Electronically delivered
March 11, 2021

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

RE: CCN: 245273
Cycle Start Date: February 24, 2021

Dear Administrator:

On February 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 24, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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March 11, 2021

Administrator
Franklin Restorative Care Center
900 3rd Street South
Franklin, MN 55333

Re: State Nursing Home Licensing Orders
Event ID: 9F1211

Dear Administrator:

The above facility was surveyed on February 22, 2021 through February 24, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00934	A. BUILDING: _____ B. WING _____	C 02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN RESTORATIVE CARE CENTER	**900 3RD STREET SOUTH FRANKLIN, MN 55333**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/22/21 through 2/24/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be	2 000		

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2 000	Continued From page 1 completed. The following complaint was found to be SUBSTANTIATED: H5273071C (MN70153) with a licensing order issued at S1545. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		3/26/21

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21545	Continued From page 3 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain and administer ordered medication for 1 of 1 residents (R2). Finding include: Review of the 2/18/21, report to the State Agency (SA) identified R2 was sent to emergency room (ER) following a seizure lasting 15 to 20 minutes and low blood glucose (sugar) levels. Upon arrival to the ER, it was identified R2 had not received his hydrocortisone medication, used for his Addison's disease (adrenal glands under-produce the hormone cortisol), for 9 days. R2's 1/27/21, quarterly Minimum Data Set (MDS), identified R2 had intact cognition with diagnosis of diabetes, unstable high and low blood sugars, Addison's disease, high blood pressure, Schizophrenia (mood disorder), and other seizure disorders. R2's current, undated, Care Plan identified R2	21545	corrected	

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21545	Continued From page 4	21545		

had behaviors of hoarding and stealing food prior to his admission. R2 had tried to "break into" the activities office to rummage for food. R2 had stolen food off of other resident's plates and had been recently found in the kitchen.

R2's February 2021, physician's orders and electronic medication administration record (eMAR) identified R2 had an order for daily administration of hydrocortisone 25 milligrams (mg) dose every morning and hydrocortisone 15 mg dose at 4:30 p.m.. R2's eMAR showed he had no hydrocortisone administered in a.m. or p.m. from 2/10/21 through 2/18/21. R2 had a total of 18 doses missed.

R2's 2/18/21, nursing progress notes identified at:
1) 7:50 a.m. R2 was found laying on the floor in his room. Licensed practical nurse (LPN)-B entered room, observed R2 in seizure activity. LPN-B requested staff to call 911 to have R2 seen in the emergency room (ER) for an evaluation. LPN-B checked R2's blood glucose and identified it was critically low at 49 (normal 60-100).
2) 7:55 a.m., LPN-B administered a glucagon injection.
3) 8:05 a.m., R2's blood glucose level was rechecked and was found to be 69. R2's seizure activity had lasted approximately twenty minutes.
4) 8:15 a.m., R2's blood glucose level dropped to 54. Now, not in any seizure like activity, he was administered 4 glucose tablets.
5) 8:20 a.m., R2 left via ambulance.

Interview on 2/23/21 at 8:00 a.m., with LPN-A identified every 2 weeks medications were delivered to the facility and verified against the resident's eMAR. If a medication had not arrived, staff were to contact the pharmacy. If medication

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21545	Continued From page 5 was out of stock or the resident needed a new prescription, the pharmacy would denote that on a pink-colored paper slip. LPN-A confirmed she had never called the physician if a medication had not arrived and indicated she would just wait for the pharmacy to deliver. Review of pharmacy pink slips identified on 2/12/21, R2's hydrocortisone tablets were marked "out of stock". Further review of R2's nursing progress notes between 2/12/21 through 2/18/21, identified there was no mention staff had contacted R2's physician and notify them of the unavailability of the hydrocortisone, or what the facility should do to keep R2 safe from the potential absence of the medication. Interview on 2/23/21 at 10:00 a.m., with R2 identified he went to the ER on 2/18/21, as a result of extremely low blood glucose levels. R2 confirmed he had not had his hydrocortisone pills for 8 days prior. He takes the medication for his Addison's disease. On the day of 2/18/21, he reported to staff he "didn't feel right" but could not identify any specific symptoms that occurred other than the low blood glucose levels. Interview on 2/23/21 at 10:50 a.m., with the consulting pharmacist (RPh)-A identified if the pharmacy was not able to provide the medication to the nursing home, the nursing home staff should immediately contact the physician to get an order to hold the medication, or determine if there is an alternate medication, etc. The RPh confirmed no dose should be marked "unavailable" on the eMAR. The RPh identified omission of R2's scheduled hydrocortisone had the potential to affect his blood glucose levels.	21545		

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21545	Continued From page 6 Interview on 2/23/21 at 11:33 a.m., with RPh-B identified if a medication was unavailable or required a new prescription, the pharmacy delivered a pink slip to the facility that identified the medication and reason it had not been delivered. He had instructed the facility staff to contact the provider if a medication was not delivered to the facility as ordered. The pharmacy's responsibility was to have checked with other pharmacies to obtain the medication or contact the physician if they were unable to obtain the medication, or if the delay could potentially cause an adverse event if not administered accordingly. He agreed R2's blood sugars may have been affected by the omission of hydrocortisone. Interview on 2/23/21 at 11:50 a.m., with (trained medication aide) TMA-A identified if a resident had no medication available to administer during medication pass, staff were to notify the charge nurse immediately. TMA-A confirmed she was aware R2's hydrocortisone was not delivered by the pharmacy and a fax had been sent to the pharmacy on 2/9/21 indicating the medication had not arrived for both doses. She reported the medication was still unavailable 3 days later when she worked again on 2/12/21, and the pharmacy was re-faxed a that time. Interview on 2/23/21 at 2:08 p.m., with medical director (MD) who was also R2's primary physician identified he was not aware R2 had missed his hydrocortisone for 9 days. His expectation was nursing should have contacted the physician if a medication was unavailable. He confirmed R2's hydrocortisone could have potentially attributed to his low blood glucose levels and seizure activity on 2/18/21, however	21545		

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21545	Continued From page 7 with R2's behaviors and history of severely low to high blood glucose levels, he could not say this was the definite cause of R2's seizures or decreased blood glucose levels. Interview on 2/24/21 at 2:46 p.m., with the director of nursing (DON) identified her expectation was staff were to contact the physician and pharmacist immediately if a medication was unavailable for delivery or unable to be administered. She confirmed R2's physician had not been contacted nor had the pharmacist regarding the failure to obtain and administer R2's hydrocortisone medication. Review of current, undated Medication and Treatment Order policy identified staff were to notify the pharmacy to reorder medication no less than three days prior to the last dose being administered to ensure availability. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered which may include but is not limited to the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could have a methodical system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of	21545		

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21545	Continued From page 8 any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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F 000	INITIAL COMMENTS On 2/22/21 through 2/24/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5273071C (MN70153) with a deficiency cited at F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		3/26/21

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

Electronically Signed | 03/15/2021

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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	245273	A. BUILDING _____ B. WING _____	C 02/24/2021

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F 755	Continued From page 1 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain and administer ordered medication for 1 of 1 residents (R2). Finding include: Review of the 2/18/21, report to the State Agency (SA) identified R2 was sent to emergency room (ER) following a seizure lasting 15 to 20 minutes and low blood glucose (sugar) levels. Upon arrival to the ER, it was identified R2 had not received his hydrocortisone medication, used for his Addison's disease (adrenal glands under-produce the hormone cortisol), for 9 days. R2's 1/27/21, quarterly Minimum Data Set (MDS), identified R2 had intact cognition with diagnosis of	F 755	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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F 755	Continued From page 2 diabetes, unstable high and low blood sugars, Addison's disease, high blood pressure, Schizophrenia (mood disorder), and other seizure disorders. R2's current, undated, Care Plan identified R2 had behaviors of hoarding and stealing food prior to his admission. R2 had tried to "break into" the activities office to rummage for food. R2 had stolen food off of other resident's plates and had been recently found in the kitchen. R2's February 2021, physician's orders and electronic medication administration record (eMAR) identified R2 had an order for daily administration of hydrocortisone 25 milligrams (mg) dose every morning and hydrocortisone 15 mg dose at 4:30 p.m.. R2's eMAR showed he had no hydrocortisone administered in a.m. or p.m. from 2/10/21 through 2/18/21. R2 had a total of 18 doses missed. R2's 2/18/21, nursing progress notes identified at: 1) 7:50 a.m. R2 was found laying on the floor in his room. Licensed practical nurse (LPN)-B entered room, observed R2 in seizure activity. LPN-B requested staff to call 911 to have R2 seen in the emergency room (ER) for an evaluation. LPN-B checked R2's blood glucose and identified it was critically low at 49 (normal 60-100). 2) 7:55 a.m., LPN-B administered a glucagon injection. 3) 8:05 a.m., R2's blood glucose level was rechecked and was found to be 69. R2's seizure activity had lasted approximately twenty minutes. 4) 8:15 a.m., R2's blood glucose level dropped to 54. Now, not in any seizure like activity, he was administered 4 glucose tablets.	F 755	It is the policy of Franklin Restorative Care Center to ensure residents receive medications ordered in a timely fashion. R2's Hydrocortisone physicians orders were reviewed, R2 was sent to ER on 2/18/2021 and administered the medication was given in the ER. The pharmacy medications were delivered on the 2/19/2021 R2 continues to receive scheduled medication per physicians' orders. All residents have the potential to be affected by the deficient practice, a record review of all residents has been completed to ensure no other residents are missing physician ordered medications. The facility has reviewed the policy and procedure of our pharmacy ordering process and made appropriate changes. Education will be provided on 3/18/2021 to staff who administer medications and Thrifty White Pharmacy on the policy and procedures of Medication Treatment orders, Administering Medications. Facility will perform audits of pharmacy orders review and audit transcription of orders to ensure accuracy. Audits will be completed by DON or by designee. Will be performed every shift for 2 weeks then 2 times a week for 1 month and 1 time a week for 1 month and then ongoing as needed. To monitor compliance, audited results will be brought to monthly and quarterly QAPI and reviewed by the QAPI team.	

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F 755	Continued From page 3 5) 8:20 a.m., R2 left via ambulance. Interview on 2/23/21 at 8:00 a.m., with LPN-A identified every 2 weeks medications were delivered to the facility and verified against the resident's eMAR. If a medication had not arrived, staff were to contact the pharmacy. If medication was out of stock or the resident needed a new prescription, the pharmacy would denote that on a pink-colored paper slip. LPN-A confirmed she had never called the physician if a medication had not arrived and indicated she would just wait for the pharmacy to deliver. Review of pharmacy pink slips identified on 2/12/21, R2's hydrocortisone tablets were marked "out of stock". Further review of R2's nursing progress notes between 2/12/21 through 2/18/21, identified there was no mention staff had contacted R2's physician and notify them of the unavailability of the hydrocortisone, or what the facility should do to keep R2 safe from the potential absence of the medication. Interview on 2/23/21 at 10:00 a.m., with R2 identified he went to the ER on 2/18/21, as a result of extremely low blood glucose levels. R2 confirmed he had not had his hydrocortisone pills for 8 days prior. He takes the medication for his Addison's disease. On the day of 2/18/21, he reported to staff he "didn't feel right" but could not identify any specific symptoms that occurred other than the low blood glucose levels. Interview on 2/23/21 at 10:50 a.m., with the consulting pharmacist (RPh)-A identified if the pharmacy was not able to provide the medication	F 755	Date Certain: 3/26/21	

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F 755	Continued From page 4	F 755		

to the nursing home, the nursing home staff should immediately contact the physician to get an order to hold the medication, or determine if there is an alternate medication, etc. The RPh confirmed no dose should be marked "unavailable" on the eMAR. The RPh identified omission of R2's scheduled hydrocortisone had the potential to affect his blood glucose levels.

Interview on 2/23/21 at 11:33 a.m., with RPh-B identified if a medication was unavailable or required a new prescription, the pharmacy delivered a pink slip to the facility that identified the medication and reason it had not been delivered. He had instructed the facility staff to contact the provider if a medication was not delivered to the facility as ordered. The pharmacy's responsibility was to have checked with other pharmacies to obtain the medication or contact the physician if they were unable to obtain the medication, or if the delay could potentially cause an adverse event if not administered accordingly. He agreed R2's blood sugars may have been affected by the omission of hydrocortisone.

Interview on 2/23/21 at 11:50 a.m., with (trained medication aide) TMA-A identified if a resident had no medication available to administer during medication pass, staff were to notify the charge nurse immediately. TMA-A confirmed she was aware R2's hydrocortisone was not delivered by the pharmacy and a fax had been sent to the pharmacy on 2/9/21 indicating the medication had not arrived for both doses. She reported the medication was still unavailable 3 days later when she worked again on 2/12/21, and the pharmacy was re-faxed a that time.

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F 755	Continued From page 5 Interview on 2/23/21 at 2:08 p.m., with medical director (MD) who was also R2's primary physician identified he was not aware R2 had missed his hydrocortisone for 9 days. His expectation was nursing should have contacted the physician if a medication was unavailable. He confirmed R2's hydrocortisone could have potentially attributed to his low blood glucose levels and seizure activity on 2/18/21, however with R2's behaviors and history of severely low to high blood glucose levels, he could not say this was the definite cause of R2's seizures or decreased blood glucose levels. Interview on 2/24/21 at 2:46 p.m., with the director of nursing (DON) identified her expectation was staff were to contact the physician and pharmacist immediately if a medication was unavailable for delivery or unable to be administered. She confirmed R2's physician had not been contacted nor had the pharmacist regarding the failure to obtain and administer R2's hydrocortisone medication. Review of current, undated Medication and Treatment Order policy identified staff were to notify the pharmacy to reorder medication no less than three days prior to the last dose being administered to ensure availability.	F 755		