STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 11/07/2024

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BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 11/6/24 through 11/7/24. The survey was prompted by complaint intakes WY00003991, WY00003988, WY00003998, WY00004009, WY00004023 and WY00004030. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: Certified Nursing Assistant MA-C: Certified Medication Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		12/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/02/2024

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F 692	Continued From page 1 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure acceptable parameters of nutritional status for 2 of 5 sample residents (#5, #6) reviewed for nutrition. The findings were: 1. Review of the annual MDS assessment dated 10/17/24 showed resident #5 had short-term and long-term memory problems and diagnoses which included chronic kidney disease stage 3, non-Alzheimer's dementia, anxiety disorder, depression, muscle wasting and atrophy, and dysphagia. Further review showed the resident had weight loss greater than 5 percent and required supervision or touching assistance with eating. The following concerns were identified: a. Review of the resident's weight history showed s/he weighed 148 pounds on 5/22/24 and 120.3 pounds on 11/6/24, a weight loss of 18.71 percent. b. Review of the meal intake record from 10/9/24 through 11/7/24 showed the resident did not have a recorded meal intake for 16 out of 88 meals, was marked "response not required" was marked for 15 out of 88 meals, ate 0 to 25 percent for 5 out of 88 meals, and ate 26 percent to 50 percent for 10 of 88 meals. Further review showed on 10/24 there was no record of dinner, on 10/25 there were no recorded meals, and on 10/26 there was no record for breakfast and lunch was recorded as 0 to 25 percent. c. Interview with the dietitian on 11/7/24 at 9:46 AM revealed the resident will sleep through	F 692	Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of State and Federal law requires it. This Plan of Correction is the facility□s credible allegation of compliance. 1. CORRECTIVE ACTION The Director of Nursing Services and the Registered Dietitian reassessed the nutritional status of Resident # 5on (11/27/2024) Revisions were made to the care plan and revised interventions were reviewed with staff involved in the care of each resident RD□s notation acknowledged unavoidable but expected weight loss and decline and this is in her notes as well as care planned in addition physician was notified (11/6/2024 by RD) and has notes acknowledging unavoidable but expected weight loss (documented in provider progress notes dated 10/22/2024 and 11/26/2024) Plans are in place per RD and physician□s instructions. Resident will continue to be supervised or assisted with meals as needed Meal intake is being recorded daily for #5 for breakfast, lunch and dinner. When she refuses to go	

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F 692	Continued From page 2 meals and the facility has to work with staff to encourage residents to get up. She revealed if the resident was up more often, his/her nutrition would improve. Further interview revealed the resident body mass index was below where she would like him/her to be. 2. Review of the annual MDS assessment dated 8/31/24 showed resident #6 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, depression, and muscle wasting and atrophy. Further review showed the resident had weight loss greater than 5 percent and required partial/moderate assistance with eating. The following concerns were identified: a. Review of the resident's weight history showed s/he weighed 103 pounds on 5/6/24 and 91 pounds on 10/1/24, a weight loss of 11.65 percent. b. Review of the meal intake record from 10/8/24 through 11/6/24 showed the resident did not have a recorded meal intake for 12 out of 87 meals, was marked "response not required" for 13 out 87 meals, ate 0 to 25 percent for 3 out of 87 meals, and ate 26 percent to 50 percent for 5 out of 87 meals. c. Interview with the dietitian on 11/7/24 at 9:46 AM confirmed the resident had a decline and revealed staff needed to ensure s/he was assisted up to the dining room. Further interview confirmed the resident's body mass index was below where she would like it to be. 3. Interview with staff member #1 on 11/6/24 at 12:52 PM revealed a lack of staff had resulted in weight loss for residents. The staff member indicated staff were not able to assist residents to	F 692	to the dining room this is recorded (TAR) and resident will receive meals per her request in her room. When she refuses to wake up or get up the staff will encourage her to eat and offer a meal upon waking up, and document this interaction Resident # 6 The Director of Nursing Services and the Registered Dietitian reassessed the nutritional status of Resident(s) # 6 on (11/27/2024) Revisions were made to the care plan and revised interventions were reviewed with staff involved in the care of each resident. Provider progress notes from 10/22/2024 under palliative care and future weight loss maybe unavoidable. RD□s notation acknowledges unavoidable weight loss due to pertinent medical diagnoses. and this is in her notes as well as care planned in addition physician was notified 11/6/2024. CarePlan and has notes acknowledging unavoidable but expected weight loss) Plans are in place per RD and physician□s instructions. Resident will continue to be supervised or assisted with meals as needed Meal intake is being recorded daily for #6 for breakfast, lunch and dinner. II. How to identity other residents Residents that have had weight loss have the potential to be affected by the alleged deficient practice. 100% audit will be completed by 12/6/2024 by Director of Nurses/designee using the meal	

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F 692	Continued From page 3 the dining room or provide assistance with meals. 4. Interview with the DON, administrator, and regional nurse on 11/7/24 at 12:08 PM revealed they were unsure why the residents were marked "response not required" and revealed the system should trigger an alarm if they did not receive a meal. Further interview revealed if a resident refused meals or did not eat their meal, staff should offer an alternative and snacks. 5. Review of the policy titled "Meal Supervision and Assistance" provided by the facility on 11/7/24 showed "...15. If the resident refuses to eat offer alternative items/meal choice, inform the supervisor of continued refusal...17. Encourage the resident to participate with his or her meal as much as possible. When indicated, provide special devices (i.e., two-handed and/or covered cups, hand holder utensils, dishes secured with suction cups, etc.) which will increase independence and participation with meals. 18. Continue feeding until the resident has had enough food or until the meal is finished...20. If the resident wishes to eat later, or cannot eat now, communicate the resident's wishes to your supervisor and other staff members caring for the resident and set a more appropriate time for the resident to receive the meal..."	F 692	supervision and assistance check list as well as the weight loss audit tool for residents who were identified in the Nutritional at Risk meeting as having weight loss concerns and needing assistance with meals. provider and family notification, and proper follow up by nursing administration to assure compliance. No other residents were identified as affected. III. Systemic changes An in-service/ education will be conducted by the Director of Nursing Services/Designee 12/6/2024 with all direct care staff addressing nutritional interventions including weight documentation, monitoring, reporting refusal of meals and assisting with meals and review of the Meal Supervision and assistance policy PRN nurses will be required to receive education prior to first scheduled workday. IV Monitoring Process The nursing management team will review each weight report to ensure appropriate measurements are recorded and complete and to monitor weight fluctuations. The Director of Nursing Services (DNS), or designee, will complete weekly chart audits for six (6) consecutive weeks and review all weight reports and residents with weight change to ensure that changes are identified, and appropriate interventions have been put in place. Care plans will be reviewed for updated information to reflect these interventions.	

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F 692	Continued From page 4	F 692	Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		12/2/24

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F 725	Continued From page 5 Based on medical record review, and staff interviews, and review of the staff schedule,the facility failed to ensure sufficient nursing staff was provided on 1 of 4 units (Courtyard) reviewed for medication administration. The findings were: 1. Review of resident #7's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of finasteride 5 milligrams (mg) related to benign prostatic hyperplasia with lower urinary tract symptoms, fluoxetine 10 mg related to depression, tamsulosin 0.4 mg related to benign prostatic hyperplasia with lower urinary tract symptoms, and protonix 40 mg related to gastrointestinal hemorrhage, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for losartan 100 mg, apply moisturizing lotion, and triamcinolone acetonide external cream 0.1% at 6 AM. 2. Review of resident #8's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of cyanocobalamin 1000 micrograms (mcg) related to supplementation, metformin 1000 mg related to type II diabetes mellitus, multiple vitamins tablet related to supplementation, vitamin D3 capsule 25 mcg related to supplementation, acetaminophen 650 mg related to pain and pacing, losartan 50 mg related to hypertension (hold for blood pressure less than 100/60), and Risperdal 1 mg related to dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance at 6 am. 3. Review of resident #9's medication	F 725	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. I. Corrective Action Residents #7, #8, #9, #10, #11, #12, #13 and #14 suffered no ill effects due to staffing. This is evidenced by chart review completed on 11/30/24 by the DON/designee and provider documentation. II. How to Identify Other Residents The administrator and DON reviewed the acuity 12/2/2024. These daily acuity reviews will occur in each hall daily with the clinical schedular to ensure that the units have sufficient and appropriate staffing. Resident acuity is reviewed daily by DON or designee as well to ensure sufficient nursing staff; This information will be stored in excel data sheet after	

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F 725	Continued From page 6 administration record for October 2024 showed on 10/10/24 the former DON signed off administration of dexlansoprazole 60 mg related to gastro-esophageal reflux disease, Zoloft 50 mg related to major depression, divalproex sodium 250 mg related to unspecified dementia, unspecified severity, with other behavioral disturbance, midodrine 5 mg related to orthostatic hypotension, and Seroquel 100 mg related to degeneration of the brain, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for acidophilus probiotic related to cellulitis of the left lower limb, aloe vera capsule related to urinary health, aspirin 81 mg related to prophylaxis, d-mannose 500 mg related to urinary health, MiraLAX 17 grams (gm) related to fecal impaction/constipation at 6 AM, nutritional snacks at 10 AM and 3 PM, Seroquel 100 mg at 11 AM, and midodrine 5 mg at 12 PM. 4. Review of resident #10's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for glycolax powder 17 gm related to constipation, meloxicam 15 mg related to bilateral primary osteoarthritis of the knee, multivitamin-minerals related to supplementation, levetiracetam 500 mg related to seizures, sennosides 8.6 mg related to constipation, Tylenol 650 mg related to pain, at 6 AM, Tylenol 650 mg at 11 AM, haloperidol 2 mg related to schizophrenia at 6 AM and 11 AM, and nutritional supplements at 9 AM and 2 PM. 5. Review of resident #11's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of amlodipine 10 mg related to	F 725	review. Resident and staff interviews were completed by administrative staff 12/2/24 to audit staffing efficiency. III. Systemic Changes Staff were educated ON 12/2/24 by the administrator on appropriate staffing for the facility. Administrative staff will complete audits daily to ensure staffing remains sufficient to provide adequate care for the residents. The facility has initiated multiple incentives for hiring such as increased pay, sign-on bonuses and offers to assist with housing/travel costs, and Human Resources has contacted a Certified nursing Instructor to begin classes offsite as written in the approved waiver granted by the State of Wyoming. IV. Monitoring Process Administrative staff will conduct audits daily for 6 weeks on (ALL) hallways to monitor staffing and resident care to ensure that the facility has the appropriate staffing to provide adequate care for residents. Administrative staff will also be conducting satisfaction surveys daily for 6 weeks with these audits. The findings of these audits and the surveys will be reviewed daily in the stand-up meeting. DON/designee and the BOM/designee will be responsible for reporting to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for 3 months. QAPI Committee will evaluate and determine	

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F 725	Continued From page 7 hypertension, donepezil 5 mg related to unspecified dementia without behavioral disturbance, lisinopril 5 mg related to hypertension (hold if blood pressure less than 100/60), meloxicam 7.5 mg related to low back pain, MiraLAX powder 17 gm related to constipation management, and Tylenol 1000 mg related to low back pain, at 6 AM. 6. Review of resident #12's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of calcium-vitamin d 600 mg-220 mg related to vitamin D deficiency and docusate sodium 100 mg related to constipation, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for urea external cream 40% related to keratosis at 6 AM and oral nutritional supplement at 2 PM. 7. Review of resident #13's medication administration record for October 2024 showed the resident had a hold order on 10/10/24, which was signed off by the administrator, metoprolol 25 mg related to chronic diastolic heart failure (hold if blood pressure is less than 100/60), polyethylene glycol 17 gm related to bowel health, quetiapine 50 mg related to vascular dementia with behavioral disturbance, sertraline 100 mg related to anxiety disorder, and acetaminophen 1000 mg related to pain, at 6 AM, sennoside-docusate 8.8 mg-50 mg related to bowel management and spironolactone 25 mg related to edema at 8 AM, acetaminophen 1000 mg at 11 AM, and trazadone 50 mg related to unspecified vascular dementia, unspecified severity, with other behavioral disturbance, at 12 PM.	F 725	the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Business office manager/designee will be responsible for following up on any recommendations made by the QAPI Committee. V. Date of Completion	

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F 725	Continued From page 8	F 725		

8. Review resident #14's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of folic acid 1 mg related to supplementation, levothyroxine 75 mcg related to drug-induced thyroiditis, potassium chloride 20 milliequivalent (mEq) related to hypokalemia, tamsulosin 0.4 mg related to benign prostatic hyperplasia, thiamine 100 mg related to supplementation, and pantoprazole 40 mg related to gastro-esophageal reflux disease, at 6 AM. Further review showed the resident had a hold order on 10/10/24, which was signed off by the administrator, for Tums 500 mg related to heartburn, probiotic, at 6 AM, and the 9 AM and 11 AM snacks.

9. Review of the staff schedule dated 10/10/24 showed no nurse or MA-C was scheduled for the 6 AM to 6:30 PM shift in the courtyard unit.

10. Interview with CNA #1 on 11/6/24 at 2 PM revealed the staff member was moved to the courtyard unit on 10/10/24 due to someone being ill and not being available to work. The CNA revealed there was not a staff member passing medications to residents that day and another CNA came to the unit at 8 AM.

11. Interview with CNA #2 on 11/6/24 at 2:16 PM revealed she replaced CNA #1 on 10/10/24 because they did not have anyone to work Courtyard.

12. Interview with MA-C #1 on 11/6/24 at 2:23 PM revealed when she left on 10/10/24 she was told to give the keys to the Courtyard medication cart to MA-C #1 until the former DON came in. MA-C #2 was assigned to the Rock Creek unit and the

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F 725	Continued From page 9	F 725		

only staff member on the Courtyard unit was a CNA. When MA-C #1 returned later that day for her next shift, there continued to be only a CNA on the Courtyard unit. The MA-C revealed the CNA told her no medications had been administered to the residents on the unit and MA-C #1 would need to administer the missed medications. At that time, MA-C #1 notified the administrator and regional operations director, the medications had not been administered. The MA-C revealed she was told it was a serious medication error and they would need to notify the regional clinical director. The MA-C revealed the residents in the Courtyard unit were pacing and some had elevated blood pressures and she attempted to keep them calm. Further interview revealed that when she reviewed the residents' notes they indicated medications had been held due to provider orders.

13. Interview with the former DON on 11/6/24 at 2:35 PM revealed on 10/10/24 he was the only nurse in the building. He stated if he remembered right, he did the morning medications. He revealed he tried to help out but was probably caught up somewhere else or probably kept getting pulled away.

14. Interview with MA-C #2 on 11/7/24 at 12:10 PM revealed she was asked to work on the Rock Creek unit on 10/10/24 and when she learned there was nobody scheduled for the Courtyard unit, she said she could not do both units. The MA-C revealed she gave the Courtyard unit medication cart keys to the former DON at 8 AM. She revealed she told the former DON she had not administered any medications to residents on the unit. At 11 AM, she was notified by the CNA on the Courtyard unit, of resident behaviors and

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F 725	Continued From page 10 the CNA needed help. The MA-C went to the unit to try and calm residents. The MA-C revealed the residents were yelling and screaming, threatening others, seemed unsettled, and were getting worked up. The MA-C revealed the behaviors seemed normal for the residents when they had not received their medications. At that time, the CNA reported the residents had not received any medications that day and the former DON had not been on the unit. 15. Interview with the administrator on 11/6/24 at 2:43 PM revealed on 10/10/24, MA-C #1 reported none of the medications were administered to residents on the Courtyard unit. The administrator revealed the former DON was assigned to administer the medications and said he forgot. The administrator revealed the former DON said he had not administered any medications to residents on the Courtyard unit that day. She revealed the scheduling that day was supposed to be a CNA in Courtyard and the former DON was to be available. 16. Interview with nurse practitioner #1 and the administrator on 11/7/24 at 8:56 AM confirmed the staff members scheduled on Courtyard between 6 AM and 6:30 PM were not able to administer medications.	F 725		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		12/6/24

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F 842	Continued From page 11	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained

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F 842	Continued From page 12 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical records were accurately documented for 6 of 8 sample residents (#7, #8, #9, #11, #12, #14) reviewed for significant medication errors. The findings were: 1. Review of resident #7's medication administration record for October 2024 showed 10/10/24 the former DON signed off administration of finasteride 5 milligrams (mg) related to benign prostatic hyperplasia with lower urinary tract symptoms, fluoxetine 10 mg related to depression, tamsulosin 0.4 mg related to benign prostatic hyperplasia with lower urinary tract symptoms, and protonix 40 mg related to gastrointestinal hemorrhage, at 6 AM.	F 842	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R (s) 483.45 (a)(2) of the state operations manual.	

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F 842	Continued From page 13 2. Review of resident #8's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of cyanocobalamin 1000 micrograms (mcg) related to supplementation, metformin 1000 mg related to type II diabetes mellitus, multiple vitamins tablet related to supplementation, vitamin D3 capsule 25 mcg related to supplementation, acetaminophen 650 mg related to pain and pacing, losartan 50 mg related to hypertension (hold for blood pressure less than 100/60), and Risperdal 1 mg related to dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance at 6 AM. 3. Review of resident #9's medication administration record for October 2024 showed 10/10/24 the former DON signed off administration of dexlansoprazole 60 mg related to gastro-esophageal reflux disease, Zoloft 50 mg related to major depression, divalproex sodium 250 mg related to unspecified dementia, unspecified severity, with other behavioral disturbance, midodrine 5 mg related to orthostatic hypotension, and Seroquel 100 mg related to degeneration of the brain, at 6 AM. 4. Review of resident #11's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of amlodipine 10 mg related to hypertension, donepezil 5 mg related to unspecified dementia without behavioral disturbance, lisinopril 5 mg related to hypertension (hold if blood pressure less than 100/60), meloxicam 7.5 mg related to low back pain, MiraLAX powder 17 gm related to constipation management, and Tylenol 1000 mg	F 842	Resident #7 is at their baseline and has no ongoing effects from the missed medications. Resident #8 is at their baseline and has no ongoing effects from the missed medications. Resident #9 is at their baseline and has no ongoing effects from the missed medications. Resident #11 is at their baseline and has no ongoing effects from the missed medications. Resident #12 is at their baseline and has no ongoing effects from the missed medications. Resident #14 is at their baseline and has no ongoing effects from the missed medications. I. Corrective Action Mar to cart audits will be done by 12-6-2024 by Director of Nurses/Designee. If there are any deficient practices noted during the process the provider will be notified for follow-up orders. Families, if needed will be notified as well. The policy for Medication Errors was reviewed with Director of Nurses by Director of Compliance on 12-1-2024. Nursing staff and medication aides will be educated on the policy by 12-6-2024 by Director of Nurses/Designee as well medication errors and the 8 rights of medication administration including follow up documentation requirements. An audit of MARS for deficient practices	

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F 842	Continued From page 14 related to low back pain, at 6 AM. 5. Review of resident #12's medication administration record for October 2024 showed the former DON signed off administration of calcium-vitamin d 600 mg-220 mg related to vitamin D deficiency and docusate sodium 100 mg related to constipation, at 6 AM. 6. Review resident #14's medication administration record for October 2024 showed on 10/10/24 the former DON signed off administration of folic acid 1 mg related to supplementation, levothyroxine 75 mcg related to drug-induced thyroiditis, potassium chloride 20 milliequivalent (mEq) related to hypokalemia, tamsulosin 0.4 mg related to benign prostatic hyperplasia, thiamine 100 mg related to supplementation, and pantoprazole 40 mg related to gastro-esophageal reflux disease, at 6 AM 7. Interview with CNA #1 on 11/6/24 at 2 PM revealed on 10/10/24 there was not a staff member passing medications to residents that day. 8. Interview with MA-C #1 on 11/6/24 at 2:23 PM revealed when she left on 10/10/24 she was told to give the keys to courtyard medication cart to MA-C #2 until the former DON came in. MA-C #2 was assigned to the rock creek unit and the only staff member on the courtyard unit was a CNA. When MA-C #1 returned later that day, there continued to be only a CNA on the Courtyard unit. The MA-C revealed the CNA told her no medications had been administered to the residents on the unit and MA-C #1 would need to administer the missed medications. At that time, MA-C #1 notified the administrator and regional	F 842	will be done by the Director of Nursing or designee weekly for four weeks, biweekly x 2 and monthly for 3 months. The findings of these quality reviews will be reported to the Quality Assurances/Performance Improvement Committee monthly until the committee determines substantial compliance has been met and recommends moving forward to quarterly monitoring by the Director of Nurses/Designee	

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F 842	Continued From page 15	F 842		

operations director the medications had not been administered. The MA-C revealed she was told it was a serious medication error and they would need to notify the regional clinical director. The MA-C revealed the residents in the courtyard unit were pacing and some had elevated blood pressures and she attempted to keep them calm. Further interview revealed when she reviewed the residents' notes they indicated medications had been held due to provider orders.

9. Interview with the former DON on 11/6/24 at 2:35 PM revealed on 10/10/24 he was the only nurse in the building. He stated if he remembered right, he did the morning medications. He revealed he tried to help out but was probably caught up somewhere else or probably kept getting pulled away.

10. Interview with MA-C #2 on 11/7/24 at 12:10 PM revealed on she was asked to work on the Rock Creek unit on 10/10/24 and when she learned there was nobody scheduled for the Courtyard unit, she said she could not do both units. The MA-C revealed she gave the Courtyard unit medication cart keys to the former DON at 8 AM. She revealed she told the former DON she had not administered any medications to residents on the unit. At 11 AM, she was notified by the CNA on the Courtyard unit, of resident behaviors and the CNA needed help. The MA-C went to the unit to try and calm residents. The MA-C revealed the residents were yelling and screaming, threatening others, seemed unsettled, and were getting worked up. The MA-C revealed the behaviors seemed normal for the residents when they had not received their medications. At that time, the CNA reported the residents had not received any medications that day and the former

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F 842	Continued From page 16 DON had not been on the unit. 11. Interview with the administrator on 11/6/24 at 2:43 PM revealed on 10/10/24, MA-C #1 reported none of the medications were administered to residents on the Courtyard unit. The administrator revealed the former DON was assigned to administer the medications and said he forgot. The administrator revealed the former DON said he had not administered any medications to residents on the courtyard unit that day and she was unsure why the medications were signed off. 12. Interview with nurse practitioner #1 and the administrator on 11/7/24 at 8:56 AM revealed when the administrator spoke to the former DON following the incident on 10/10/24, he was unable to explain why the medications were not administered. They confirmed the other staff members scheduled on Courtyard between 6 AM and 6:30 PM were not able to administer medications.	F 842		