STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY NURSING AND REHABILITATION CENTER	625 N MAIN ST BOERNE, TX 78006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure residents were free from neglect for 1 of 5 Residents (Resident #1) whose care was reviewed for neglect, in that: The facility failed to implement their oversight and monitoring process to provide [MEDICATION NAME] tablet 32.4 mg (medication was used to control [MEDICAL CONDITION]) for Resident #1 that were necessary to avoid physical harm and fail to have structure in place to ensure the availability of [MEDICATION NAME] for Resident #1. As a result Resident #1 missed 20 of 21 doses of [MEDICATION NAME], suffered from [MEDICAL CONDITION], and was hospitalized . This deficient practice was determined to be past non-compliance, with an immediate jeopardy situation that began on [DATE] and ended on [DATE] due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the investigation. This deficient practice could place residents who received [MEDICAL CONDITION] medication at risk for not receiving therapeutic treatment and could place them at risk for for physical harm, pain, mental anguish, emotional distress or death. The findings were: Record review of Resident #1's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's care plan dated [DATE] revealed (Resident #1 had) a [MEDICAL CONDITION] disorder. Interventions: give medications as order. Obtain and monitor lab/diagnostic work as ordered. Report result to MD and follow up as indicated. Record review of Resident #1's physician progress notes [REDACTED]. [MEDICAL CONDITION] disorder: stable on combination of [MEDICATION NAME], and [MEDICATION NAME]. Labs from [DATE] are reasonable and no recent [MEDICAL CONDITION] activity. Record review of Resident #1's progress note dated [DATE] at 7:10 AM written by RN A revealed Resident #1 had [MEDICAL CONDITION] lasted approx. 2 minutes at which point (Resident #1) turned pale white and lips cyanotic and then lost consciousness. Resident #1 was having increased respirations. (Resident #1) was moved to his bed with (head of the bed elevated) and neurological checks started. Vital sign: (blood pressure) ,[DATE], (pulse) 103, (oxygen saturation) 95%, (Respiration)24. (Nurse Practitioner) notified and family notified. Record review of Resident #1's progress note dated [DATE] at 9:41 AM written by RN A revealed (Resident #1 was) lying in bed and this nurse went to check vital sign (and observed Resident #1) had (second) [MEDICAL CONDITION] lasted (approximately) 1.5 minutes at which point Resident #1 color became pale lips cyanotic and Resident #1 loss consciousness. Vital sings: (blood pressure) ,[DATE], (pulse) 107, (oxygen saturation) 96%, (respiration) 24. (Nurse practitioner) notified. Family member notified and wanted Resident#1 to (send) out to ER. (Nurse Practitioner) gave order to send Resident #1 out (per) family member's request. (New order) stat - [MEDICATION NAME] level, [MEDICATION NAME] level, [MEDICATION NAME] level, CBC, CMP. Blood drawn, and pickup ordered. Interview on [DATE] at 4:19 PM with RN A confirmed Resident#1 was up in wheel chair and drinking coffee in the dining room and had [MEDICAL CONDITION]. RN A described Resident #1 had violent [MEDICAL CONDITION], his body clenched and his whole body was stiff. RN A further described Resident #1's tongue stuck out, his bottom denture fell out, his face was pale, his lips were cyanotic. RN A confirmed Resident #1 had [MEDICAL CONDITION] for two and half minutes. When Resident #1's [MEDICAL CONDITION] concluded, RN A with MA E tilted his wheel chair and transported resident back to his room. RN A said she checked Resident #1's vital signs - Resident #1 was non-responsive, breathing was labored, using accessory muscle to breath, and tachypnea (rapid, shallow breathing). RN A confirmed Resident #1 became minimally responsive after [MEDICAL CONDITION] activity - pupils round and slow to react, lung sound clear, tongue swollen, good oxygen saturation level and Resident #1 began stabilizing after [MEDICAL CONDITION] activity. RN A confirmed Resident #1 did not answer her questions, but Resident #1 responded by looking up when RN A called his name. RN A said she remained with Resident #1 for about 10 - 15 minute to ensure Resident #1 was stable. RN A confirmed while she was on the phone with the doctor and family, RN A asked the CNA to observe Resident #1 to watch for signs of [MEDICAL CONDITION] activity. RN A confirmed when CNA was about to check Resident #1's vital signs, Resident#1 had another [MEDICAL CONDITION], and the CNA informed RN A to check on Resident #1. RN A confirmed Resident #1 had [MEDICAL CONDITION] activity. When Resident #1 was stable from his second [MEDICAL CONDITION], she notified the Nurse Practitioner and Resident #1's family. RN A confirmed she received an order to draw Resident #1's blood to check the drug level of [MEDICAL CONDITION] medication and to transfer Resident #1 to local hospital per Nurse Practitioner's order and family request. Record review of Resident #1's diagnostic laboratory dated [DATE] revealed [MEDICATION NAME] level was 6.8 ug/mL which meant the medication was lower than normal therapeutic level (therapeutic range for [MEDICATION NAME] is 15 - 40 ug/mL). During an interview on [DATE] at 5:57 PM with the DON, she confirmed Resident #1's drug levels in July ([MEDICATION NAME], and [MEDICATION NAME]) were all within therapeutic range. The DON further confirmed the drug level of [MEDICATION NAME] was low on [DATE] because Resident #1 did not receive his medication. Record review of resident #1's ambulance record dated [DATE] revealed Nursing staff states (Resident #1) had two [MEDICAL CONDITION] an hour apart from each other. The first [MEDICAL CONDITION] was around 0900 (9:00 AM) followed by another [MEDICAL CONDITION] around 1000 (10:00 AM). (Resident #1 had primary history) of [MEDICAL CONDITION] and takes [MEDICATION NAME] to control [MEDICAL CONDITION]. (Resident #1) received his medication this morning and is compliant with all other medications. (Resident #1) [MEDICAL CONDITION] was reported a grand mal [MEDICATION NAME] ,[DATE] minutes. No trauma noted from [MEDICAL CONDITION]. (Resident #1) was moved to stretcher and secured with all straps and 2 guard rails. (Resident #1) was transported to main local hospital. (Resident #1) had a [MEDICAL CONDITION] while in route to hospital and was placed in right side with airway suctioned for appx 10 seconds to clear secretions. (Resident #1) remained in postictal state (altered state of consciousness after [MEDICAL CONDITION] activity) during transport. Vital signs were continuously monitored and stable. Arrived to destination and (Resident #1) care released to receiving RN. Record review of Resident #1's physician order dated [DATE] revealed an order of [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times per day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable (not easily controlled or managed), without [DIAGNOSES REDACTED]. (G40.509) Start date [DATE]. Record review of Resident #1's narcotic sheet titled individual control drug record dated from [DATE] to 8/ ,[DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was completed on [DATE] at 2000 (8:00 PM) with 0 amount remaining. Record review of Resident #1's medication administration record dated [DATE] - [DATE] revealed administration schedule for [MEDICATION NAME] tablet 32.4 mg at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM). Further review revealed the medication scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 5 - hold/see progress notes and coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)

meant the medication was not administered; the medication schedule at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered. Record review of Resident #1's progress note dated on [DATE] at 8:59 AM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. Record review of Resident #1's progress note dated on [DATE] at 8:21 PM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. During an interview on [DATE] at 1:37 PM with MA B, he confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM), on [DATE] scheduled at 2000 (8:00 PM), and on [DATE] at 2000 (8:00 PM) because the medication was out of supply. MA B stated he made mistakes to document with check marks on Resident #1's MAR on [DATE] at 2000 (8:00 PM) and [DATE] at 2000 (8:00 PM) as administering the [MEDICATION NAME] 32.4 mg, and MA B said he should have coded as 9 on Resident #1's MAR and documented under progress note that the medication was still in process to deliver. During the interview with MA B, he confirmed he informed RN A and LVN I the [MEDICATION NAME] for Resident #1 was out of supply. MA B said he wrote the information down on a Post-It note and gave it to the nurses so that the nurses would call the pharmacy to refill the medication. MA B further confirmed he did not follow up with the nurses or inform the DON about the [MEDICATION NAME] for Resident #1 being out of supply because he did not work all the time in the East unit where Resident #1 resided. He stated he mainly worked in West unit. During an interview on [DATE] at 10:11 AM, RN A confirmed she did not recall if a medication aide informed her about the [MEDICATION NAME] for Resident #1 being completely out of supply. RN A confirmed when there was no [MEDICAL CONDITION] medication to administer for any Resident, she monitored if the Resident had any sign and symptom of [MEDICAL CONDITION]. RN A confirmed she received in-service and understood if the medication was out of supply, the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication aide was about to document the medication was not available to administer, and pharmacy had not delivered the medication, then charge nurse had to inform the ADON or DON. RN A confirmed she did not recall if she informed the ADON and DON about the [MEDICATION NAME] being not available to administer to Resident #1. RN A confirmed when the medication was not available to give to any resident, she would call the physician when she needed a new prescription to refill or authorization paperwork. RN also confirmed she would call physician if the medication for the resident was not available and resident had symptoms. RN confirmed she did not call the physician when the medication for any resident was completely out because she could resolve with the pharmacy. Record review of Resident #1's progress note dated [DATE] at 10:20 AM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Record review of Resident #1's progress note dated [DATE] at 8:24 PM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Interview via telephone on [DATE] at 5:59 PM with MA C confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) and on [DATE] scheduled at 2000 (8:00 PM) because the medication was out of supply. MA C further confirmed he made an error when he documented on Resident #1's MAR that he administered the [MEDICATION NAME] 32.4 mg, but the medication was not available to give. MA C stated he wrote Resident #1's name and medication on a piece of paper and gave to the nurse, and the nurse would call pharmacy to refill. MA C said he did not remember which nurse he gave the information to. Record review of Resident #1's progress note dated [DATE] at 5:42 AM written by MA D revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) pending delivery. Interview via telephone on [DATE] at 11:00 AM with MA D confirmed the [MEDICATION NAME] 32.4 mg was not available to administered for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM). MA D confirmed she informed LVN H about the [MEDICATION NAME] for Resident #1 was out of supply, and she saw LVN H call the pharmacy to refilled Resident #1's [MEDICATION NAME]. MA D confirmed she did not inform the ADON or DON when Resident #1's [MEDICATION NAME] was out of supply because she assumed LVN H informed ADON or DON during clinical meeting. Record review of Resident #1's progress note dated on [DATE] at 8:05 AM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy. Record review of Resident #1's progress note dated on [DATE] at 1:11 PM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy, notified charge nurse. Interview on [DATE] at 3:05 PM with MA E, she confirmed she did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) because there was no medication to give and the medication was pending delivery from pharmacy. MA E confirmed she informed LVN H about Resident #1's [MEDICATION NAME] was not available to administer. Record review of Resident #1's progress note dated [DATE] at 9:47 PM written by MA F revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) on order. Record review of Resident #1's progress note date [DATE] at 11:20 AM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:09 PM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:52 PM by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Interview via telephone on [DATE] at 11:43 AM with MA G confirmed the [MEDICATION NAME] for Resident #1 was out of supplies for couple days. MA G stated she did not remember what date the medication was not available to give to Resident #1. MA G confirmed she recalled the [MEDICATION NAME] was out of supply, and she informed LVN H. Interview via telephone on [DATE] at 1:06 PM with LVN H confirmed the medication aide informed her on [DATE] about the [MEDICATION NAME] for Resident #1 needed to refill. LVN H stated she did not recall the [MEDICATION NAME] was low on supply or completely out of supply. LVN H stated she called the pharmacy and pharmacy said they would get the medication out to the facility. LVN H stated she did not remember what date when the [MEDICATION NAME] was not delivered, and she called pharmacy again. LVN H said when she called pharmacy on the second time, pharmacy informed they need the physician's prescription to refill the [MEDICATION NAME] for Resident #1. LVN H explained when the pharmacy need refill prescription or authorization, pharmacy communicate with nurse manager via email instead of informing the floor nurse, so the floor nurse only know if the pharmacy need refilled prescription or authorization when the floor nurse called pharmacy to ask about why the medication had not been delivery. LVN H said she went to physician website to fill out a form to request refill for [MEDICATION NAME]. LVN H confirmed she did not remember what date she completed the request form for refill the [MEDICATION NAME] for Resident #1. LVN H added when the physician signed the refilled request form, the physician would send the prescription refill to the pharmacy. LVN H further confirmed she did not remember when the [MEDICATION NAME] was delivered to the facility. LVN H confirmed she did not call the doctor or inform the ADON or DON about the [MEDICATION NAME] that was out of supply because she just kept following up with the pharmacy. Interview on [DATE] at 1:59 PM with LVN I confirmed MA F informed her on [DATE] that the [MEDICATION NAME] for Resident #1 was out of supply. LVN I confirmed she filled a request form and fax to physician office to inform the physician that the medication was out of supply and need to refill. LVN I confirmed the [MEDICATION NAME] was delivered on [DATE] around 2:30 PM. LVN I confirmed there was no communication from the previous shift about the [MEDICATION NAME] for Resident #1 was out of supply. LVN I confirmed she did not inform the DON or ADON regarding the [MEDICATION NAME] was out of supply for Resident #1. Interview on [DATE] at 5:18 PM with the Administrator confirmed she was not aware of the [MEDICATION NAME] for Resident #1 ran out. The Administrator further confirmed medication aide and charge nurse should have informed the Administrator about Resident #1's [MEDICATION NAME] was out of supply. Interview on [DATE] at 5:49 PM with the DON, she confirmed she was not aware of the [MEDICATION NAME] for Resident #1 was out of supply until Resident #1's family member brought it to her attention on [DATE] because Resident #1 called to inform his family member. The DON further confirmed based on the documentation on Resident #1's MAR, the [MEDICATION NAME]

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) was not administered to Resident #1 from [DATE] at 0800 (8:00 AM) through [DATE] at 1400 (2:00 PM). Interview on [DATE] at 6:18 PM with the DON confirmed the medication aide should check the medication cart by going over each blister pack to ensure the medication availability at minimum for 3 days. If the medication not available, the mediation aide had to notify the charge nurse, then, charge nurse should have notified the physician. The DON further confirmed depend on certain medication, the physician could put the medication on hold for 2 days. The DON stated charge nurse should have informed the DON so that the DON could order the [MEDICATION NAME] from a contracted emergency pharmacy for 2 - 3 days supplies for Resident #1. Interview on [DATE] at 6:54 PM with the DON confirmed [DATE] was delivery date indicated on three blister packs - [MEDICATION NAME] 32.4 mg for Resident #1. Interview on [DATE] at 6:55 PM with the DON and RN J - ADON confirmed staff did not informed them when the [MEDICATION NAME] for Resident #1 was out of supply. Interview on [DATE] at 2:22 PM with RN J confirmed she did not know the supply of [MEDICATION NAME] for Resident #1 was low. RN J - ADON confirmed the nurse and medication aide on the East side did not communicate with the RN J ADON regarding Resident #1's [MEDICATION NAME] was not available. RN J ADON further confirmed she did not audit the medication cart on East unit and did not check the fax for reordering medication on East unit to ensure enough medication supply for Resident #1. Interview on [DATE] at 4:16 PM with the DON confirmed she did not review the shift report on Resident #1 from [DATE] to [DATE] because she was off work on [DATE] and she assisted state surveyor on [DATE] and [DATE], therefore, she did not see the documentation of medication aide on the [MEDICATION NAME] not available for Resident #1. During an interview on [DATE] 4:44 PM with the DON, she confirmed she considered it was neglect regarding the [MEDICATION NAME] was not available to administer for Resident #1 because the facility failed to provide medical needs for Resident #1 and resulted in Resident #1 having [MEDICAL CONDITION]. The DON further confirmed it was her responsibility to prevent neglect from happening again. During an interview on [DATE] at 5:21 PM, the Administrator confirmed there was a lack of the communication between the facility and the pharmacy. The Administrator confirmed the facility did not call pharmacy, pharmacy did not let the facility know the order refill request was needed, and staff did not inform the administrator or DON that Resident #1 was out of [MEDICATION NAME]. The Administrator confirmed [DATE] was the date when the facility faxed the refill order form to the pharmacy, and pharmacy received refill order on [DATE]. The Administrator said the physician office could not provide any log to show when the facility notified the physician office to get refill order request. The Administrator also said she did not know when pharmacy contacted physician regarding refill order request for Resident #1's [MEDICATION NAME]. During an interview on [DATE] at 5:31 PM, the Administrator confirmed the unavailability of [MEDICATION NAME] to administer for Resident #1 was neglect because there was lack of oversight to obtain Resident #1's [MEDICATION NAME] in timely manner and it caused harm to him. Record review of fax confirmation titled Refill Reorder Form dated [DATE] revealed Resident #1's name and [MEDICATION NAME] 32.4 mg was faxed to pharmacy on [DATE] at 2:20 PM. Record review of Electronic Order Status Inquiry for Resident #1 dated [DATE] revealed This prescription ([MEDICATION NAME] tablet 32.4 mg) has been electronically signed. Facility/provider sent [DATE]. Message broker received [DATE] 06:06 PM. Interview on [DATE] at 4:07 PM with pharmacy general manager confirmed if nursing facility call and request stat order (immediately/urgent order) for the [MEDICATION NAME], the pharmacy would delivery medication within ,[DATE] hours. Record review of the facility's undated policy titled with Medication ordering: Operating and monitoring system revealed To ensure all medications, pursuant to a valid physician order, are available in the facility at all times . Nursing should be ordering meds when they are down to 5 - 7-day supply. Nursing must identify refill is in facility when they are down to 3-day supply. Nursing must identify refill is in facility when they are down to 3-day supply and place refill card in med cart. Nursing must indicate any change of direction to pharmacy on reorder sheet. All incidents of meds not available during med pass should be reported to DON immediately. Monitoring: nurse management should verify all nurses have been in-serviced on med order/reorder system. Re-order book should be audited on daily basis to verify all med orders can be accounted for. Med carts should be audited on a weekly basis to verify no less than 3-day supply of med are available. Record review of the facility policy titled with Abuse prevention program dated ,[DATE] revealed Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. It was determined these failures placed Resident #1 in an immediate Jeopardy (IJ) situation from [DATE] to [DATE]. The facility took the following action to correct the non-compliance from [DATE] through [DATE]: - Weekly cart audits to be completed by DON/ADON for assure medication availability, medication labeled correctly, no expired medication on cart and identify any issues. - Each day a medication audit report pulled to include 9 to identify medication not given for reason and follow-up immediately. - [DATE] an in-service on medication availability to guarantee to have a minimum 3 days of medication available at all times. Also completed in-service if medication is not on cart after order to bring awareness to the ADON/DON immediately. - Communication form to be completed by charge nurse with medication availability follow up: resident name, medication, issue, follow-up and corrective action taken. This form is to be reviewed daily by DON/ADON. Observation on [DATE] at 6:54 AM with the DON revealed there were three blister packs (30 tablets/blister pack) of [MEDICATION NAME] 32.4 mg for Resident #1 dated [DATE] was in the narcotic locked box. Further observation revealed one tablet was taken out from one of the blister packs. Interview with the DON on [DATE] at 6:54 PM confirmed the date of [DATE] on the blister pack of [MEDICATION NAME] 32.4 mg for Resident #1 was the date the medication was delivered. Record review of Resident #1's narcotic sheet titled with individual control drug record dated [DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was administered the first dose for Resident #1 at 2000 on [DATE] with amount remaining 89 of 90 tablets of [MEDICATION NAME] 32.4 mg. Interview on [DATE] 12:19 PM with MA F confirmed she administered the evening dose of [MEDICATION NAME] to Resident #3 on [DATE]. MA F further confirmed she received supplies of 90 pills and punch out one pill for Resident #1's evening dose. Record review of Medication Administration Record of Resident #2, #3, #4 and #5 revealed they did not miss any dose of their [MEDICAL CONDITION] medication from [DATE] through [DATE]. Observation of medication administration on [DATE] at 3:36 PM revealed RN A administered the [MEDICATION NAME] to Resident #2 via feeding tube as physician order. Interview on [DATE] at 10:11 AM with RN A confirmed she received and understood in-service on ordering medication. RN A stated if the medication was out of supply the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication was not delivered by the next day and about to document the medication was not available on the MAR and pharmacy had not delivered the medication, then charge nurse had to inform the ADON or DON. Interview on [DATE] at 11:17 AM with MA D confirmed she received and in-service on ordering medication on [DATE]. MA D further confirmed she had to inform the charge nurse to call pharmacy for medication refill when there were 3 to 4-day supplies. MA D stated when the medication was out of supply, she had to notify the ADON or ADON. Interview with 7 interviewable Residents on [DATE], they confirmed they had not missed any dose of medication recently. Interview on [DATE] at 2:25 PM with RN J - ADON confirmed she provided in-service for charge nurse and medication aide regarding there was a binder in place for any communication that staff had with pharmacy. RN J - ADON confirmed there would be a communication form for medication aide, charge nurse, and ADON to initial daily to hold accountable for resident medication supply. RN J - ADON confirmed she also trained new hire or temporary staff the same process and protocol for obtaining medication and ensure enough medication supply for residents in the facility. RN ADON confirmed she had to ensure with staff what had been ordered, what pending delivery, and make sure what in the communication log match with the pharmacy log. RN ADON confirmed when the medication was out of supply staff had to notify the physician immediately and would order the medication through emergency pharmacy. RN ADON confirmed in-service staff once a month to ensure staff know what to do when the medication was not available to administer for resident. RN ADON confirmed she would randomly pick on staff and ask question to test their knowledge on obtaining and re-ordering medication for resident. Interview on [DATE] at 4:27 PM with the DON, she confirmed she would continue checking with staff during clinical meeting to ensure medications available for residents. The DON confirmed she continued in-service staff regarding ordering medication in timely manner, if medication was not available staff should check the emergency kit and immediately contact pharmacy to follow up on the medication delivery. The DON confirmed every medication aide and nurse had her phone number, so they could contact the DON any time regarding the medication supply for residents. The DON confirmed communication form utilized to ensure communication among staff to obtain the medication for resident in timely manner. The DON confirmed she and the ADON would monitor the communication form and make sure the issue resolved during the shift. The DON further confirmed she would make round and ask staff on the floor if there was any issue with medication supply for residents to ensure staff do what they supposed to. Interview on [DATE] at 4:38 PM with the DON confirmed she continue provide staff with in-service and competence check off regarding ordering the medication and administering medication. The DON confirmed there was a test for staff to complete to ensure staff understanding the in-service and training. Interview on [DATE] at 4:39 PM with the DON confirmed she would document any finding or concern with the current interventions, check if the system needed to be

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	455796	A. BUILDING _____ B. WING _____	**08/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY NURSING AND REHABILITATION CENTER	**625 N MAIN ST BOERNE, TX 78006**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) improved, continued with nurse competency for 90 days or more. DON further confirmed continue with audit medication cart to see if there was anything wrong and ensure there was no gap in the process of obtaining medication for Resident. The DON confirmed the Resident #1's incident regarding missed doses of [MEDICATION NAME] would be discussed in QAPI meeting to prevent happening again. Interview on [DATE] at 4:41 PM with the DON confirmed she ensured staff utilize communication board and shift change report to communicate among staff to make sure medication available for residents. Interview on [DATE] at 5:28 PM with the Administrator confirmed to prevent Residents' medications out of supply, staff were required to notify with the administrator or DON if the medication run lower than 3-day supply, utilize communication form among staff, ask staff during clinical meeting need to ensure medication enough for resident; audit medication cart and medication once a week. Interview on [DATE] at 5:39 PM the Administrator confirmed the incident of Resident #1 would be discussed in QAPI meeting every month until the facility saw the improvements. The Administrator further confirmed new hire would have to go through all training from abuse/neglect and orientation on acquiring medication before working on the floor. Record review of staff employees' files revealed staff received abuse and neglect in-service and back ground check. .

F 0607

Level of harm - Immediate jeopardy

Residents Affected - Few

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

. Based on interview and record review, the facility failed to implement policies and procedures that prevent neglect for 1 of 5 Residents (Resident #1) whose care was reviewed for neglect, in that: The facility failed to implement their neglect policy that assured residents were free from neglect by having the structures and processes in place to provide needed medications for Resident #1. As a result, Resident #1 missed 20 of 21 doses of [MEDICATION NAME] tablet 32.4 mg (medication was used to control [MEDICAL CONDITION]), suffered from [MEDICAL CONDITION], and was hospitalized . This deficient practice was determined to be past non-compliance, with an immediate jeopardy situation that began on [DATE] and ended on [DATE] due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the investigation. This deficient practice could place residents who received [MEDICAL CONDITION] medication at risk for not receiving therapeutic treatment and could place them at risk for for physical harm, pain, mental anguish, emotional distress or death. The findings were: Record review of the facility policy titled with Abuse prevention program dated ,[DATE] revealed Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Further review revealed the policy did not have definition of neglect. Record review of Resident #1's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's care plan dated [DATE] revealed (Resident #1 had) a [MEDICAL CONDITION] disorder. Interventions: give medications as order. Obtain and monitor lab/diagnostic work as ordered. Report result to MD and follow up as indicated. Record review of Resident #1's physician progress notes [REDACTED]. [MEDICAL CONDITION] disorder: stable on combination of [MEDICATION NAME], and [MEDICATION NAME]. Labs from [DATE] are reasonable and no recent [MEDICAL
CONDITION] activity. Record review of Resident #1's progress note dated [DATE] at 7:10 AM written by RN A revealed Resident #1 had [MEDICAL CONDITION] lasted approx. 2 minutes at which point (Resident #1) turned pale white and lips cyanotic and then lost consciousness. Resident #1 was having increased respirations. (Resident #1) was moved to his bed with (head of the bed elevated) and neurological checks started. Vital sign: (blood pressure) ,[DATE], (pulse) 103, (oxygen saturation) 95%, (Respiration)24. (Nurse Practitioner) notified and family notified. Record review of Resident #1's progress note dated [DATE] at 9:41 AM written by RN A revealed (Resident #1 was) lying in bed and this nurse went to check vital sign (and observed Resident #1) had (second) [MEDICAL CONDITION] lasted (approximately) 1.5 minutes at which point Resident #1 color became pale lips cyanotic and Resident #1 loss consciousness. Vital sings: (blood pressure) ,[DATE], (pulse) 107, (oxygen saturation) 96%, (respiration) 24. (Nurse practitioner) notified. Family member notified and wanted Resident#1 to (send) out to ER. (Nurse Practitioner) gave order to send Resident #1 out (per) family member's request. (New order) stat - [MEDICATION NAME] level, [MEDICATION NAME] level, [MEDICATION NAME] level, CBC, CMP. Blood drawn, and pickup ordered.

Interview on [DATE] at 4:19 PM with RN A confirmed Resident#1 was up in wheel chair and drinking coffee in the dining room and had [MEDICAL CONDITION]. RN A described Resident #1 had violent [MEDICAL CONDITION], his body clenched and his whole
body was stiff. RN A further described Resident #1's tongue stuck out, his bottom denture fell out, his face was pale, his lips were cyanotic. RN A confirmed Resident #1 had [MEDICAL CONDITION] for two and half minutes. When Resident #1's [MEDICAL CONDITION] concluded, RN A with MA E tilted his wheel chair and transported resident back to his room. RN A said she checked Resident #1's vital signs - Resident #1 was non-responsive, breathing was labored, using accessory muscle to breath, and tachypnea (rapid, shallow breathing). RN A confirmed Resident #1 became minimally responsive after [MEDICAL CONDITION] activity - pupils round and slow to react, lung sound clear, tongue swollen, good oxygen saturation level and Resident #1 began stabilizing after [MEDICAL CONDITION] activity. RN A confirmed Resident #1 did not answer her questions, but Resident #1 responded by looking up when RN A called his name. RN A said she remained with Resident #1 for about 10 - 15 minute to ensure Resident #1 was stable. RN A confirmed while she was on the phone with the doctor and family, RN A asked the CNA to observe Resident #1 to watch for signs of [MEDICAL CONDITION] activity. RN A confirmed when CNA was about
to check Resident #1's vital signs, Resident#1 had another [MEDICAL CONDITION], and the CNA informed RN A to check on Resident #1. RN A confirmed Resident #1 had [MEDICAL CONDITION] activity. When Resident #1 was stable from his second [MEDICAL CONDITION], she notified the Nurse Practitioner and Resident #1's family. RN A confirmed she received an order to draw Resident #1's blood to check the drug level of [MEDICAL CONDITION] medication and to transfer Resident #1 to local hospital per Nurse Practitioner's order and family request. Record review of Resident #1's diagnostic laboratory dated [DATE] revealed [MEDICATION NAME] level was 6.8 ug/mL which meant the medication was lower than normal therapeutic level (therapeutic range for [MEDICATION NAME] is 15 - 40 ug/mL). During an interview on [DATE] at 5:57 PM with the DON, she confirmed Resident #1's drug levels in July ([MEDICATION NAME], and [MEDICATION NAME]) were all within therapeutic range.

The DON further confirmed the drug level of [MEDICATION NAME] was low on [DATE] because Resident #1 did not receive his medication. Record review of resident #1's ambulance record dated [DATE] revealed Nursing staff states (Resident #1) had two [MEDICAL CONDITION] an hour apart from each other. The first [MEDICAL CONDITION] was around 0900 (9:00 AM) followed by
another [MEDICAL CONDITION] around 1000 (10:00 AM). (Resident #1 had primary history) of [MEDICAL CONDITION] and takes
[MEDICATION NAME] to control [MEDICAL CONDITION]. (Resident #1) received his medication this morning and is compliant with
all other medications. (Resident #1) [MEDICAL CONDITION] was reported a grand mal [MEDICATION NAME] ,[DATE] minutes. No
trauma noted from [MEDICAL CONDITION]. (Resident #1) was moved to stretcher and secured with all straps and 2 guard rails. (Resident #1) was transported to main local hospital. (Resident #1) had a [MEDICAL CONDITION] while in route to hospital and was placed in right side with airway suctioned for appx 10 seconds to clear secretions. (Resident #1) remained in postictal state (altered state of consciousness after [MEDICAL CONDITION] activity) during transport. Vital signs were continuously monitored and stable. Arrived to destination and (Resident #1) care released to receiving RN. Record review of Resident #1's physician order dated [DATE] revealed an order of [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times per day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable (not easily controlled or managed), without [DIAGNOSES REDACTED]. (G40.509) Start date [DATE]. Record review of Resident #1's narcotic
sheet titled individual control drug record dated from [DATE] to 8/ ,[DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was completed on [DATE] at 2000 (8:00 PM) with 0 amount remaining. Record review of Resident #1's medication administration record dated [DATE] - [DATE] revealed administration schedule for [MEDICATION NAME] tablet 32.4 mg at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM). Further review revealed the medication scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 5 - hold/see progress notes and coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered. Record review of Resident #1's progress note dated on [DATE] at 8:59 AM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. Record review of Resident
#1's progress note dated on [DATE] at 8:21 PM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by

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F 0607

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 4)

mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. During an interview on [DATE] at 1:37 PM with MA B, he confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM), on [DATE] scheduled at 2000 (8:00 PM), and on [DATE] at 2000 (8:00 PM) because the medication was out of supply. MA B stated he made mistakes to document with check marks on Resident #1's MAR on [DATE] at 2000 (8:00 PM) and [DATE] at 2000 (8:00 PM) as administering the [MEDICATION NAME] 32.4 mg, and MA B said he should have coded as 9 on Resident #1's MAR and documented under progress note that the medication was still in process to deliver. During the interview with MA B, he confirmed he informed RN A and LVN I the [MEDICATION NAME] for Resident #1 was out of supply. MA B said he wrote the information down on a Post-It note and gave it to the nurses so that the nurses would call the pharmacy to refill the medication. MA B further confirmed he did not follow up with the nurses or inform the DON about the [MEDICATION NAME] for Resident #1 being out of supply because he did not work all the time in the East unit where Resident #1 resided. He stated he mainly worked in West unit. During an interview on [DATE] at 10:11 AM, RN A confirmed she did not recall if a medication aide informed her about the [MEDICATION NAME] for Resident #1 being completely out of supply. RN A confirmed when there was no [MEDICAL CONDITION] medication to administer for any Resident, she monitored if the Resident had any sign and symptom of [MEDICAL CONDITION]. RN A confirmed she received in-service and understood if the medication was out of supply, the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication aide was about to document the medication was not available to administer, and pharmacy had not delivered the medication, then charge nurse had to inform the ADON or DON. RN A confirmed she did not recall if she informed the ADON and DON about the [MEDICATION NAME] being not available to administer to Resident #1. RN A confirmed when the medication was not available to give to any resident, she would call the physician when she needed a new prescription to refill or authorization paperwork. RN also confirmed she would call physician if the medication for the resident was not available and resident had symptoms. RN confirmed she did not call the physician when the medication for any resident was completely out because she could resolve with the pharmacy. Record review of Resident #1's progress note dated [DATE] at 10:20 AM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Record review of Resident #1's progress note dated [DATE] at 8:24 PM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Interview via telephone on [DATE] at 5:59 PM with MA C confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) and on [DATE] scheduled at 2000 (8:00 PM) because the medication was out of supply. MA C further confirmed he made an error when he documented on Resident #1's MAR that he administered the [MEDICATION NAME] 32.4 mg, but the medication was not available to give. MA C stated he wrote Resident #1's name and medication on a piece of paper and gave to the nurse, and the nurse would call pharmacy to refill. MA C said he did not remember which nurse he gave the information to. Record review of Resident #1's progress note dated [DATE] at 5:42 AM written by MA D revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) pending delivery. Interview via telephone on [DATE] at 11:00 AM with MA D confirmed the [MEDICATION NAME] 32.4 mg was not available to administered for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM). MA D confirmed she informed LVN H about the [MEDICATION NAME] for Resident #1 was out of supply, and she saw LVN H call the pharmacy to refilled Resident #1's [MEDICATION NAME]. MA D confirmed she did not inform the ADON or DON when Resident #1's [MEDICATION NAME] was out of supply because she assumed LVN H informed ADON or DON during clinical meeting. Record review of Resident #1's progress note dated on [DATE] at 8:05 AM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy. Record review of Resident #1's progress note dated on [DATE] at 1:11 PM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy, notified charge nurse. Interview on [DATE] at 3:05 PM with MA E, she confirmed she did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) because there was no medication to give and the medication was pending delivery from pharmacy. MA E confirmed she informed LVN H that Resident #1's [MEDICATION NAME] was not available to administer. Record review of Resident #1's progress note dated [DATE] at 9:47 PM written by MA F revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) on order. Record review of Resident #1's progress note date [DATE] at 11:20 AM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:09 PM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:52 PM by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Interview via telephone on [DATE] at 11:43 AM with MA G confirmed the [MEDICATION NAME] for Resident #1 was out of supplies for couple days. MA G stated she did not remember what date the medication was not available to give to Resident #1. MA G confirmed she recalled the [MEDICATION NAME] was out of supply, and she informed LVN H. Interview via telephone on [DATE] at 1:06 PM with LVN H confirmed the medication aide informed her on [DATE] about the [MEDICATION NAME] for Resident #1 needed to refill. LVN H stated she did not recall the [MEDICATION NAME] was low on supply or completely out of supply. LVN H stated she called the pharmacy and pharmacy said they would get the medication out to the facility. LVN H stated she did not remember what date when the [MEDICATION NAME] was not delivered, and she called pharmacy again. LVN H said when she called pharmacy on the second time, pharmacy informed they need the physician's prescription to refill the [MEDICATION NAME] for Resident #1. LVN H explained when the pharmacy need refill prescription or authorization, pharmacy communicated with nurse manager via email instead of informing the floor nurse, so the floor nurse only know if the pharmacy need refilled prescription or authorization when the floor nurse called pharmacy to ask why the medication had not been delivery. LVN H said she went to physician website to fill out a form to request refill for [MEDICATION NAME]. LVN H confirmed she did not remember what date she complete the request form for refill the [MEDICATION NAME] for Resident #1. LVN H added when the physician signed the refilled request form, the physician would send the prescription refill to the pharmacy. LVN H further confirmed she did not remember when the [MEDICATION NAME] was delivered to the facility. LVN H confirmed she did not call the doctor or inform the ADON or DON about the [MEDICATION NAME] that was out of supply because she just kept following up with the pharmacy. Interview on [DATE] at 1:59 PM with LVN I confirmed MA F informed her on [DATE] that the [MEDICATION NAME] for Resident #1 was out of supply. LVN I confirmed she filled a request form and fax to physician office to inform the physician that the medication was out of supply and need to refill. LVN I confirmed the [MEDICATION NAME] was delivered on [DATE] around 2:30 PM. LVN I confirmed there was no communication from the previous shift about the [MEDICATION NAME] for Resident #1 was out of supply. LVN I confirmed she did not inform the DON or ADON regarding the [MEDICATION NAME] was out of supply for Resident #1. Interview on [DATE] at 5:18 PM with the Administrator confirmed she was not aware of the [MEDICATION NAME] for Resident #1 ran out. The Administrator further confirmed medication aide and charge nurse should have informed the Administrator about Resident #1's [MEDICATION NAME] was out of supply. During an interview on [DATE] at 5:49 PM with the DON, she confirmed she was not aware of the [MEDICATION NAME] for Resident #1 was out of supply until Resident #1's family member brought it to her attention on [DATE] because Resident #1 called to inform his family member. The DON further confirmed based on the documentation on Resident #1's MAR, the [MEDICATION NAME] was not administered to Resident #1 from [DATE] at 0800 through [DATE] at 1400. Interview on [DATE] at 6:18 PM with the DON confirmed the medication aid should check the medication cart by going over each blister pack to ensure the medication availability at minimum for 3 days. If the medication not available, the mediation aide had to notify the charge nurse, then, charge nurse should have notified the physician. The DON further confirmed depend on certain medication, the physician could put the medication on hold for 2 days. The DON stated charge nurse should have informed the DON so that the DON could order the [MEDICATION NAME] from a contracted emergency pharmacy for 2 - 3 days supplies for Resident #1. Interview on [DATE] at 6:54 PM with the DON confirmed [DATE]

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) was delivery date indicated on three blister packs - [MEDICATION NAME] 32.4 mg for Resident #1. Interview on [DATE] at 6:55 PM with the DON and RN J - ADON confirmed staff did not informed them when the [MEDICATION NAME] for Resident #1 was out of supply. Interview on [DATE] at 2:22 PM with RN J confirmed she did not know the supply of [MEDICATION NAME] for Resident #1 was low. RN J - ADON confirmed the nurse and medication aide on the East side did not communicate with the RN J ADON regarding Resident #1's [MEDICATION NAME] was not available. RN J ADON further confirmed she did not audit the medication cart on East unit and did not check the fax for reordering medication on East unit to ensure enough medication supply for Resident #1. Interview on [DATE] at 2:37 PM with RN J - ADON confirmed information regarding abuse coordinator and phone number posted on the wall on hallway both units; in-service staff regarding neglect quarterly by lecturing or computer. RN J - ADON confirmed there was test post the training to ensure staff understand the training on neglect. RN J - ADON confirmed she made sure staff not burn out by balance out over time to ensure staff not getting burn out. Staff had to report any suspect neglect or any behavior of neglect to the Administrator - abuse coordinator. Interview on [DATE] at 4:16 PM with the DON confirmed she did not review the shift report on Resident #1 from [DATE] to [DATE] because she was off work on [DATE] and she assisted state surveyor on [DATE] and [DATE], therefore, she did not see the documentation of medication aide on the [MEDICATION NAME] not available for Resident #1. Interview on [DATE] at 4:44 PM with the DON confirmed she considered it was neglect regarding the [MEDICATION NAME] was not available to administer for Resident #1 because the facility fail to provide medical needs for Resident #1 and resulted Resident #1 had [MEDICAL CONDITION]. The DON further confirmed it was her responsibility to prevent neglect happened again. Interview on [DATE] at 4:44 PM with the DON confirmed the facility policy on neglect was providing in-service and training for staff on different forms of neglect. The DON further confirmed anyone including herself involved in Resident #1's incident would receive disciplinary action. The DON stated she would conduct the investigation of neglect related to Resident #1. The DON confirmed to prevent neglect she would continue implementing in-service, competency check, monitoring progress of the interventions to make sure in the right direction. Interview on [DATE] at 5:21 PM with the Administrator confirmed there was a lack of the communication between the facility and the pharmacy. The Administrator confirmed the facility did not call pharmacy, pharmacy did not let the facility know the order refill request was needed, and staff did not inform the administrator or DON about Resident #1 was out of [MEDICATION NAME]. The Administrator confirmed [DATE] was the date when the facility faxed the refill order form to the pharmacy, and pharmacy received refill order on [DATE]. The Administrator said the physician office could not provide any log to show when the facility notify the physician office to get refill order request. The Administrator also said she did not know when pharmacy contact with physician regarding refill order request for Resident #1's [MEDICATION NAME]. Record review of fax confirmation titled Refill Reorder Form dated [DATE] revealed Resident #1's name and [MEDICATION NAME] 32.4 mg was faxed to pharmacy on [DATE] at 2:20 PM. Record review of Electronic Order Status Inquiry for Resident #1 dated [DATE] revealed This prescription ([MEDICATION NAME] tablet 32.4 mg) has been electronically signed. Facility/provider sent [DATE]. Message broker received [DATE] 06:06 PM. Interview on [DATE] at 4:07 PM with pharmacy general manager confirmed if nursing facility call and request stat order (immediately/urgent order) for the [MEDICATION NAME], the pharmacy would delivery medication within ,[DATE] hours. Interview on [DATE] at 5:31 PM with the Administrator confirmed the unavailability of [MEDICATION NAME] to administer for Resident #1 was neglect because it caused harm to him and lack of oversight to obtain Resident #1's [MEDICATION NAME] in timely manner. Interview on [DATE] at 5:36 PM The Administrator confirmed the facility policy on neglect was report immediately to the Administrator any type of neglect so that the Administrator can start investigation. The Administrator confirmed to prevent neglect in the facility by making round, speaking with staff, family, and residents, and educating staff. The Administrator confirmed re-educate staff on neglect, ask staff what they know about neglect and who to report, and spot check staff by walking around to make sure staff doing things right. Record review of the facility's undated policy titled with Medication ordering: Operating and monitoring system revealed To ensure all medications, pursuant to a valid physician order, are available in the facility at all times . Nursing should be ordering meds when they are down to 5 - 7-day supply. Nursing must identify refill is in facility when they are down to 3-day supply. Nursing must identify refill is in facility when they are down to 3-day supply and place refill card in med cart. Nursing must indicate any change of direction to pharmacy on reorder sheet. All incidents of meds not available during med pass should be reported to DON immediately. Monitoring: nurse management should verify all nurses have been in-serviced on med order/reorder system. Re-order book should be audited on daily basis to verify all med orders can be accounted for. Med carts should be audited on a weekly basis to verify no less than 3-day supply of med are available. It was determined these failures placed Resident #1 in an Immediate Jeopardy (IJ) situation from [DATE] to [DATE]. The facility took the following action to correct the non-compliance from [DATE] through [DATE]: - Weekly cart audits to be completed by DON/ADON for assure medication availability, medication labeled correctly, no expired medication on cart and identify any issues. - Each day a medication audit report pulled to include 9 to identify medication not given for reason and follow-up immediately. - [DATE] an in-service on medication availability to guarantee to have a minimum 3 days of medication available at all times. Also completed in-service if medication is not on cart after order to bring awareness to the ADON/DON immediately. - Communication form to be completed by charge nurse with medication availability follow up: resident name, medication, issue, follow-up and corrective action taken. This form is to be reviewed daily by DON/ADON. Observation on [DATE] at 6:54 AM with the DON revealed there were three blister packs (30 tablets/blister pack) of [MEDICATION NAME] 32.4 mg for Resident #1 dated [DATE] was in the narcotic locked box. Further observation revealed one tablet was taken out from one of the blister packs. Interview with the DON on [DATE] at 6:54 PM confirmed [DATE] on three blister packs of [MEDICATION NAME] 32.4 mg for Resident #1 was the date the medication was delivered. Record review of Resident #1's narcotic sheet titled with individual control drug record dated [DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was administered the first dose for Resident #1 at 2000 on [DATE] with amount remaining 89 of 90 tablets of [MEDICATION NAME] 32.4 mg. Interview on [DATE] 12:19 PM with MA F confirmed she administered the evening dose of [MEDICATION NAME] to Resident #3 on [DATE]. MA F further confirmed she received supplies of 90 pills and punch out one pill for Resident #1's evening dose. Record review of Medication Administration Record of Resident #2, #3, #4 and #5 revealed they did not miss any dose of their [MEDICAL CONDITION] medication from [DATE] through [DATE]. Observation of medication administration on [DATE] at 3:36 PM revealed RN A administered the [MEDICATION NAME] to Resident #2 via feeding tube as physician order. Interview on [DATE] at 10:11 AM with RN A confirmed she received and understood in-service on ordering medication. RN A stated if the medication was out of supply the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication was not delivered by the next day and about to document the medication was not available on the MAR and pharmacy had not delivered the medication, then charge nurse had to inform the ADON or DON. Interview on [DATE] at 11:17 AM with MA D confirmed she received and in-service on ordering medication on [DATE]. MA D further confirmed she had to inform the charge nurse to call pharmacy for medication refill when there were 3 to 4-day supplies. MA D stated when the medication was out of supply, she had to notify the ADON or ADON. Interviews with 7 interviewable Residents on [DATE], they confirmed they had not missed any dose of medication recently. Interview on [DATE] at 2:25 PM with RN J - ADON confirmed she provided in-service for charge nurse and medication aide regarding there was a binder in place for any communication that staff had with pharmacy. RN J - ADON confirmed there would be a communication form for medication aide, charge nurse, and ADON to initial daily to hold accountable for resident medication supply. RN J - ADON confirmed she also trained new hire or temporary staff the same process and protocol for obtaining medication and ensure enough medication supply for residents in the facility. RN ADON confirmed she had to ensure with staff what had been ordered, what pending delivery, and make sure what in the communication log match with the pharmacy log. RN ADON confirmed when the medication was out of supply staff had to notify the physician immediately and would order the medication through emergency pharmacy. RN ADON confirmed in-service staff once a month to ensure staff know what to do when the medication was not available to administer for resident. RN ADON confirmed she would randomly pick on staff and ask question to test their knowledge on obtaining and re-ordering medication for resident. Interview on [DATE] at 4:27 PM with the DON, she confirmed she would continue checking with staff during clinical meeting to ensure medications available for residents. The DON confirmed she continued in-service staff regarding ordering medication in timely manner, if medication was not available staff should check the emergency kit and immediately contact pharmacy to follow up on the medication delivery. The DON confirmed every medication aide and nurse had her phone number, so they could contact the DON any time regarding the medication supply for residents. The DON confirmed communication form utilized to ensure communication among staff to obtain the medication for resident in timely manner. The DON confirmed she and the ADON would monitor the communication form and make sure the issue resolved during the shift. The DON further confirmed she would make round and ask staff on the floor if there was any issue

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	455796	A. BUILDING _____ B. WING _____	**08/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY NURSING AND REHABILITATION CENTER	**625 N MAIN ST BOERNE, TX 78006**

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) with medication supply for residents to ensure staff do what they supposed to. Interview on [DATE] at 4:38 PM with the DON confirmed she continue provide staff with in-service and competence check off regarding ordering the medication and administering medication. The DON confirmed there was a test for staff to complete to ensure staff understanding the in-service and training. Interview on [DATE] at 4:39 PM with the DON confirmed she would document any finding or concern with the current interventions, check if the system needed to be improved, continued with nurse competency for 90 days or more. DON further confirmed continue with audi

F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide treatment and prevention of [MEDICAL CONDITION] for 1 of 5 Residents (Resident #1) reviewed for quality of care, in that: Resident #1 did not receive 20 of 21 doses of [MEDICATION NAME] tablet 32.4 mg (medication used to control [MEDICAL CONDITION]). As a result, Resident #1 suffered from [MEDICAL CONDITION] and was hospitalized . This deficient practice was determined to be past non-compliance, with an immediate jeopardy situation that began on [DATE] and ended on [DATE] due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the investigation. This deficient practice could place residents who received [MEDICAL CONDITION] medication at risk for not receiving therapeutic treatment and could place them at risk for harm or death. The findings were: Record review of Resident #1's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's care plan dated [DATE] revealed (Resident #1 had) a [MEDICAL CONDITION] disorder. Interventions: give medications as order. Obtain and monitor lab/diagnostic work as ordered. Report result to MD and follow up as indicated. Record review of Resident #1's physician progress notes [REDACTED]. [MEDICAL CONDITION] disorder: stable on combination of [MEDICATION NAME], and [MEDICATION NAME]. Labs from [DATE] are reasonable and no recent [MEDICAL CONDITION] activity. Record review of Resident #1's progress note dated [DATE] at 7:10 AM written by RN A revealed Resident #1 had [MEDICAL CONDITION] lasted approx. 2 minutes at which point (Resident #1) turned pale white and lips cyanotic and then lost consciousness. Resident #1 was having increased respirations. (Resident #1) was moved to his bed with (head of the bed elevated) and neurological checks started. Vital sign: (blood pressure) ,[DATE], (pulse) 103, (oxygen saturation) 95%, (Respiration)24. (Nurse Practitioner) notified and family notified. Record review of Resident #1's progress note dated [DATE] at 9:41 AM written by RN A revealed (Resident #1 was) lying in bed and this nurse went to check vital sign (and observed Resident #1) had (second) [MEDICAL CONDITION] lasted (approximately) 1.5 minutes at which point Resident #1 color became pale lips cyanotic and Resident #1 loss consciousness. Vital signs: (blood pressure) ,[DATE], (pulse) 107, (oxygen saturation) 96%, (respiration) 24. (Nurse practitioner) notified. Family member notified and wanted Resident#1 to (send) out to ER. (Nurse Practitioner) gave order to send Resident #1 out (per) family member's request. (New order) stat - [MEDICATION NAME] level, [MEDICATION NAME] level, [MEDICATION NAME] level, CBC, CMP. Blood drawn, and pickup ordered. Interview on [DATE] at 4:19 PM with RN A confirmed Resident#1 was up in wheel chair and drinking coffee in the dining room and had [MEDICAL CONDITION]. RN A described Resident #1 had violent [MEDICAL CONDITION], his body clenched and his whole body was stiff. RN A further described Resident #1's tongue stuck out, his bottom denture fell out, his face was pale, his lips were cyanotic. RN A confirmed Resident #1 had [MEDICAL CONDITION] for two and half minutes. When Resident #1's [MEDICAL CONDITION] concluded, RN A with MA E tilted his wheel chair and transported resident back to his room. RN A said she checked Resident #1's vital signs - Resident #1 was non-responsive, breathing was labored, using accessory muscle to breath, and tachypnea (rapid, shallow breathing). RN A confirmed Resident #1 became minimally responsive after [MEDICAL CONDITION] activity - pupils round and slow to react, lung sound clear, tongue swollen, good oxygen saturation level and Resident #1 began stabilizing after [MEDICAL CONDITION] activity. RN A confirmed Resident #1 did not answer her questions, but Resident #1 responded by looking up when RN A called his name. RN A said she remained with Resident #1 for about 10 - 15 minute to ensure Resident #1 was stable. RN A confirmed while she was on the phone with the doctor and family, RN A asked the CNA to observe Resident #1 to watch for signs of [MEDICAL CONDITION] activity. RN A confirmed when CNA was about to check Resident #1's vital signs, Resident#1 had another [MEDICAL CONDITION], and the CNA informed RN A to check on Resident #1. RN A confirmed Resident #1 had [MEDICAL CONDITION] activity. When Resident #1 was stable from his second [MEDICAL CONDITION], she notified the Nurse Practitioner and Resident #1's family. RN A confirmed she received an order to draw Resident #1's blood to check the drug level of [MEDICAL CONDITION] medication and to transfer Resident #1 to local hospital per Nurse Practitioner's order and family request. Record review of Resident #1's diagnostic laboratory dated [DATE] revealed [MEDICATION NAME] level was 6.8 ug/mL which meant the medication was lower than normal therapeutic level (therapeutic range for [MEDICATION NAME] is 15 - 40 ug/mL). During an interview on [DATE] at 5:57 PM with the DON, she confirmed Resident #1's drug levels in July ([MEDICATION NAME], and [MEDICATION NAME]) were all within therapeutic range. The DON further confirmed the drug level of [MEDICATION NAME] was low on [DATE] because Resident #1 did not receive his medication. Record review of resident #1's ambulance record dated [DATE] revealed Nursing staff states (Resident #1) had two [MEDICAL CONDITION] an hour apart from each other. The first [MEDICAL CONDITION] was around 0900 (9:00 AM) followed by another [MEDICAL CONDITION] around 1000 (10:00 AM). (Resident #1 had primary history) of [MEDICAL CONDITION] and takes [MEDICATION NAME] to control [MEDICAL CONDITION]. (Resident #1) received his medication this morning and is compliant with all other medications. (Resident #1) [MEDICAL CONDITION] was reported a grand mal [MEDICATION NAME] ,[DATE] minutes. No trauma noted from [MEDICAL CONDITION]. (Resident #1) was moved to stretcher and secured with all straps and 2 guard rails. (Resident #1) was transported to main local hospital. (Resident #1) had a [MEDICAL CONDITION] while in route to hospital and was placed in right side with airway suctioned for appx 10 seconds to clear secretions. (Resident #1) remained in postictal state (altered state of consciousness after [MEDICAL CONDITION] activity) during transport. Vital signs were continuously monitored and stable. Arrived to destination and (Resident #1) care released to receiving RN. Record review of Resident #1's physician order [REDACTED]. (G40.509) Start date [DATE]. Record review of Resident #1's narcotic sheet titled individual control drug record dated from [DATE] to 8/ ,[DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was completed on [DATE] at 2000 (8:00 PM) with 0 amount remaining. Record review of Resident #1's medication administration record dated [DATE] - [DATE] revealed administration schedule for [MEDICATION NAME] tablet 32.4 mg at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM). Further review revealed the medication scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 5 - hold/see progress notes and coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 2000 (8:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 0800 (8:00 AM) and 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered; the medication schedule at 1400 (2:00 PM) on [DATE] was coded 9 - Other/see progress notes which meant the medication was not administered. Record review of Resident #1's progress note dated on [DATE] at 8:59 AM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. Record review of Resident #1's progress note dated on [DATE] at 8:21 PM written by MA B revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) in progress. During an interview on [DATE] at 1:37 PM with MA B, he confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM), on [DATE] scheduled at 2000 (8:00 PM), and on [DATE] at 2000 (8:00 PM) because the medication was out of supply. MA B stated he made mistakes to document with check marks on Resident #1's MAR on [DATE] at 2000 (8:00 PM) and [DATE] at 2000 (8:00 PM) as administering the [MEDICATION NAME] 32.4 mg, and MA B said he should have coded as 9 on Resident #1's MAR and documented under progress note that the medication was still in process to deliver. During the interview with MA B, he confirmed he informed RN A and LVN I the [MEDICATION NAME] for Resident #1 was out of supply. MA B said he wrote the information down on a Post-It note and gave it to the nurses so that the nurses would call the pharmacy to refill the medication. MA B further confirmed he did not follow up with the nurses or inform the DON about the [MEDICATION NAME] for

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F 0684

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 7)

Resident #1 being out of supply because he did not work all the time in the East unit where Resident #1 resided. He stated he mainly worked in West unit. During an interview on [DATE] at 10:11 AM, RN A confirmed she did not recall if a medication aide informed her about the [MEDICATION NAME] for Resident #1 being completely out of supply. RN A confirmed when there was no [MEDICAL CONDITION] medication to administer for any Resident, she monitored if the Resident had any sign and symptom of [MEDICAL CONDITION]. RN A confirmed she received in-service and understood if the medication was out of supply, the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication aide was about to document the medication was not available to administer, and pharmacy had not delivered the medication, then charge nurse had to inform the ADON or DON. RN A confirmed she did not recall if she informed the ADON and DON about the [MEDICATION NAME] being not available to administer to Resident #1. RN A confirmed when the medication was not available to give to any resident, she would call the physician when she needed a new prescription to refill or authorization paperwork. RN also confirmed she would call physician if the medication for the resident was not available and resident had symptoms. RN confirmed she did not call the physician when the medication for any resident was completely out because she could resolve with the pharmacy. Record review of Resident #1's progress note dated [DATE] at 10:20 AM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Record review of Resident #1's progress note dated [DATE] at 8:24 PM written by MA C revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (g40.509) Medication on order. Interview via telephone on [DATE] at 5:59 PM with MA C confirmed he did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) and on [DATE] scheduled at 2000 (8:00 PM) because the medication was out of supply. MA C further confirmed he made an error when he documented on Resident #1's MAR that he administered the [MEDICATION NAME] 32.4 mg, but the medication was not available to give. MA C stated he wrote Resident #1's name and medication on a piece of paper and gave to the nurse, and the nurse would call pharmacy to refill. MA C said he did not remember which nurse he gave the information to. Record review of Resident #1's progress note dated [DATE] at 5:42 AM written by MA D revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) pending delivery. Interview via telephone on [DATE] at 11:00 AM with MA D confirmed the [MEDICATION NAME] 32.4 mg was not available to administered for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM). MA D confirmed she informed LVN H about the [MEDICATION NAME] for Resident #1 was out of supply, and she saw LVN H call the pharmacy to refilled Resident #1's [MEDICATION NAME]. MA D confirmed she did not inform the ADON or DON when Resident #1's [MEDICATION NAME] was out of supply because she assumed LVN H informed ADON or DON during clinical meeting. Record review of Resident #1's progress note dated on [DATE] at 8:05 AM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy. Record review of Resident #1's progress note dated on [DATE] at 1:11 PM written by MA E revealed [MEDICATION NAME] Tablet 32.4 MG Give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509). Pending medication from pharmacy, notified charge nurse. During an interview on [DATE] at 3:05 PM with MA E, she confirmed she did not administer [MEDICATION NAME] 32.4 mg for Resident #1 on [DATE] scheduled at 0800 (8:00 AM) and 1400 (2:00 PM) because there was no medication to give and the medication was pending delivery from pharmacy. MA E confirmed she informed LVN H that Resident #1's [MEDICATION NAME] was not available to administer. Record review of Resident #1's progress note dated [DATE] at 9:47 PM written by MA F revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) on order. Record review of Resident #1's progress note date [DATE] at 11:20 AM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:09 PM written by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Record review of Resident #1's progress note date [DATE] at 1:52 PM by MA G revealed [MEDICATION NAME] tablet 32.4 mg give 1 tablet by mouth three times a day related to epileptic [MEDICAL CONDITION] related to external causes, not intractable, without [DIAGNOSES REDACTED] (G40.509) Pending from pharmacy. Interview via telephone on [DATE] at 11:43 AM with MA G confirmed the [MEDICATION NAME] for Resident #1 was out of supplies for couple days. MA G stated she did not remember what date the medication was not available to give to Resident #1. MA G confirmed she recalled the [MEDICATION NAME] was out of supply, and she informed LVN H. Interview via telephone on [DATE] at 1:06 PM with LVN H confirmed the medication aide informed her on [DATE] about the [MEDICATION NAME] for Resident #1 needing refill. LVN H stated she did not recall the [MEDICATION NAME] was low on supply or completely out of supply. LVN H stated she called the pharmacy and pharmacy said they would get the medication out to the facility. LVN H stated she did not remember what date the [MEDICATION NAME] was not delivered, prior to her calling pharmacy again. LVN H said when she called pharmacy the second time, pharmacy informed they need the physician's prescription to refill the [MEDICATION NAME] for Resident #1. LVN H explained when the pharmacy need refill prescription or authorization, pharmacy communicated with a nurse manager via email instead of informing the floor nurse, so the floor nurse only knew if the pharmacy need refilled prescription or authorization when the floor nurse called pharmacy to ask about why the medication had not been delivered. LVN H said she went to physician website to fill out a form to request refill for [MEDICATION NAME]. LVN H confirmed she did not remember what date she completed the request form for refill of the [MEDICATION NAME] for Resident #1. LVN H added when the physician signed the refilled request form, the physician would send the prescription refill to the pharmacy. LVN H further confirmed she did not remember when the [MEDICATION NAME] was delivered to the facility. LVN H confirmed she did not call the doctor or inform the ADON or DON about the [MEDICATION NAME] that was out of supply because she just kept following up with the pharmacy. Interview on [DATE] at 1:59 PM with LVN I confirmed MA F informed her on [DATE] that the [MEDICATION NAME] for Resident #1 was out of supply. LVN I confirmed she completed a request form and faxed to physician office to inform the physician that the medication was out of supply and needed refill. LVN I confirmed the [MEDICATION NAME] was delivered on [DATE] around 2:30 PM. LVN I confirmed there was no communication from the previous shift about the [MEDICATION NAME] for Resident #1 being out of supply. LVN I confirmed she did not inform the DON or ADON regarding the [MEDICATION NAME] being out of supply for Resident #1. Interview on [DATE] at 5:18 PM with the Administrator confirmed she was not aware of the [MEDICATION NAME] for Resident #1 ran out. The Administrator further confirmed medication aide and charge nurse should have informed the Administrator about Resident #1's [MEDICATION NAME] was out of supply. During an interview on [DATE] at 5:49 PM with the DON, she confirmed she was not aware of the [MEDICATION NAME] for Resident #1 was out of supply until Resident #1's family member brought it to her attention on [DATE] because Resident #1 called to inform his family member. The DON further confirmed based on the documentation on Resident #1's MAR, the [MEDICATION NAME] was not administered to Resident #1 from [DATE] at 0800 through [DATE] at 1400. During an interview on [DATE] at 6:18 PM, the DON confirmed the medication aid should check the medication cart by going over each blister pack to ensure the medication availability at minimum for 3 days. If the medication was not available, the medication aide had to notify the charge nurse, then, charge nurse should have notified the physician. The DON further confirmed depending on certain medication, the physician could put the medication on hold for 2 days. The DON stated the charge nurse should have informed the DON so that the DON could order the [MEDICATION NAME] from a contracted emergency pharmacy for 2 - 3 days supplies for Resident #1. Interview on [DATE] at 6:54 PM with the DON confirmed [DATE] was delivery date indicated on three blister packs - [MEDICATION NAME] 32.4 mg for Resident #1. Interview on [DATE] at 6:55 PM with the DON and RN J - ADON confirmed staff did not inform them when the [MEDICATION NAME] for Resident #1 was out of supply. Interview on [DATE] at 2:22 PM with RN J confirmed she did not know the supply of [MEDICATION NAME] for Resident #1 was low. RN J - ADON confirmed the nurse and medication aide on the East side did not communicate with the RN J ADON regarding Resident #1's [MEDICATION NAME] was not available. RN J ADON further confirmed she did not audit the medication cart on East unit and did not check the fax for reordering medication on East unit to ensure enough medication supply for Resident #1. Interview on [DATE] at 4:16 PM with the DON confirmed she did not review the shift report on Resident #1 from [DATE] to [DATE] because she was off work on [DATE] and she assisted state surveyor on [DATE] and [DATE], therefore, she did not see the documentation of medication aide on the [MEDICATION NAME] not available for Resident #1. Interview on [DATE] at 5:21 PM with the Administrator confirmed there was a lack of

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) communication between the facility and the pharmacy. The Administrator confirmed the facility did not call pharmacy, pharmacy did not let the facility know the order refill request was needed, and staff did not inform the administrator or DON about Resident #1 was out of [MEDICATION NAME]. The Administrator confirmed [DATE] was the date when the facility faxed the refill order form to the pharmacy, and pharmacy received refill order on [DATE]. The Administrator said the physician office could not provide any log to show when the facility notified the physician office to get refill order request. The Administrator also said she did not know when pharmacy contacted physician regarding refill order request for Resident #1's [MEDICATION NAME]. Record review of fax confirmation titled Refill Reorder Form dated [DATE] revealed Resident #1's name and [MEDICATION NAME] 32.4 mg was faxed to pharmacy on [DATE] at 2:20 PM. Record review of Electronic Order Status Inquiry for Resident #1 dated [DATE] revealed This prescription ([MEDICATION NAME] tablet 32.4 mg) has been electronically signed. Facility/provider sent [DATE]. Message broker received [DATE] 06:06 PM. Interview on [DATE] at 4:07 PM with pharmacy general manager confirmed if nursing facility call and request stat order (immediately/urgent order) for the [MEDICATION NAME], the pharmacy would delivery medication within ,[DATE] hours. Record review of the facility's undated policy titled Medication ordering: Operating and monitoring system revealed To ensure all medications, pursuant to a valid physician order, are available in the facility at all times . Nursing should be ordering meds when they are down to 5 - 7 days' supply. Nursing must identify refill is in facility when they are down to 3 days' supply. Nursing must identify refill is in facility when they are down to 3-day supply and place refill card in med cart. Nursing must indicate any change of direction to pharmacy on reorder sheet. All incidents of meds not available during med pass should be reported to DON immediately. Monitoring: nurse management should verify all nurses have been in-serviced on med order/reorder system. Re-order book should be audited on daily basis to verify all med orders can be accounted for. Med carts should be audited on a weekly basis to verify no less than 3-day supply of med are available. It was determined these failures placed Resident #1 in an immediate Jeopardy (IJ) situation from [DATE] to [DATE]. The facility took the following action to correct the non-compliance from [DATE] through [DATE]: - Weekly medication cart audits to be completed by DON/ADON to assure medication availability, medication labeled correctly, no expired medication on cart and identify any issues. - Each day a medication audit report pulled to include 9 to identify medication not given for reason and follow-up immediately. - [DATE] an in-service on medication availability to guarantee to have a minimum 3 days of medication available at all times. Also completed in-service if medication is not on cart after order to bring awareness to the ADON/DON immediately. - Communication form to be completed by charge nurse with medication availability follow up: resident name, medication, issue, follow-up and corrective action taken. This form is to be reviewed daily by DON/ADON. Observation on [DATE] at 6:54 AM with the DON revealed there were three blister packs (30 tablets/blister pack) of [MEDICATION NAME] 32.4 mg for Resident #1 dated [DATE] in the narcotic locked box. Further observation revealed one tablet was taken out from one of the blister packs. Interview with the DON on [DATE] at 6:54 PM confirmed the date of [DATE] on the blister pack of [MEDICATION NAME] 32.4 mg for Resident #1 was the date the medication was delivered. Record review of Resident #1's narcotic sheet titled individual control drug record dated [DATE] revealed [MEDICATION NAME] 32.4 mg give 1 tablet by mouth 3 times a day was administered the first dose for Resident #1 at 2000 on [DATE] with amount remaining 89 of 90 tablets of [MEDICATION NAME] 32.4 mg. Interview on [DATE] 12:19 PM with MA F confirmed she administered the evening dose of [MEDICATION NAME] to Resident #1 on [DATE]. MA F further confirmed she received supplies of 90 pills and punch out one pill for Resident #1's evening dose. Record review of Medication Administration Record of Resident #2, #3, #4 and #5 revealed they did not miss any dose of their [MEDICAL CONDITION] medication from [DATE] through [DATE]. Observation of medication administration on [DATE] at 3:36 PM revealed RN A administered the [MEDICATION NAME] to Resident #2 via feeding tube as physician order. Interview on [DATE] at 10:11 AM with RN A confirmed she received and understood in-service on ordering medication. RN A stated if the medication was out of supply the medication aide had to inform the charge nurse, charge nurse would call pharmacy to make sure the medication was delivered, and if the medication was not delivered by the next day to document the medication was not available on the MAR and indicate pharmacy had not delivered the medication. Then charge nurse had to inform the ADON or DON. Interview on [DATE] at 11:17 AM with MA D confirmed she received and in-service on ordering medication on [DATE]. MA D further confirmed she had to inform the charge nurse to call pharmacy for medication refill when there were 3 to 4-day supplies. MA D stated when the medication was out of supply, she had to notify the ADON or ADON. Interviews with 7 interviewable Residents on [DATE], they confirmed they had not missed any dose of medication recently. Interview on [DATE] at 2:25 PM with RN J - ADON, she confirmed providing in-service for charge nurses and medication aides regarding there was a binder in place for any communication that staff had with pharmacy. RN J - ADON confirmed there would be a communication form for medication aide, charge nurse, and ADON to initial daily to hold accountable for resident medication supply. RN J - ADON confirmed she also trained new hire or temporary staff the same process and protocol for obtaining medication and ensure enough medication supply for residents in the facility. RN ADON confirmed she had to ensure with staff what had been ordered, what pending delivery, and make sure the communication log matched the pharmacy log. RN ADON confirmed when the medication was out of supply, staff had to notify the physician immediately and would order the medication through emergency pharmacy. RN ADON confirmed in-service staff once a month to ensure staff know what to do when the medication was not available to administer for resident. RN ADON confirmed she would randomly pick staff and ask question to test their knowledge on obtaining and re-ordering medication for resident. Interview on [DATE] at 4:27 PM with the DON, she confirmed she would continue checking with staff during clinical meeting to ensure medications available for residents. The DON confirmed she continued in-service staff regarding ordering medication in timely manner, if medication was not available staff should check the emergency kit and immediately contact pharmacy to follow up on the medication delivery. The DON confirmed every medication aide and nurse had her phone number, so they could contact the DON any time regarding the medication supply for residents. The DON confirmed communication form utilized to ensure communication among staff to obtain the medication for resident in timely manner. The DON confirmed she and the ADON would monitor the communication form and make sure any issue resolved during the shift. The DON further confirmed she would make rounds and ask staff on the floor if there was any issue with medication supply for residents to ensure staff knew what they were supposed to do. Interview on [DATE] at 4:38 PM with the DON confirmed she would continue to provide staff with in-service and competence check off regarding ordering the medication and administering medication. The DON confirmed there was a test for staff to complete to ensure staff understanding the in-service and training. Interview on [DATE] at 4:39 PM with the DON confirmed she would document any finding or concern with the current interventions, check if the system needed to be improved, continued with nurse competency for 90 days or more. DON further confirmed medication cart audits continued to see if there was anything wrong and ensure there was no gap in the process of obtaining medication for Resident. The DON confirmed Resident #1's incident regarding missed doses of [MEDICATION NAME] would be discussed in QAPI meeting to prevent happening again. Interview on [DATE] at 4:41 PM with the DON confirmed she ensured staff utilized communication board and shift change report to communicate among staff to make sure medication available for residents. Interview on [DATE] at 5:28 PM with the Administrator confirmed to prevent Residents' medications out of supply, staff were required to notify the Administrator or DON if the medication ran lower than 3-day supply, utilize communication form among staff, ask staff during clinical meeting need to ensure medication enough for resident; audit medication cart and medication once a week. Interview on [DATE] at 5:39 PM the Administrator confirmed the incident of Resident #1 would be discussed in QAPI meeting every month until the facility saw the improvements. The Administrator further confirmed new hire would have to go through all training from abuse/neglect and orientation on acquiring medication before working on the floor. .