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L 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 12/3/2024 through 12/4/2024. Event ID# RHKV11. The following intakes were investigated NC00224561 and NC00224266. 2 of the 4 complaint allegations resulted in deficiency.	L 000		
L 026	.2203(A) PATIENTS NOT TO BE ADMITTED 10A-13D.2203 (a) Patients who require health, habilitative or rehabilitative care beyond those for which the facility is licensed and is capable of providing shall not be admitted to the licensed nursing home. This Rule is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to place a resident who required continuous skilled nursing care which included gastrostomy tube care (flexible tube inserted through the abdomen and into the stomach in residents who have difficulty swallowing to provide nutrition, fluids, and medications), tube feeding, percussion vest (inflatable vest attached to a machine that performs physical therapy on the chest), and suctioning in a skilled level nursing bed for 1 of 1 resident (Resident #1) reviewed for FL2 documentation. The findings included: Review of the facility census revealed Resident #1 was in an adult care home bed and was private pay. Resident #1 was initially admitted to the facility on	L 026		

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2/3/2023, and was readmitted on 10/25/2024, with diagnoses which included cerebral infarction (stroke, caused by blood flow being blocked from the brain), gastrostomy status (flexible tube inserted through the abdomen and into the stomach in residents who have difficulty swallowing to provide nutrition, fluids, and medications), and vascular dementia (dementia/memory loss, that occurs when there is not an adequate amount of blood flow to the brain to supply oxygen and other nutrients).

Review of an activities of daily living (ADL) tracking form dated July 2024 revealed Resident #1 was totally dependent for bed mobility, transfers, locomotion of chair, dressing, toilet use, and personal hygiene.

Review of a FL2 form dated 9/6/2024 revealed Resident #1 was recommended for a skilled nursing facility and was signed by a hospital staff member.

Review of hospital documentation dated 10/11/2024 revealed Resident #1 was transferred from the facility to the hospital with a chief complaint of a recent urinary tract infection (UTI), was febrile with Emergency Medical Services (EMS), had an oxygen saturation of 86% on room air, and was only moaning in response to verbal stimuli. Resident #1 was admitted to the hospital for sepsis (severe infection) likely secondary to multifocal pneumonia (infection affects multiple areas of one or both lungs) and acute cystitis (infection of the bladder that causes inflammation). Resident #1 was admitted to the critical care unit.

Review of a care plan dated 11/21/2024 revealed Resident #1 was at risk for altered

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cardiac/respiratory status related to a stroke, history of pneumonia, and gastrostomy tube with interventions which included for staff to check tube patency and position, keep the head of bed elevated, monitor for signs/symptoms of aspiration, and apply percussion vest (inflatable vest attached to a machine that performs physical therapy on the chest) per orders. Resident #1 was unable to express emotion and share information with interventions which included for staff to watch Resident #1's mouth when he was speaking and encourage Resident #1 to pronounce and enunciate words slowly and clearly. Resident #1 planned to stay long term in the skilled nursing facility due to a diagnosis of dementia. Resident #1 had chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making, and thought process related to vascular dementia which interventions which included ensuring that Resident #1's physiological needs were met. Resident #1 had an activities of daily living (ADL) self-care deficit with interventions which included staff were to transfer Resident #1 with a mechanical lift and two staff members.

An interview was conducted on 12/3/2024 at 1:11 pm with Nurse Aide (NA) #1. NA #1 stated she worked first shift (7:00 am to 3:00 pm) and frequently was assigned Resident #1. NA #1 stated Resident #1 was incontinent of bowel and bladder, was nonverbal, required total care for all ADL, required a mechanical lift and two persons assist for transfers, wore a percussion vest multiple times throughout the day, required suctioning, and had a feeding tube. NA #1 stated Resident #1 was unable to assist with any of his care.

An interview was conducted on 12/3/2024 at 1:24

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pm with Nurse #1. Nurse #1 stated she worked third shift (7:00 pm to 7:00 am) and was frequently assigned Resident #1. Nurse #1 stated Resident #1 was totally dependent for all care and required tube feedings through his gastrostomy tube.

An interview was conducted on 12/4/2024 at 9:20 am with Nurse #2. Nurse #2 stated she worked first shift (7:00 am to 7:00 pm) and was assigned Resident #1 everyday she worked in the facility. Nurse #2 stated Resident #1 had to have the head of his bed elevated, frequent turning and repositioning, bolus feeds through a gastrostomy tube, heel protecting boots, was incontinent of bowel and bladder, and required the use of a mechanical lift and two persons for transfers. Nurse #2 stated Resident #1 was sick frequently and his health status had declined over the last six months. Nurse #2 states that Resident #1 has a frequent cough, is prone to choking, and required suctioning. Nurse #2 stated he does not have strength to cough up sputum and requires the use of a percussion vest multiple times throughout the day. Nurse #1 stated Resident #1 required frequent dressing changes to his gastrostomy tube site due to leakage. Nurse #1 stated residents on the assisted living hall required vital signs to be collected once a week, on Tuesdays, weekly skin assessments, and assessments quarterly.

An interview was conducted on 12/4/2024 at 10:18 am with Nurse Practitioner (NP) #1. NP #1 stated Resident #1 was non-verbal, had a gastrostomy tube, required tube feedings, and wore a percussion vest to help loosen up secretions in his lungs. NP #1 stated residents on the adult care home unit ordered to obtain vital signs weekly and assessments as needed.

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L 026	Continued From page 4 An interview was conducted on 12/4/2024 at 10:35 am with NP #2. NP #2 stated Resident #1 was extremely debilitated from a previous stroke. NP #2 stated Resident #1 had chronic aspiration (when foreign material accidently enters the lungs and airway), chronic leakage from a gastrostomy tube, chronic cough, percussion vest, and nebulizer (machine that transforms medication into a mist which is then inhaled) treatments. NP #2 stated he had been frequently hospitalized over the last 3 to 4 months for urinary tract infections (UTIs) and pneumonia. An interview was conducted on 12/4/2024 at 11:34 am with Nurse #3. Nurse #3 stated Resident #1 was non-verbal, required a gastrostomy tube, a percussion vest because he had a hard time expelling secretions, was on an air mattress, received breathing treatments, required a mechanical lift for transfers, and was incontinent of bowel and bladder. Nurse #3 stated he had been hospitalized for recurrent pneumonia. Nurse #3 stated residents on the acute care home hall were ordered vital signs every week on Tuesdays, unless otherwise ordered, and assessments were performed when there was a change in condition. An interview was conducted on 12/4/2024 at 1:04 pm with the Admissions Coordinator. The Admissions Coordinator stated when she received a referral she would review the referral to see if there were any "yellow or red lights," such as violent behaviors/suicidal ideation/bariatric weights, that would potentially be a reason the facility could not meet the resident's needs. The Admissions Coordinator stated she would determine if a resident was appropriate for skilled or adult home care per	L 026		

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their FL2. The Admissions Coordinator verbalized she was unsure why Resident #1 was in an adult care home bed when his FL2 stated he was recommended for skilled nursing.

An interview was conducted on 12/4/2024 at 1:17 pm with the Admissions Director. The Admissions Director stated the facility had both adult care home and skilled nursing beds. The Admissions Director stated there was no difference in the level of care provided to skilled nursing beds and adult care home beds.

An observation was conducted on 12/4/2024 at 1:19 pm of Resident #1. Resident #1 was laying in bed with his eyes closed. Nurse #2 was administering bolus tube feeding as ordered through Resident #1's gastrostomy tube. Resident #1 was observed to have suction at bedside, a gastrostomy tube, and required total care while Nurse #2 was in the room.

An interview was conducted on 12/4/2024 at 1:33 pm with the Business Office Manager. The Business Office Manager stated there was no difference in the facility's adult care home and skilled nursing beds other than the payer source. The Business Office Manager stated residents on the adult care home hall received the same level of care as residents on the skilled nursing hall. The Business Office Manager stated the only reason Resident #1 was in an adult care home bed was because he was a private pay resident.

An interview was conducted on 12/4/2024 at 1:45 pm with the Minimum Data Set (MDS) Nurse. The MDS Nurse stated she did not conduct assessments on residents in the adult care home beds at the facility. The MDS Nurse stated vital signs and assessments are performed as

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L 026	Continued From page 6 ordered by the provider. An interview was conducted on 12/4/2024 at 3:14 pm with the Former Director of Nursing (DON). The Former DON stated Resident #1 was totally dependent and required tube feeding through his gastrostomy tube. The Former DON stated he was nonverbal and unable to communicate his needs verbally. The Former DON stated residents in skilled nursing beds received vital signs every shift and adult care home residents received vital signs weekly. The Former DON stated Resident #1 was private pay, which is the only reason he was in an adult care home bed. The Former DON stated he received the same level of care as skilled nursing bed resident. An interview was conducted on 12/4/2024 at 3:36 pm. The Administrator stated adult care home beds at the facility were non-certified and residents with Medicare of Medicaid could not be housed in those beds. The Administrator stated the only reason Resident #1 was in an adult care home bed was because he was a private pay resident. The Administrator stated he had an Advantage Medicare plan but that he was not eligible for rehabilitation. The Administrator stated the same level of care was provided for all residents at the facility regardless of which type of bed the resident was in.	L 026		
L 035	.2207 PATIENT RIGHTS 10A-13D.2207 (a) The facility shall enforce the Nursing Facility Patient's Bill of Rights as described in G.S. 131E-115 through G.S. 131E-127. (b) In matters of patient abuse, neglect or misappropriation the	L 035		

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L 035	Continued From page 7 definitions shall have the meaning defined in Rule .2001 of this Subchapter. This Rule is not met as evidenced by: Based on record review, and Responsible Party (RP), staff, and Nurse Practitioner (NP) interviews the facility failed to honor a request from a RP on a grievance as it was indicated for 1 of 3 residents (Resident #1) reviewed for resident rights. The findings included: Review of the facility's "Resident Grievances and Concerns Policy", last revised August 2018, revealed "residents have the right to voice grievances to the facility, or other agencies, or entities that hear grievances, without discrimination or reprisal. Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff and other residents and any other concern regarding the resident's stay." A written grievance decision should obtain the following: "the date the grievance was received, a summary of the statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, whether any corrective action was or will be taken, if corrective action was or will be taken, a summary of the corrective action, and the date the written decision was issued." Resident #1 was initially admitted to the facility on 2/3/2023, and was readmitted on 10/25/2024,	L 035		

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with diagnoses which included cerebral infarction (stroke, caused by blood flow being blocked from the brain), gastrostomy status (flexible tube inserted through the abdomen and into the stomach in residents who have difficulty swallowing to provide nutrition, fluids, and medications), and vascular dementia (dementia/memory loss, that occurs when there is not an adequate amount of blood flow to the brain to supply oxygen and other nutrients).

Review of an email dated 6/6/2024 revealed Resident #1's Responsible Party (RP) had voiced concern about "what ifs" had Resident #1 not have been sent to the Emergency Department where they identified pneumonia in his right lower lung. The RP inquired if any precautions were taken daily such as a temperature or listening to lung sounds. The email was sent to the Administrator, and Former Director of Nursing (DON).

Review of a grievance dated 6/6/2024 revealed Resident #1's RP had voiced a concern to the Administrator. There was no documented concern under the "Documentation of Concern." Nursing was assigned to act of the grievance and the documented results of action taken included vital signs every shift and lung sounds every shift. The grievance was documented as resolved on 6/6/2024 after the RP was notified via telephone that an order had been placed for vital signs and lung sounds. The grievance was signed as completed by the Former Director of Nursing (DON) and the Administrator.

Review of Resident #1's June 2024 through December 2024 physicians orders revealed an order was placed on 6/6/2024 for staff to listen to lung sounds every shift and obtain vital signs

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every shift. Both orders were discontinued on 7/1/2024. An order was placed on 11/14/2024 for vital signs to be obtained once a day during the morning medication pass (7:00 am to 11:00 am).

An interview was conducted on 12/4/2024 at 3:03 pm with the Social Worker (SW). The SW stated anyone in the facility, including family, could file a grievance. The SW stated once a grievance was filled out, she made a copy of the grievance to keep in a file in her office and gave the original copy to the appropriate department manager. The SW stated once the grievance was completed by the appropriate department manager, the form was returned to her. The SW stated she then gave the copy to the Administrator for her to sign, then she received the grievance back, placed the original copy in the grievance book, and shredded the copy she initially made for herself. The SW stated the Administrator was the Grievance Official.

An interview was conducted on 12/4/2024 at 3:14 pm with the Former DON. The Former DON stated Resident #1's RP had placed multiple grievances. The Former DON stated she was not able to recall the specific 6/6/2024 grievance and thought the reason why the daily vital signs and lung sounds had been discontinued, was because he had come back from the hospital and was cleared by the provider to go back on weekly vital signs instead of daily vital signs.

An interview was conducted on 12/4/2024 at 3:36 pm with the Administrator. The Administrator stated anyone could fill out a grievance. The Administrator stated once a grievance had been placed, the SW would make a copy of the grievance and give the grievance to the appropriate department manager. The

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L 035	Continued From page 10 Administrator stated grievances were reviewed during the morning meeting, and once there was a resolution to the grievance that she would sign it as completed and give it to the SW. The Administrator stated she remembered the grievance had been filed after she had received an email from Resident #1's RP. The Administrator stated the orders for vital signs and lung sounds every shift were discontinued once Resident #1 had returned from the hospital.	L 035		
L 077	.2305(B) QUALITY OF CARE 10A.13D.2305 (b) Acute changes in the patient's physical, mental or psychosocial status shall be evaluated and reported to the physician or other persons legally authorized to perform medical acts. This Rule is not met as evidenced by: Based on record review, Responsible Party, staff, and Nurse Practitioner (NP) interviews the facility failed to recognize a change in condition, obtain on-going vital signs, and ongoing assessments when Resident #1's family member approached Nurse #1 as she was passing medications on another hall and stated she thought Resident #1 had a change in condition. Resident #1 was transferred to the emergency department where he was admitted to the critical care unit for sepsis (severe infection) secondary to multifocal pneumonia (infection in multiple areas of one or both lungs) and acute cystitis for 1 of 3 residents (Resident #1) reviewed for change in condition. The findings included:	L 077		

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L 077	Continued From page 11 Resident #1 was initially admitted to the facility on 2/3/2023, and was readmitted on 10/25/2024, with diagnoses which included cerebral infarction (stroke, caused by blood flow being blocked from the brain), gastrostomy status (flexible tube inserted through the abdomen and into the stomach in residents who have difficulty swallowing to provide nutrition, fluids, and medications), and vascular dementia (dementia/memory loss, that occurs when there is not an adequate amount of blood flow to the brain to supply oxygen and other nutrients). Review of a care plan dated 8/5/2024 revealed Resident #1 was at risk for altered cardiac/respiratory status related to a stroke, history of pneumonia, and gastrostomy tube with interventions which included for staff to check tube patency and position, keep the head of bed elevated, monitor for signs/symptoms of aspiration, and apply percussion vest (inflatable vest attached to a machine that performs physical therapy on the chest) per orders. Resident #1 was unable to express emotion and share information with interventions which included for staff to watch Resident #1's mouth when he was speaking and encourage Resident #1 to pronounce and enunciate words slowly and clearly. Resident #1 planned to stay long term in the skilled nursing facility due to a diagnosis of dementia. Resident #1 had chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making, and thought process related to vascular dementia which interventions which included ensuring that Resident #1's physiological needs were met. Resident #1 had an activities of daily living (ADL) self-care deficit with interventions which included staff were to transfer Resident #1 with a	L 077		

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mechanical lift and two staff members.

An interview was conducted on 12/3/2024 at 1:11 pm with Nurse Aide (NA) #1. NA #1 stated she worked first shift (7:00 am to 3:00 pm) and was assigned Resident #1 on 10/10/2024 and 10/11/2024. NA #1 stated she was unable to recall any changes in Resident #1's condition on 10/10/2024 or 10/11/2024.

An interview was conducted on 12/4/2024 at 9:20 am with Nurse #2. Nurse #2 stated she worked first shift (7:00 am to 7:00 pm) and was assigned Resident #1 on 10/10/2024. Nurse #2 stated she was unable to recall Resident #1's specific condition on 10/10/2024. Nurse #2 stated Resident #1 always had a chronic cough and stated that he had been declining over the last six months.

An interview was conducted on 12/3/2024 at 1:24 pm with Nurse #1. Nurse #1 stated she worked third shift (7:00 pm to 7:00 am) and was assigned Resident #1 on 10/11/2024. Nurse #1 stated she was approached by Resident #1's Responsible Party (RP) on 10/11/2024 while she was passing medications on 300 hall. Nurse #1 stated the RP told her Resident #1 needed to be sent to the hospital because his congestion had worsened. Nurse #1 stated she went to the room with the RP and the RP was insistent the Resident #1 be sent to the hospital. Nurse #1 stated she was not able to recall if she assessed his vital signs and stated she did not perform an assessment on Resident #1. Nurse #1 stated she went to the nurse's station, called the on-call provider, and was told to send Resident #1 to the hospital if the RP had requested it. Nurse #1 stated she then called EMS. Nurse #1 stated when EMS had gotten to the facility they went to the room and came out to

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talk to her and asked why Resident #1 was being transferred at which time she referred them to the RP and was told by EMS that the RP was not at the bedside. Nurse #1 went with EMS to Resident #1's room, gave report, and Resident #1 was transferred to the hospital.

An interview was conducted on 12/4/2024 at 11:11 am with Resident #1's Responsible Party (RP). The RP stated she had seen Resident #1 on 10/9/2024 at which time he appeared at his baseline. The RP stated she went to the facility around 7:00 or 7:30 pm on 10/11/2024 at which time she noted Resident #1 to have a deeper, harder cough, and overall did not look well. The RP stated as she checked to see if Resident #1's brief was wet, she could "feel heat radiating off of him." The RP stated that she approached Nurse #1 around 8:00 pm to 8:15 pm and requested that he go to the hospital because he was "gurgling with congestion." The RP was stated Nurse #1 tried to convince her to let the facility keep Resident #1 in the facility and she insisted that he be transferred. The RP stated she did not recall Nurse #1 performing or asking to perform an assessment on Resident #1.

Review of Emergency Medical Services (EMS) documentation dated 10/11/2024 revealed EMS had been dispatched to the facility at 10:35 pm in reference to a sick call. EMS arrived at Resident #1's bedside at 10:44 pm at which time Resident #1 was found in bed and noted with congestion in his throat and an initial oxygen saturation level of 84% on room air. EMS placed Resident #1 on 15 liters of oxygen per minute via a non-rebreather mask. At 10:47 pm Resident #1's vital signs were a heart rate of 129 beats per minute (normal heart rate is 60 to 100 beats per minute), a blood pressure of 104/45 (normal blood pressure is

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L 077	Continued From page 14 120/80), and a respiration rate of 32 breaths per minute (normal respiration rate is 12-20 breaths per minute). Resident #1 was noted to have shallow respirations. An intravenous catheter (IV) was placed and Resident #1 was given a bolus of IV fluids en route to the hospital. At 10:54 pm Resident #1 was noted to have a temperature of 102.8 degrees axillary. Resident #1 was transferred to the hospital at 11:16 pm. Review of hospital documentation dated 10/11/2024 revealed Resident #1 was transferred from the facility to the hospital with a chief complaint of a recent urinary tract infection (UTI), was febrile with Emergency Medical Services (EMS), had an oxygen saturation f 86% on room air, and was only moaning in response to verbal stimuli. Resident #1 was admitted to the hospital for sepsis (severe infection) likely secondary to multifocal pneumonia (infection affects multiple areas of one or both lungs) and acute cystitis (infection of the bladder that causes inflammation). Resident #1 was admitted to the critical care unit. An interview was conducted on 12/4/2024 at 10:18 am with Nurse Practitioner (NP) #1. NP #1 stated when Resident #1 was admitted to the facility, he was nonverbal, had a gastrostomy tube, had issues with his lungs and utilized a vest to help loosen up secretions. NP #1 stated the wife frequently requested that Resident #1 be sent to the hospital. NP #1 stated she would not have expected Nurse #1 to obtain vital signs, ongoing vital signs, or a head-to-toe assessment when the RP requested to have Resident #1 sent to the hospital because it would take longer to take vital signs and assess Resident #1 than to just call 911.	L 077		

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L 077	Continued From page 15 An interview was conducted on 12/4/2024 at 10:35 am with NP #2. NP #2 stated she frequently saw Resident #1 and stated he was extremely debilitated from a previous stroke. NP #2 stated Resident #1 always had a chronic cough and aspiration. NP #2 stated she had seen Resident #1 on 10/9/2024 for a regulatory visit at which time there was no issues. NP #2 stated she saw Resident #1 again on 10/10/2024 for a follow up on his cough and congestion at which time she prescribed Doxycycline (an antibiotic) and recommended a chest x-ray and sputum culture if his symptoms did not improve. NP #2 stated he had rhonchi during the visit on 10/10/2024 and stated that was not new for him. NP #2 stated she had not seen Resident #1 on 10/11/2024 and was told that he had been sent to the hospital after spiking a fever later that night. NP #2 stated when there was a change in condition or if the family requested a resident to be sent to the hospital, the Nurse should assess the resident and obtain a full set of vital signs prior to transfer. An interview was conducted on 12/4/2024 at 1:50 pm with the Assistant Director of Nursing (ADON). The ADON stated Resident #1 had issues with recurrent urinary tract infections (UTIs) and pneumonia. The ADON stated Resident #1's RP frequently requested for Resident #1 to be sent to the hospital. the ADON stated when a resident had a change in condition or if the family requested for a resident to be sent to the hospital the Nurse should obtain vital signs and complete an assessment.	L 077		
L 094	.2306(D)(4) MEDICATION ADMINISTRATION 10A-13D.2306 (d) The facility shall	L 094		

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L 094	Continued From page 16 ensure that procedures aimed at minimizing medication error rates include, but are not limited to, the following: (4) Omission of medications and the reason for omission shall be indicated in the patient's medical record. This Rule is not met as evidenced by: Based on record review, staff, and Nurse Practitioner (NP) interviews, the facility failed to initiate antibiotic therapy to treat Resident #1 for an increased congested cough for greater than 24 hours after it was ordered for 1 of 3 residents (Resident #1) reviewed for medication administration. The findings included: Resident #1 was initially admitted to the facility on 2/3/2023, and was readmitted on 10/25/2024, with diagnoses which included cerebral infarction (stroke, caused by blood flow being blocked from the brain), gastrostomy status (flexible tube inserted through the abdomen and into the stomach in residents who have difficulty swallowing to provide nutrition, fluids, and medications), and vascular dementia (dementia/memory loss, that occurs when there is not an adequate amount of blood flow to the brain to supply oxygen and other nutrients). A Nurse Practitioner (NP) #2 note dated 10/10/2024 revealed Resident #1 was seen in bed with "notable increased congested cough" and was due for his nebulizer treatment and vest percussion. NP #2 recommended to add Doxycycline (an antibiotic used to treat infection) 100 mg twice a day for ten days and to follow up	L 094		

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with chest x-ray and sputum culture if there was no improvement.

An order dated 10/10/2024 at 3:14 pm revealed Resident #1 was ordered Doxycycline 100 mg twice a day for increased cough and congestion and was ordered for the medication to start during the night shift medication pass (7:00 pm to 11:00 pm) on 10/11/2024.

The October 2024 Medication Administration Record (MAR) revealed Resident #1 was scheduled to start Doxycycline 100 mg on 10/11/2024 during the night shift medication pass (7:00 pm to 11:00 pm) and was documented by Nurse #1 as having not received the medication due to being sent to the Emergency Department (ED).

An interview was conducted on 12/4/2024 at 10:35 am with NP #2. NP #2 stated she had seen Resident #1 on 10/10/2024 for a follow up on his feeding tube along with cough and congestion. NP #2 stated Resident #1 always had rhonchi (abnormal snoring/gurgling sound often caused by blockages in the main airway that can be due to mucous and secretions) but stated she ordered Doxycycline 100 mg due to increased cough and congestion.

A follow up interview was conducted on 12/4/2024 at 12:35 pm with NP #2. NP #2 stated she was not sure why the medication was ordered to start on 10/11/2024 during the night shift medication pass, and thought the order might have been entered by a nurse and placed under her name. NP #2 stated he should have gotten the medication on 10/10/2024 and stated that a delay in the initiation of antibiotics of over 24 hours could cause worsening in his condition. NP #2

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L 094	Continued From page 18 stated the delay could also have been because Resident #1's Responsible Party (RP) obtained his medications from an outside pharmacy, and she may not have been able to get them until the afternoon of 10/11/2024. An interview was conducted on 12/4/2024 at 4:22 pm with the Administrator. The Administrator stated Resident #1's RP insisted on using an outside pharmacy to get Resident #1's medications. The Administrator stated the delay in the initiation of antibiotics was because the RP could not pick up the medications from the pharmacy until 10/11/2024. The Administrator was unable to verify if anyone at the facility had called the RP to ask if she could pick the medications up sooner or explain the importance of initiating antibiotic therapy as soon as possible. The Administrator stated Doxycycline was kept as a back up medication and stated she was unsure if anyone from the facility had called to offer the RP that option.	L 094		