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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one sampled resident (Resident #1) was free of significant medication error when on 9/14/24 he/she did not receive an ordered dose of his/her seizure medication Lamotrigine Extended Release (ER) 24 hour 200 milligram (mg), 2 tablets by mouth at bedtime for seizures and on 9/16/24 and 9/17/24 he/she received incorrect doses of this medication out of four sampled residents. The facility census was 104 residents. The Administrator was notified on 9/25/24 of Past Non-Compliance which occurred on 9/14/24, 9/16/24 and 9/17/24. An all nursing staff in-service was completed on medication administration and medication administration observations were completed by 9/19/24. The deficiency was corrected 9/19/24. Review of the facility policy on medication administration revised 1/1/22 showed: -Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record (MAR). -Facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in the facility's medication administration schedule.	F 760	Past noncompliance: no plan of correction required.	

Kathleen Simpson — 10/25/24

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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-Facility staff should confirm that the MAR reflected the most recent medication order.

1. Review of Resident #1's Admission Record face sheet showed the resident was admitted to the facility on 5/2/24 with the following diagnoses:
-Epilepsy (a nervous system disorder that can cause unprovoked, recurrent seizures which are sudden, uncontrolled electrical disturbances in the brain).
-History of falling.

Review of the resident's undated Care Plan showed he/she had a seizure disorder and interventions included giving medications as ordered.

Review of the resident's hospital Discharge Summary for Facility Orders dated 9/14/24 showed:
-The resident's discharge date from the hospital was 9/14/24.
-He/She had a history of seizure disorder and was followed by neurology.
-He/She was to continue his/her medications.
-His/Her discharge order showed a physican order for Lamotrigine Extended Release (ER) 24 Hour 200 mg by mouth, 400 mg were to be given at bedtime for seizures.

Review of the resident's physician's Order Summary Report showed he/she had an order for Lamotrigine Extended Release (ER) 24 Hour 200 mg. Two tablets by mouth were to be given at bedtime for seizures. The order was dated 9/14/24 with a start date of 9/15/24 and an end date of 9/20/24.

Review of the resident's MAR for 9/24 showed:

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-He/She did not receive the Lamotrigine on 9/14/24.
-He/She had an order for Lamotrigine Extended Release (ER) 24 Hour 200 mg. Two tablets by mouth were to be given at bedtime for seizures. The order was dated 9/14/24 with a start date of 9/15/24 and an end date of 9/20/24.
-There was no note as to why the medication was not administered.

Review of the facility investigation on 9/14/24 with hospital discharge order, timeline showed:
-The resident was admitted to the facility from the hospital on 9/14/24.
-He/She had an order for Lamotrigine 200 mg, 2 tablets at bedtime.
-On 9/14/24 the dose of Lamotrigine was not administered related to new admission and the medication did not arrive from the pharmacy.
-On 9/16/24 the resident was transferred to the hospital for seizure-like activity.
-Observation of the Lamotrigine medication card revealed the pharmacy delivered 100 mg tablets, 4 tablets to be given at bedtime until the 200 mg tablets were available. Staff did not give 4 tablets at bedtime.

Observation of the resident's medication card for Lamotrigine Extended Release (ER) 24 Hour 100 mg. tablets, showed 4 tablets to be taken by mouth at bedtime for 3 days until the 200 mg strength was available and 5 pills were taken from the card.

Observation of the resident's medication card for Lamotrigine Extended Release (ER) 24 Hour 200 mg. tablets, 2 tablets to be taken by mouth at bedtime, showed:
-An incorrect deliver date of 9/14/24 was printed

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on the card.
-One pill had been taken from the card.

During an interview on 9/25/24 at 12:40 P.M., the resident said:
-He/She had not had a seizure in 15 years.
-He/She had pneumonia and believed stress threw him/her into a seizure.
-The staff may have messed up his/her medications.
-He/She was back to normal now.

During an interview on 9/25/224 at 1:25 P.M., Licensed Practical Nurse (LPN) E said:
-He/She would help the nurses by putting orders in the computer.
-The hospital would send orders to the facility computer and they would download them.
-The orders the hospital sent might not be the orders that the resident arrived with.
-When the resident arrived, the nurses would make sure the orders they came with matched the orders on the computer.
-They would do chart checks in the mornings to make sure the orders were correct in the computer, and that care plans and assessments were done.
-This was how they caught the resident's medication error.
-If a medication was not available or pharmacy didn't send it, they could get a medication from the Omnicell.
-If the dose in the Omnicell (an automated medication dispensing cabinet) was not correct either they give the correct dose or call the physician.
-If a medication was not available, they should let the physician know.
-All of the nursing staff were aware of the

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Omnicell.

During an interview on 9/25/24 at 1:40 P.M., LPN F said;
-The managers would try to put the orders in the computer before a resident arrived.
-The admitting nurse should double check the orders.
-If there were discrepancies, they call the physician to clarify any questions.
-All of the orders were supposed to be verified by the physicians.
-The next morning, the managers would collect the charts and take them to the morning clinical meeting (or Monday if a resident were admitted on a weekend) and would go through and audit the orders.
-If the pharmacy did not send the medication, it could be pulled from the Omnicell.
-If the medication was not in the Omnicell, the should notify the physician and get an alternative.
-He/She had been trained about this prior to the incident.

During an interview on 9/25/224 at 2:25 P.M., LPN B said:
-He/She only worked with the resident one time; this was the first time he/she worked with him/her. He/She did not admit him/her.
-He/She would check the MAR and orders before giving medications.
-He/She would check the MAR and the medication cards together.
-The resident had two medication cards with different doses of the medication.
-He/She pulled the card that matched the MAR.
-He/She gave the lower dose of the medication.
-He/She did not notify anyone about the other card.

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During an interview on 9/25/24 at 2:15 P.M., the Director of Nursing (DON) said:
-The resident arrived at the facility on 9/14/24 from the hospital. This was a Saturday.
-When he/she arrived, the pharmacy did not sent his/her seizure medication, however, it was available in the Omnicell.
-The resident did not get the medication on the date of his/her admission.
-Two doses were given incorrectly.
-There was no policy or process to determine how many tablets were removed from each medication card by each staff person.
-The charge nurse was responsible to enter orders in the computer and sent paper prescriptions to the pharmacy.
-LPN A was in charge when the resident was admitted. He/She had been educated on the admission orders procedure before. He/She did not give an explanation for why he/she did not give the medication.
-The breakdown occurred when the medication was not pulled from the Omnicell since it was available.
-The pharmacy sent incorrect cards because the correct dose was not available, and then sent the correct dose.
-He/She felt LPN C gave the dose correctly and LPN B and LPN D gave the lower dose, which was not enough.
-When he/she interviewed the LPNs, LPN C was able to verbalize everything that was in the orders and was very clear about giving the 400 mg and that he/she double checked the orders without being prompted. LPN B and LPN D were not able to relay the orders and they had not taken anything out of the Omnicell.
-The resident had a history of seizures, but when

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he/she was sent out to the hospital, it was not like a typical seizure; they were tremors.
-The hospital kept the resident for pneumonia.
-When the resident went back to the hospital, the facility did a root cause analysis and found the medication errors.
-The expectation was when a resident was admitted, the nurse would enter all orders in the computer and fax any prescriptions to the pharmacy as soon as possible, so that medication could be received in a timely manner.
-He/She would expect the physician would be called if order clarification was needed or if a medication was needed that the resident was not admitted with.
-For any medications that were not available prior to pharmacy delivery, they could be pulled from the Omnicell.
-Medications should be administered according to policy using the five rights.
-Pharmacy did not notify him/her that the medication had been filled with a different dose.
-If a wrong dosage or medication were sent, he/she would expect the pharmacy to be contacted to notify them and have the correct medication or dosage sent.
-The admitting nurse did not call the physician for clarification of whether the dose ordered from the hospital should be given or notified that the pharmacy had sent an alternative dosage.
-He/She would expect that the medication cards would be checked against the orders.

During an interview on 9/25/24 at 2:45 P.M., the Administrator said:
-The nurses were expected to follow policy and double check a resident's orders to make sure they were in the system and to make sure they matched the medication that came from the

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pharmacy.
-The nurses were expected to make sure that a prescription was filled quickly and if there was a delay to reach out to the DON and the physician.

During an interview on 10/3/24 at 11:45 A.M., LPN C said:
-He/She gave the resident all four 100 mg tablets of Lamotrigine.
-He/She checked the order before he/she gave them, because he/she felt like it was a large dose.
-The medication came from pharmacy between 9:00 P.M. and 9:30 P.M.
-When he/she gave the medication, the 200 mgs tablets were not yet available.
-When a nurse would admit a resident to the facility, the orders should be double checked to make sure they were the most recent orders.
-If the pharmacy did not send a medication, the Omnicell should be checked to see if they could be taken from it.
-If the medication was not available, the nurse should notify the physician to see if an alternative could be ordered and the pharmacy to see when the medication could be sent.
-The nursing staff were trained to know to do these things.

During an interview on 10/6/24 at 12:00 P.M., LPN D said:
-He/She thought when he/she cared for the resident, they had received the 200 mg tablets.
-He/She would have administered two 200 mg tablets.
-He/She would pull up the physician's orders and check the medication cards against them before administering the medication.
-If he/she did not have the correct dose available,

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F 760	Continued From page 8 he/she would notify the DON, notify the pharmacy and notify the physician. MO00242293	F 760		