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	345133	A. BUILDING _____ B. WING _____	C 05/17/2023

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 05/15/23 through 05/17/23. Event ID: MLJ811. The following intake was investigated NC00201463 and resulted in a deficiency.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Medical Director interviews the facility failed to assess a resident who had no reported bowel movement for eight days and failed to initiate their bowel protocol for 1 of 4 residents (Resident #1) reviewed. Resident #1 was transferred to the local emergency room and was found to have a large fecal impaction in the distal colon and required multiple enemas, laxatives, and stool softeners to resolve the impaction. The findings included: Review of a document titled "Standing Orders" revealed the following: 11. If no Bowel Movement in 72 hours, Milk of Magnesia 30 milliliters (ml) by mouth or Dulcolax Suppository everyday as needed unless (dialysis	F 684	Facility will ensure resident #1 will receive treatment to prevent constipation. Resident #1 care plan updated on 5/22/23 to reflect chronic constipation. Resident #1 cognition was assessed on 5/21/23. All residents have the potential to be affected by deficient practice. On 5/21/23 100% audit of residents was completed to ensure no residents had more than three days with no bowel movement without intervention. Interventions initiated as indicated. Director of Nursing was educated by Chief Nursing Officer on 5/21/23 on ensuring bowel protocol for residents with no documented bowel movement for three days. Nursing staff was educated by	5/22/23

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

Electronically Signed | 05/23/2023

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F 684	Continued From page 1 or Stage 2 renal disease present.) Not to exceed 2 times weekly. Resident #1 was admitted to the facility on 11/10/22 with diagnoses that included drug induced constipation, chronic pain syndrome, and incomplete lesion of cervical spinal cord. Review of a physician order dated 11/10/22 read; Sennosides-Docusate sodium (stool softener) 8.6/50 milligrams (mg) give two tablets by mouth two times a day for constipation. Review of a physician order dated 11/14/22 read: Lactulose (used to treat constipation) 10 gram (gm)/15 ml give 30 ml three times a day for constipation for forty-five days. Review of a Brief Interview for Mental Status (BIMS) dated 12/08/22 revealed that Resident #1 was cognitively intact. Review of a consultation report dated 01/16/23 read: start Movantik 25 mg daily for opiate induced constipation. The consult indicated that a prescription was sent. Review of a physician order dated 01/17/23 read: Movantik 25 mg by mouth daily for constipation for thirty days. Review of the quarterly Minimum Data Set (MDS) assessment dated 02/18/23 revealed Resident #1's cognition was not assessed. The MDS further revealed that Resident #1 required extensive assistance of two staff members for toileting and personal hygiene and was always incontinent of bowel.	F 684	Director of Nursing or designee on appropriate bowel protocol for residents who report or documented to not have bowel movement for three days. Nursing staff should review clinical alerts daily and initiate standing or request order per bowel protocol. Treatment should be initiated and if unsuccessful, nurse should notify provider for further treatment. Director of Nursing or designee will pull the Clinical Alerts Report from prior day and review in morning clinical to ensure no residents went three days without bowel movement without proper procedure initiated five days a week for four weeks, then 3 days a week for four weeks and then 2 days a week for four weeks. Results of audits will be brought to monthly Quality Assurance Performance Improvement meeting x 3 months or unil substantial compliance is met.	

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Review of Resident #1's medical record revealed no care plan addressing his diagnosis of chronic constipation.

Review of Resident #1's bowel record dated March 2023 revealed that Resident #1 had no documented bowel movements from 03/01/23 through 03/09/23.

Review of a physician's order dated 03/08/23 read; Fleet enema rectally one time for no bowel movement in three days.

Review of the Medication Administration Record (MAR) dated March 2023 revealed the following: Fleet enema insert one rectally one time for no bowel movement in three days. There was no initials on 03/08/23 indicating the enema had been given and on 03/09/23 the order was coded as the resident was on leave of absence.

Review of nurses note dated 03/09/23 read in part; Resident #1 requested to be sent to the hospital for evaluation and treatment due to resident stating he thought he was septic (serious infection) due to his wounds. Medical Doctor (MD) notified, and order placed to send per resident request. Resident #1 left the facility via stretcher at 2:30 PM. The note was electronically signed by Nurse #1.

Resident #1 was discharged to the local hospital on 03/09/23.

Review of a discharge summary from the local hospital dated 03/14/23 read in part; diagnoses: fecal impaction. Scan of the abdomen read; large fecal burden with impaction of the distal colon up to 7.5 centimeters (cm). No small bowel

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obstruction. The discharge summary further read; large fecal impaction in the distal colon that required multiple enemas, stool softeners, and laxatives but did resolve.

Nurse #1 (agency) was interviewed via phone on 05/16/23 at 9:02 AM. Nurse #1 stated she routinely cared for and was familiar with Resident #1 and recalled in March 2023 when Resident #1 went to the hospital. She stated that either on 03/08/23 or 03/09/23 Resident #1 had requested an enema but she could not recall if she actually administered the enema or not. She stated that at the same time he was also requesting to go to hospital because Resident #1 thought that he was septic from his wounds. Nurse #1 stated she called the MD and got an order to send him to the hospital per Resident #1's request. Nurse #1 explained that Resident #1 often times had trouble with his bowel movements because he was a paraplegic and did not have sensation or feeling below his under-arm area down to his feet. Nurse #1 stated that during the time in March 2023 when Resident #1 went to the hospital the Unit Managers (UMs) were responsible for reviewing the report in the electronic health record to determine which residents had not had a bowel movement in three days and would initiate our standing orders and administer something. She stated that if the UMs were not able to check the report she tried to do so as well but there were times when she did not have the time especially if she was working the medication cart.

An interview was conducted with Resident #1 on 05/15/23 at 10:06 AM. Resident #1 stated that in March 2023 he went for eight days without having a bowel movement. He stated that he was a

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paraplegic and had no feeling or sensation from his under-arm area down to his feet. He added that he had no control of his bowels, and he was dependent on the staff to assist him with cleaning him after a bowel movement because he was not aware of when he went. Resident #1 stated that before he went to the hospital in March 2023, he knew he was impacted, he stated he had told several staff members and they kept telling him that he was on stool softeners every day. He stated that his stomach was distended, and it was very uncomfortable for him to sit in his chair. Resident #1 stated that he would have spams in his stomach but the muscles that were used to push out fecal matter were paralyzed so it was very difficult for him to have a bowel movement and as the stool built up over the days leading up to the hospitalization, he got more and more uncomfortable. Resident #1 stated that in the past he had received enemas in the facility but confirmed that he did not receive an enema by Nurse #1 in the facility prior to being discharged to the hospital on 03/09/23 nor did he refuse to have the enema but did request to go to the hospital.

An interview was conducted with UM #1 on 05/15/23 at 10:48 AM who stated that she was the UM up until a few weeks ago. She stated that in March 2023 Director of Nursing (DON) #2 would check the clinical alerts in the electronic health record and see which residents flagged as not having a bowel movement in three days. Then during the clinical meeting each morning, we would make note of those resident on our units and after the meeting the UMs would go and have the hall nurse determine if the resident had a bowel movement or not and if not then they were to initiate the bowel protocol. UM #1 stated

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that when DON #2 left the facility she began reviewing the clinical alerts but there were days that she did not have time to. She added that the facility currently did not have any UMs and DON #1 was the only one that had access to the clinical report about bowel movements. She stated a lot of times she was pulled to work the medication cart or do other tasks and she did not have to time to review that report on a consistent basis. UM #1 stated that she was aware Resident #1 took several medications that would cause constipation but was unaware that he had gone to the hospital in March 2023 and was diagnosed with a fecal impaction.

An interview was conducted with UM #2 on 05/15/23 at 3:52 PM who confirmed that she was a UM up until a few weeks ago. She stated that in March 2023 DON #2 checked the clinical alerts in the electronic medical record to see which residents flagged as not having a bowel movement in three days. Then during the clinical meeting each morning, we would make note of those residents on our units and after the meeting have the hall nurse initiate the bowel protocol. UM #2 stated that when DON #2 left the facility she began reviewing the clinical alerts. UM #2 stated that a lot of times she was pulled to the medication cart and did not review the clinical alerts and did not attend the morning meeting, so she was not aware of the residents that were triggered on the alert. UM #2 stated Resident #1 was discussed a lot in morning meeting, but she never recalled him flagging on the report for not having a bowel movement in three days. UM #2 stated she was aware Resident #1 went to the hospital on 03/09/23 and stated Nurse #1 was going to give him an enema but he demanded to go the hospital.

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Attempts to speak to Nurse #2 were made on 05/15/23 and were unsuccessful. Nurse #2 cared for Resident #1 on 03/01/23.

Nurse Aide (NA) #1 was interviewed on 05/15/23 at 11:44 AM. NA #1 confirmed that she cared for Resident #1 on 03/01/23 and stated that he reported his bowel needed to move and his belly was hurting. She stated that she reported Resident #1's concerns to Nurse #1. NA #1 explained that Resident #1 could not push the fecal material out because his muscles were paralyzed. She stated that recently she had Resident #1 in the shower, and he asked her to push on his belly and when she pushed on his belly, he was able to pass "quite a bit of" of stool. NA #1 also stated that she documented in the electronic record that Resident #1 did not have a bowel movement on the shift that she was assigned to care for him on 03/01/23.

NA #2 was interviewed on 05/15/23 at 6:03 PM. She stated that rarely cared for Resident #1 but confirmed that she had cared for him on 03/01/23 and he did not have a bowel movement during the time she was assigned to care for him. She stated if he would have had a bowel movement, she would have documented that in the electronic record. She did not recall Resident #1 complaining of being constipated or his abdomen hurting at that time.

NA #3 was interviewed via phone on 05/16/23 at 10:28 AM and confirmed that he had cared for Resident #1 on 03/02/23 but stated to his recollection Resident #1 did not have bowel movement or he would have documented it in the medical record. NA #3 stated Resident #1 told

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him "Quite often" that he was constipated and if it had been several days that he had not had a bowel movement we would let the nurse know. NA #3 stated that if Resident #1 was really uncomfortable due to his constipation he would request an enema.

NA #4 (agency) was interviewed via phone on 05/15/23 at 4:45 PM. NA #4 stated she had not worked at the facility in awhile but confirmed that she had cared for Resident #1 on 03/02/23. She stated that during that time Resident #1 did not have a bowel movement and if he had she would have documented that in the electronic medical record.

An attempt to speak to Medication Aide (MA) #1 was made on 05/16/23 at 10:26 AM was unsuccessful. MA #1 provided care to Resident #1 on 03/03/23 and 03/06/23.

Contact information was unavailable for Nurse #4 who provided care to Resident #1 on 03/03/23 from 7:00 AM to 7:00 PM.

MA #3 was interviewed via phone on 05/16/23 at 4:10 PM and confirmed that she cared for Resident #1 on 03/03/23 from 7:00 PM to 7:00 AM, 03/04/23 from 7:00 PM to 7:00 AM, and 03/08/23 from 7:00 PM to 7:00 AM. She stated she could not recall if he had a bowel movement during those shifts but if he did, she would have documented it in the electronic record. She stated that Resident #1 had mentioned to her before that he had not used the bathroom in a few days, and she stated she had given him his ordered stool softener.

NA #5 (agency) was interviewed via phone on

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05/15/23 at 3:30 PM. NA #5 stated that she had not worked at the facility in a couple of months but confirmed that she cared for Resident #1 on 03/03/23 and 03/07/23. She stated that Resident #1 did not have a bowel movement during those shifts, and she charted that. She stated that Resident #1 did say that he was constipated, and he was going to have to go to the hospital if what they gave him did not work. NA #5 stated she did not report that to anyone because Resident #1 had indicated that the nurse had given him something.

MA #2 was interviewed via phone on 05/16/23 at 10:33 AM. MA #2 stated confirmed that he cared for Resident #1 on 03/04/23 and 03/05/23. MA #2 could not recall if Resident #1 had a bowel movement on those days but stated if he did, he would have documented that in the electronic medical record. He did say that Resident #1 had told him a few times that he was constipated and needed something. MA #2 stated he would consult with the nurse and then administer what the nurse instructed him to give.

NA #6 (agency) was interviewed via phone on 05/15/23 at 4:40 PM who confirmed that she had cared for Resident #1 on 03/04/23 but could not recall specifically if he had a bowel movement during that shift. She stated that if he had a bowel movement, she would have documented it in the medical record. NA #6 further stated she did not recall Resident #1 complaining of any constipation or issues with his bowels.

An attempt to speak to NA #7 was made on 05/16/23 at 4:29 PM and was unsuccessful. NA #7 cared for Resident #1 on 03/04/23.

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An attempt to speak to NA #8 was made on 05/15/23 at 3:35 PM was unsuccessful. NA #8 cared for Resident #1 on 03/05/23 and 03/08/23.

Nurse #5 (agency) was interviewed via phone on 05/16/23 at 5:08 PM. Nurse #5 confirmed that she worked the night shift on 03/06/23 and cared for Resident #1. She stated that during that shift he did not report any issues with constipation or indicated he had bowel issues.

An attempt to speak to NA #9 was made on 05/17/23 at 10:31 AM and was unsuccessful. NA #9 cared for Resident #1 on 03/06/23.

NA #10 (agency) was interviewed via phone on 05/15/23 at 3:41 PM who confirmed that she cared for Resident #1 on 03/06/23. She stated that she did not recall if Resident #1 had a bowel movement during that shift but stated if he had a bowel movement, she would have documented that in the electronic medical record.

MA #4 was interviewed via phone on 05/16/23 at 10:37 AM who confirmed that she cared for Resident #1 on 03/07/23. She stated that Resident #1's bowel movements were infrequent, and he would often times request something to make his bowel move. She stated she would consult with the nurse and administer whatever was ordered.

Nurse #6 (agency) was interviewed via phone on 05/15/23 at 4:13 PM who confirmed that she was covering the MA that was responsible for Resident #1 on 03/07/23. Nurse #6 stated that Resident #1 was alert and oriented and was able to tell if he had not had bowel movement or if he was having trouble. She stated he never reported

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to her issues with his bowels or requested something for constipation. She stated that she rarely interacted with Resident #1 and that most of the time she was supervising the MA on the unit and not providing direct care. Nurse #6 also stated that if she had the time, she would review the clinic alerts to determine which resident on her unit had not had a bowel movement in three days and would follow up. She would ask the resident and/or staff and if the resident had indeed not had a bowel movement in three days, she would initiate the bowel protocol.

Nurse #7 (agency) was interviewed via phone on 05/16/23 at 5:22 PM. Nurse #7 confirmed that she cared for Resident #1 on 03/07/23 and during that shift she did not recall any issues with constipation or Resident #1 requesting something for his bowels. She stated if Resident #1 had complained of being constipated she would have contacted the medical provider and written a note about it. She further explained that she relied on the NAs to tell her which residents had not had a bowel movement or any resident complaint about being constipated.

NA #11 was interviewed on 05/15/23 at 12:28 PM and confirmed that he cared for Resident #1 on 03/07/23 but could not recall if he had a bowel movement during that shift. He stated if Resident #1 had a bowel movement, then he would have documented it in the medical record. NA #11 stated that in the past Resident #1 had complained of having trouble with bowel movements and that at times he requested and received an enema.

DON #2 was interviewed via phone on 05/15/23 at 11:16 AM. She stated she was the DON at the

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facility until mid-March 2023. During her time in the facility, she would review the electronic medical record for residents that flagged as not having a bowel movement in three days or seventy-two hours under the clinical alerts. She stated the UMs monitored them daily and if the resident had not had bowel movement in three days, they would initiate the bowel protocol. She recalled Resident #1 flagged a couple of times on the report but was not a constant issue. DON #2 stated she was unaware of why Resident #1 went to the hospital in March, but she was certain it was not related to constipation issues.

DON #1 was interviewed on 05/15/23 at 4:49 PM who confirmed that she had been the DON at the facility since April 7, 2023. She stated that was not aware of any bowel protocol or clinical alerts that she needed to monitor until today when she was educated by a corporate staff member. DON #1 stated that she was educated to check the clinic alerts each day for residents that had not had a bowel movement in three days and then discuss in the morning clinical meeting to ensure that the bowel protocol was initiated if needed.

The MD was interviewed via phone on 05/15/23 at 1:33 PM. The MD explained that he was not currently the MD but was the MD in March 2023. He confirmed that Resident #1 was a paraplegic and his bowels were being managed with stool softeners. The MD stated that the Gastrointestinal (GI) doctor had started Movantik in January for opioid induced constipation, and he stated he would have started MiraLAX after Movanik was stopped if he would have known about Resident #1's ongoing bowel issues. The MD stated that "the hand that writes for the opioids is also the hand that has to write for

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F 684	Continued From page 12 something for the bowel" and confirmed that he had prescribed Resident #1's opioids. The MD stated that "he had overlooked the issue and somehow it fell through the cracks."	F 684		
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 record review, resident, staff, and Medical Director interviews the facility failed to prevent a significant medication error by failing to administer a physician ordered post-surgical antibiotic for three days after the resident readmitted to the facility for 1 of 1 resident reviewed for significant medication errors (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/10/22 and was readmitted to the facility on 05/06/23 with diagnoses that included nephrolithiasis (kidney stone) and chronic suprapubic catheter use. Review of a Brief Interview for Mental Status (BIMS) dated 12/08/22 revealed that Resident #1 was cognitively intact. Review of the quarterly Minimum Data Set (MDS) assessment dated 02/18/23 revealed Resident #1's cognition was not assessed. The MDS further revealed that Resident #1 required extensive to total assistance with activities of daily	F 760	Resident #1 received his antibiotic on 5/9/23. Residents who receive medications have potential to be affected by the deficient practice. 100% MAR to cart audit was completed on 5/21/23 by Director of Nursing and Regional Nurse Consultant to ensure medications ordered are available on the cart. Refills or new orders were initiated as indicated. Education was completed by Chief Nursing Officer to Director of Nursing for process when medications are not available. If medication not available, nurse should contact pharmacy to see if medication will be delivered on the next run. Nurse should check cubex for medication and dose and obtain from cubex if available. If not available in cubex, contact provider for alternative order or to hold until available. If medication not available in cubex, nurse	5/22/23

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living. The MDS further revealed that Resident #1 had an indwelling catheter, and his bladder incontinence was coded as not rated.

Review of a discharge summary from the local hospital dated 05/06/23 read in part; Current Discharge Medication List: New medications: Cefpodoxime (antibiotic) 200 milligrams (mg) by mouth two times a day for five days. Start 05/05/23 and end 05/10/23.

Review of a physician order dated 05/07/23 read; Cefpodoxime 200 mg give one tablet by mouth two times a day for infection. The order was entered by Nurse #8.

Review of a physician order dated 05/08/23 read discontinue Cefpodoxime. The order was entered by Nurse #1.

Review of a physician order dated 05/08/23 read Cefpodoxime 200 mg give one tablet by mouth two times a day for infection. The order was entered by Nurse #1.

Review of Resident #1's Medication Administration Record (MAR) dated May 2023 revealed the following: Cefpodoxime 200 mg give one tablet by mouth two times a day. On 05/06/23 at 9:00 AM and 5:00 PM there are x's indicating the medication was not given. On 05/07/23 at 9:00 AM and 5:00 PM it was coded as being held and see nurse's notes. On 05/08/23 at 9:00 AM and 9:00 PM it was coded as being held see nurse's notes.

Review of a nurses Medication Administration Note dated 05/07/23 at 3:12 PM by Nurse #8 read pharmacy contact regarding Cefpodoxime 200

should contact pharmacy to send to backup pharmacy. Until medication is obtained from backup pharmacy, nurse should contact provider to hold medication or prescribe alternative that is available in the cubex. Director of Nursing should be notified if medication is not available and the above process should be initiated.

Education was completed by Director of Nursing or designee educated licensed nurses and medication aides for process when medications are not available. If medication not available, nurse should contact pharmacy to see if medication will be delivered on the next run. Nurse should check cubex for medication and dose and obtain from cubex if available. If not available in cubex, contact provider for alternative order or to hold until available. If medication not available in cubex, nurse should contact pharmacy to send to backup pharmacy. Until medication is obtained from backup pharmacy, nurse should contact provider to hold medication or prescribe alternative that is available in the cubex. Director of Nursing should be notified if medication is not available and the above process should be initiated. Education was completed on 5/21/23. Any staff who have not receive education will not work until education completed. Newly hired nursing staff and nursing management will be educated upon hire of the above process.

Director of Nursing or designee will pull the Administration report from prior day and review in morning clinical to ensure

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F 760	Continued From page 14 mg. Review of a nurses Medication Administration Note dated 05/07/23 at 6:08 PM by Nurse #8 read, Cefpodoxime awaiting pharmacy. Review of a nurses Medication Administration Note dated 05/08/23 at 9:35 AM by Nurse #1 read, Cefpodoxime spoke with pharmacy about medication and medication will be sent out on run today. Review of a nurses Medication Administration Note dated 05/09/23 at 6:31 AM by Nurse #9 read; Cefpodoxime not in stock, on order. An interview was conducted with Resident #1 on 05/15/23 at 10:06 AM. Resident #1 stated that he recently returned to the facility after having a surgical procedure to remove a kidney stone on 05/06/23. He stated he was supposed to be on an antibiotic to prevent infection from the surgical procedure, but he had not received his first dose until 05/09/23. He added that the last dose was to be on 05/10/23 but he did not get it timely, so he remained on the antibiotic at this time. Nurse #9 (agency) was interviewed via phone on 05/15/22 at 10:47 AM. Nurse #9 confirmed that she worked in the facility on 05/08/23 from 7:00 PM to 7:00 AM and was taking care of Resident #1. She stated Resident #1 was prescribed an antibiotic and it had not come in from the pharmacy, so she did not have it to give. Nurse #9 stated that another staff member who she did not know had told her that it would be coming from the pharmacy. On 05/09/23 the staff member that was relieving her was running late so at approximately 7:00 AM the pharmacy	F 760	no medications were missed without proper procedure initiated five days a week for four weeks, then 3 days a week for four weeks and then 2 days a week for four weeks. Director of Nursing or Designee will complete a MAR to cart audit on one cart per week x 4 weeks to ensure all medications ordered are available on the cart. Results of audits will be brought to Quality Assurance Performance Improvement meeting by the Director of Nursing monthly x 3 months or until substantial compliance is met.	

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arrived with the delivery of medications. Nurse #9 stated that she obtained the antibiotic medication from the pharmacy tote and placed it on the medication cart to be administered at 9:00 AM.

The Pharmacist in Charge was interviewed via phone on 05/15/23 at 1:51 PM who stated that the pharmacy received the Cefpodoxime order on 05/08/23 at 4:50 PM and was filled on 05/08/23 and was delivered to the facility on 05/09/23 at 7:03 AM.

Nurse #8 (agency) was interviewed via phone on 05/15/23 at 2:35 PM who confirmed that she worked on 05/06/23 and 05/07/23 and was responsible for Resident #1. She stated that she could not recall if she made a note when he returned to the facility and did not know what time he returned to the facility. She stated that she did not enter any orders but gave the packet of information to the oncoming shift to handle but could not recall which nurse that was. Nurse #8 stated that when a resident readmitted to the facility, they generally did not receive any new medications until the following day when they arrived from the pharmacy. Nurse #8 stated she did not recall contacting the pharmacy but if she documented that she did, then she did. She further stated she did not recall contacting the Medial Doctor (MD) regarding the antibiotic but stated if there were new orders, she would have entered them into the electronic record.

Nurse #1 (agency) was interviewed via phone on 05/16/23 at 9:43 AM and confirmed that she had worked with Resident #1 on 05/08/23. She stated that the Cefpodoxime had not come in the from the pharmacy so she contacted the pharmacy, and they stated that it would be coming that

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evening on 05/08/23 but Nurse #1 stated her shift ended before the delivery arrived from the pharmacy, so she was not sure if it came in or not. Nurse #1 stated that she had discontinued the original order and re-entered it so that it would be correct on the MAR of when the medication was started and was to end. If the Cefpodoxime had an end date she would have entered that date was well so that it would be stopped on the MAR after the correct number of doses.

Director of Nursing (DON) #1 was interviewed on 05/15/23 at 4:49 PM. DON #1 stated that when Resident #1 returned from the hospital on 05/06/23 his medications should have been reordered and the staff should have gone to the back up supply and pulled what they could and administered those medications. Then the staff should have contacted the MD for an order to hold the other medication until they arrived from the pharmacy. DON #1 stated that she was not made aware of any issues with Resident #1's Cefpodoxime or medications.

The MD was interviewed via phone on 05/15/23 at 1:33 PM who stated that he was no longer the MD at the facility effective 05/07/23. He stated that new orders for antibiotics should be started no later than twenty-four hours after the order was given to significantly reduce the risk of infection post operatively. If the antibiotic was not available in twenty-four hours, then the provider should have been made aware to make other recommendations to get the antibiotic started sooner rather than later.