STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/13/25 through 4/16/25. Surveyors returned to the facility on 4/24/25 to investigate new complaint allegations, and received aditional information on 4/29/25, therefore the exit date was changed to 4/29/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #03M511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/13/25 through 4/16/25. Surveyors returned to the facility on 4/24/25 to investigate new complaint allegations, and received aditional information on 4/29/25. Therefore, the exit date was changed to 4/29/25. Event ID# 03M511. The following intakes were investigated NC00229714, NC00226065, NC00227729, NC00223959, NC00229129, and NC00229248. 4 of the 20 complaint allegations resulted in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		5/27/25

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

Electronically Signed | 05/21/2025

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F 561	Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to allow residents who were assessed to be safe smokers to smoke independently per their individual preference for 2 of 3 residents (Resident #8 and #249) reviewed for smoking. The findings included: Review of the Facility Smoking Acknowledgement read, in part: "patients who wish to smoke will be evaluated using the smoking safety screen upon admission and as needed to determine need for supervision. The patient must also agree to the policy and sign the Patient Smoking Acknowledgement form ... based on the Smoking Safety Screen, a patient may smoke in designated smoking area either independently or	F 561	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F-561 Resident Rights / Exercise Rights 1. Facility failed to allow residents who were assessed to be safe smokers to smoke independently per their individual preference. Resident #249 is no longer at the facility. Resident #8 remains at the facility.	

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F 561	Continued From page 2 with supervision ..." The smoking schedule for the facility dated 3/18/25 was reviewed. Times for smoking were listed as 8:30 AM, 11:00 AM, 1:30 PM, 3:30 PM, 5:30 PM, and 8:00 PM. The form read "Staff members go with residents out back to designated smoking areas. Ensure the resident is in proper clothing and has shoes or foot pedals in place. No adjustments will be made to these times." a. Resident #8 was admitted to the facility 11/27/24. A Patient Smoking Acknowledgement form dated 12/2/24 was signed by Resident #8. The admission Minimum Data Set (MDS) assessment dated 12/4/24 documented Resident #8 was cognitively intact, and she did not use tobacco. Review of Resident #8's medical record revealed a smoking assessment dated 3/10/25 that determined Resident #8 was a safe smoker and she could smoke unsupervised. A care plan initiated on 12/9/24 and the most recent revised date on 3/13/25 documented Resident #8 preferred to smoke cigarettes, and included the goal Resident #8 would smoke safely through the review period. The interventions included educating Resident #8 on the facility smoking policy and conducting smoking assessments as needed. Resident #8 was interviewed on 4/15/25 at 1:39 PM. Resident #8 reported while she was glad	F 561	2. All current residents who were assessed as a safe smoker at risk. 100% of smokers audited. Residents reassessed. All identified independent smokers per assessment and care plan with BIMS of > 13 informed of allowance to smoke without a schedule. 3. All staff educated by the Staff Development Coordinator (SDC) regarding smokers□ rights. Education completed 05/18/25. Any staff not receiving education by 5/27/2025 will receive education prior to the start of their shift. Future employees to be trained during orientation by the Staff Development Coordinator or designee annually and as needed. 4. Unit Managers or Designee will observe independent smokers 5X per week for four weeks, then 3X per week for four weeks, then once for one month. 5. The results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution if needed. 6. Date of compliance 05/27/25	

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F 561	Continued From page 3	F 561		

she was able to smoke at the facility, she wanted to be able to go out to smoke any time she wanted. She explained she was not allowed to go out to smoke after 8:00 PM and this made her feel anxious.

During an interview with Nursing Assistant (NA) #2 on 4/16/25 at 9:52 AM, she reported Resident #8 would ask to go outside to smoke frequently.

An interview was conducted with NA #1 on 4/16/25 at 10:06 AM and she reported Resident #8 became upset if she was not able to go out to smoke.

Nurse #5 was interviewed on 4/16/25 at 10:44 AM and she reported Resident #8 became anxious if she was unable to go out to smoke.

b. Resident #249 was admitted to the facility 4/7/25.

A Patient Smoking Acknowledgement form dated 4/7/25 was signed by Resident #249.

Review of the medical record for Resident #249 revealed the smoking assessment dated 4/7/25 documented Resident #249 was a safe smoker and could smoke unsupervised.

A care plan initiated 4/7/25 documented Resident #249 preferred to smoke cigarettes and included a goal he would smoke safely through the review period. The interventions included educating him on the facility smoking policy and conducting a smoking assessment as needed.

The admission MDS dated 4/14/25 documented Resident #249 was cognitively intact. The

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F 561	Continued From page 4	F 561		

admission MDS was in progress and not completed for tobacco use.

Resident #249 was interviewed on 4/16/25 at 8:25 AM. Resident #249 reported he was looking for someone to open the door so he could go out to the smoking area. He reported he was frustrated he had to wait for certain times to smoke and had to wait for a staff member to take him out to the smoking area. Resident #249 reported he had been smoking for 50+ years, he was able to determine when he wanted to have a cigarette and waiting for the smoking times was upsetting to him.

The Director of Nursing (DON) was interviewed on 4/16/25 at 1:04 PM. The DON reported the facility had been non-smoking in the past, but residents who wanted to smoke were going outside and smoking on the porch, down the steep hill of the driveway that led to the street, and back by the dumpsters, to name a few places. The DON reported the facility felt that those smoking behaviors were unsafe and decided to allow smoking in a designated area at the rear of the building at certain times and with staff supervision. The DON explained that the smoking times had become a social activity for residents, and they seemed to enjoy it. The DON reported she was aware Resident #8 wanted to go outside to smoke whenever she wanted but reported Resident #249 had not expressed frustration over not being able to choose his own smoking times.

The Administrator was interviewed on 4/16/25 at 1:32 PM. The Administrator explained the facility was previously smoke-free, but they had several residents who refused a nicotine patch and were

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F 561	Continued From page 5 going outside to smoke, at various places. The Administrator explained that the interdisciplinary team did not feel this was safe for the residents and they decided to implement supervised smoking for all residents, and determined the times they would offer smoking. The Administrator explained that the facility decided to develop a system that provided residents with the opportunity to smoke if they wished, while providing them with safety through supervision. The Administrator was unable to explain why the residents who were assessed as independent smokers were required to smoke at the designated times with supervision.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 565		5/27/25

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F 565	Continued From page 6 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances that were reported in the Resident Council meetings for 4 of 6 months (11/19/2024, 12/18/2024, 1/29/2025 and 2/26/2025). Findings included: A review of the Resident Council Minutes indicated the residents had complained on 11/19/2024, 12/18/2024, 1/29/2025, and 2/26/2025, during the Resident Council meeting, that they received potatoes and green beans several times during the same week. A Departmental Response/Resolution dated 11/26/2024 indicated the facility's menu was provided by the corporate office and the Dietary Manager stated the menu could not be changed. The Department Response/Resolution also stated green beans were served three times a week and mashed potatoes were served two times a week per the facility's menu.	F 565	F-565 Resident/Family Group Response 1. Facility failed to resolve grievances that were reported in the Resident Council meetings for 4 of 6 months. Unable to identify resident #15. 2. Menus were modified and repeat vegetables were replaced with substitutes. The Registered dietician reviewed and accepted changes to menu 3. Activities staff and Administrator educated 05/16/25 regarding residents rights including resolution of grievances by the by the Staff Development Coordinator (SDC) regarding residents right to assemble and obtain resolution to grievances. Facility Activities staff will conduct weekly focus meetings to obtain concerns. The concerns are to be addressed by the Administrator designated staff member within 72 hours. Any new activity staff or facility administrator will receive education during the orientation process. 4. The Activities Director or Designee	

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F 565	Continued From page 7 On 12/18/2024 the Departmental Response/Resolution form updated by the Administrator stated they continued to report the residents' concerns to the Dietary Manager to see if any substitutions could be made. On 1/29/2025 the Departmental Response/Resolution form was updated and stated the Dietary Manager would contact the corporate office to ask about substitutions and at your request options for residents. On 2/27/2025 the Departmental Response/Resolution form was updated by the Administrator and stated she emailed the Senior Regional Director of Operations regarding the resident's concerns and asked about the availability of alternate options. On 3/26/2025 the Departmental Response/Resolution form was updated and stated the menu would change for the season in May or June of 2025. An interview was conducted with the Resident Council on 4/15/2025 at 3:20 pm during which the council members indicated they had brought up concerns that the same foods were being served repeatedly. Resident #15 stated they shared multiple times in the past six months that they were being served the same food items for lunch and dinner several times a week, but they continued to be served the same things, and it continued to be an issue. Resident #15 stated residents were served potatoes and green beans multiple times a week and the facility did not respond to the concern and correct the issue. On 4/15/2025 at 3:49 pm the Activity Director was	F 565	will audit/ record and resolve identified concerns 1X per week for eight weeks then once monthly. 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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F 565	Continued From page 8 interviewed, and she stated the concerns were written in the Resident Council Minutes and a Departmental Response/Resolution form was sent to the Department Manager of the area of concern. The Activity Director stated the complaint about being served the same food items had been a consistent problem and the Administrator was notified of the concern, and the Administrator had contacted the contracted dietary company and there was a plan to change the menus in either May 2025 or June 2025. The Activity Director stated she did not know why it had taken so long for something to be done about the mashed potatoes and green beans being served so frequently. She indicated the response form for the complaint was dated 11/26/2024 and green beans had been served three times a week and potatoes two times a week. The Administrator was interviewed on 4/16/2025 at 12:46 pm and stated she was aware of the grievances during the Resident Council Meetings on 11/19/2024, 12/18/2024, 1/29/2025 and 2/26/2025. She stated she talked with the Dietary Manager to replace the potatoes and green beans to make sure the residents were happy with their meals. She stated she thought the reason the issue had taken so long was because the Dietary Manager had not been comfortable with substituting what was on the menu.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		5/27/25

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F 578	Continued From page 9 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to completely fill out the Do Not Resuscitate (DNR) form for 1 of 2 residents	F 578	F-578 Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir 1. Facility failed to completely fill out the	

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F 578	Continued From page 10 reviewed and Advanced Directives (Resident # 30). The findings included: Resident # 30 was admitted to the facility on 1/19/2023. Resident # 30's diagnosis included hypertension, and cognitive impairment. Review of Resident # 30's paper medical record revealed Resident # 30's DNR form signed by the Nurse Practitioner (NP) # 1 was not dated. Review of Resident # 30's Electronic Medical Record (EMR) revealed a physician's order dated 1/21/2025 for code status DNR. An interview was conducted on 4/14/2025 at 1:05 PM with Unit Manager # 2. Unit Manager # 2 revealed upon admission, the nurse would complete the DNR. Unit Manager # 2 continued by stating the form would then go to the Nurse Practitioner (NP) to be signed, dated, and then scanned into the EMR. The hard copy would be kept at the nurse's station in a binder. Unit Manager # 2 further stated the DNR form should correspond with a matching date and should also match what was documented in the EMR. Upon review of the form Unit Manager # 2 indicated the date was missing from the DNR form. The Nurse Practitioner (NP) # 1 was interviewed on 4/16/2025 at 11:29 AM. She stated DNR forms are usually dated before they are given to her to sign. NP # 1 further stated she usually received a stack of forms to sign with the date already on them. An interview was conducted with the Director of	F 578	Do Not Resuscitate (DNR) form for 1 of 2 residents reviewed and Advanced Directives. Resident #30 continues to reside at the facility. 2. All residents have the potential to be affected. The DNR form for Resident #30 was updated to reflect the correct code status. Unit Manager audited 100% of DNR forms to ensure all were correct. 3. Staff Development Coordinator educated facility Nurse Practitioners (NP) regarding the completion of the DNR forms. Education completed 05/17/25. All new Nurse Practitioners will be educated during orientation by the Staff Development Coordinator or designee annually and as needed. 4. The DON and/ or designee will audit the DNR forms during daily clinical meetings. 5X per week for four weeks, then 3X per week for four weeks, then weekly for one month. 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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F 578	Continued From page 11 Nursing (DON) on 4/14/2025 at 1:13 PM. The DON revealed the admissions nurse would be responsible for completing the DNR form. The DON indicated information on the form should be checked during the twenty-four-hour chart check after admission. The DNR form should have an effective date. An interview was completed with the Administrator on 4/16/2025 at 11:44 AM. The Administrator revealed NP # 1 was responsible for signing and dating the DNR form. The Administrator further stated NP # 1 was new and may need additional training or retraining of the process.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		5/27/25

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F 580	Continued From page 12 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and Nurse Practitioner and staff interviews, the facility failed to notify the Nurse Practitioner (NP) after an International Normalized Ratio (INR) test (monitors the effectiveness of blood-thinning medications) was not completed as ordered for 1 of 1 resident (Resident # 255) reviewed for monitoring anticoagulant medicine. The findings included:	F 580	F-580 Notify of Changes 1. Facility failed to notify the Nurse Practitioner (NP) after an International Normalized Ratio (INR) test (monitors the effectiveness of blood-thinning medications) was not completed as ordered. Resident #255 no longer resides at the facility. 2. All residents have the potential to be affected DON audited 100% of residents	

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F 580	Continued From page 13 Resident #255 was admitted to the facility on 03/30/21 with diagnoses which included atrial fibrillation. Resident #255's physician order dated 01/30/25 revealed the resident was ordered to receive a warfarin sodium (anticoagulant/blood thinner) oral tablet 2 milligram (mg), give 1 tablet by mouth at bedtime related to unspecified atrial fibrillation. A progress note dated 03/05/25 completed by Nurse Practitioner (NP) #1 revealed Resident #225's INR was recently checked, and it was at 4.0 that morning (normal range 2-3). It was further noted Resident #255's warfarin was to be held until 3/7/25. The note indicated Resident #255's INR was to be rechecked on 03/07/25 and to notify NP #1 of any bleeding or changes. Resident #255's physician orders revealed an order dated 03/07/25 to check Resident #255's INR on 03/07/25 and hold Warfarin until further notice. Resident #255's MAR revealed from 03/05/25 through 03/12/25 warfarin was not administered to Resident #255. Further review revealed Nurse #1 signed off on 03/07/25 that an INR was completed on the resident but there was no documented INR result. Resident #255's labs and progress notes indicated no results for an INR lab for Resident #255 for the 03/07/25 ordered INR. A phone interview conducted with Nurse #1 on 04/24/25 at 8:00 pm revealed on 03/07/25 she was assigned Resident #255. Nurse #1 could not	F 580	with PT/INR orders. No others noted during survey. 3. Current licensed nurses were educated by the Staff Development Coordinator regarding obtaining PT/INR as ordered and performing the notification of change in condition to the MD or NP. Education completed 05/17/25. Any licensed nurse not receiving education by 5/27/2025 will receive education prior to the start of their shift. All newly hired nurses will be educated during orientation by the Staff Development Coordinator or designee annually and as needed. 4. The UM or designee will audit the orders and flowsheets during clinical morning meeting 5X per week for four weeks, then 3X per week for four weeks, then weekly for four weeks (one month). 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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F 580	Continued From page 14	F 580		

recall if she had completed Resident #255's INR on that date but explained if she had completed the resident's INR it would have been in the resident's chart. Nurse #1 stated if the INR result was not in the residents' chart, then she did not complete it.

A phone interview conducted with NP #1 on 04/24/25 at 1:10 PM revealed Resident #255's INR was being followed closely due to the resident's INR numbers fluctuating. NP #1 revealed on 03/05/25 Resident #255 had an INR rate of 4.0 and she wanted the resident's warfarin held and the INR to be rechecked on 03/07/25. The NP indicated Resident #255 was checked on 03/12/25 and Resident #255 had an INR result of 1.3. The NP stated there was no harm or negative outcome as a result of the resident's INR was not checked on 03/07/25 but expected nursing staff to follow through with orders given and notification of any changes. The NP indicated she was not notified the lab was not completed and would expect staff to notify her if it was not completed as ordered.

An interview conducted with the Director of Nursing (DON) on 04/24/25 at 3:00 PM revealed Resident #255 had ongoing issues with her INR not being consistent. The DON further revealed it was being followed closely by the medical providers. The DON stated she was not aware it was not checked on 03/07/25 but expected nursing staff to follow orders. The DON revealed she was not aware the lab had been missed, but the NP should have been notified for Resident #255's lab not being completed as ordered on 03/07/25.

An interview conducted on 04/28/25 at 1:00 PM

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F 580	Continued From page 15 the Administrator revealed she had reviewed Resident #255's chart and could not find any documentation Resident #255 received an INR check on 03/07/25. The Administrator further revealed she expected orders to be followed through with and believed Resident #255's order from 03/07/25 to have her INR checked was missed and the NP was not notified.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to ensure a resident swallowed medications during medication administration when Nurse #5 left medications at the bedside for 1 of 5 residents observed for medication administration (Resident #2). The findings included: Resident #2 was admitted to the facility 12/19/24 with diagnoses including diabetes and congestive heart failure. The quarterly Minimum Data Set assessment dated 3/26/25 assessed Resident #2 to be moderately cognitively impaired. Review of the physician orders for Resident #2 revealed the following medications to be administered:	F 658	F-658 Services Provided Meet Professional Standards 1. Facility failed to ensure a resident swallowed medications during medication administration Resident #2 continues to reside at the facility. 2. All residents have the potential to be affected. Nurse #5 pulled from the medcart and educated by the Director of Nursing at the time of the event. 3. Staff Development Coordinator educated all nurses regarding the medication administration. Education completed 05/05/25. Any licensed nurse not receiving education by 5/27/2025 will receive education prior to the start of their shift. All new nurses will be educated during orientation by the SDC or designee annually and as needed.	5/27/25

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F 658	Continued From page 16 - Digoxin 125 micrograms 1 tablet daily for atrial fibrillation at 9:00 AM - Furosemide 20 milligrams (mg) 1 tablet daily for blood pressure at 8:00 AM - Nadolol 40 mg 1 tablet daily for blood pressure at 9:00 AM - Oxybutynin chloride 5 mg 1 tablet daily for bladder spasm at 8:00 AM - Sennosides-docusate sodium 8.6 mg/50 mg 2 tablets daily for constipation at 9:00 AM - Divalproex Sodium 125 mg 1 tablet daily for anxiety at 9:00 AM - Metformin 500 mg 1 tablet twice daily for diabetes at 9:00 AM - Methenamine Hippurate 1 gram 1 tablet for urinary tract at 9:00 AM Resident #2 was observed on 4/13/25 at 11:50 AM. A medication cup with 9 pills was on her overbed table. Resident #2 was asked about the medications, and she reported she did not know what they were or why they were on her table. Nurse #5 was asked to come to Resident #2's room and she arrived at 12:00 PM. When shown the medication on the overbed table, Nurse #5 exclaimed, "Oh, you didn't take your medication!" Resident #2 shook her head 'no' and refused to take the medications. During the observation on 4/13/25 at 12:00 PM, Nurse #5 was asked why the medications were left on the overbed table and Nurse #5 reported that Resident #2 had put the pills in her mouth and must have spit them out. Nurse #5 explained she had an urgent need to use the bathroom and had left the medications with Resident #2 and had not watched her swallow the medications. The medication administration record was reviewed with Nurse #5 and the medications had	F 658	4. The UM or designee will perform 5 medication observations 5X per week for four weeks, then 3X per week for four weeks, then weekly for four weeks. 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly by the Unit Manager or designee. 6. Date of compliance 05/27/25	

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F 658	Continued From page 17 been administered to Resident #2 at 10:11 AM. The Director of Nursing (DON) was interviewed on 4/13/25 at 12:40 PM. The DON reported that the medications should not have been left on the overbed table and Nurse #5 should have watched her swallow the medications. The DON was interviewed again on 4/16/25 at 12:53 PM and she reported she expected all nurses to ensure the residents were taking their medications by watching them swallow the medications and not leaving pills at the bedside. The DON reported Nurse #5 notified the physician of Resident #2's refusal to take the medications on 4/13/25. The Administrator was interviewed on 4/16/25 at 1:32 PM and she reported that Nurse #5 had to urgently use the bathroom during the medication administration to Resident #2, and she left the pills for Resident #2 to take. The Administrator reported she expected all nurses to follow the 6 rights of medication administration and to watch the residents swallow the medications.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		5/27/25

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F 689	Continued From page 18 Based on observations, record reviews and staff and Psychiatric Nurse Practitioner interviews, the facility failed to provide the necessary supervision to prevent a resident with known wandering behaviors from entering the room of another resident and attempting to take the other resident's (Resident #94's) belongings during the night for 1 of 3 residents reviewed for accidents (Resident #91). The findings included: Resident #91 was admitted to the facility on 3/10/25 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by imbalances in the body's metabolism, often due to underlying systemic illnesses), alcohol-induced persisting dementia, major depressive disorder, and anxiety disorder. A physician's order for Resident #91 dated 3/11/25 indicated Olanzapine (an antipsychotic medication) 5 milligrams (mg) every 8 hours for severe alcohol abuse disorder with unspecified mood disorder. A care plan developed on 3/11/25 addressed behaviors for Resident #91, including safety concerns regarding ambulating independently, spitting out medications, sitting on the floor, and not following directions. Interventions included consulting psychiatric services and redirection of Resident #91 when she exhibited behaviors. A Nurse Practitioner (NP) note dated 3/15/25 documented that Resident #91 had agitation, was disoriented to place, date, and situation. Resident #91 was observed to be self-propelling in a wheelchair. The plan described in the note	F 689	F-689 Free of Accidents Hazards/Supervision/Devices 1. Facility failed to provide the necessary supervision to prevent a resident with known wandering behaviors from entering the room of Resident 94. Resident #91 continues to reside at the facility. Resident #94 no longer resides at the facility. 2. Resident #91 has one on one sitter while appropriate placement is being located. Resident with BIMS of 13-15 will be interviewed by facility social services to determine if they have any concerns with other residents coming into their room. Interviews will be completed by 5/23/2025. 2. Staff Development Coordinator educated all staff regarding residents with behaviors who roam and may need supervision. Education completed 05/17/25. Any staff not receiving education by 5/27/2025 2ill receive education prior to the start of their shift. All new staff will be educated during orientation by the Staff Development Coordinator or designee annually and as needed. 3. The social services team or designee will complete interviews to patients with BIMS 13-15 weekly to determine if residents are wandering to their room. This will be done weekly x4 then monthly x 2. 4. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly by Unit Manager or designee.	

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F 689	Continued From page 19 indicated medication adjustments to be made based on Resident #91's behavior, and staff continued to monitor her behavior and report changes. A physician's order for Resident #91 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 did not reject care at the time of the assessment. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility, and was dependent on staff for ambulation. The MDS documented Resident #91 used a walker and wheelchair for mobility. Antipsychotic medications were documented as received on a routine basis. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #91 had intermittent confusion during the assessment, and she had been experiencing anxiety. The note documented anti-anxiety medication to be increased to three times per day, and staff to continue to monitor Resident #91 for changes in behavior. A physician note dated 3/19/25 documented	F 689	5. Date of compliance 05/27/25	

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marked cognitive impairment, with wandering and repeating questions.

A physician's order for Resident #91 dated 3/19/25 indicated Diazepam 5 mg 3 times per day for anxiety.

A nursing note dated 3/21/25 documented that Resident #91 was exhibiting behaviors: itching, picking at skin, restlessness, agitation, hitting, biting, kicking, spitting, cussing, racial slurs, stealing, delusions, hallucinations, and refusing care. The note documented Resident #91 was wandering into other resident rooms, touching residents, and attempting to leave the facility. The note documented 2 nurses, and 1 nursing assistant (NA) were attempting to redirect Resident #91.

A NP note dated 3/21/25 documented Resident #91 was observed pacing up and down the hallway, wandering in and out of resident's rooms, and following visitors and staff members. The note documented Resident #91 was not easily redirected.

A NP note dated 3/22/25 documented Resident #91 was observed walking up and down the hallway, attempting to walk in and out of other residents' rooms. The note documented Resident #91 had a 1:1 sitter and she was not easily redirected. The note documented that staff reported that Resident #91 was refusing medications and had been resistant to care. Lab work was ordered, and results were pending. The note documented Resident #91's symptoms were difficult to control due to metabolic encephalopathy and Resident #91 had poor safety awareness.

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The care plan that addressed Resident #91's behaviors was modified on 3/26/25 to add 1:1 sitter and noted the family was assisting with supervision.

Unit Manager #1 was interviewed on 4/16/25 at 11:48 AM and she reported the facility initiated a 1:1 sitter assigned to Resident #91 on 3/26/25 from 7:00 AM to 11:00 PM, but there had been no assigned sitter on 11:00 PM to 7:00 AM shift. Unit Manger #1 explained that all staff were responsible for supervising Resident #91.

A NP note dated 3/29/25 documented Resident #91 was observed ambulating in the hall with a sitter present. The note documented Resident #91 was confused and restless.

A NP note dated 3/30/25 documented nursing report that Resident #91 had an increase in restlessness and going into other resident rooms. The note documented Resident #91 was wandering with poor sleep at night. The note documented a one-time dose of haloperidol (antipsychotic medication used to treat nervous, emotional, and mental conditions) for restlessness and requested a psychiatric NP evaluation. The note documented to continue the 1:1 sitter and to notify the NP of any changes in behavior.

A nursing note dated 3/30/25 documented the administration of haloperidol without any effect on behavior for Resident #91. The note documented Resident #91 continued to roam the halls and attempted to enter other resident rooms, and she was aggressive with staff when staff attempted to redirect her.

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A NP note dated 3/31/25 documented Resident #91 remained restless and wandered the halls. The note documented Resident #91 had poor sleep, poor attention span, and poor safety awareness.

A nursing note written by Nurse #1 and dated 3/31/25 documented Resident #91 continued to have poor safety awareness and was taking other resident's personal items.

A NP note dated 4/1/25 documented Resident #91 was in the hallway, confused, and difficult to redirect. The note documented Resident #91 continued to wander in and out of other resident rooms.

A Psychiatric NP note dated 4/2/25 documented Resident #91 had been experiencing increased confusion and behavioral changes, including attempts to elope and sleep disturbances. The note documented medication adjustments and continued monitoring.

On 4/2/25 Resident #91's physician orders indicated her Divalproex Sodium 250 mg twice daily was increased to 250 mg 3 times per day and Olanzapine was changed from 5 mg in the morning to 10 mg at bedtime.

A NP note dated 4/3/25 documented Resident #91 was ambulating in the hall with a 1:1 sitter. The note documented staff reported Resident #91 was attempting to bite staff and slapping at their hands when they attempted to redirect her.

A nursing note dated 4/3/25 documented Resident #91 was aggressive and combative

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towards staff.

A nursing note in Resident #91's medical record written by Nurse #1 and dated 4/4/25 at 3:40 AM documented Resident #91 entered Resident #94's room and attempted to take his cell phone and glasses. The nurse was alerted to this by Resident #94 yelling out, "stop, put that down". The note documented the items were returned to Resident #94 and Resident #91 was redirected to exit the room.

A nursing note in Resident #94's medical record written by Nurse #1 and dated 4/4/25 at 3:40 AM documented Resident #94 was heard to be yelling "stop, stop, put that down." The note documented when staff entered the room, Resident #91 was noted to be standing beside Resident 94's bed with his cell phone and glasses in her hands. The note documented after Resident #91 was removed from the room. Upon assessment, small indentations on the back of Resident #94's right hand were noted, without bruising. The skin was intact and Resident #94 denied pain.

An interview was conducted with Nurse #1 on 4/15/25 at 10:34 AM. Nurse #1 reported she was working 11:00 PM to 7:00 AM shift on 4/4/25 when Resident #91 wandered into Resident #94's room and tried to take his cell phone and glasses. Nurse #1 described NA #4 had been assigned to supervise Resident #91, but she was not assigned to be a 1:1 sitter for the resident. Nurse #1 explained another resident called out for assistance and NA #4 went into the room and asked Nurse #1 to help her with the resident. During the care, Nurse #1 reported she heard yelling and when she went out into the hall,

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followed the yelling to Resident #94's room where she observed Resident #91 standing beside Resident #94's bed with his (Resident #94's) cell phone and glasses in her (Resident #91's) hands. Nurse #1 reported she did not see Resident #91 grab Resident #94, and she was able to redirect Resident #91 to leave the cell phone and glasses and leave the room.

NA #4 was interviewed by phone on 4/16/25 at 12:28 PM. NA #4 reported she was not assigned to provide 1:1 care for Resident #91 on 4/4/25, but she was told to "keep an eye on her". NA #4 reported she worked a "split" assignment between halls and during the time Resident #91 wandered into Resident #94's room, she was providing care to another resident.

Resident #94 was interviewed by phone on 4/15/25 at 8:57 AM. Resident #94 was alert and oriented person, place, time, situation and reported he very clearly remembered the incident on 4/4/25 with Resident #91. Resident #94 explained he was woken up by someone at the side of his bed on 4/4/25 "about 3:00 AM", and when he fully awoke, he realized it was Resident #91, and she had his cell phone and glasses. Resident #94 explained he knew Resident #91 was confused and he grabbed to get his phone and glasses away from her. Resident #94 reported Resident #91 grabbed at him and one of her fingernails pressed into his skin. Resident #94 described an indentation of Resident #91's fingernail on the back of his right hand that did not leave a mark or bruise his skin afterwards.

Resident #91 was observed on 4/14/25 at 9:47 AM. She was walking in the hall with NA #3 and she was observed standing at the door and

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pointing at the conference table. NA #4 attempted to redirect Resident #91 away from the conference room, but Resident #91 pushed her aside, came into the conference room and sat down at the table and spoke nonsensically for several minutes. NA #3 attempted to redirect Resident #91 to leave the conference room, but she would not leave with NA #3. An attempt was made to interview Resident #91, but she was unable to answer questions.

An interview was conducted with NA #3 on 4/14/25 at 9:47 AM. NA #3 reported she was assigned to provide 1:1 care to Resident #91 during the day shift (7:00 AM to 3:00 PM) on 4/14/25. NA #3 explained Resident #91 had been up walking the halls for 4 hours at that point, and she was very difficult to redirect. NA #3 explained that Resident #91 would become very focused on something and would not stop until she was able to see and pick up whatever got her attention. NA #3 explained she would attempt to redirect Resident #91 from taking other resident's belongings, but if she tried to take the object away from Resident #91, that caused her to become agitated.

The Psychiatric NP (NP #3) was interviewed on 4/16/25 at 9:28 AM. NP #3 explained she visited the facility every month and had last assessed Resident #91 on 4/2/25, before the incident with Resident #94. NP #3 explained Resident #91's behaviors were difficult to control due to the metabolic encephalopathy and multiple medication adjustments had been made, as well has a 1:1 sitter during the day. NP #3 explained that she was adding a medication to start on 4/16/25 that would hopefully help Resident #91 sleep at night and reduce her wandering

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F 689	Continued From page 26 behaviors. The NP reported she was notified of the incident on 4/4/25 this morning (4/16/25) when she arrived at the facility to perform her rounds. On 4/16/25 Resident #91's Divalproex Sodium medication order was changed to 500 mg at bedtime only. The Director of Nursing (DON) was interviewed on 4/16/25 at 12:53 PM. The DON explained that the facility had been attempting to place Resident #91 in a locked dementia facility that could better supervise her, but until that time, they had assigned sitters from 7:00 AM until 11:00 PM, and the depending on staffing, a sitter could be assigned on the 11:00 PM to 7:00 AM shift, but that was not the case on 4/4/25. The DON explained that all staff were responsible for supervising Resident #91, as well as other residents, and she did not know if the incident could have been prevented because of Resident 91's persistent behaviors and difficulty with being redirected. The Administrator was interviewed on 4/16/25 at 1:32 PM. The Administrator explained that the facility was attempting to find placement for Resident #91 in a facility better suited to provide her with 24 hours of supervision. The Administrator explained that the facility had 1:1 sitter during the day and staffing was being adjusted to provide that 1:1 supervision during the night shift from 11:00 PM to 7:00 AM.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F 693		5/27/25

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F 693	Continued From page 27 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe for 1 of 3 residents (Resident #79) reviewed for enteral feeding management. This practice had the potential for bacterial growth and contamination. Findings included: Resident #79 was admitted to the facility on 3/24/2025 with diagnoses of stroke and difficulty swallowing. A Physician's order dated 3/24/2025 stated Resident #79 should have placement checked to	F 693	F-693 Tube feeding Mgmt/ Restore Eating Skills 1. Facility failed to store a plastic enteral feeding syringe with the plunger separated from the barrel of the syringe for 1 of 3 residents (Resident #79) reviewed for enteral feeding management. Resident #79 continues to reside at the facility. 2. Resident #79 syringe was separated and stored separately at the time of the finding. The nurse who had used the syringe prior to storage received education on the appropriate way to store a tube feeding syringe. 3. All Nurses educated by Staff	

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F 693	Continued From page 28 her gastrotomy tube before each feeding and medication administration every shift; her residual should be checked each shift; a 20 to 30 milliliter flush of water should be given before and after administration of medication; she should receive a flush of 150 milliliters of water four times a day, and she should receive 50 milliliters an hour of enteral feeding. An admission Minimum Data Set assessment dated 4/1/2025 indicated Resident #79 was cognitively intact and received 51% or more of her total calories and more than 501 milliliters of fluids per day by enteral feedings. A review of Resident #79's Medication Administration Record for 4/13/2025 revealed she received medications, a 20 to 30 milliliter flush, 150 milliliters of water, and her residual feeding was checked at 9:00 am on 4/13/2025. During an observation of Resident #79 on 4/13/2025 at 11:03 am the plastic syringe used to check the residual amount of feeding in her stomach and flush her gastrotomy tube was stored in a plastic bag hanging from her feeding pump pole. The plastic syringe had a cream-colored liquid in the tip of the syringe and the plunger was engaged in the barrel of the syringe. The syringe was stored in a plastic bag hanging from the feeding pump pole. On 4/13/2025 at 2:41 pm the plastic syringe continued to have a cream-colored liquid in the tip and the plunger was engaged in the barrel of the syringe. The syringe was stored in a plastic bag hanging from the feeding pump pole. Nurse #2 was interviewed on 4/13/2025 at 2:52	F 693	Development Coordinator regarding proper enteral feeding equipment storage techniques. Education completed 04/22/25. Any licensed nurse not receiving education before 5/27/2025 will receive education prior to the start of their shift. All new nursing staff will be educated during orientation by the Staff Development Coordinator or designee annually and as needed. 4. The UM or designee will observe and monitor feeding tube care, equipment storage and complete an audit tool 5X per week four weeks, then 3X per week for four weeks, then weekly for four weeks (one month). 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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pm and she stated she was training Nurse #3 and Nurse #3 had checked the residual and gave Resident #79 her medications this morning at 9:00 am. She stated she did not go into the room with Nurse #3 when the residual was checked and when Nurse #3 gave Resident #79 her medications around 9:00 am. Nurse #2 stated she was not aware the plunger should be removed from the barrel of the syringe to allow the syringe to dry completely after it was rinsed when it was used to give Resident #79 her medications. Nurse #2 stated she was aware the syringe should be rinsed after each use and the feeding should not have been left in the syringe.

Nurse #3 stated she was in training and was not aware she should have separated the plunger from the barrel of the syringe, rinsed the syringe and the plunger, and allowed them to dry before placing them in the plastic bag after she checked Resident #79's enteral feeding residual and gave her medications through her gastrostomy tube this morning at 9:00 am.

During an interview with Nurse Practitioner #1 on 4/15/2025 at 3:06 pm she stated the enteral feeding Resident #79 received had sugar in it and the product sitting in the plastic syringe with the plunger engaged would have caused bacteria to grow. She stated Resident #79 had not had any issues that would indicate the enteral feeding syringe being left with feeding in the tip had caused her any harm.

The Director of Nursing was interviewed on 4/16/2025 at 12:30 pm and she stated the enteral feeding syringe should have had the plunger removed, rinsed out and placed so that it could air dry, and then stored with the plunger not

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F 693	Continued From page 30 engaged. The Director of Nursing stated she planned to re-educate all the nursing staff. On 4/16/2025 at 12:42 pm the Administrator was interviewed and stated the enteral feeding syringe should have been taken apart and cleaned, allowed to dry and then stored in the bag with the plunger separate from the syringe.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff, resident and Nurse Practitioner, the facility failed to: 1) provide oxygen at the rate ordered by the physician: provide clean air intake filters on oxygen concentrators for 1 of 5 residents (Resident #79); 2) post oxygen signs for 3 of 5 residents (Resident #10, Resident #13, and Resident #33); 3) change oxygen tubing for 2 of 5 residents (Resident #10 and Resident #33); and 4) obtain physician's order for oxygen delivery for 1 of 5 residents (Resident #250) reviewed for respiratory care. Findings included:	F 695	F-695 Respiratory/Tracheostomy Care and Suctioning 1. Facility failed to: 1) provide oxygen at the rate ordered by the physician: provide clean air intake filters on oxygen concentrators for 1 of 5 residents (Resident #79); 2) post oxygen signs for 3 of 5 residents (Resident #10, Resident #13, and Resident #33); 3) change oxygen tubing for 2 of 5 residents (Resident #10 and Resident #33); and 4) obtain physician's order for oxygen delivery for 1 of 5 residents (Resident #250) reviewed for respiratory care Resident #10, 33, 79, 250 continue to reside at the facility.	5/27/25

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F 695	Continued From page 31 1. Resident #79 was admitted to the facility on 3/24/2025 with diagnoses of respiratory failure, pneumonia, and stroke. A Physician's Order dated 3/24/2025 indicated Resident #79 should receive 2 liters per minute oxygen by nasal cannula. An admission Minimum Data Set assessment dated 4/1/2025 indicated Resident #79 was cognitively intact and required oxygen therapy. The 10-liter Oxygen Concentrator Guide stated the air filter should be cleaned at least once a week with warm water and dishwashing detergent, rinsed thoroughly with warm tap water and towel dried. The filter should be completely dry before reinstalling. The guide also stated the exterior cabinet of the oxygen concentrator should be cleaned with a damp cloth or sponge with mild household cleaner and wiped dry weekly. On 4/13/2025 at 11:05 am Resident #79 was observed in her room with the head of her bed elevated. Resident #79 had a tracheostomy with an inner cannula and tracheostomy collar and dressing in place. The tracheostomy, tracheostomy collar, and tracheostomy dressing were clean with no stain or sputum noted. Resident #79's oxygen concentrator had approximately ½ inch of dust covering the air intake filter. During an observation on 04/15/25 at 12:44 PM of Nurse #1 providing Resident #79's tracheostomy tie and dressing change the oxygen was set at 4 liters per minute by tracheostomy collar. Nurse #1 stated the resident was ordered	F 695	2. Resident # 79 oxygen flow rated was corrected to the ordered amount. 100% oxygen and trach residents orders audited, and concentrators reviewed to flow rates filter cleanliness and tubing. Identified issues corrected. 3. Staff Development Coordinator educated all nursing staff regarding oxygen tubing policy, posting of signage, rate/ flow as per orders and proper cleaning of concentrator machines. Oxygen orders audited. Oxygen settings immediately adjusted as per orders. Oxygen signage posted and tubing changed for residents. Central Supply clerk and Floor Tech cleaned oxygen concentrator filters as per manufacturer instructions. Education completed 04/22/25 of nurses and central supply staff. Any licensed nurse not receiving education by 5/27/2025 will be educated prior to the start of their shift. Newly hired nursing staff will be educated by the Staff Development Coordinator or designee during orientation annually and as needed. 4. The UM or designee will complete an audit tool for oxygen settings and cleanliness of oxygen concentrators 5X per week four weeks, then 3X per week for four weeks, then weekly for four weeks. 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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2 liters per minute by her tracheostomy collar and the order was written 3/24/2025 but her oxygen was set at 4 liters per minute. Nurse #1 stated she did not know why Resident #79's oxygen was set higher than what was ordered.

On 4/14/2025 at 1:05 pm an interview was conducted with Nurse #1, and she stated she thought the nurse that worked from 7:00 pm to 7:00 am should clean the oxygen machines but she was not sure how often the machine should be cleaned. Nurse #1 stated there was a 1/8-inch film of grey dust on the oxygen concentrator filter.

During an interview with the Central Supply Technician on 4/15/2025 at 12:58 pm she stated she cleaned the oxygen concentrator before she assigns the machine to a resident when they are admitted, and she checks them once a month and either dusts them out or cleans them with an air gun. The Central Supply Technician stated she was not aware of the manufacturer's instructions.
Unit Manager #1 was interviewed on 4/15/2025 at 1:10 pm and she stated she was not aware of a schedule for cleaning the oxygen concentrators on a regular basis, but they should be checked daily by the nurse.

During an interview with the Nurse Practitioner #1 on 4/15/2025 at 3:06 pm she stated the nursing staff should have followed the order that was written for oxygen at 2 liters per minute for Resident #79's oxygen and notified her if the oxygen needed to be increased for any reason. Nurse Practitioner #1 stated she changed Resident #79's oxygen order to 2 to 4 liters per minute to keep her oxygen saturation above 90%. Nurse Practitioner #1 stated she did not know the

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protocol for cleaning the oxygen concentrators.

The Director of Nursing was interviewed on 4/16/2025 at 12:30 pm and stated the oxygen concentrators should be cleaned at least every two weeks and the nurse should clean them when they change the oxygen tubing. She stated the facility's policy stated the oxygen concentrator should be cleaned according to the manufacturer's guidelines.

On 4/16/2024 at 12:42 pm the Administrator was interviewed and stated Resident #79's oxygen should have been set at the level that was ordered by the Physician, and the concentrator should have been cleaned as needed and periodically per the manufacturer's guidelines for the oxygen concentrator.

2. a. Resident #10 was admitted on 03/21/25 with diagnoses of asthma, respiratory failure, and muscle weakness.

A physician order for Resident #10 dated 03/21/25 read oxygen at 3 liters per minute via nasal canula every shift.

Review of Resident #10's admission Minimum Data Set (MDS) 03/28/25 revealed the resident was cognitively intact and was coded for the use of oxygen.

An observation conducted on 04/13/25 at 11:55 AM revealed there was no signage for oxygen use found anywhere near the entrance of Resident # 10's room. Resident #10 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator

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was observed in Resident # 10's room.

An observation conducted on 04/14/24 at 12:50 PM revealed there was no signage for oxygen use found anywhere near the entrance of Resident # 10's room. Resident #10 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 10's room.

b. Resident #13 was admitted on 04/02/25 with diagnoses of asthma, respiratory failure, and muscle weakness.

A physician order for Resident #13 dated 04/01/25 read oxygen at 3 liters per minute via nasal canula every shift.

Review of Resident #13's significant change MDS revealed the resident was cognitively intact and was coded for the use of oxygen.

An observation conducted on 04/13/25 at 11:55 AM revealed there was no signage for oxygen use found anywhere near the entrance of Resident #13's room. Resident #13 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 13's room.

An observation conducted on 04/14/24 at 12:50 PM revealed there was no signage for oxygen use found anywhere near the entrance of Resident # 13's room. Resident #13 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 13's room.

c. Resident #33 was admitted on 02/28/25 with

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diagnoses of asthma, hypertension, respiratory failure, and muscle weakness.

A physician order for Resident #33 dated 02/28/25 read oxygen at 2 liters per minute via nasal canula every shift.

Review of Resident #33's admission MDS dated 03/07/25 revealed the resident was cognitively intact and was coded for the use of oxygen.

An observation conducted on 04/13/25 at 11:45 AM revealed there was no signage for oxygen use found anywhere near the entrance of Resident #33's room. Resident #33 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident # 33's room.

An observation conducted on 04/14/24 at 1:15 PM revealed there was no signage for oxygen use found anywhere near the entrance of Resident # 33's room. Resident #33 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident # 33's room.

An interview conducted with Unit Manager (UM) #1 on 04/15/25 at 11:20 AM revealed she was aware Resident #10, Resident #13, and Resident #33 had continuous oxygen but was not aware the residents did not have oxygen signs posted outside or inside their rooms. UM #1 indicated she was not aware rooms had to have signage.

An interview conducted with the Director of Nursing (DON) on 05/15/25 at 3:45 PM revealed unit managers, housekeeping supervisors, and admissions were responsible for hanging signage

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when a resident was on oxygen. The DON stated she was not aware signage had not been posted but should have been because it was facility policy.

3.a. Resident #10 was admitted on 03/21/25 with diagnoses of asthma, respiratory failure, and muscle weakness.

Review of Resident #10's admission Minimum Data Set (MDS) 03/28/25 revealed the resident was cognitively intact and was coded for the use of oxygen.

A physician order for Resident #10 dated 03/21/25 read oxygen at 3 liters per minute via nasal canula every shift.

A physician order for Resident #10 dated 3/22/25 read oxygen tubing change weekly every Saturday during night shift.

An observation and interview on 04/13/25 at 11:55 AM revealed Resident #10's tubing was dated 03/30/25. Resident #10 stated nursing staff had not recently changed her tubing and felt like her nasal canula was dirty. Observation indicated the nasal canula to be cloudy and with a crust like substance.

b. Resident #33 was admitted on 02/28/25 with diagnoses of asthma, hypertension, respiratory failure, and muscle weakness.

Review of Resident #33's admission MDS dated 03/07/25 revealed the resident was cognitively intact and was coded for the use of oxygen.

A physician order for Resident #33 dated

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	345419	A. BUILDING _____ B. WING _____	C 04/29/2025

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02/28/25 read oxygen at 2 liters per minute via nasal canula every shift.

A physician order for Resident #33 dated 3/21/25 read oxygen tubing change weekly every Saturday during night shift.

An interview and observation conducted with Nurse #5 on 04/14/25 at 1:15 PM revealed Resident #33's and Resident #10 oxygen tubing was dated 03/30/25 and had not been changed in two weeks. Nurse #5 indicated oxygen tubing should have been changed and needed to be changed.

A phone interview conducted with Nurse #6 on 04/16/25 at 10:30 AM revealed on 04/05/25 she worked evening shift and was assigned Resident #33 and Resident #10. It was further revealed she did not change oxygen tubing due to not having enough supplies. Nurse #6 indicated she had voiced concerns of lack of supplies to upper management before she left her shift on 04/06/25.

A phone interview with Nurse #7 on 04/15/25 at 11:30 AM revealed they were assigned Resident #10 and Resident #33 on 04/12/25. Nurse #7 stated he had not changed tubing due to lack of supplies or the shift being chaotic. Nurse #7 indicated night shift can be hectic and there are other priorities.

An interview conducted with the Director of Nursing (DON) on 04/15/25 at 3:50 PM revealed Resident #10 and Resident #33 were on continuous oxygen. The DON stated she was not aware the residents' oxygen tubing had not been changed as ordered but should have been

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changed on 04/05/15 and 04/12/25.

4. Resident #250 was admitted the facility on 03/26/25 with diagnoses which included muscle weakness and hypertension.

Review of Resident #250's admission MDS dated 04/02/25 revealed the resident was moderately cognitively impaired and was not coded for oxygen use.

Review of Resident #250's care plan revealed no plan or interventions for oxygen use.

Review of Resident #250's physician orders revealed no orders in place for continuous oxygen use.

An observation was conducted on 04/13/25 at 12:00 PM revealed Resident #250 sitting up in her wheelchair with oxygen running at 2 liters per minute.

An observation was conducted on 04/14/25 at 1:45 PM revealed Resident #250 sitting up in her wheelchair with oxygen running at 2 liters per minute.

An interview conducted with UM #1 on 04/15/25 at 2:15 PM revealed she did not recall when Resident #250 had started on oxygen but indicated she had been on continuous oxygen for at least a week. UM #1 stated nursing staff had been educated to ensure orders were initiated when residents started oxygen. UM #1 indicated Resident #250 was seen by a Nurse Practitioner on 04/07/25 due to respiratory concerns and believed the order got missed.

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F 695	Continued From page 39 A phone interview conducted with Nurse Practitioner (NP) #2 on 04/15/25 at 11:20 AM revealed she had filled in on 04/07/25 to assist the facility and recalled assessing Resident #250. NP #2 saw the resident due to shortness of breath and wheezing. The NP stated she did not order oxygen because the resident was already on oxygen when she arrived and thought it was already ordered. The NP indicated Resident #250 should have had an order put in for oxygen due to the resident having continuous oxygen for several days. An interview with the DON on 04/15/25 at 3:50 PM revealed NP #2 had assessed Resident #250 on 04/07/25 due to respiratory concerns. The DON further revealed she was not aware there had been no oxygen order put in for Resident #250. The DON indicated she was unable to determine when Resident #250 had started using oxygen, but nursing staff should have completed an order if the NP failed to enter one.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757		5/27/25

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F 757	Continued From page 40 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to complete an International Normalized Ratio (INR) test as ordered by the physician for 1 of 1 resident (Resident # 255) reviewed for monitoring anticoagulant medicine. The findings included: Resident #255 was admitted to the facility on 03/30/21 with diagnoses which included atrial fibrillation. Review of Resident #255's quarterly Minimum Data Set (MDS) dated 02/22/25 revealed the resident was coded for anticoagulant use. Review of Resident #255's care plan created on 03/30/21 revealed the was on anticoagulant therapy. The goal for Resident #255 would be to be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions included complete labs as ordered and report abnormal lab results to the Medical Director (MD). Review of Resident #255's physician order dated 01/30/25 revealed the resident was ordered to	F 757	F-757 Drug Regimen is Free from Unnecessary Drugs 1. Facility failed to complete an International Normalized Ratio (INR) test as ordered by the physician for 1 of 1 resident (Resident # 255) reviewed for monitoring anticoagulant medicine. Resident #255 no longer resides at the facility. 2. Resident # 255 no longer resides at the facility. Current residents with PT/INR orders were audited on 5/22/2025 and all PT/INRs are up to date and reviewed by the provider. 3. DON and all nurses educated by Staff Development Coordinator regarding obtaining PT/INR as per written order. Education completed 05/17/25. Any licensed nurse not receiving education by 5/27/2025 will receive education prior to the start of their shift. All newly hired nurses will be educated during orientation by the Staff Development Coordinator or designee annually and as needed. 4. The UM or designee will complete an audit tool by reviewing the progress notes and the order listing for the past 24 hours during daily clinical meetings to ensure	

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F 757	Continued From page 41 receive a warfarin sodium(anticoagulant/blood thinner) oral tablet 2 milligram (mg), give 1 tablet by mouth at bedtime related to unspecified atrial fibrillation. Review of an INR lab dated 03/03/25 revealed Resident #255's INR was at 3.54 (therapeutic range 2.0 to 3.0). It was ordered to hold warfarin for 2 days and re-check the INR level on 03/05/25. Review of Resident #255's Medication Administration Review (MAR)revealed from 03/03/25-03/05/25 warfarin 2mg was documented as having been held daily. Review of INR lab dated 03/05/25 revealed Resident #255's INR was 4.0. Review of a progress note dated 03/05/25 completed by Nurse Practitioner (NP) #1 revealed Resident #225's INR was recently checked, and it was at 4.0 that morning (normal range 2-3). It was further noted Resident #255's warfarin was to be held until 3/7/25. The note indicated Resident #255's INR was to be rechecked on 03/07/25 and to notify NP #1 of any bleeding or changes. Review of Resident #255's physician orders revealed an order dated 03/07/25 to check Resident #255's INR on 03/07/25 and hold Warfarin (anticoagulant) until further notice. Review of Resident #255's MAR revealed from 03/05/25- 03/12/25 warfarin was not administered to Resident #255. Further review revealed Nurse #1 signed off on 03/07/25 that an INR was completed on the resident, there was no	F 757	that all PT/INR have been obtained and reviewed by provider for 5X per week four weeks, then 3X per week for four weeks, then weekly for four weeks (1 month). 5. Results of these audits will be reviewed at the Quarterly QA meeting X1 for further problem resolution, if needed the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	

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documented INR result.

Review of Resident #255's labs and progress notes indicated no results for an INR lab as ordered for Resident #255 for the 03/07/25 ordered INR.

A phone interview conducted with Nurse #1 on 04/24/25 at 8:00 pm revealed on 03/07/25 she was assigned Resident #255. Nurse #1 could not recall if she had completed Resident #255's INR on that date but explained if she had completed the resident's INR it would have been in the resident's chart. Nurse #1 stated if the INR result was not in the residents' chart, then she did not complete it.

Review of the NP note dated 03/12/25 revealed Resident #255 was seen for a follow up on PT/INR. The note further revealed Resident #255 was lying in bed, on room air, alert, in no acute respiratory distress. The note indicated Residents INR was checked and her INR was a 1.3. It was ordered for Resident #255 to continue Warfarin 2mg daily and recheck PT/INR on 3/17/25. Resident #255 was agreeable to plan of care and denied additional acute concerns at this time.

Review of an INR lab dated 03/12/25 revealed Resident #255's INR was at 1.3. It was ordered to re-start 2 mg of Warfarin for 5 days and re-check the INR level on 03/17/25.

Review of Resident #255's MAR revealed Resident #255 was administered Warfarin 2 mg from 03/12/25 until 03/17/25.
Review of INR lab dated 03/17/25 revealed Resident #255's INR was 2.18.

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A phone interview conducted with NP #1 on 04/24/25 at 1:10 PM revealed Resident #255's INR was being followed closely due to the resident's INR numbers fluctuating. NP #1 revealed on 03/05/25 Resident #255 had an INR rate of 4.0 and she wanted the resident's warfarin held and the INR to be rechecked on 03/07/25. The NP indicated Resident #255 was checked on 03/12/25 and Resident #255 had an INR result of 1.3. The NP stated there was no harm or negative outcome as a result of the resident's INR was not checked on 03/07/25 but expected nursing staff to follow through with orders given and notification of any changes.

An interview conducted with the Director of Nursing (DON) on 04/24/25 at 3:00 PM revealed Resident #255 had ongoing issues with her INR not being consistent. The DON further revealed it was being followed closely by the medical providers. The DON stated she was not aware it was not checked on 03/07/25 but expected nursing staff to follow orders.

An interview conducted on 04/28/25 at 1:00 PM the Administrator revealed she had reviewed Resident #255's chart and could not find any documentation Resident #255 received an INR check on 03/07/25. The Administrator further revealed she expected orders to be followed through with and believed Resident #255's order from 03/07/25 to have her INR checked was missed.