'Awaiting clarification'."

In an interview with Staff E, MA, 04/04/2024, at 10:22 AM, they said they recalled R4 had moved into the facility [redacted] 2023. Staff E said R4 did not have any medications with them when admitted and after several days of R1 not being administered their prescribed medications, R4's behavior changed. Staff E said R1 became, "Combative, throwing their walker around, cussing at staff, and exit seeking." Staff E said the nurse had to ask for medication to "calm them [R4] down."

In an interview with Collateral Contact 3 (CC 3), Pharmacy Manager, Costless Senior

Services, on 04/08/2024, at 9:51 AM, they recalled the situation with R4 and the lapsed insurance coverage. CC 3 said the pharmacy had attempted to get R4's correct insurance information and the correct contact and billing information of R4's representative from the facility several times. CC 3 stated, "The facility continued to send us the expired insurance information, which just compounded the problem."

In an interview with Staff A, Licensed Practical Nurse (LPN), Associate Executive Director (AED) on 03/04/2024, at 2:47 PM, they said R4 went without her prescribed medications from Jan. 8 2024 through Jan. 12 2024, and resumed all ordered medications on Jan. 13 2024. In a follow-up interview on 04/19/2024 at 1:00 PM, Staff A said it was not acceptable for staff to document "awaiting clarification" if a resident had not received a prescribed medication. Staff A said they were not aware R4 missed so many doses of their prescribed medications. Staff A said if a resident's care plan documented the facility would order, provide, and store a resident's medications, it was the facility's responsibility to ensure the resident was administered their medications as prescribed.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, The Cottage is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Administrator (or Representative) Date