

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345144</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/05/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE RIDGE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 PINEYWOOD ROAD</b> <b>THOMASVILLE, NC 27360</b>		
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E 004 SS=F	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p>	E 004		7/1/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/29/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	<p>Continued From page 1</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness plan was reviewed and updated to reflect a change in the Administrator and Director of Nursing positions.</p> <p>The findings included:</p> <p>The Facility's Emergency Preparedness Plan was reviewed and indicated the last review of the plan was completed on 1/17/2025. The former Administrator and former Director of Nursing were listed as the Administrator and Director of Nursing of record.</p> <p>The Administrator was interviewed on 6/5/2025 at 11:17 am and she stated that she came to the facility as the Administrator in 3/2025 and the Director of Nursing came to the facility in 3/2025. She stated the Emergency Preparedness Plan had not been updated to include the change in the administration positions when they came to the facility. The Administrator stated the lack of update was just an oversight and she would update the Emergency Preparedness Plan to reflect the corrected names.</p>	E 004	<p>1. What corrective action will be accomplished for each resident found to be affected.</p> <p>On 6/5/25, the Administrator reviewed and updated the Emergency Preparedness (EP) Plan to include an updated signature sheet to reflect the change in the Administrator and the Director of Nursing positions.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice</p> <p>The current residents are at risk for this deficient practice</p> <p>3. What measures are put in place or systemic changes are made to ensure practice will not re-occur.</p> <p>The Director of Nursing and Administrator was educated on 6/5/25 by the Regional Vice President of Operations on ensuring that the Emergency Preparedness plan is</p>		

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E 004	Continued From page 2	E 004	<p>reviewed and updated to include an updated signature sheet when changes are made with the Administrator and or the Director of Nursing.</p> <p>After 6/5/25, education will be provided by the Regional Vice President of Operations for any newly hired, interim, or contract Administrators and/or Directors of Nursing.</p> <p>4. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur</p> <p>The Regional Nurse Consultant will audit the EP Plan weekly x 4 weeks and monthly x 2 months to ensure that the EP plan continues to be reviewed, updated, and signature sheet signed when changes in Administrators and/or Directors of Nursing occur.</p> <p>The Administrator will present the findings of the Emergency Preparedness Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring;</p>		
F 000	<p>INITIAL COMMENTS</p> <p>A recertification and complaint investigation survey was conducted from 6/2/25 through 6/5/25. Event ID# LFDP11. The following intakes were investigated NC00222907, NC00230687, NC00229357, NC00225428, and NC00219298.</p>	F 000			

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F 000	Continued From page 3	F 000			
F 628	3 of the 13 complaint allegations resulted in deficiency.				
SS=C	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii)	F 628		7/1/25	
	<p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>§483.15(c)(3) Notice before transfer.</p> <p>Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The</p>				

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F 628	<p>Continued From page 4</p> <p>facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p>	F 628			

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F 628	<p>Continued From page 5</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p>			F 628			

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F 628	<p>Continued From page 6</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <ul style="list-style-type: none"> <li>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</li> <li>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</li> <li>(iv) The information specified in paragraph (e)(1) of this section.</li> </ul> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p>	F 628			

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F 628	<p>Continued From page 7</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and interviews with Resident Representatives (RR) and staff, the facility failed to provide the resident or RR written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization (Residents #32, #59 and #63). In addition, the facility failed to provide a discharge summary to Resident #87 when they were discharged home or complete a recapitulation of a resident stay after discharge for 1 of 1 resident reviewed for a planned discharge.</p> <p>The findings included:</p> <p>1. Resident #32 was initially admitted to the facility on 2/13/18. Her medical record indicated that a family member was her RR.</p>	F 628	<p>1. Address how corrective action will be accomplished for those residents found to have been affected by this deficient practice:</p> <p>On 6/20/25, the social worker sent by mail Resident #32's written notice of transfer to include reason for the prior hospitalizations to the resident representative. The social worker also contacted the resident representative via phone on 6/23/25.</p> <p>On 6/20/25, the social worker sent by mail Resident #59's written notice of transfer to include reason for the prior hospitalizations to the resident representative. The social worker also</p>		



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F 628	<p>Continued From page 8</p> <p>Resident #32 was transferred to the hospital on 3/23/25 for vomiting and on 5/30/25 for respiratory distress.</p> <p>On 6/4/25 at 9:43 AM, an interview occurred with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the RR was notified by phone of the reason for the transfer.</p> <p>On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer notice was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the RR.</p> <p>A phone call was placed to Resident #32's RR on 6/4/25 at 12:34 PM. He stated that he was called when Resident #32 was discharged to the hospital, but he had never received anything in writing regarding the reason for the hospital transfers.</p> <p>An interview was conducted with the Social Worker (SW) on 6/4/25 at 1:30 PM. She stated she had been employed at the facility since the end of February 2025. The SW stated she was unaware a written reason for hospital transfer was to be provided to the resident or mailed to the RR.</p> <p>On 6/4/25 at 1:48 PM, another interview was completed with the Administrator who had been employed at the facility since March 2025. She verified the RR was notified by phone when a</p>	F 628	<p>contacted the resident representative via phone on 6/23/25.</p> <p>On 6/20/25, the social worker sent by mail Resident #63's written notice of transfer to include reason for the prior hospitalizations to the resident representative. The social worker also contacted the resident representative via phone on 6/23/25.</p> <p>Resident #87 discharge summary was completed by the provider on 6/25/25.</p> <p>2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>The current residents are at risk for this deficient practice.</p> <p>An audit of the residents who have discharged and/or transferred from the facility in the last 30 days will be completed by social services by 6/25/25 to ensure written notice of transfer/discharge including the reason have been completed and sent to the resident representative and/or provide resident. Any identified missing written notices of transfer and/or discharge will be sent to the resident representative and/or the resident to include reason for discharge and/or transfer.</p> <p>An audit of the current residents was completed on 6/23/25 by the Director of Nursing of the planned discharges for the last 30 days to ensure discharge summaries and recapitulation of resident stay have been completed by the</p>		

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F 628	<p>Continued From page 9</p> <p>resident was transferred to the hospital and a copy of the transfer form was sent in the packet going to the hospital. She was unaware a written reason for the hospital transfer was required to be provided to the resident or RR.</p> <p>2. Resident #59 was initially admitted to the facility on 11/3/22. Her medical record indicated that she had a guardian for her medical and financial concerns.</p> <p>Resident #59 was transferred to the hospital on 2/28/25 for altered mental status.</p> <p>On 6/4/25 at 9:43 AM, an interview occurred with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the RR was notified by phone of the reason for the transfer.</p> <p>On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer notice was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the RR.</p> <p>A phone call was placed to Resident #59's guardian on 6/4/25 at 12:17 PM. She stated that she was called when Resident #59 was discharged to the hospital, but she had never received anything in writing regarding the reason for the hospital transfer.</p> <p>An interview was conducted with the Social Worker (SW) on 6/4/25 at 1:30 PM. She stated</p>	F 628	<p>provider. Any identified concerns will be followed up with the provider.</p> <p>3.Address what measures will be into place or systemic changes made to ensure that deficient practice will not recur: The Administrator educated the social Worker on 6/23/25 related to ensuring that resident representatives and/or residents are provided written notice of transfer/discharge to include the reason of the transfer when resident's transfers and/or discharged from the facility and documentation is completed in the medical record. The Director of Nursing educated the Medical Director on 6/23/25 related to ensuring that a discharge summary to include a recapitulation of a resident stay is completed on planned discharges.</p> <p>4.How will the facility monitor its performance to ensure the deficient practice does not recur:</p> <p>The Administrator will complete audits of residents that transfer and/or discharged from the facility to ensure written notice of transfers to include reason of transfer have been sent to the resident representative and/or resident weekly x 2 weeks and monthly x 2 months to ensure ongoing compliance. The Director of Nursing will complete audits of planned discharges to ensure discharge summaries to include recapitulation of resident stay continue to be completed weekly x 2 weeks and</p>		

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F 628	<p>Continued From page 10</p> <p>she had been employed at the facility since the end of February 2025. The SW stated she was unaware a written reason for hospital transfer was to be provided to the resident or mailed to the RR.</p> <p>On 6/4/25 at 1:48 PM, another interview was completed with the Administrator who had been employed at the facility since March 2025. She verified the RR was notified by phone when a resident was transferred to the hospital and a copy of the transfer form was sent in the packet going to the hospital. She was unaware a written reason for the hospital transfer was required to be provided to the resident or RR.</p> <p>3. Resident #63 was admitted to the facility 7/30/24 with her most recent readmission on 12/9/24. Diagnoses for Resident # 63 included stroke and feeding tube.</p> <p>a. Review of the medical record for Resident # 63 revealed a nursing change of condition note dated 10/30/24 at 11:53 PM. The note documented a change of condition for Resident #63 and a physician order was received to transfer her to the hospital for evaluation and treatment.</p> <p>A nursing progress note dated 11/4/24 documented Resident #63 was readmitted to the facility.</p> <p>Review of the medical record revealed no notice of transfer was in the record for the hospitalization from 10/30/24 to 11/4/24.</p> <p>b. Review of the medical record for Resident #63 revealed a nursing progress note dated 11/11/24</p>	F 628	<p>monthly x 2 months to ensure ongoing compliance.</p> <p>The Administrator and the Director of Nursing are responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 months to determine trends and/or issues that need further interventions and the need for additional monitoring.</p>		

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F 628	<p>Continued From page 11</p> <p>at 9:15 PM documented a change in status for Resident #63 and noted a physician order to send Resident #63 to the hospital for evaluation and treatment.</p> <p>A nursing note dated 12/9/24 documented Resident #63 was readmitted to the facility after hospitalization.</p> <p>Review of the medical record revealed no notice of transfer was in the record for the hospitalization from 11/11/24 to 12/9/24.</p> <p>Resident #63's Responsible Party was interviewed by phone on 6/5/25 at 9:40 AM. The Responsible Party reported she had not received a written notice of transfer anytime Resident #63 has been admitted to the hospital.</p> <p>On 6/4/25 at 9:43 AM, an interview was conducted with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the Responsible Party was notified by phone of the reason for the transfer.</p> <p>On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer information for the hospital was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the Responsible Party.</p> <p>The Director of Nursing was interviewed again on 6/5/25 at 10:14 AM and she reported she did not</p>	F 628			

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F 628	<p>Continued From page 12</p> <p>know that a written notice of transfer was required to be sent to the residents and the Responsible Party.</p> <p>The Administrator was interviewed again on 6/5/25 at 12:52 PM and she reported she did not know why the written notice of transfer was not sent to Resident #63 or her Responsible Party, but she expected a written notice to be sent.</p> <p>4. Resident #87 was admitted to the facility 4/22/25 with diagnoses including hypertension and dementia.</p> <p>Resident #87 was discharged home on 5/27/25.</p> <p>Review of the medical record revealed no discharge summary including a recapitulation of Resident #87's stay.</p> <p>The Social Worker was interviewed on 6/4/25 at 12:01 PM and she reported she did not know who was responsible for completing the discharge summary for residents leaving the facility. The Social Worker explained she did not think she was responsible for the discharge summary.</p> <p>Resident #87's Responsible Party was interviewed by phone on 6/4/25 at 1:24 PM. The Responsible Party reported she had not received a discharge summary for Resident #87 when she was discharged from the facility.</p> <p>The Director of Nursing was interviewed on 6/5/25 at 10:14 AM and she reported she was not aware the facility was not completing a discharge summary.</p> <p>The Administrator was interviewed on 6/5/25 at</p>	F 628			

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F 628	Continued From page 13 12:52 PM and she reported that any resident and Responsible Party should receive a written discharge summary.	F 628			
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 record review and Medical Director and staff interviews, the facility failed to prevent Resident #83 from receiving a dose of Lyrica (a medication used to treat nerve and muscle pain) that was prescribed for Resident #13. This affected 1 of 6 residents whose medications were reviewed (Resident #83).  The findings included:  Resident #83 was admitted to the facility on 2/18/25 with diagnoses that included neuralgia and neuritis (pain and inflammation of the nerves).  An admission Minimum Data Set (MDS) assessment dated 2/25/25 indicated that Resident #83 had severely impaired cognition.  Review of Resident #83's May 2025 physician orders included an order dated 2/18/25 for Pregabalin (Lyrica) 25 milligrams (mg) 1 capsule by mouth twice a day for neuropathic pain.  Resident #13 was admitted to the facility on	F 658	Past noncompliance: no plan of correction required.		

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F 658	<p>Continued From page 14</p> <p>4/27/23 with diagnoses that included radiculopathy of the cervical region, bursitis of the left shoulder, and chronic pain syndrome.</p> <p>A quarterly MDS assessment dated 4/10/25 indicated that Resident #13 was cognitively intact.</p> <p>A review of Resident #13's May 2025 physician orders included an order dated 8/22/24 for Lyrica 100 mg one tablet by mouth three times a day for neuropathic pain.</p> <p>A facility investigational summary dated 5/15/25 indicated that Nurse #2 completed a narcotic count on 5/15/25 at 11:00 PM and found a discrepancy with the count for Resident #83 and Resident #13. Both residents received a dose of Lyrica at 8:00 PM, however there had not been a Lyrica 25 mg removed from Resident #83's blister pack for the 8:00 PM dose and two pills had been removed from Resident #13's Lyrica 100 mg blister pack. The incident was reported to the Medical Director and Resident #83's Resident Representative (RR).</p> <p>A review of Resident #83's May 2025 Medication Administration Record (MAR) indicated Lyrica was provided at 8:00 PM. The MAR didn't indicate the medication was not provided to Resident #83.</p> <p>A nursing progress note dated 5/16/25, written by Nurse #2, revealed that a medication count discrepancy was noted with Residents #83 and #13's Lyrica. The note read that both residents received Lyrica at the same time but at different dosages. Nurse #2 indicated he couldn't recall if had given Resident #83 Lyrica 100 mg that was ordered for Resident #13 but immediately notified</p>	F 658			

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F 658	<p>Continued From page 15</p> <p>the former Assistant Director of Nursing (ADON), began evaluations of Resident #83 and notified the Medical Director and RR.</p> <p>A phone interview was completed with Nurse #2 on 6/4/25 at 9:35 PM who recalled the medication error incident. He explained that he had provided medications at 8:00 PM as ordered to Resident #83 and #13. A narcotic count was completed at 11:00 PM and it was noted that Resident #13 had an extra dose of Lyrica 100 mg removed from the medication card while Resident #83's Lyrica 25 mg had the same count as when he started the shift at 7:00 PM. Nurse #2 stated he failed to look at the medication label to ensure the correct medication was pulled for the correct resident. Nurse #2 stated that when he found the discrepancy, he went to assess Resident #83 who was at her baseline, contacted the former ADON, Medical Director and Resident #83's RR. The Medical Director stated to continue monitoring Resident #83 for any side effects. Nurse #2 stated that Resident #83's vital signs remained within normal limits, and she displayed no side effects from receiving the incorrect dosage of Lyrica during the remainder of the night.</p> <p>A review of Resident #83's vital signs from 5/16/25 indicated that at 12:44 AM, 3:04 AM and 6:23 AM they were all within normal limits.</p> <p>On 6/4/25 at 10:57 AM, an interview occurred with the Director of Nursing (DON). She explained that on 5/15/25 Nurse #1 had two residents that received Lyrica at the same time but at different dosages. Resident #83 received 25 mg and Resident #13 received 100 mg at 8:00 PM. Nurse #1 completed his medication pass and</p>	F 658			



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F 658	<p>Continued From page 16</p> <p>completed a narcotic count at 11:00 PM where he found a discrepancy for Lyrica. During the narcotic count he noted that Lyrica 25 mg had not been utilized at 8:00 PM for Resident #83 and two pills had been used out of the Lyrica 100 mg pack for Resident #13. The DON stated that Nurse #2 self-reported the discrepancy, the Medical Director and Resident #83's RR were notified, and Resident #83 was monitored for the rest of the shift. The DON further stated that education was provided to Nurse #2 regarding medication errors and a medication pass observation was completed.</p> <p>A phone interview occurred with the Medical Director on 6/5/25 at 9:00 AM and stated he was notified of the medication error, but didn't feel there would have been any harm caused to Resident #83 from receiving Lyrica 100 mg instead of Lyrica 25 mg one time. He recalled instructing the nurse to monitor Resident #83 throughout the remainder of the shift.</p> <p>Multiple attempts were made to contact the former ADON without success.</p> <p>The facility provided the following corrective action plan:</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/15/25 the nurse noted there was a narcotic count discrepancy on two residents' Lyrica with different dosages. The nurse assessed both residents with no noted adverse outcome identified. The residents and/or responsible party as well as the physician were notified. The nurse received one-to-one education on the Rights of</p>	F 658			

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F 658	<p>Continued From page 17</p> <p>Medication Administration on 5/16/25.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/16/25 the DON/designee initiated a 100% audit of all current residents who receive Lyrica to ensure the right dosage was administered to the resident as per physician order. The DON/designee will notify the physician of all areas of concern identified during the audit. On 5/17/25 the DON/designee initiated an audit of all incident reports for the past 30 days to identify trends and identify any incidents related to medication administration to ensure appropriate interventions were initiated, physician notified, and resident assessed as indicated.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All nursing staff to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Medication Aides received education regarding Rights of Medication Administration on 5/16/25 by the former ADON. Education will be provided to any agency nursing staff before taking an assignment and will be incorporated in the new hire process.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when correction action will be completed: The DON/designee will complete random audits of medication administration weekly for 12 weeks. The physician will be notified of any identified areas of concern, and the staff will receive re-training of the Rights of Medication</p>			F 658			

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F 658	Continued From page 18  Administration. The Administrator or DON will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for two months. The QAPI committee will meet monthly for two months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. This was reviewed in the QAPI meeting on 5/22/25.  The plan alleged compliance on 5/22/25.  As part of the validation process, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Education was provided all licensed nursing staff and Medication Aides on the Rights of Medication Administration. A review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with licensed nurses and Medication Aides revealed they had received education on proper medication administration. Medication Administration was observed as part of the recertification survey and no errors were noted. The compliance date of 5/22/25 for the corrective action plan was validated.	F 658			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		7/1/25	

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F 684	<p>Continued From page 19</p> <p>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and resident and staff interviews, the facility failed to provide treatments as ordered by the physician for a non-pressure wound for 1 of 4 residents reviewed for non-pressure skin integrity (Resident #292).</p> <p>The findings included:</p> <p>Resident #292 was admitted to the facility on 05/26/25 with diagnoses which included non-pressure chronic ulcer of other part of left foot with unspecified severity, diabetes mellitus with other skin complications, and cellulitis of both right and lower limb.</p> <p>Review of Resident #292's initial nursing assessment dated 05/27/25 revealed Resident #292 was alert and oriented.</p> <p>Review of Resident #292's care plan initiated 05/27/25 revealed the resident was at risk of skin breakdown related to peripheral vascular disease, chronic venous stasis, changes of lower extremities, diabetic, problems with mobility, and fragile skin. Interventions included observations for changes in skin integrity or skin impairment left great toe ulcer and notify physician as necessary and skin care per facility protocol.</p> <p>Review of physician order dated 05/28/25 revealed Resident #292 was ordered to cleanse left foot second toe with wound cleanser and apply dry gauze daily.</p>	F 684	<p>1. What corrective action will be accomplished for each resident found to be affected.</p> <p>On 6/2/25, the Charge Nurse completed the treatment to the non-pressure wound on Resident #292 as ordered by the provider.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice</p> <p>The current residents with treatments orders related to skin integrity are at risk for this deficient practice.</p> <p>An audit was completed on 6/20/25 by the Nurse Managers and the Wound Nurse on all residents with treatment to ensure no other omission of treatments were identified. Any identified concerns were corrected and addressed during the audit to include updating the care plan and notification of the medical provider and resident or resident representative.</p> <p>3. What measures are put in place or systemic changes are made to ensure practice will not re-occur.</p> <p>Starting 6/4/25 the licensed nurses to</p>		

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F 684	<p>Continued From page 20</p> <p>A progress note dated 06/04/25 made by Wound Nurse #1 indicated Resident #292's treatment was not completed over the weekend 05/31/25 through 06/01/25. The note further revealed that the Director of Nursing (DON) and the Medical Director (MD) were notified.</p> <p>Review of Resident #292's Treatment Administration Record (TAR) revealed on 05/31/25 and 06/01/25 the resident was checked off for receiving treatment.</p> <p>An interview was conducted with Resident #292 on 06/02/25 at 2:30 PM revealed from 05/31/25 through 06/01/25 the resident did not receive treatment for his toe. It was further revealed he was supposed to have his toe cleaned and new bandage applied daily. Resident #292 stated Wound Nurse #1 was aware because when she changed Resident #292's bandage on 06/02/25 he still had the bandage on that Wound Nurse #1 had applied and dated on 05/30/25.</p> <p>An interview conducted with Wound Nurse #1 on 06/04/25 at 10:15 AM revealed Resident #292 did not receive wound treatment as ordered 5/31/25 through 06/01/25. It was further revealed Resident #292 was supposed to have his ulcer cleaned and bandaged changed over the weekend by the assigned Nurse. Wound Nurse #1 indicated Resident #292 had the same bandage that she had put on 05/30/25.</p> <p>An interview conducted with Nurse #5 on 06/04/25 at 2:30 PM revealed she was assigned to Resident #292 on 05/31/25 and 06/01/25 to complete treatments. It was further revealed she thought she had completed all treatments, but had accidentally overlooked Resident #292 and</p>	F 684	<p>include agency and prn licensed nurses will be educated by the Director of Nursing and/or Unit Managers on ensuring resident non pressure skin integrity treatments are being competed as ordered. The in-service will be completed by 6/30/25.</p> <p>After 6/30/25, licensed nurses to include agency nurses, will not be allowed to work until the education is completed. Newly hired licensed nurses will be educated during orientation.</p> <p>4.How will the facility monitor corrective actions to ensure the deficient practice does not re-occur</p> <p>The Director of Nursing (DON) and/or Nurse Managers will complete an audit on at least 5 residents who receive non pressure skin integrity treatments weekly x 4 weeks and monthly x 2 months to ensure residents with non-pressure skin integrity treatments continue to be completed as ordered.</p> <p>The Administrator and/or DON will review the findings of the treatment Audit Tool in the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further intervention and the need for additional monitoring.</p>		

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F 684	Continued From page 21 did not do his.	F 684			
F 689 SS=D	<p>A joint interview conducted with the DON and Administrator on 06/05/25 at 12:00 PM revealed they were made aware that Resident #292 had not received treatment on his toe and they expected orders to be followed.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide effective supervision for residents with severely impaired cognition that resided on the memory care unit. Resident #91 had a history of wandering and wandered into Resident #92's room and Resident #91 hit Resident #92 in the nose, which caused Resident #92 to sustain a closed fracture of the nasal bone. This was for 1 of 3 residents reviewed for accidents (Resident #92).</p> <p>The findings included:</p> <p>Resident #92 was admitted to the facility on 02/16/24 and discharged on 07/11/24. Diagnoses included age related osteoporosis, osteoarthritis, dementia, and other behavioral disturbances.</p>	F 689	Past noncompliance: no plan of correction required.		

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F 689	<p>Continued From page 22</p> <p>Review of Resident #92's quarterly Minimum Data Set (MDS) dated 05/21/24 revealed the resident was severely cognitively impaired and required limited assistance for most activities of daily living (ADL). The MDS further revealed the resident was not coded for behaviors or wandering.</p> <p>Review of Resident #92's care plan initiated 02/23/24 revealed the resident was at risk expressing emotion, sharing information, and decrease and lack of speech related to impaired memory. Also, the resident was at risk of difficulty understanding speech, difficulty forming thoughts, and requiring cues and directions. The goal was for Resident #92's needs to be met through the next review.</p> <p>Resident #91 was admitted to the facility on 12/1/23 and discharged 12/30/24. Diagnoses included abnormalities of gait and mobility, dementia, anxiety, and cognitive communication deficit.</p> <p>Review of Resident #91's care plan initiated on 12/17/24 revealed the resident had a problematic manner in which resident had ineffective coping such as wandering and wandering into other residents' beds. The goal was Resident #91 would have no episodes through the next review. Interventions included document episodes of wandering per facility protocol, approach wandering resident in non-threatening manner, orient to surrounding and room number as frequently as needed, place familiar objects, furniture, pictures in resident surroundings, and provide assistance in locating own room.</p> <p>Review of Resident #91's quarterly MDS dated</p>	F 689			

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F 689	<p>Continued From page 23</p> <p>05/16/24 revealed the resident was severely cognitively impaired. The MDS further revealed the resident was not coded for behaviors or wandering.</p> <p>Review of progress note dated 07/10/24 created by Nurse #4 revealed Resident #92 was in her doorway to her room yelling for help and stated she had been hit in the nose by another resident. Moderate amounts of blood were observed coming from Resident #92's nose and mouth. A compression (pressure on the nose) was used to stop the bleeding followed by cleansing of mouth to check for further injury. The note indicated the Medical Director (MD) was notified and Resident #92 was sent out to the hospital to be further assessed. The note revealed Resident #92's Responsible Party (RP) was notified.</p> <p>A phone interview conducted with Nurse #4 on 06/05/25 at 9:00 AM revealed she was assigned to both Resident #91 and Resident #92 on 7/10/24 when the incident occurred. Nurse #4 indicated Resident #91 had prior behaviors of wandering but had never been aggressive towards other residents. It was further revealed on 07/10/25 around 3:00 AM she was assisting another staff member and Resident #91 wandered across the hall into Resident #92's room. Nurse #4 indicated she had just checked resident rooms 15 minutes prior and Resident #91, and Resident #92 were both asleep in their bed. Nurse #4 indicated she heard Resident #92 yell and found her standing in her doorway with her nose and mouth bleeding. Nurse #4 revealed Resident #91 was in Resident #92's bed asleep. Nurse #4 stated Resident #92's nose was bleeding, there was some swelling, and it appeared to be disfigured. Nurse #4 indicated</p>	F 689			



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F 689	<p>Continued From page 24</p> <p>she contacted the prior DON, MD, and RP and Resident #92 was sent to the hospital to be further assessed. Nurse #4 revealed Resident #91 was directed back to his bed and was assessed and no injuries were found. The Nurse indicated Resident #91 was put on one-to-one care.</p> <p>An initial facility report dated 07/10/24 indicated Resident #91 hit another resident in the face and was removed immediately. It further revealed Resident #92 was observed yelling out and bleeding from her nose.</p> <p>Review of hospital discharge summary dated 07/10/24 revealed Resident #92 was seen in the emergency room for a facial injury and was assessed and diagnosed with a closed fracture to the nasal bone. The summary further revealed Resident #92 was to schedule a follow up appointment with an ear, throat, and nose doctor.</p> <p>Review of progress note dated 07/10/24 revealed later that day Resident #92 returned to the facility and was diagnosed with a fracture to the nasal bone.</p> <p>Review of progress note dated 07/12/24 revealed a psychiatrist referral was completed for Resident #91 date and the RP was notified.</p> <p>A 5-day investigation was completed by the facility dated 07/12/24 and revealed Resident #91 had a history of wandering behaviors and will lay down in whatever bed he finds. It was believed Resident #91 got into Resident #92's bed confused and startled Resident #91 which resulted in Resident #91 hitting Resident #92 and injured Resident #92's nose. The investigation</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>indicated nursing staff had left Resident #92's room 15 minutes prior to the incident and did not witness Resident #91 wandering. The investigation concluded that staff did not witness the incident but had Resident #91 on one to one for observations of behaviors.</p> <p>A phone interview conducted with the prior Director of Nursing (DON) dated 06/05/25 at 8:50 AM revealed she was the DON at the time of the incident between Resident #91 and Resident #92. The DON further revealed she was not at the facility when the incident occurred but was notified by Nurse #4. The DON indicated she received a call from Nurse #4 that Resident #91 had wandered into Resident #92's room while nursing staff were giving care to another resident. The DON stated she believed Resident #92 yelled at Resident #91 and Resident #91 got startled and struck out at Resident #92. It was reported to her that Resident #92's nose was bleeding, and the RP and MD were notified, and Resident #92 was sent to the hospital. DON revealed Resident #91 had not had aggressive behaviors prior to the incident but was put on one to one for observations and a psychiatrist referral was made.</p> <p>An interview conducted with the current DON and Administrator on 06/05/25 at 11:50 AM revealed neither one of them worked in the facility at the time of the incident. The interview further revealed they both expected staff to monitor and watch residents in the memory care unit to prevent accidents.</p> <p>The facility provided the following corrective action plan:</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>1. What corrective action will be accomplished for each resident found to be affected.</p> <p>On 7/10/24 Resident # 91 wandered into Resident # 92's room and was resting on the bed. Resident # 92 came into the room and awakened Resident # 91 startling the resident. Resident # 91 experienced a startle response which resulted in the resident making physical contact with Resident # 92's nose.</p> <p>The facility staff responded immediately by separating Resident # 91 and Resident # 92 and placing Resident # 91 on one-to-one supervision while an investigation of the accident was initiated.</p> <p>A pain and skin assessment on Resident # 92 was completed on 7/10/24. The resident was noted to have a bloody nose and was transferred to the hospital for evaluation.</p> <p>A pain and skin assessment completed on 7/10/24 Resident # 91 revealed the resident had no pain or injury.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the same deficient practice.</p> <p>On 7/10/24 100% of residents progress notes and behavior alerts in the electronic medical record (EMR) were audited by the Quality Assurance Nurse to identify any behavior, to include wandering, that occurred in the last 14 days. The audit was to ensure interventions were in place to address behaviors and interventions were in place on the resident care plan. The audit</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>was completed on 7/10/24. Any identified concerns were addressed during the audit to include updating the care plan and notification of the medical practitioner and resident representative.</p> <p>On 7/10/24 100% skin checks were initiated by the hall nurse for signs and symptoms of injury not previously identified. No signs of injuries were indicated from the assessments.</p> <p>On 7/10/24 the Director of Nursing (DON) reviewed incident reports related to resident-to-resident altercations for the past 30 days to identify patterns and trends. No new areas of concern were identified.</p> <p>3. What measures are put in place or systemic changes are made to ensure the deficient practice will not re-occur.</p> <p>On 7/10/24 an in-service was initiated, to all staff, by the DON and Staff Development Coordinator (SDC) regarding managing residents with behaviors, utilization of non-pharmacological interventions for behaviors, prevention of resident-to-resident altercations, providing as needed medications/interventions as appropriate to help reduce behavior escalation, and documentation.</p> <p>On 07/10/24 a QAPI meeting was held to discuss resident to resident altercations and residents on the memory care unit with dementia. Multiple people including department heads and the Medical Director participated.</p> <p>The in-service was completed by 7/12/24. After 7/12/24 staff that had not completed the</p>			F 689			

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F 689	<p>Continued From page 28</p> <p>in-service were provided with the in-service on their next scheduled shift. This education is provided to newly hired staff ongoing.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>100% of all progress notes and behaviors alerts were reviewed by the DON, Unit Manager (UM), Unit Coordinator, SDC and Quality Assurance Nurse 5 days a week for 4 weeks during the daily interdisciplinary team meeting utilizing the Behavior Audit Tool. The purpose of the review was to ensure all behaviors were being addressed to include notification of the medical practitioner, responsible party and that care plans were reviewed/revised as appropriate.</p> <p>The Administrator or DON reviewed and initialed the audits weekly x 4 weeks, then monthly x 1 month to ensure all areas of concern were addressed appropriately.</p> <p>The Administrator and DON presented the findings of the Behavior Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 2 months.</p> <p>The QAPI committee met monthly for 2 months and reviewed the Behavior Audit Tool to determine trends and/or issues that needed further interventions and the need for additional monitoring.</p> <p>Corrective Action Plan completion date: 07/13/24</p> <p>As part of the validation process conducted on 06/04/25, the plan of correction was reviewed and</p>	F 689			

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F 689	Continued From page 29 verified through review of audit sheets, education records and staff interviews. Education was provided for all nursing staff. A review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with nursing staff revealed they had received education. The compliance date of 07/13/24 for the corrective action plan was validated.	F 689			
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 reviews, observations, and Medical Director, resident and staff interviews, the facility failed to discontinue an order for the use of supplemental oxygen when a new order was received (Resident #1). In addition, the facility failed to display a cautionary sign indicating the use of oxygen for residents with supplemental oxygen (Residents #2, #18 and #22) and secure a oxygen tank in a Resident's room (Resident #18). This was for 4 of 4 residents reviewed for respiratory care.  The findings included:  1. Resident #1 was initially admitted to the facility	F 695	1. What corrective action will be accomplished for each resident found to be affected.  On 6/05/25, Resident #18, Resident #22 and Resident # 2 cautionary sign indicating the use of oxygen was placed on the residents" door by the Nurse Manager.  Resident #1 duplicate supplemental oxygen order was discontinued on 6/04/25 by the provider.  On 6/05/25, Resident #18 unsecured	7/1/25	

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F 695	<p>Continued From page 30</p> <p>on 5/1/23 with diagnoses that included chronic respiratory failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).</p> <p>A review of Resident #1's active physician orders included the following orders:</p> <ul style="list-style-type: none"> <li>- An order dated 8/18/24 for oxygen at 3 liters per minute via nasal cannula.</li> <li>- An order dated 4/3/25 for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%.</li> </ul> <p>The annual Minimum Data Set (MDS) assessment dated 4/8/25 indicated that Resident #1 was cognitively intact and received oxygen therapy.</p> <p>A review of Resident #1's active care plan, last reviewed 4/21/25, included a focus area for potential for or actual ineffective breathing pattern related to COPD, reflux, dysphagia, asthma, CHF, and hiatal hernia. Interventions included oxygen therapy as ordered.</p> <p>A nursing progress note dated 5/11/25 read that Resident #1 used oxygen at 2 liters per minute via nasal cannula.</p> <p>A review of the May 2025 and June 2025 Medication Administration Records (MARs) revealed an entry for oxygen at 3 liters per minute via nasal cannula. The MARs had a check mark and staff initials for day and night shift. In addition, the MARs had entry for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. The MARs had a check mark and staff initials for day and night shift.</p>	F 695	<p>oxygen tank was removed from the resident's room by the Nurse Manager.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice The current residents that receive oxygen therapy are at risk for this deficient practice.</p> <p>An audit was completed on 6/20/25 by the Nurse managers on all residents who require oxygen to ensure cautionary sign indicating the use of oxygen are on residents' doors, duplicate orders have been addressed by the provided and discontinued, and any unsecured oxygen tanks in residents' rooms are placed in a holder or removed from the room. Any identified concerns were corrected and addressed during the audit.</p> <p>3. What measures are put in place or systemic changes are made to ensure practice will not re-occur.</p> <p>On 6/6/25, the Director of Nursing and/or Nurse Managers, initiated education to the licensed nurses to include agency and prn nurses regarding placement of cautionary signs indicating the use of oxygen on residents' door for residents that receive oxygen therapy, ensuring that residents with oxygen have no duplicate oxygen orders and oxygen tanks in residents' room are in a holder and/or removed from the room.</p>		

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F 695	<p>Continued From page 31</p> <p>On 6/2/25 at 11:40 AM, an observation and interview occurred with Resident #1. She had oxygen flowing at 2 liters per minute via nasal cannula and stated that she used oxygen at 2 liters.</p> <p>Another observation occurred of Resident #1 on 6/4/25 at 9:32 AM who had oxygen flowing at 2 liters.</p> <p>On 6/4/25 at 9:35 AM, an interview occurred with Medication Aide #1 who was familiar with Resident #1 and was assigned to provide medications to her. She stated Resident #1 used oxygen continuously at 2 liters per minute via nasal cannula. After reviewing the June 2025 MAR, MA #1 indicated she checked and initialed both entries for oxygen use but couldn't say why she had not noticed an entry for 2 liters of oxygen and an entry for 3 liters of oxygen.</p> <p>Unit Manager #1 was interviewed on 6/4/25 at 9:43 AM and had been the nurse that created the order for oxygen at 2 liters per minute on 4/3/25. She reviewed Resident #1's active physician orders and verified that there was an order for oxygen at 3 liters and an order for oxygen at 2 liters that were showing as active. She stated when she received the order for oxygen at 2 liters per minute via nasal cannula on 4/3/25 she should have discontinued the order for oxygen at 3 liters per minute via nasal cannula. She felt this was an oversight.</p> <p>The Medical Director was interviewed via phone on 6/5/25 at 9:00 AM and stated that he was aware Resident #1 was using 2 liters of oxygen currently and would have expected the nurse who</p>	F 695	<p>The in-service was completed by 6/30/25. After 6/30/25 any staff that had not completed the in-service was provided the in-service on their next scheduled shift. This education is provided to newly hired staff ongoing to include any agency personnel.</p> <p>4.How will the facility monitor corrective actions to ensure the deficient practice does not re-occur</p> <p>The DON, Unit Manager (UM), SDC and Quality Assurance Nurse will audit residents who are receiving oxygen therapy weekly x 4 weeks and monthly x 2 months to ensure oxygen signs are on the resident doors.</p> <p>The DON and ADON will audit all resident receiving oxygen orders weekly x 2 months and monthly x 2 months to ensure no duplicate orders are in the resident's electronic medical record.</p> <p>The Administrator and DON will present the findings of the Respiratory Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months, to determine trends and/or issues that needed further interventions and the need for additional monitoring</p>		



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F 695	<p>Continued From page 32</p> <p>received the order for oxygen at 2 liters per minute on 4/3/25 to have discontinued the previous order for oxygen at 3 liters per minute.</p> <p>The Administrator and Director of Nursing were interviewed on 6/5/25 at 9:29 AM and stated they would have expected Unit Manager #1 to discontinue the order for oxygen at 3 liters per minute when the new order for oxygen at 2 liters per minute was received on 4/3/25.</p> <p>2. Resident #2 was admitted to the facility 10/17/2009 with diagnoses including heart failure and diabetes.</p> <p>The most recent quarterly Minimum Data Set assessment dated 4/3/25 assessed Resident #2 to be moderately cognitively impaired and she received oxygen therapy.</p> <p>A physician order dated 4/3/25 specified for oxygen to be administered at 2 liters per minute by nasal cannula.</p> <p>Resident #2 was observed on 6/2/25 at 1:54 PM. She had oxygen administered by nasal cannula at 2 liters per minute. No oxygen cautionary sign was noted on the door to her room or in her room.</p> <p>Resident #2 was observed with oxygen administered by nasal cannula at 2 liters per minute on 6/3/25 at 8:53 AM. No cautionary oxygen sign was observed.</p> <p>An observation of Resident #2 oxygen administered by nasal cannula at 2 liters per minute was conducted on 6/4/25 at 2:58 PM and no cautionary oxygen sign was observed.</p>	F 695			

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F 695	<p>Continued From page 33</p> <p>Resident #2 was observed with oxygen administered by nasal cannula at 2 liters per minute on 6/5/25 at 8:26 AM with Nurse #3. There was no oxygen cautionary sign observed. Nurse #3 was interviewed at the time of the observation and explained that a sign should be posted outside of the room, and she did not know why there was no oxygen sign for Resident #2.</p> <p>The Director of Nursing (DON) was interviewed on 6/5/25 at 10:14 AM and she reported the facility had completed an audit of all residents using oxygen, and part of the audit was to make certain cautionary signs were posted for oxygen. The DON reported she did not know why there was no sign for Resident #2's oxygen.</p> <p>The Administrator was interviewed on 6/5/25 at 12:52 PM. The Administrator explained the facility had completed a check of residents using oxygen on 6/2/25 and part of the check was ensuring the cautionary signs were in place. The Administrator reported that she did not know why there was no oxygen cautionary sign posted for Resident #2.</p> <p>3. Resident #18 was admitted to the facility on 03/08/24 with diagnoses which included hypertension and congestive heart failure.</p> <p>Review of resident #18's quarterly Minimum Data Set (MDS) dated 04/13/25 revealed the resident was moderately cognitively impaired.</p> <p>Review of a physician order dated 05/21/25 revealed Resident #18 was ordered to start oxygen at 2 liters per minute per nasal cannula for respiratory distress or when oxygen saturation drops under 92%.</p>	F 695			

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F 695	<p>Continued From page 34</p> <p>An observation on 06/02/25 at 11:50 AM revealed Resident #18 had gone to dialysis, but a free-standing (unsecured) oxygen tank, not in a holster or wheeled rack, was sitting in the corner of the resident's room behind his bed. It was further revealed there was no oxygen signage outside of the room or in the room.</p> <p>An observation was conducted in conjunction with an interview with Resident #18 on 06/03/25 at 10:00 AM. The observation revealed there was still a free-standing oxygen tank in Resident #18's room. Resident #18 stated he sometimes used oxygen if he was having issues breathing. It was further observed there was no signage hanging outside of the room, or inside of the room, for oxygen use.</p> <p>An interview conducted with the Unit Manager (UM) on 06/04/25 at 2:00 PM revealed Resident #18 used oxygen as needed. It was further revealed she was not aware Resident #18 did not have oxygen in use signage outside of his room. UM #1 indicated she and all nursing staff were responsible for posting signage, and all oxygen users were expected to have signage posted.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 06/05/25 at 11:50 AM revealed they were unaware Resident #18 did not have oxygen in use signage posted outside of his room. The DON indicated she was aware Resident #18's tank was stored in the corner of his room. It was further revealed both the DON and the Administrator expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms.</p>	F 695			

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F 695	<p>Continued From page 35</p> <p>4. Resident #22 was admitted to the facility on 05/17/16 with diagnoses which included chronic obstructive pulmonary disease.</p> <p>Review of Resident #22's quarterly Minimum Data Set (MDS) dated 05/21/25 revealed the resident was cognitively intact.</p> <p>Review of a physician order dated 05/22/25 revealed Resident #22 was ordered oxygen at 3 liters per minute via nasal cannula. It further read to keep the oxygen saturation greater than 90% every day and night shift.</p> <p>An observation on 06/02/25 at 11:55 AM revealed Resident #22 had gone to dialysis. An oxygen concentrator was observed in the resident's room. It was further revealed no signage of oxygen was posted outside of, or inside, the resident's room.</p> <p>An observation on 06/03/25 at 9:45 AM revealed Resident #22 in his wheelchair with oxygen on and receiving oxygen via a nasal canula and was in the hall talking to another resident.</p> <p>An interview conducted with the Unit Manager (UM) on 06/04/25 at 2:00 PM revealed Resident #22 used oxygen continuously. It was further revealed she was not aware Resident #22 did not have oxygen in use signage outside of his room. UM #1 indicated she and all nursing staff were responsible for posting signage, and all oxygen users were expected to have signage posted.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 06/05/25 at 11:50 AM revealed they were unaware Resident #22 did not have oxygen in use signage posted</p>			F 695			

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F 695	Continued From page 36 outside of his room. It was further revealed both the DON and the Administrator expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms.	F 695			
F 757 SS=E	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 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 reviews and Medical Director and staff interviews, the facility failed to hold blood pressure medications as ordered by the physician (Resident #13). This was for 1 of 5 residents reviewed for unnecessary medications.  The findings included:	F 757	1. What corrective action will be accomplished for each resident found to be affected.  Review of the medication record by the Director of Nursing (DON) on 6/5/25 revealed that Resident #13 has had no	7/1/25	

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F 757	<p>Continued From page 37</p> <p>Resident #13 was admitted to the facility on 4/27/23 with diagnoses that included congestive heart failure (CHF), coronary artery disease (CAD), and hypertension.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 4/10/25 indicated Resident #13 was cognitively intact.</p> <p>a. Review of Resident #13's active physician orders included an order dated 4/30/25 for Amlodipine (a blood pressure medication) 5 milligrams (mg). Give one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure (SBP) less than 100, diastolic blood pressure (DBP) less than 60 and pulse less than 60.</p> <p>The May 2025 Medication Administration Record (MAR) was reviewed and revealed Resident #13 had received Amlodipine, despite the SBP less than 100 and DBP less than 60.</p> <ul style="list-style-type: none"> <li>- 5/14/25 SBP was 96 and DBP was 49.</li> <li>- 5/15/25 SBP was 96 and DBP was 49.</li> <li>- 5/28/25 SBP was 97 and DBP was 51.</li> </ul> <p>b. Review of Resident #13's active physician orders included an order dated 4/26/25 for Isosorbide Mononitrate Extended Release (a blood pressure medication) 30 mg. Give one tablet by mouth one time a day for CAD. Hold for SBP less than 110 and DBP less than 60.</p> <p>The May 2025 MAR was reviewed and revealed Resident #13 had received Isosorbide Mononitrate Extended Release, despite the SBP less than 110 and DBP less than 60.</p> <ul style="list-style-type: none"> <li>- 5/7/25 SBP was 102 and DBP was 52</li> </ul>	F 757	<p>adverse outcomes related to receiving medication outside of the parameters per the provider.</p> <p>The provider was notified on 6/5/25 by the Director of Nursing that the resident received blood pressure medication outside of the providers parameters and no new orders were given.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice</p> <p>Current residents who receive blood pressure medications that require specific hold parameters are at risk for this deficient practice.</p> <p>An audit was completed on 6/20/25 by the Nurse Manager of all current residents who have orders for blood pressure medications with parameters to ensure medication parameters are being followed as ordered. The Nurse Managers addressed and followed up with the provider and the resident and/or resident representative any identified concerns.</p> <p>3. What measures are put in place or systemic changes are made to ensure practice will not re-occur.</p> <p>On 6/6/25, an in-service was initiated to the licensed nurses and medication aides to include agency and prn staff by the</p>		

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F 757	<p>Continued From page 38</p> <ul style="list-style-type: none"> <li>- 5/14/25 SBP was 96 and DBP was 49.</li> <li>- 5/15/25 SBP was 96 and DBP was 49.</li> <li>- 5/16/25 SBP was 96 and DBP was 49.</li> </ul> <p>c. Review of Resident #13's active physician orders included an order dated 4/25/25 for Carvedilol (a blood pressure medication) 25 mg. Give one tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and DBP less than 60.</p> <p>The May 2025 MAR was reviewed and revealed Resident #13 had received Carvedilol, despite the SBP less than 110 and DBP less than 60.</p> <ul style="list-style-type: none"> <li>- 5/7/25 SBP was 102 and DBP was 52 for the 8:30 AM dose.</li> <li>- 5/14/25 SBP was 96 and DBP was 49 for the 4:30 PM dose.</li> <li>- 5/15/25 SBP was 96 and DBP was 49 for the 8:30 AM dose and SBP was 96 and DBP was 49 for the 4:30 PM dose.</li> <li>- 5/16/25 SBP was 96 and DBP was 49 for the 8:30 AM dose.</li> <li>- 5/28/25 SBP was 97 and DBP was 51 for the 4:30 PM dose.</li> </ul> <p>On 6/4/25 at 10:49 AM, a phone call was placed to Medication Aide #2. He had provided medications to Resident #13 on 5/14/25 at 8:30 AM and 4:30 PM. A message was left for a return call that was not received during the survey.</p> <p>On 6/4/25 at 10:50 AM, a phone call was placed to Medication Aide #3. She had provided medications to Resident #13 on 5/28/25 at 8:30 AM and 4:30 PM. A message was left for a return call that was not received during the survey.</p>	F 757	<p>DON and Nurse Managers related to ensuring that blood pressure medications administration parameters are being followed as ordered.</p> <p>The in-service was completed by 6/30/25. After 6/30/25 any licensed nurse or medication aide to include agency and prn staff who have not completed the education will not be allowed to work. Newly hired licensed nurses and medication aides will be required to receive this education in orientation.</p> <p>4.How will the facility monitor corrective actions to ensure the deficient practice does not re-occur</p> <p>The DON and the Nurse Managers will complete audits on 10 residents who are receiving blood pressure medications with parameters weekly x 4 weeks and monthly x 2 months to ensure blood pressure parameters continue to be followed as ordered.</p> <p>The Administrator and DON will present the findings of the blood pressure medication parameter Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring.</p>		

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F 757	<p>Continued From page 39</p> <p>An interview occurred with Medication Aide #4 on 6/4/25 at 2:44 PM. She had provided medications to Resident #13 on 5/7/25 and 5/14/25. She reviewed the May 2025 MAR and verified Isosorbide Mononitrate Extended Release was signed off as given outside the parameter on 5/7/25 and 5/14/25 as well as Carvedilol on 5/7/25. She felt it was an oversight.</p> <p>On 6/4/25 at 5:20 PM, a phone call was placed to Nurse #1. She had provided medications to Resident #13 on 5/15/25 and 5/16/25. A message was left for a return call that was not received.</p> <p>The Medical Director was interviewed by phone on 6/5/25 at 9:00 AM and stated if Resident #13 had received a few dosages of Amlodipine, Isosorbide Mononitrate Extended Release and Carvedilol outside the parameters it should not have caused any serious harm. The Medical Director added he would expect the nurses to follow the orders for the blood pressure medications parameters as written.</p> <p>The Administrator and Director of Nursing were interviewed on 6/5/25 at 9:30 AM, and stated they expected the nursing staff to follow parameters to hold blood pressure medications per physician orders.</p>	F 757			
F 842 SS=B	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in</p>	F 842			7/1/25



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F 842	<p>Continued From page 40</p> <p>accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p>			F 842			

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F 842	<p>Continued From page 41</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, and resident and staff interviews, the facility failed to maintain complete and accurate medical records related to a resident's wound when a nurse documented the completion of wound care inaccurately for another nurse (Resident #292) and oxygen administration (Resident #1) for 2 of 4 residents reviewed for complete and accurate medical records.</p> <p>The findings included:</p> <p>1. Resident #292 was admitted to the facility on 05/26/25.</p> <p>Review of Resident #292's initial nursing assessment dated 05/27/25 revealed Resident</p>	F 842	<p>1. What corrective action will be accomplished for each resident found to be affected.</p> <p>On 6/2/25, the wound nurse completed the treatment as ordered on Resident # 292. On 6/4/25, the provider was notified of the treatment omission with no new orders.</p> <p>A skin assessment for Resident #292 was completed on 6/2/25 by the wound nurse with no adverse findings noted.</p> <p>On 6/4/25, the Nurse Manager clarified the oxygen orders for Resident #1 with the provider and discontinued the order for</p>		

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F 842	<p>Continued From page 42</p> <p>292 was alert and oriented.</p> <p>Review of physician order dated 05/28/25 revealed Resident #292 was ordered was to cleanse left foot second toe with wound cleanser and apply dry gauze daily.</p> <p>Review of Resident #292's Medication Administrator Report dated 05/31/25 and 06/01/25 indicated Unit Manager #1 checked that treatment was completed on Resident #292's toe.</p> <p>Review of progress note dated 06/04/25 revealed Wound Nurse #1 revealed Resident #292 completed the resident's treatment and it was reported that the treatment was not completed on 05/31/25 and 06/01/25. The note further revealed that the Director of Nursing (DON) and the Medical Director (MD) were notified.</p> <p>An interview was conducted with Resident #292 on 06/02/25 at 2:30 PM revealed over the weekend, give dates the resident did not receive treatment for his toe. It was further revealed he was supposed to have it cleaned and new bandage applied daily. Resident #292 stated Wound Nurse #1 was aware because she changed Resident #292's bandage on 06/02/25 and it still had date and the initials on the bandage that she applied on 05/30/25.</p> <p>An interview conducted with Wound Nurse #1 on 06/04/25 at 10:15 AM revealed Resident #292 did not receive wound treatment as ordered. It was further revealed Resident #292 was supposed to have his ulcer cleaned and bandaged changed over the weekend by the assigned Nurse. Wound Nurse #1 indicated Resident #292 had the same bandage that she had put on 05/30/25, but did not</p>	F 842	<p>3liters of oxygen.</p> <p>2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice</p> <p>The current residents are at risk for this deficient practice.</p> <p>An audit of the current residents' treatment administration records (TAR) for the last 30 days was completed on 6/20/25 by the Nurse Managers and the wound nurse to ensure no omissions of treatments were identified. Any identified concerns were corrected and addressed during the audit to include notification of the medical provider and resident or resident representative.</p> <p>An audit of the current residents that receive oxygen medication orders was completed on 6/18/25 by the Nurse Managers to ensure that there are no duplicate oxygen orders. Any identified concerns were corrected and addressed during the audit to include updating the care plan and notification of the medical provider and resident or resident representative.</p> <p>3. What measures are put in place or systemic changes are made to ensure practice will not re-occur.</p>		

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F 842	<p>Continued From page 43</p> <p>see any outcome of it not being changed, but did notify the DON.</p> <p>An interview conducted with Unit Manager (UM) 1 on 06/04/25 at 2:00 PM revealed on 06/02/25 when she checked treatments, she saw that Resident #292 was not checked off on the MAR. It was further revealed she contacted Nurse #5 who indicated that she had completed all treatments. UM #1 stated she checked off the resident for Nurse #5 but should not have done that because she was not aware the residents' treatment was not completed. UM #1 stated she rarely documented for other nursing staff, but would not do it anymore.</p> <p>An interview conducted with Nurse #5 on 06/04/25 at 2:30 PM revealed she was assigned to Resident #292 on 05/31/25-06/01/25 to complete treatments. It was further revealed she thought she had completed all treatments, but had accidentally overlooked Resident #292 and did not do his. Nurse #5 stated she had told UM #1 she had completed the treatment.</p> <p>An interview conducted with the DON and Administrator on 06/05/25 at 12:00 PM revealed they were made aware that Resident #292 had not received treatment on his toe from Wound Nurse #1 on 06/04/25. It was further revealed they expected documentation to be documented correctly and not to document for other staff.</p> <p>2. Resident #1 was initially admitted to the facility on 5/1/23.</p> <p>A review of Resident #1's active physician orders included the following orders: - An order dated 8/18/24 for oxygen at 3 liters per</p>	F 842	<p>On 6/6/25, an in-service was initiated, to all licensed nurses to include agency and prn staff by the DON and the Nurse Managers related to ensuring resident treatment are completed as ordered. The in-service was completed by 6/30/25. After 6/30/25 any licensed nurses to include agency and prn staff that had not completed the in-service will not be allowed to work. Newly hired licensed nurses will receive this education in orientation.</p> <p>4. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The DON and the Nurse Managers will audit 5 residents who receive treatment's weekly x 2 weeks and monthly x 2 months to ensure residents treatment continues to be completed as orders. The DON and the Nurse Managers will audit 5 residents who receive oxygen medication orders weekly x 2 weeks and monthly x 2 months to ensure residents have no duplicate oxygen orders.</p> <p>The Administrator and DON will present the findings of the treatment Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring.</p>		

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F 842	<p>Continued From page 44</p> <p>minute via nasal cannula.</p> <p>- An order dated 4/3/25 for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%.</p> <p>A review of the May 2025 and June 2025 Medication Administration Records (MARs) revealed an entry for oxygen at 3 liters per minute via nasal cannula. The MARs had a check mark and staff initials for day and night shift. In addition, the MARs had entry for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. The MARs had a check mark and staff initials for day and night shift.</p> <p>On 6/4/25 at 9:35 AM, an interview occurred with Medication Aide #1 who was familiar with Resident #1 and was assigned to provide medications to her. She stated Resident #1 used oxygen continuously at 2 liters per minute via nasal cannula. After reviewing the June 2025 MAR, MA #1 indicated she checked and initialed both entries for oxygen use but couldn't say why she had not noticed an entry for 2 liters of oxygen and an entry for 3 liters of oxygen.</p> <p>Unit Manager #1 was interviewed on 6/4/25 at 9:43 AM and had been the nurse that created the order for oxygen at 2 liters per minute on 4/3/25. She reviewed Resident #1's active physician orders and verified that there was an order for oxygen at 3 liters and an order for oxygen at 2 liters that were showing as active. She stated when she received the order for oxygen at 2 liters per minute via nasal cannula on 4/3/25 she should have discontinued the order for oxygen at 3 liters per minute via nasal cannula. She felt this was an oversight.</p>			F 842			

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F 842	Continued From page 45  The Administrator and Director of Nursing (DON) were interviewed on 6/5/25 at 9:29 AM and stated they would have expected Resident #1's medical record to be accurate. The DON stated the nursing staff should have asked for clarification when they observed the two active orders for oxygen.	F 842			