STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 04/10/2025

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HARBORVIEW LUMBERTON	1555 WILLIS AVENUE LUMBERTON, NC 28358

(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 The survey team entered the facility on 03/31/25 to conduct a recertification and complaint investigation survey and exited on 04/03/25. Additional information was obtained on 04/10/25. Therefore, the exit date was changed to 04/10/25. Event ID #WCHO11. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 03/31/24 to conduct a recertification and complaint investigation survey and exited on 04/03/25. Additional information was received on 04/10/25. Therefore the exit date was changed to 04/10/25. Event ID# WCHO11. The following intakes were investigated: NC00217325, NC00218989, NC00220798, and NC00222844. 6 of the 12 complaint allegations resulted in deficiency.	F 000		
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	F 580		4/23/25

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

Electronically Signed | 04/25/2025

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F 580	Continued From page 1 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). (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 staff and the	F 580	Based on record review, staff and the	

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F 580	Continued From page 2 Wound Care Physicians interviews, the facility failed to notify the Wound Care Physician for evaluation and treatment of a Stage IV (full thickness skin and tissue loss with exposed muscle, tendon, ligament or bone)pressure wound on the left trochanter (boney protrusion on the femur bone) that was present on admission. This occurred for 1 of 1 resident reviewed for wound care (Resident #1). Findings included. Resident #1 was admitted to the facility on 3/8/25 with diagnoses including a Stage IV pressure wound to the left trochanter, protein calorie malnutrition, and anemia. An admission note dated 3/8/25 at 3:01 PM documented by Nurse #11 revealed in part; Resident #1 admitted to the facility from the hospital on 3/8/25 at 12:18 AM. Resident #1 was non-verbal and required total care. Contractures noted of all extremities. Wounds to the left hip and sacrum were noted, with dressings clean, dry and intact. A physicians order dated 3/8/25 for Resident #1 revealed calcium alginate with silver every day shift for wound care. Cleanse the area to the left hip with normal saline, place alginate with silver to the wound bed then cover with foam border dressing. A progress note dated 3/10/25 documented by the Nurse Practitioner revealed in part; Resident #1 with a stage four pressure ulcer. She is receiving nutrition via a gastrostomy tube (feeding tube) with continuous feedings. Pressure ulcer of unspecified part of back, Stage II. Implement the	F 580	Wound Care Physician interviews, the facility failed to notify the Wound Care Physician for evaluation and treatment of a Stage IV (full thickness skin and tissue loss with exposed muscle, tendon, ligament or bone) pressure wound on the left trochanter (boney protrusion on the femur bone) that was present on admission. This occurred for 1 of 1 resident reviewed for wound care (Resident #1). Resident #1 was seen by the wound care physician on 4/3/25. No other residents were identified at this time as needing to be evaluated by the wound care physician. The wound care nurse was educated on 4/3/25 by the Director of Nursing and Administrator on ensuring that the wound care physician is notified of any resident needing to be added to the next physician's assessment list. All residents have the potential to be affected by this practice. The Director of Nursing or Assistant Director of Nursing in collaboration with the wound care nurse will review all new wounds and new admissions with wounds 5 times weekly to discuss if the resident needs to be assessed by the wound care physician. Any deficiencies found with the audits will be corrected immediately and re-education done as necessary by the Director of Nursing. The Director of Nursing will review and discuss the audit result in the QAPI	

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F 580	Continued From page 3	F 580		

wound care protocol, including regular dressing changes and pressure relief measures. Consult the wound care specialist for advanced management.

A weekly wound evaluation dated 3/14/25 completed by the Wound Treatment Nurse for Resident #1 revealed Stage IV left trochanter identified on 3/8/25. The wound measured 1.0 centimeter (cm) x 0.6 cm x 0.8 cm., with no tunneling (when the wound extends deep creating a tunnel causing increased risk of infection and impedes wound healing) or undermining (separation of the wound edges from the surrounding healthy tissue creating a pocket which impedes wound healing). Moderate serous exudate (thin watery drainage) was noted. The wound bed with erythema (redness) noted, with 100% granulation tissue. Surrounding tissue with erythema. Current treatment included collagen powder and calcium alginate with silver dry dressing. This was signed and dated by the wound treatment nurse on 3/14/25.

Review of Resident #1's electronic medical record from 3/8/25 through 4/2/25 revealed no documentation that the Wound Care Physician was notified of the stage IV left hip wound.

An interview was conducted on 04/03/25 at 9:19 AM with the Wound Care Physician. She stated she evaluated Resident #1 today for the first time. She stated Resident #1 had a Stage IV to the left hip measuring 0.7 cm x 0.7 cm x 0.7 cm (depth), with undermining at 6:00 o'clock measuring 2.5 cm. The wound had 100% granulation with moderate serous drainage. She stated she was not notified of Resident #1's stage IV hip wound until today. She stated she should have been

meeting monthly for the next three months to determine if additional training is required.

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F 580	Continued From page 4 notified of the stage IV upon admission to the facility so that she could evaluate and treat the wound and that did not occur. She stated the stage IV hip wound had decreased in size since the last documented measurements. An interview was conducted on 4/3/25 at 1:45 PM with the Wound Treatment Nurse. She stated she was not in the facility daily, and she had resigned and was working out her notice. She stated she was only in the facility 2-3 days per week and when she was not here the assigned nurse was responsible for the wound care. When asked why the Wound Care Physician was not notified of the stage IV left hip pressure wound on admission she did not give an answer. An interview was conducted on 04/03/25 at 4:00 PM with the Director of Nursing (DON) along with Administrator. The DON stated she was not aware that the Wound Care Physician had not been notified upon admission of Resident #1's stage IV pressure wound. Both the Administrator and DON stated the Wound Care Physician should have been notified on admission of the stage IV wound. The Administrator stated education would be provided.	F 580		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		4/25/25

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F 684	Continued From page 5 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Registered Dietitian, Wound Care Physician, and the Medical Director's interviews the facility failed to 1a.) implement treatment orders on admission and provide daily wound treatments as ordered for a resident (Resident#17) with a chronic venous wound on the left lower extremity. b.) obtain daily weights as ordered for Resident #17 who had a diagnosis of congestive heart failure and on fluid restrictions. 2a.) provide treatments as ordered for a resident with arterial ulcers (Resident #24). b.) obtain weekly weights as ordered for Resident #24 with edema, fluid retention and an elevated Brain Natriuretic Peptide (BNP) level (a blood test used to monitor fluid volume status that when elevated is a strong indicator of heart or kidney failure or infection) and required close monitoring and treatment with a diuretic, a medication used to remove excess fluid. 3.) provide daily wound treatments to non pressure related wounds (Resident #93). This occurred for 3 of 7 residents who were reviewed for wound care and weight monitoring (Resident #17, Resident #24, Resident #93). Findings included. 1a.) Resident #17 was admitted to the facility on 1/3/25 with diagnosis including congestive heart failure, diabetes, and chronic venous wound (sores caused by blood circulation problems that damage your veins) to the left lower extremity. A care plan dated 1/3/25 revealed Resident #17 had skin alteration related to a venous stasis ulcer of the lower extremity. Interventions	F 684	Based on record review, and staff, Registered Dietician, Wound Care Physician, and Medical Director's interviews, the facility failed to: 1a.) Implement treatment orders on admission and provide daily wound treatments as ordered for a resident (Resident #17) with a chronic venous wound on the left lower extremity. b.) obtain daily weights as ordered for Resident #17 who had a diagnosis of congestive heart failure and on fluid restrictions. 2a.) Provide treatments as ordered for a resident with arterial ulcers (Resident #24). b.)obtain weekly weights as ordered for Resident #24 with edema, fluid retention and an elevated Brain Natriuretic Peptide (BNP) level (a blood test used to monitor fluid volume status that when elevated is a strong indicator of heart or kidney failure or infection) and required close monitoring and treatment with a diuretic, a medication used to remove excess fluid. 3. Provide daily wound treatments to non-pressure related wounds (Resident #93). This occurred for 3 of 7 residents who were reviewed for wound care and weight monitoring (Residents #17, #24, #93). 1 a.)Resident #17 received wound	

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F 684	Continued From page 6	F 684		

included to evaluate the wound for size, depth, margins, exudate (discharge) , edema, granulation (pink-red moist tissue that fills an open wound, when it starts to heal), and infection. Document the progress of wound healing on an ongoing basis. Notify the physician as indicated. Observe for signs of infection and provide treatments as ordered.

Review of Resident #17's admission skin assessment dated 1/3/25 documented by Nurse #4 revealed venous statis ulcer to the front left lower extremity. There was no assessment of the wound to include wound size, depth, exudate, edema, or granulation. There was no wound treatment initiated on 1/3/25.

During a phone interview on 4/10/25 at 2:15 PM Nurse #4 stated she was the admission nurse on 1/3/25 and completed an initial skin assessment on Resident #17. She stated a venous ulcer was observed on the front left lower extremity, the area was nickel size and looked like a blister that had ruptured and dried. She stated there was no drainage and Resident #17 had no dressing on the area when she was admitted. She stated since the area appeared dry with no drainage and no dressing she did not initiate any type of wound treatment. She indicated she did not recall seeing any other wounds on the left lower extremity.

A physicians order for Resident #17 was initiated on 1/8/25 for calcium alginate with silver to the left lower leg daily for wound care. Cleanse the area with normal saline, apply calcium alginate with silver, apply gauze pads, and wrap with kerlix.

The Minimum Data Set (MDS) admission

treatment orders 3/4/25.
b.)Resident #17 daily weight order was discontinued per MD order 3/25/25.
2 a.)Resident #24 received treatment orders 4/1/25.
b.)Resident #24 weighed 4/3/25 with result provided to Registered Dietician and Nurse Practitioner with no new orders.
3. Education initiated with licensed nurses, CNA IIs, and CMAs that if the wound care nurse is unavailable, the assigned nurse is ultimately responsible for ensuring the completion of the wound care.

All residents have the potential to be affected by this practice.

1a.)New, full-time treatment nurse has been hired and begins 4/21/25. Extensive new hire education will take place for her role.

1b.)Daily weight orders reduced per IDT review with MD and RD to enable better compliance with orders.

2a.)New, full-time treatment nurse hired and to begin 4/21/25. Extensive new hire education will take place for her role.

2b.)Admission/Readmission weight tracking tool revised to allow closer monitoring of compliance with new admission weights.

3.New, full-time treatment nurse hired

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F 684	Continued From page 7 assessment dated 1/9/25 revealed Resident #17 was cognitively intact. She had a venous wound to the left lower extremity. She had no rejection of care. The Wound Care Physician's initial evaluation dated 1/9/25 revealed Resident #17 was evaluated for venous wound of the left lower lateral calf full thickness. The wound size measured 8.7 centimeters (cm) x 6.5 cm x 0.4 cm (depth). The surface area measured 56.55 cm, with 70% granulation tissue, and heavy serosanguinous exudate (wound drainage that is a combination of serous fluid and blood). The wound was noted to be present on admission. The initial weekly wound evaluation that was completed by the Treatment Nurse was dated 1/10/25. The wound description with measurements were the same as the Wound Care Physician's evaluation on 1/9/25. Review of the Treatment Administration Record (TAR) for Resident #17 dated January 2025 revealed calcium alginate with silver to left lower leg daily for wound care with a start date of 1/8/25. Cleanse the area with normal saline, apply calcium alginate with silver, apply gauze pads, and wrap with kerlix. Scheduled for administration between 7:00 AM until 3:00 PM and was not signed off as administered on the following dates: There was no treatment order implemented to the left lower extremity from 1/3/25 through 1/8/25. 1/10/25: not signed as administered, the assigned nurse was Nurse #4 1/11/25: not signed as administered, the assigned	F 684	and to begin 4/21/25. Extensive new hire education will take place for her role. On 4/17/25 all nurses were in-serviced by the Staff Development Coordinator, Director of Nursing, and Administrator that if the wound care nurse is unavailable, the assigned nurse is ultimately responsible for the completion of the wound care. All newly hired nurses will be educated on this practice during their orientation. Starting the week of 4/28/25, the Director or Nursing or Assistant Director of Nursing will conduct an audit of all new admissions/readmissions 5 times per week to ensure weights are being obtained weekly x 4 weeks. This audit will be conducted for 12 weeks. Any deficiencies found with the audits will be corrected immediately and re-education done as necessary by the Director of Nursing or Assistant Director of Nursing. The Director of Nursing will review and discuss the audit result during the QAPI meeting monthly for 3 months to determine if additional training is necessary.	

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F 684	Continued From page 8	F 684		

nurse was Nurse #5
1/14/25: not signed as administered, the assigned nurse was Nurse #4
1/17/25: not signed as administered, the assigned nurse was Nurse #2
1/24/25: not signed as administered, the assigned nurse was Nurse #2

During an interview on 04/03/25 at 10:16 AM Nurse #2 the assigned nurse on 1/17/25, and 1/24/25 stated she was routinely assigned to provide care for Resident #17. She stated she did not do daily wound care, and she thought the Treatment Nurse was responsible for wound care. She reported she had completed the dressing change on Resident #17's lower extremity at times and signed off on the TAR on the days she did the wound treatments. She stated that if she did not sign off on the TAR then she did not do the wound care because she thought the wound nurse had done the treatment.

During a phone interview on 4/10/25 at 2:15 PM Nurse #4 stated if she did not sign off on the TAR then she did not complete the treatment. She stated the wound nurse was responsible for the treatments.

During a phone interview on 4/10/25 at 3:05 PM Nurse #5 stated she was assigned to Resident #17 on 1/11/25 but it was a Saturday. She reported on weekends there was a treatment aide that completed wound care.

During a phone interview on 4/10/25 at 4:30 the weekend Treatment Aide stated she called out on 1/11/25 so it would have been the nurses responsibility to complete the wound care.

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F 684	Continued From page 9	F 684		

Review of the Treatment Administration Record (TAR) for Resident #17 dated February 2025 revealed Calcium alginate with silver to left lower leg daily for wound care. Cleanse the area with normal saline, apply calcium alginate with silver, apply gauze pads, and wrap with kerlix. Scheduled for administration between 7:00 AM until 3:00 PM and was not signed off as administered on the following dates:

2/07/25: not signed as administered, the assigned nurse was Nurse #2
2/14/25: not signed as administered, the assigned nurse was Nurse #2
2/19/25: not signed as administered, the assigned nurse was Nurse #2
2/21/25: not signed as administered, the assigned nurse was Nurse #2
2/28/25: not signed as administered, the assigned nurse was Nurse #10

During an interview on 04/03/25 at 10:16 AM Nurse #2 stated she was the assigned nurse on the February dates listed but thought the treatment nurse completed the wound care.

An attempt was made to contact Nurse #10 on 4/10/25 at 4:50 PM, there was no response.

Record review revealed Resident #17 was hospitalized on 2/26/25 due to congestive heart failure and unrelated to wound care. She readmitted to the facility on 2/28/25.

There was no treatment order implemented to the left lower extremity from 2/28/25 through 3/7/25.

Review of the Treatment Administration Record (TAR) for Resident #17 dated March 2025

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F 684	Continued From page 10	F 684		

revealed calcium alginate with silver to left lower leg daily for wound care with a start date of 3/7/25. Cleanse the area with normal saline, apply calcium alginate with silver, apply gauze pads, and wrap with kerlix. Scheduled for administration between 7:00 AM until 3:00 PM and was not signed off as administered on the following dates:

3/10/24: not signed as administered, the assigned nurse was Nurse #2
3/11/25: not signed as administered, the assigned nurse was Nurse #2
3/12/25: not signed as administered, the assigned nurse was Nurse #2
3/14/25: not signed as administered, the assigned nurse was Nurse #2
3/25/25: not signed as administered, the assigned nurse was Nurse #2
3/27/25: not signed as administered, the assigned nurse was Nurse #2
3/28/25: not signed as administered, the assigned nurse was Nurse #2
3/30/25: not signed as administered, the assigned nurse was Nurse #7
3/31/25: not signed as administered, the assigned nurse was Nurse #2

During an interview on 04/03/25 at 10:16 AM Nurse #2 stated she was the assigned nurse on the March dates listed but thought the treatment nurse completed the wound care.

During a phone interview on 04/03/25 at 12:04 PM Nurse #7 stated she did provide wound care to Resident #17 at times. She indicated that if she did not sign off on the TAR then she did not do the treatment. She stated the wound nurse also provided the wound treatments. She stated if she

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did not do the treatment at any time then she must have thought the wound nurse did the treatment.

Review of the Treatment Administration Record (TAR) for Resident #17 dated April 2025 revealed calcium alginate with silver to left lower leg daily for wound care with a start date of 3/7/25. Cleanse the area with normal saline, apply calcium alginate with silver, apply gauze pads, and wrap with kerlix. Scheduled for administration between 7:00 AM until 3:00 PM and was not signed off as administered on the following dates:

4/02/25: not signed as administered, the assigned nurse was Nurse #2
4/05/25: not signed as administered, assigned to the weekend Treatment Aide
4/06/25: not administered, signed with chart code number 8 by Nurse #7

During an interview on 04/03/25 at 10:16 AM Nurse #2 stated she was the assigned nurse on 4/02/25 but thought the treatment nurse completed the wound care.

During a phone interview on 04/10/25 at 4:20 PM Nurse #7 stated the Treatment Aide was responsible for wound care on 4/5/25 so she did not complete it. She stated she attempted to provide wound care on 4/6/25 but Resident #17 refused at that time. She indicated she did not attempt to try again at a later time.

During a phone interview on 4/10/25 at 4:30 PM the weekend Treatment Aide stated she left early on 4/5/25 and she did not do the treatment. She stated it would have been the nurses responsibility to complete the wound care.

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The most recent Wound Care Physicians note dated 4/3/25 documented Resident #17 with chronic venous wound of the left, lower, lateral calf. The wound was evaluated as a candidate for wound treatment using a skin substitute. This wound had been present for greater than 385 days and had failed to respond appropriately for over 30 days despite standard management. Management has included compression using two-layer compression wraps, pillow elevation, and pressure off-loading boots, elevation, and management of any significant comorbid arterial vascular disease. Compliance to treatment regimen has been observed. The wound has no signs of infection or osteomyelitis.

Review of the progress notes from 1/3/25 through 4/6/25 revealed no additional documentation that wound care was completed for Resident #17.

An interview was conducted on 4/3/25 at 2:00 PM with Resident #17. She was alert and oriented to person, place, and situation. She stated she received wound care but not every day. She stated she would not refuse wound care.

An interview was conducted on 4/3/25 at 1:30 PM with the Wound Treatment Nurse. She stated she was not in the facility daily; she had resigned and was working out her notice. She stated she was only in the facility 2-3 days per week and when she was not here the assigned nurse was responsible for the wound care. She stated there was a second nurse who did wound care at times unless she had a resident assignment, and a treatment aide did wound care some weekends. She stated some days she may be in the facility for charting and not doing wound care and the

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nurse would be responsible. She stated Resident #17 admitted 1/3/25 and the admission nurse (Nurse #4) completed the initial skin assessment. She stated the Wound Care Physician evaluated Resident #17 on 1/9/25. The first documented assessment with a wound description and measurements following admission in January completed by her as the wound nurse was on 1/10/25. She acknowledged that treatment orders to the left lower extremity venous wound were not initiated until 1/8/25 which was 5 days after admission. She indicated she was not working on the days following admission and could not say why no treatment was started. She stated she assumed the nurses were doing the wound care. When asked who ordered the treatment on 1/8/25 she stated Resident #17 admitted from another nursing facility and the order was from the admission orders. She stated Resident #17 was hospitalized 2/26/25 and returned to the facility 2/28/25 but stated she was not working on 2/28/25 and did not implement the treatment order when she readmitted because that would have been the admission nurse. She did not say why the treatment order was not started until 3/7/25 which was 7 days after readmission to the facility. She stated if she had completed the treatment it would be signed off on the TAR.

During a phone interview on 4/10/25 at 3:00 PM the Wound Care Physician stated she was in the facility weekly on Thursdays. She stated she knew Resident #17 from her previous facility and managed her wound care at the previous facility. She stated she was aware of the transfer and last evaluated her at the other facility on 12/31/24 and on that day the wound measured 8.7 centimeters (cm) x 6.2 cm x 0.4 cm, and it was present on admission on 1/3/25. She stated she had spoken

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with the Wound Treatment Nurse and had given her the treatment orders prior to admission so the treatment with calcium alginate would start on 1/3/25. She stated she was not aware that the treatment order was not started on 1/3/25 or that the daily treatments were not being done consistently. She was not aware that the treatment was not started back until 3/7/25 following hospitalization and readmission on 2/28/25. She reported the wound had been getting smaller each week until recently. She evaluated the wound today and stated it looked okay, but it has looked better, and it had progressed and was larger this week measuring 4.2 cm x 2.1 cm x 0.2 cm. She stated not completing daily treatments as ordered would cause this wound to deteriorate and it had worsened this week.

An interview was conducted on 04/03/25 at 4:00 PM with the Director of Nursing (DON) along with Administrator. The DON stated the treatment nurses were responsible for wound care when here, otherwise the assigned nurse was responsible. She stated either the treatment nurse or the assigned nurse was responsible for completing an initial assessment that included a wound description with measurements on admission and document the assessment in the medical record and ensuring treatment orders were implemented. She stated the current treatment nurse only worked part time, but they had hired a new treatment nurse who was in training. The DON stated she was not aware the daily treatments were not getting done. Both the Administrator and DON stated wound care should have been completed daily as ordered. The Administrator stated education would be provided.

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During a phone interview on 04/03/25 at 5:11 PM the Medical Director stated Resident #17 had multiple comorbidities and her wounds were managed by the Wound Care Physician. She stated she expected the treatment orders to be implemented and followed.

During an interview on 4/10/25 at 5:00 PM the Director of Nursing stated she was not aware that there was a delay in starting the treatment orders on admission 1/3/25 or on readmission 2/28/25. She stated they were working to resolve the issue with wound care and indicated the new wound nurse would be starting soon.

1b.) A care plan dated 1/10/25 revealed Resident #17 was at risk for impaired cardiovascular status related to congestive heart failure (CHF). Interventions included to monitor weights and report any significant changes.

A physician's order dated 2/26/25 for Resident #17 to maintain 1500 milliliter fluid restrictions per shift: 720 milliliters from dietary, and 780 milliliters from nursing for chronic systolic and diastolic congestive heart failure.

A physicians order dated 3/1/25 for Resident #17 was to obtain daily weights due to congestive heart failure.

Review of the Medication Administration Record (MAR) dated March 2025 for Resident #17 revealed the following weights recorded:

3/01/25 weight 318.6 pounds (lbs.) documented by Nurse #7
3/02/25 weight 318.6 lbs. documented by Nurse

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#7
3/08/25 weight 292 lbs. documented by Nurse #7
3/09/25 weight 292 lbs. documented by Nurse #7
3/15/25 weight 292 lbs. documented by Nurse #7
3/16/25 weight 292 lbs. documented by Nurse #7
3/17/25 weight 292 lbs. documented by Nurse #7
3/22/25 weight 292 lbs. documented by Nurse #7
3/23/25 weight 292 lbs. documented by Nurse #7

Further review of Resident #17's electronic medical record revealed the following weight recorded that was not included on the MAR.

3/6/2025 weight 295.6 lbs. documented by the Restorative Aide.

The physicians order dated 3/1/25 for Resident #17 to obtain daily weights due to congestive heart failure was discontinued on 3/25/25.

Review of Resident #17's progress notes from 3/1/25 through 3/25/25 revealed no other daily weights recorded.

During an interview on 04/03/25 at 9:59 AM the Registered Dietitian stated the facility process for obtaining weights was that after the weekly weight meeting the Director of Nursing (DON) gave her a copy of the current weight orders and then sent the orders out to the staff. She stated the Restorative Aide was the primary staff member who was assigned to obtain the weights. She indicated Resident #17 was to receive daily weights due to congestive heart failure and that the weight orders should be followed.

During an interview on 04/03/25 at 10:35 AM the Restorative Aide stated that she was responsible for obtaining all resident weights. She stated she

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attended the weekly care plan meetings. During the weekly meetings, the DON will give her a list to let her know what the weight orders were, and which residents needed daily or weekly weights. She stated she was also assigned as a nurse aide on the floor some days and assigned to transport residents to appointments at times which made it difficult to do weights and she was unable to gets the weights done at times.

During a phone interview on 04/03/25 at 1:19 PM Nurse #7 stated that when she recorded Resident#17's weights on the Medication Administration Record MAR) she used the previous weight that she found in the medical record. She stated that she did not obtain the daily weights that she recorded on the MAR from 3/01/25 through 3/23/25. She stated she had not obtained any weights on Resident #17 because she was not sure how the Restorative Aide obtained Resident #17's weight and whether the Restorative Aide used the wheelchair or the mechanical lift to get the weight. She stated she knew that was wrong and she should have obtained the weight and documented accurate weights.

During an interview on 04/03/25 at 2:00 PM Nurse #2 stated she was routinely assigned to Resident #17. She stated the Restorative Aide was responsible for obtaining the weights. She indicated she had not obtained weights on Resident #17.

An interview was conducted on 04/03/25 at 3:33 PM with the Director of Nursing (DON) along with the Administrator. The DON stated the Restorative Aide was responsible for obtaining weights. She stated the Restorative Aide attended

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the weekly weight meetings and she was given a list of residents that needed daily or weekly weights. She indicated that if the Restorative Aide was not available to get the daily weight for a resident the assigned nurse was responsible for getting the weights. She stated the physicians orders should be followed, and they would review their process for obtaining weights and provide staff education.

During a phone interview on 04/03/25 at 5:11 PM the Physician stated Resident #17 was ordered daily weights due to congestive heart failure to monitor fluid retention which was an indicator of worsening heart failure. She had bilateral lower extremity edema and received diuretics. She stated the goal of care was to keep her asymptomatic. She indicated there had been no change in condition reported to her and Resident #17 has remained asymptomatic. She stated she expected the daily weights to be completed according to the order.

2a.) Resident #24 was admitted on 4/13/23 with diagnosis which included stroke, failure to thrive, peripheral artery disease, and diabetes. Resident #24 was discharged to the hospital on 2/18/25 and readmitted on 3/3/25 following a left above knee amputation.

The hospital discharge summary dated 3/3/25 indicated that Resident #24 had osteomyelitis (an infection of the bone tissue) of the left foot and underwent left above knee amputation. Resident #24's discharge summary indicated a diagnosis of right foot chronic osteomyelitis and required continued treatment with betadine to the wounds on the right foot.

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Resident #24's care plan dated 3/3/25 included a 3/3/25 care plan of resident had actual impairment to the skin integrity with osteomyelitis of the right foot with arterial wounds (wounds or ulcers caused by poor circulation) to the right foot and heel with treatment in between the toes on the right foot. The goal indicated Resident #24 will maintain or develop intact skin by next review. Interventions indicated providing treatment as ordered.

Physician orders dated 3/7/25 for Resident #24 indicated:

-Apply betadine to right 2nd toe and right lateral distal foot (the outer edge of the foot from the heel to the little toe) topically every day shift for wound care and wrap with gauze.
-Apply calcium alginate in between the right toes every day shift for wound care.
-Apply betadine to the right heel and wrap with gauze every day shift.

Review of Resident #24's significant change Minimum Data Set (MDS) dated 3/9/25 indicated the resident had mild cognitive impairment with no episodes of rejection of care. Resident #24 had 2 venous and arterial ulcers, had an infection of the foot, and had application of ointments/medications other than to the feet and application of dressing to the feet.

Resident #24's Treatment Administration Record (TAR) revealed no documentation of the application of betadine to the right 2nd toe, right lateral distal foot, and right heel or application of the calcium alginate between the toes on 3/10/25, 3/11/25, 3/14/25, 3/27/25, 3/27/25 and 3/31/25.

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The facility's daily assignment sheet for 3/10/25, 3/11/25, 3/14/25, 3/25/25, 3/27/25 and 3/31/25 revealed there was no assigned treatment nurse.

An interview was conducted with Nurse #5 on 4/2/25 at 10:15 AM. Nurse #5 stated she was assigned to Resident #24 regularly and was familiar with her care. Nurse #5 verified that she was assigned to Resident #24 on 3/10/25, 3/11/25, 3/14/25, 3/27/25 and 3/31/25. Nurse #5 stated there was a Wound Care Nurse who was supposed to complete the wound care treatments however she had recently resigned and had decreased her hours that she worked. Nurse #5 stated the floor nurses were often required to complete the ordered wound care treatments. Nurse #5 stated it was hard to administer the residents' ordered medications and complete the ordered wound care treatments. Nurse #5 indicated that wound care treatments on the electronic TAR that were not electronically signed as completed were not done. Nurse #5 stated the days that she was assigned to Resident #24 that she did not electronically sign the TAR for the ordered wound care treatments indicated that she did not complete the ordered care.

A wound care observation was conducted for Resident #24 with the Wound Care Nurse on 4/2/25 at 2:00 PM. The wound care to Resident #24's foot was completed as ordered and the wounds did not have any signs of infection and the skin surrounding the wounds did not have any redness.

An interview was conducted with the Wound Care Nurse on 4/2/25 at 3:00 PM. The Wound Care Nurse stated she had turned in her resignation and was only working part time until her last day.

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The Wound Care Nurse indicated that the floor nurses were responsible for completing the ordered wound care when she was not working and there was not an assigned treatment nurse. The Wound Care Nurse stated she was not aware of any problems with wound care not being completed on the days that she was not working, and she did not review the TARs for completion of the ordered treatments.

An interview was conducted with the Director of Nursing (DON) and Administrator on 4/3/25 at 2:50 PM. The DON and Administrator indicated that the Wound Care Nurse had turned in her resignation in January but had agreed to continue to work a few days per week until a replacement could be hired. The DON and Administrator stated that when a wound care nurse was not scheduled, it was the responsibility of the floor nurse to complete the ordered wound care treatments. The DON and Administrator indicated that they expected wound care to be completed as ordered. The DON stated she did not review the TARs and was not aware of any problems with the completion of the daily wound care treatments.

An interview was conducted with the Nurse Practitioner on 4/3/25 at 3:45 PM. The NP indicated that she expected wound care to be completed as ordered. The NP stated that Resident #24 was severely debilitated with multiple risk factors, and this made it even more important for wound care to be completed as ordered.

2b.) Review of Resident #24's hospital discharge summary dated 3/3/25 indicated resident's weight upon discharge was 161 pounds (lb.).

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Review of Resident #24's weights listed in the electronic health record revealed:

2/3/25 157 pounds (lb.) (Weight prior to hospitalization and amputation)
3/5/25 184.7 lb. recorded by the Director of Nursing (DON)
3/14/25 164.7 lb. recorded by the DON
3/20/25 No weight was recorded
3/21/25 No weight was recorded
3/28/25 No weight was recorded

Review of a Patient at Risk/Standard of Care progress note dated 3/6/2025 at 4:03 PM written by the Assistant Director of Nursing revealed that the interdisciplinary team met and reviewed Resident #24 for weight monitoring with the Registered Dietitian present. Resident#24 had a significant weight gain of 27.7 pounds. A re-weight was conducted. Resident #24 had an above knee amputation during recent hospitalization with all over body swelling at this time. The note indicated weight loss was expected due to the amputation. Resident continues to receive tube feeding as ordered. Tube feeding will be adjusted as needed and Resident #24 will be monitored for weight fluctuations.

Review of Resident #24's significant change Minimum Data Set (MDS) assessment dated 3/9/25 indicated resident was cognitively intact, weighed 185 lb. with no weight loss and weight gain not on a physician prescribed weight gain regimen.

Resident #24's physician orders indicated an order dated 3/10/25 indicated give furosemide, a

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potent diuretic medication that removes excess fluid used to treat conditions such as hypertension, heart failure and fluid retention causing edema 20 milligrams (mg) give 3 tablets via gastrostomy tube STAT (as soon as possible) for elevated BNP level (Brain Natriuretic Peptide, a blood test that measures a hormone in the blood released when the heart is under stress such as from heart or kidney failure or infection) .

A 3/11/25 Nurse Practitioner progress note indicated Resident #24 was evaluated due to an elevated BNP level of 15, 751.

Resident #24's physician orders indicated an order dated 3/11/25 for furosemide 40 milligrams (mg) twice per day via gastrostomy tube for 5 days for edema (the condition characterized by swelling with abnormal accumulation of fluid in the body's tissues). The order was discontinued on 3/13/25.

A 3/13/25 Nurse Practitioner progress note indicated Resident #24 was evaluated due to edema with weight gain and elevated BNP level of 12, 383. The plan indicated Resident #24 was to receive furosemide 40 milligrams twice per day until 3/20/25. The note indicated Resident #24 was to be monitored for respiratory distress, crackles in the lungs or wheezing and contact the provider if needed.

Resident #24's physician orders indicated an order dated 3/13/25 for furosemide 40 mg. twice per day for 7 days for edema.

Review of Resident #24's care plan last revised on 3/17/25 indicated a care plan for altered cardiovascular status related to diagnoses of

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hypertension and peripheral vascular disease. The interventions included obtain weights as ordered and monitoring for increased edema.

A 3/20/25 Nurse Practitioner progress note revealed Resident #24 had decreased edema. The assessment and plan indicated that daily weights with the first one now were to be obtained due to an elevated BNP.

Review of Resident #24's weights listed in the electronic health record revealed: 3/20/25 No weight was recorded.

A Registered Dietitian (RD) nutrition progress note dated 3/21/25 at 11:55 AM indicated that Resident # 24 was reviewed due to a weight warning with a current weight of 164.7 Lb. The note indicated Resident #24 was readmitted after an above knee amputation and had significant edema. Resident's edema was improving with weight trending back to baseline. The plan indicated to continue to monitor weights weekly.

Review of Resident #24's physician orders revealed an order dated 3/21/25 for weights per policy.

Review of Resident #24's weights listed in the electronic health record revealed:
3/21/25 No weight was recorded
3/28/25 No weight was recorded

An interview was conducted with the Administrator on 4/3/25 at 9:00 AM. The Administrator stated that weights were to be obtained weekly for 4 weeks following admission or readmission. After the 4 weeks, then weights were to be obtained monthly or as ordered by the

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physician. The Administrator indicated that weights were to be obtained as ordered and documented in the electronic health record.

An interview was conducted with the Registered Dietitian (RD) on 4/3/25 at 10:00 AM. The RD stated that new admissions and readmissions were to be weighed as close to the admission or readmission date as possible and then weekly for 4 weeks. The RD indicated Resident #24 had weights recorded twice since readmission on 3/3/25 and she should have been weighed weekly for 4 weeks. The RD indicated it was important to have accurate weights, to obtain weights timely and according to the provider's recommendations. The RD indicated that weights were a clinical indicator and were important for monitoring the resident's condition. The RD stated that Resident #24 had an elevated BNP and had changes to her diuretic order and weights were necessary for monitoring her condition. The RD stated she was not aware that the provider requested daily weights on 3/20/25 but the weights should have been obtained per the provider's recommendation.

An interview was conducted with the Restorative Nursing Assistant (NA) on 4/3/25 at 10:40 AM. Restorative NA indicated she was responsible for obtaining all resident weights. Restorative NA stated she was assigned to work as an NA on the floor at times and she went to appointments with residents at times, so it was difficult to obtain all the weights. Restorative NA stated there was not a backup system to ensure that weights were obtained as required. Restorative NA indicated there was not a system to ensure that she was informed of admissions and readmissions and to track the resident weights for the first 4 weeks

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following admission. Restorative NA stated she looked on the hallways and if she saw a new admission or readmission, then she obtained the weight. Restorative NA stated that all residents were to be weighed weekly for 4 weeks and then as ordered. Restorative NA stated when Resident #24 was readmitted, someone else obtained her readmission weight, although she did not recall who. Restorative NA stated someone, she did not recall who, asked her to obtain a reweigh on Resident #24 due to weight gain. Restorative NA stated she obtained the reweight on 3/5/25 and observed that the weight she obtained was a significant weight gain, so she rechecked it. Restorative NA stated she gave both the weights that she obtained on 3/5/25 to the DON to record. The Restorative NA did not recall what the 2 weights were but recalled that the reweight was the same or close to the initial weight that she obtained. The Restorative NA stated she did not know why she had not obtained Resident #24's weekly weights on 3/21/25 or 3/28/25 but thought it was probably because she was assigned to work the floor or to go out to appointments with residents and was not able to obtain them. The Restorative NA stated the DON gave her a list of residents each week and how often the weights were required.

An interview was conducted with the Director of Nursing (DON) on 4/3/25 at 2:50 PM. The DON stated that she expected that resident weights were obtained and recorded weekly for the first four weeks after admission and then monthly unless otherwise specified by the physician or Nurse Practitioner.

An interview was conducted with the Nurse Practitioner (NP) on 4/3/25 at 3:15 PM. The NP

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stated that she expected that weights were obtained for all residents as specified. The NP stated that weekly weights for 4 weeks following admission or readmission were to be obtained. The NP indicated that Resident #24 had edema and required monitoring of weights as an indicator of resident's health status. The NP indicated the BNP was used to determine the resident's fluid volume status and how much weight and fluid a resident was retaining. The NP stated she planned on ordering daily weights for monitoring but then decided to continue with weekly weights. Weights should be obtained for monitoring.

An interview was conducted with the Physician on 4/3/25 at 5:05 PM. The Physician stated it was the facility's responsibility to obtain weekly weights for 4 weeks following admission or readmission and then as indicated. The physician stated that weights were important for monitoring the resident's health status.

3.) Resident #93 was admitted on 3/17/25 with diagnosis of sacral ulcer, diabetes, stroke and peripheral vascular disease.

Review of a care plan dated 3/18/25 indicated potential for pressure ulcer development related to impaired mobility, incontinence with a treatment to skin alteration of the left heel and ointment to the sacrum. The care plan problem was revised on 4/1/25 to indicate a treatment change to the left medial sacrum. Interventions included administer treatments as ordered and observe for effectiveness.

Review of a Wound Care Specialist evaluation note dated 3/20/25 indicated Resident #93 had

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the following wounds:

a non-pressure wound on the right posterior medial (the back and outer side of the leg) thigh partial thickness wound measuring 4.5 centimeters (cm.) in length, 8.0 cm width and 1 cm depth.
a non-pressure wound to the left medial sacrum partial thickness wound measuring 5.0 cm in length, 3.0 cm width and 0.1 cm depth
a non-pressure wound to the right lateral (the outer area) thigh full thickness measuring 0.7 cm in length and 1.0 cm width and 0.2 cm depth.

A physician order dated 3/21/25 indicated to apply calcium alginate and dry dressing to the right lateral thigh once per day.

A physician order dated 3/21/25 indicated to apply zinc paste to the left medial sacrum and right posterior thigh once per shift.

Review of Resident #93's admission Minimum Data Set (MDS) dated 3/23/25 indicated resident was cognitively intact, had no pressure ulcers, and application of ointments and medications other than to feet.

Review of Resident #93's electronic Treatment Administration Record revealed the ordered wound care treatment calcium alginate and dry dressing to right lateral thigh once per day was not signed as completed on 3/27/25 , 3/28/25 and 3/31/25. The ordered wound care treatment zinc paste to the sacrum and right posterior thigh once per shift was not signed as completed on 3/22/25 evening shift, 3/22/25 night shift, 3/23/25 evening shift, 3/23/25 night shift, 3/27/25 day shift, 3/28/25 day shift, 3/31/25 day shift.

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F 684	Continued From page 29 An interview was conducted with Nurse #4 on 4/2/25 at 9:55 AM. Nurse #4 stated there was supposed to be a wound care nurse to do treatments, but the current treatment nurse resigned and was not working her regular schedule. Nurse #4 stated that when there was not a wound care nurse the floor nurses were expected to complete the ordered wound care treatments. Nurse #4 stated it was hard to complete the ordered wound care in addition to her other scheduled tasks. Nurse #4 indicated she did not recall anything about Resident #93 having any wound care treatments ordered and was not aware of her having any skin breakdown. If the electronic Treatment Administration Record was blank for the ordered wound care, Nurse #4 stated she did not complete it. An interview was conducted with the Wound Care Specialist Physician on 4/3/25 at 9:20 AM. The Wound Care Specialist Physician stated she initiated care with the resident on 3/20/25 regarding wounds on the right lateral thigh, right posterior thigh, and sacrum. The Wound Care Specialist indicated that the treatments should be completed daily and that she expected that the wound care would be completed as ordered. The Wound Care Specialist Physician stated that Resident #93's wounds to the sacrum and the posterior thigh are larger today and the treatments were changed due to the worsening of the wounds. The Wound Care Specialist Physician stated wound care treatments need to be completed daily as ordered to prevent further breakdown and worsening of the wounds. Wound treatments require consistent care and monitoring to prevent worsening.	F 684		

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F 684	Continued From page 30 Attempts were made to interview Nurse #6 via phone with messages left x 2 on 4/3/25. No return call was received. Nurse #6 was assigned to Resident #93 on the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shifts on 3/22/25 and 3/23/25. An interview was conducted with the Nurse Practitioner on 4/3/25 at 3:45 PM. The NP indicated that she expected that wound care would be completed as ordered.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, Wound Care Physician, and the Medical Director's interviews the facility failed to 1.) conduct an initial wound assessment on admission for a Stage IV (fullthickness skin and tissue loss with exposed muscle, tendon, ligament or bone) left trochanter (bony protrusion on the femur bone) wound to include the wound	F 686	Based on observation, record review, and staff, wound care physician, and the medical director's interviews, the facility failed to 1.)Conduct an initial wound assessment on admission for a Stage IV (full thickness skin and tissue loss with exposed muscle,	4/25/25

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F 686	Continued From page 31 description with measurements and perform daily wound care treatments according to the physicians orders for a resident (Resident #1) admitted with a stage IV pressure wound and who developed a stage II (partial thickness skin loss involving the dermis) pressure wound on the sacrum and lower back following admission. 2.) provide daily wound care to a stage IV pressure wound (Resident #71). This occurred for 2 of 2 residents (Resident #1, Resident #71) reviewed for pressure wound care. Findings included. 1.) Resident #1 was admitted to the facility on 3/8/25 with diagnoses including a Stage IV pressure wound to the left trochanter, protein calorie malnutrition, and anemia. An admission note dated 3/8/25 at 3:01 PM documented by Nurse #11 revealed in part; Resident #1 admitted to the facility from the hospital on 3/8/25 at 12:18 AM. Resident #1 was non-verbal and required total care. Contractures noted of all extremities. Wounds to the left hip and sacrum were noted, with dressings clean dry and intact. A physicians order dated 3/8/25 for Resident #1 revealed Calcium alginate with silver every day shift for wound care. Cleanse the area to the left hip with normal saline, place alginate with silver to the wound bed then cover with foam bordered dressing. A physicians order dated 3/8/25 for Resident #1 revealed Calmoseptine external ointment 0.44-20.6 % (Menthol-Zinc Oxide) Apply to	F 686	tendon, ligament or bone) left trochanter (bony protrusion on the femur bone) wound to include the wound description with measurements and perform daily wound care treatments according to the physicians orders for a resident (Resident #1)admitted with a stage IV pressure wound on the sacrum and lower back following admission. 2.)Provide daily wound care to a stage IV pressure wound (Resident #71). This occurred for 2 of 2 residents (Resident #1, Resident #71) reviewed for pressure wound care. Wound assessments completed on Resident #1 3/14/25. Education initiated with licensed nurses, CNA IIs, and CMAs that if the wound care nurse is unavailable, the assigned nurse is ultimately responsible for ensuring the completion of the wound care. All residents with wounds have the potential to be affected by this practice. New, full-time treatment nurse hired and to begin 4/21/25. Extensive new hire education will take place for her role. On 4/17/25 all nurses were in-serviced by the Staff Development Coordinator, the Director of Nursing, and Administrator that when the the wound care nurse is unavailable, the assigned nurse is ultimately responsible for ensuring the completion of wound care. All newly hired nurses will be educated on this during	

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F 686	Continued From page 32 sacrum topically every day and evening for protection. Review of Resident #1's electronic medical record from 3/8/25 through 3/14/25 revealed no documentation of a wound assessment of the stage IV left hip or sacrum wound with a wound description and measurements. Attempts were made on 4/03/25 at 4:00 PM and 4:50 PM to contact Nurse #11 the admission nurse on 3/8/25, there was no response. A progress note dated 3/10/25 documented by the Nurse Practitioner revealed in part; Resident #1 with a stage four pressure ulcer. She is receiving nutrition via a gastrostomy tube (feeding tube) with continuous feedings. Pressure ulcer of unspecified part of back, Stage II. Implement the wound care protocol, including regular dressing changes and pressure relief measures. Consult the wound care specialist for advanced management. The Minimum Data Set (MDS) admission assessment dated 3/14/25 revealed Resident #1 was severely cognitively impaired. Her weight was 89 pounds, and the stage IV wound was present on admission. A care plan dated 3/14/25 revealed Resident #1 had the potential for pressure ulcer development related to impaired mobility, and incontinence. She was admitted with a Stage IV pressure ulcer to the left hip and moisture associated dermatitis to the lower back. Observe, document, and report any changes in skin status: appearance, color, wound healing, signs of infection, wound size, and stage.	F 686	their orientation. Starting the week of 4/28/25, the Director of Nursing or Assistant Director of Nursing will conduct an audit of all new admissions/readmissions 5 times per week for 12 weeks to ensure that an initial wound assessment is obtained on admission/readmission to include the wound description with measurements. The Director of Nursing or Assistant Director of Nursing will also conduct an audit of all TARs 5 times per week for 12 weeks to ensure that wound orders are being followed. Any deficiencies found with the audits will be corrected immediately and re-education done as necessary by the Director of Nursing. The Director of Nursing will review and discuss the audit findings in the monthly QAPI meeting for 3 months to determine if any changes need to be made.	

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Review of Resident #1's electronic medical record from admission on 3/8/25 through 4/2/25 revealed the following weekly wound evaluations:

A weekly wound evaluation dated 3/14/25 for Resident #1 revealed Stage IV left trochanter identified on 3/8/25. Measuring 1.0 centimeters (cm) x 0.6 cm x 0.8 cm. No tunneling (when the wound extends deep creating a tunnel causing increased risk of infection and impedes wound healing) or undermining (separation of the wound edges from the surrounding healthy tissue creating a pocket which impedes wound healing). Moderate serous exudate (thin watery drainage). Wound bed with erythema. 100% granulation tissue. Surrounding tissue with erythema. Current treatment collagen powder and calcium alginate with silver dry dressing. This was signed and dated by the Wound Treatment Nurse on 3/14/25.

A weekly wound evaluation dated 3/14/25 for Resident #1 revealed moisture related wound to the lower back measuring 3.0 cm x 1.0 cm x 0.1 cm. The wound was identified 3/8/25. Moderate serosanguineous exudate (mix of blood and fluid drainage) . Tender to touch with 20 % granulation tissue. Surrounding tissue with erythema (redness). Current treatment collagen powder and zinc paste. Treatment ordered 3/14/25. This was signed and dated by the wound treatment nurse on 3/14/25.

A weekly wound evaluation dated 3/21/25 for Resident #1 revealed Stage IV left trochanter identified on 3/8/25. Measuring 2.0 centimeters (cm) x 1 cm x 0.8 cm. No tunneling or undermining. Moderate serous exudate. Wound bed with erythema (redness). 100% granulation

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tissue. Surrounding tissue with erythema. Current treatment collagen powder and calcium alginate with silver dry dressing. This was signed and dated by the wound treatment nurse on 3/21/25.

A weekly wound evaluation dated 3/21/25 for Resident #1 revealed moisture-related wound to the lower back measuring 3.5 cm x 3.5 cm x 0.1 cm. The wound was identified 3/8/25. Moderate serosanguineous exudate. Tender to touch with 20 % granulation tissue. Surrounding tissue with erythema. Current treatment collagen powder and zinc paste. Treatment ordered 3/14/25. This was signed and dated by the wound treatment nurse on 3/21/25.

A weekly wound evaluation with an effective date of 3/25/25 for Resident #1 revealed Stage IV left trochanter identified on 3/8/25. Measuring 2.0 centimeters (cm) x 1.2 cm x 0.7 cm. No tunneling or undermining. Moderate serous exudate. Wound bed with erythema. 100% granulation tissue. Surrounding tissue with erythema. Current treatment collagen powder and calcium alginate with silver dry dressing. This was signed and dated by the wound treatment nurse on 4/2/25 and entered into the electronic medical record on 4/2/25.

A weekly wound evaluation with an effective date of 3/25/25 for Resident #1 revealed moisture-related wound to the lower back measuring 3.5 cm x 3.4 cm x 0.1 cm. The wound was identified 3/8/25. Moderate serosanguineous exudate. Tender to touch with 20 % granulation tissue. Surrounding tissue with erythema. Current treatment collagen powder and zinc paste. Treatment ordered 3/14/25. This was signed and dated by the wound treatment nurse on 4/2/25

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and entered into the electronic medical record on 4/2/25.

A wound evaluation progress note dated 4/1/25 at 3:37 PM for Resident #1 documented by Nurse #12 revealed the wound treatment was changed to the sacrum. Medi honey and foam dressing ordered daily. The dressing was applied. The wound bed was pink with scant serous drainage. Wound edges noted with dry, peeling skin. Periwound (skin surrounding the wound) intact. Dressing changed to lower back with wound bed pink with scant serous drainage. Periwound was intact. Dressing was changed to the Left hip. The wound bed was pink with a small amount of serous drainage. Undermining was noted at 12 o'clock and 9 o'clock areas. Resident #1 tolerated well. No signs of pain or discomfort. Resident #1 was repositioned using pillows. The stage IV left hip measured 0.9 cm x 0.6 cm x 1.2 cm. The medial lower back measured 0.8 cm x 0.9 cm x 0.1 cm.

A care plan dated 4/1/25 for Resident #1 revealed actual pressure ulcer development. Stage II pressure ulcer of the lower back, and stage II pressure ulcer of the sacrum. Interventions included to administer treatments as ordered and observe for effectiveness.

Review of the Treatment Administration Record (TAR) for Resident #1 dated March 2025 revealed: Calcium alginate with silver every day shift for wound care. Cleanse the area to the left hip with normal saline, place alginate with silver to wound bed then cover with foam bordered dressing with a start date of 3/8/25 and scheduled to be completed between 7:00 AM until 3:00 PM. The wound care was not signed off as completed

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on the following dates:

3/10/25: not signed as completed, the assigned nurse was Nurse #2.
3/14/25: not signed as completed, the assigned nurse was Nurse #2
3/27/25: not signed as completed, the assigned nurse was Nurse #2
3/28/25: not signed as completed, the assigned nurse was Nurse #2
3/31/25: not signed as completed, the assigned nurse was Nurse #2

Review of the Treatment Administration Record (TAR) for Resident #1 dated March 2025 revealed: Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide) Apply to sacrum topically every day and evening shift for Protection with a start date of 3/8/25 and scheduled to be completed between 7:00 AM until 3:00 PM. The wound care was not signed off as completed on the following dates:

3/10/25: not signed as completed, the assigned nurse was Nurse #2.
3/14/25: not signed as completed, the assigned nurse was Nurse #2
3/27/25: not signed as completed, the assigned nurse was Nurse #2
3/28/25: not signed as completed, the assigned nurse was Nurse #2
3/31/25: not signed as completed, the assigned nurse was Nurse #2

Review of the Treatment Administration Record (TAR) for Resident #1 dated March 2025 revealed: Collagen powder, zinc paste, and dry dressing to open area located on lower back every day shift for wound care. Cleanse area with

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normal saline, apply collagen powder, zinc paste, and dry dressing start date 3/15/24 and scheduled to be completed between 7:00 AM until 3:00 PM. The wound care was not signed off as completed on the following dates:

3/27/25: not signed as completed, the assigned nurse was Nurse #2
3/28/25: not signed as completed, the assigned nurse was Nurse #2
3/31/25: not signed as completed, the assigned nurse was Nurse #2

Review of the Treatment Administration Record (TAR) for Resident #1 dated April 2025 revealed: wound care to the stage IV hip, stage II sacrum, and stage II lower back were completed as ordered.

During an interview on 04/02/25 at 3:33 PM Nurse #2 stated she was routinely assigned to provide care for Resident #1. She stated she did not do daily wound care, and she thought the treatment nurse was responsible for wound care. She reported she had completed the dressing change on Resident #1 once or twice and signed off on the TAR on the days she did the wound treatments. She stated that if she did not sign off on the TAR then she did not do the wound care because she thought the wound nurse had done the treatment. She stated she was not aware Resident #1 had a stage II on her sacrum, but she knew she had the Stage IV on her hip and an area on her lower back but reported she was not aware it was a stage II.

An interview was conducted on 04/02/25 at 10:04 AM with Nurse #12. She stated she typically did not work in this facility but was brought in this

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week to assist with wound care. She stated Resident #1 had a Stage IV hip wound that was small but deep. She stated she completed the wound care the previous day and the area was clean, with no slough. The order was to pack with iodoform packing strips daily. She reported the lower back wound was now a stage II pressure wound. The treatment ordered was collagen powder with dry dressing. She stated Resident #1 also had a stage II pressure wound to the sacrum that developed since admission. The treatment ordered on 4/1/25 to the sacrum was Medi honey with foam dressing and change daily. She stated the wounds on her lower back and sacrum started as excoriation (raw irritated skin) on admission but now had developed into stage II pressure wounds.

A wound observation was conducted on 04/02/25 at 10:04 AM with Nurse #12. The areas observed were stage IV left hip, stage II sacrum and stage II lower back. The stage IV wound was a small area, with no exudate, no odor, with undermining noted. The wound was packed with iodoform packing strips. Medi honey applied to stage II sacrum and collagen powder with dry dressing applied to lower back wound. There were no concerns with the wound care observation.

During a phone interview on 04/02/25 at 3:08 PM Nurse #13 stated she did assist with wound care at times. She stated she primarily worked weekends. She stated some days she would have an assignment and other days she may be assigned to wounds only. She stated if she had completed Resident #1's dressing changes she would have signed it off on the TAR. She stated if she had a resident assignment then it would be up to the assigned nurse to complete the wound

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treatments.

During a phone interview on 04/03/25 at 12:04 PM Nurse #7 stated she was the assigned nurse on Saturday 3/8/25 from 7:00 AM until 3:00 PM. She stated she did skin assessments, but she did not complete wound assessments with a description of the wound or measurements. She stated the wound treatment nurse was responsible for the wound descriptions with measurements.

An interview was conducted on 4/3/25 at 1:45 PM with the Wound Treatment Nurse. She stated she was not in the facility daily; she had resigned and was working out her notice. She stated she was only in the facility 2-3 days per week and when she was not here the assigned nurse was responsible for the wound care. She stated there was a second nurse who did wound care at times unless she had a resident assignment, and a treatment aide would complete wound care some weekends. She stated at times she may be in the facility for charting and not doing wound care and the assigned nurse would be responsible. She stated she did an initial assessment of Resident #1's wounds to the left hip and lower back with measurements and a description of wound status on 3/14/25. When asked why the initial assessment with measurements was not completed until 3/14/25, 6 days after admission, she did not give an answer. When asked why she did not enter the wound evaluation on 3/25/25 with measurements until 4/2/25 she stated she left early that day and never entered the measurements. She stated the sacrum was only an area of excoriation and treated with calmoseptine until this week and was now a stage II wound. She stated the wound treatment

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to the sacrum was changed to Medi honey. She stated if she had completed any of the wound treatments she would have signed it off on the TAR.

During a phone interview on 04/03/25 at 11:50 AM Medication Aide #1 stated she only worked weekends and was only assigned to complete wound treatments. She stated she recalled doing Resident#1's wound treatment on the day of admission. She recalled applying calcium alginate to her left hip and stated she thought she also had a wound on her lower back. She stated she did not do wound assessments or measurements and that was the responsibility of the wound treatment nurse.

An interview was conducted on 04/03/25 at 9:19 AM with the Wound Care Physician. She stated she evaluated Resident #1 today for the first time. She stated Resident #1 had a Stage IV to the left hip measuring 0.7 cm x 0.7 cm x 0.7 cm., with undermining at 6:00 o'clock measuring 2.5 cm. The wound had 100% granulation with moderate serous drainage. She stated she kept the treatment to the stage IV wound the same and to continue iodoform packing strips daily. She stated the second area was a Stage II to the medial lower back measuring 0.8 cm x 0.9 cm x 0.1 cm. with light serous drainage. The treatment was collagen powder applied daily. She reported the third area was a Stage II pressure wound to the sacrum measuring 3.2 cm x 2.3 cm x 0.1 cm with light serous drainage. She stated that Medi honey was started 2 days ago, and she was willing to try it then reevaluate next week. She stated she was not notified of Resident #1's stage IV hip wound until today. She stated she should have been notified of the stage IV upon admission to the

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facility so that she could evaluate and treat the wound and that did not occur. She stated the stage IV hip wound had decreased in size since the last documented measurements.

An interview was conducted on 04/03/25 at 4:00 PM with the Director of Nursing (DON) along with Administrator. The DON stated the treatment nurses were responsible for wound care when they were here, otherwise the assigned nurse was responsible. She stated either the treatment nurse or the assigned nurse was responsible for completing an initial assessment that included a wound description with measurements on admission and document the assessment in the medical record. She stated the current treatment nurse only worked part time, but they had hired a new treatment nurse who was in training. The DON stated she was not aware the daily treatments were not getting done, and she was not aware that the Wound Care Physician had not been notified upon admission of Resident #1's stage IV wound. Both the Administrator and DON stated wound care should have been completed daily as ordered, an initial evaluation with measurements completed and documented in the medical record and the Wound Care Physician notified of the wound. The Administrator stated education would be provided.

During a phone interview on 04/03/25 at 5:11 PM the Medical Director stated Resident #1 was admitted with a stage IV pressure wound to the left hip and multiple comorbidities. Resident #1 required a high level of care. She received enteral feedings and had been declining. She reported Resident #1 was at high risk for wound development and the new areas showed how frail her skin was, therefore, the stage II pressure

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wounds that developed on the sacrum and lower back were unavoidable. She stated she did expect that wound care orders were followed.

2.) Resident #71 was admitted on 1/27/23 with diagnoses which included dementia, diabetes and diabetic neuropathy.

Resident #71's care plan included a care plan problem dated 12/13/24 which indicated actual impairment to skin integrity with pressure ulcer Stage 4 (full-thickness skin and tissue loss) to the sacrum and an unstageable ulcer due to necrosis (dead skin tissue due to injury, infection or lack of blood supply) to the right second toe with potential for further pressure ulcer development related to impaired mobility, incontinence, malnutrition and history of pressure ulcers. The goal indicated that the resident would have intact skin by the next review date. Interventions included administer treatments as ordered and observe effectiveness.

Resident #71's quarterly Minimum Data Set (MDS) dated 12/27/24 indicated the resident had severe cognitive impairment and one Stage 4 pressure ulcer which was present upon admission, entry or reentry. Pressure ulcer care and pressure reducing device for the bed were coded.

Physician's orders dated 3/7/25 for Resident #71 indicated:
- apply calcium alginate to the sacrum and a dry dressing once per day for wound care
- apply skin prep (a treatment used to provide a thin, protective film over the skin) to the right second toe every day shift for wound care

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Resident #71's March 2025 Treatment Administration Record (TAR) revealed no documentation of the application of calcium alginate to the sacrum and a dry dressing or the application of skin prep to the right second toe on 3/10/25 and 3/11/25.

The facility's daily assignment sheet for 3/10/25 and 3/11/25 revealed there was no assigned treatment nurse and Medication Aide #1 was assigned to Resident #71 with Nurse #4 assigned to oversee Medication Aide #1.

The Wound Care Specialist Physician documentation dated 3/13/25 indicated the following measurements of Resident #71's pressure ulcers:
- Stage 4 pressure ulcer: length 4.8 centimeters (cm), width 4.1 cm, and depth 1.1 cm
- Unstageable deep tissue injury to the right second toe: length 0.3 cm, width 0.3 cm

Resident #71's March 2025 TAR revealed no documentation of the application of calcium alginate to the sacrum and a dry dressing or the application of skin prep to the right second toe on 3/14/25.

The facility's daily assignment sheet for 3/14/25 revealed there was no assigned treatment nurse, and that Medication Aide #1 was assigned to Resident #71 with Nurse #4 assigned to oversee the Medication Aide.

The Wound Care Specialist Physician documentation dated 3/20/25 indicated the following measurements of Resident #71's pressure ulcers:

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- Stage 4 pressure ulcer: length 5.1 cm, width 4.0 cm, and depth 1.1 cm
- Unstageable deep tissue injury to the right second toe: length 0.5 cm, width 0.5 cm

The Wound Care Specialist Physician documentation dated 3/25/25 indicated the following measurements of Resident #71's pressure ulcers:
- Stage 4 pressure ulcer: length 5.0 cm, width 3.1 cm, and depth 1.0 cm
- Unstageable deep tissue injury to the right second toe: length 0.3 cm, width 0.3 cm

Resident #71's March 2025 TAR revealed no documentation of the application of calcium alginate to the sacrum and a dry dressing or the application of skin prep to the right second toe on 3/25/25, 3/27/25, and 3/31/25.

The facility's daily assignment sheet for 3/25/25, 3/27/25, and 3/31/25 revealed there was no assigned treatment nurse, and that Medication Aide #1 was assigned to Resident #71 with Nurse #4 assigned to oversee the Medication Aide.

An interview was conducted with Nurse #4 on 4/2/25 at 9:55 AM. Nurse #4 stated she worked Monday through Friday on the 7:00 AM to 3:00 PM shift and was assigned to the 800 hall, part of the 700 hall and was assigned to oversee the medication aide on 500 hall, the hall that Resident #71 resided on. Nurse #4 stated she was aware that in the absence of the Wound Care Nurse or an assigned treatment nurse, she was responsible for completion of the ordered wound care for her assigned residents. Nurse #4 stated the Wound Care Nurse frequently was not working and there was no assigned treatment

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nurse. Nurse #4 stated she did not know if the Medication Aide completed the ordered wound care for her assigned residents when the Wound Care Nurse was not working and there was no assigned treatment nurse. Nurse #4 stated she did not complete the wound care treatments for Resident #71 when she was assigned to oversee the Medication Aide on 3/10/25, 3/11/25, 3/14/25, 3/25/25, 3/27/25, and 3/31/25.

An interview with Medication Aide #1 was conducted with on 4/3/25 at 12:30 PM. Medication Aide #1 indicated that she worked Monday through Friday on the 7:00 AM to 3:00 PM shift and was assigned to Resident #71. Medication Aide #1 stated that when the Wound Care Nurse was not working and there was not an assigned treatment nurse, the nurse that was overseeing her was responsible for completion of the ordered wound care treatments. Medication Aide #1 stated that Nurse #4 had not notified her that she had not completed Resident #71's ordered wound care. Medication Aide #1 stated she assumed that Nurse #4 completed the ordered wound care on the days that the Wound Care Nurse was not working.

An interview was conducted with the Wound Care Nurse on 4/2/25 at 3:00 PM. The Wound Care Nurse stated she had turned in her resignation and was only working part time until her last day. The Wound Care Nurse indicated that the floor nurses were responsible for completing the ordered wound care when she was not working and there was not an assigned treatment nurse. The Wound Care Nurse stated it was the responsibility of the nurse assigned to oversee the Medication Aide to complete the wound care treatments for those assigned residents.

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An interview was conducted with the Wound Care Specialist Physician on 4/3/25 at 9:20 AM. The Wound Care Specialist Physician stated she had been seeing Resident #71 due to the Stage 4 pressure ulcer to the sacrum. The Wound Care Specialist Physician stated Resident #71 had an extensive wound to the sacrum that was down to the muscle. The Wound Care Specialist indicated Resident #71's wounds were stable but had the potential for maceration (a softening and breakdown of the skin tissue due to prolonged exposure to moisture), further skin breakdown and worsening of the wound. The Wound Care Specialist indicated that the treatments should be completed daily and that she expected that the wound care would be completed as ordered. The Wound Care Specialist Physician stated that Resident #71's wound treatments were to be completed daily as ordered. Not completing the wound care treatments as ordered to Resident #71's sacrum and toe had the potential to cause worsening of the wounds, however the wounds were currently stable. Wound treatments required consistent care and monitoring to prevent worsening and further complications.

An interview was conducted with the Director of Nursing (DON) and Administrator on 4/3/25 at 2:50 PM. The DON and Administrator indicated that the Wound Care Nurse had turned in her resignation in January but had agreed to continue to work a few days per week until a replacement could be hired. The DON and Administrator stated that when a wound care nurse was not scheduled, it was the responsibility of the floor nurse to complete the ordered wound care treatments. The DON and Administrator stated that when a Medication Aide was assigned to a

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F 686	Continued From page 47 resident with an ordered wound care treatment it was the responsibility of the nurse overseeing the Medication Aide to complete the wound care. The DON and Administrator indicated that they expected wound care to be completed as ordered. The DON stated she did not review the TARs and was not aware of any problems with the completion of the daily wound care treatments. An interview was conducted with the Nurse Practitioner on 4/3/25 at 3:45 PM. The NP indicated that she expected wound care to be completed as ordered.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		4/24/25

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F 692	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and the Physician's interviews, the facility failed to obtain weekly weights as ordered for a resident (Resident #1) who was a new admission and receiving enteral feedings (tube feeding). This occurred for 1 of 5 residents reviewed for nutrition. Findings included. Resident #1 was admitted to the facility on 3/8/25 with diagnoses including Stage IV pressure wound to the left hip, protein calorie malnutrition, and anemia. The Minimum Data Set (MDS) admission assessment dated 3/14/25 revealed Resident #1 was severely cognitively impaired. She had no rejection of care. The care plan dated 3/18/25 revealed Resident #1 received enteral tube feedings and was at risk for dehydration. Interventions included in part to observe, document, and report signs or symptoms of dehydration or sudden weight loss. An order dated 3/21/25 for Resident #1 revealed weights per policy. Review of Resident #1's electronic medical record revealed the following: 3/08/25 no admission weight was recorded 3/13/25 the weight was 89.0 pounds (lbs.) 3/21/25 there was no weight recorded. 3/28/25 the weight was 87.7 lbs.	F 692	Based on observations, record review, and staff and the Physician's interviews, the facility failed to obtain weekly weights as ordered for a resident (Resident #1) who was a new admission and receiving enteral feedings (tube feeding). This occurred for 1 of 5 residents reviewed for nutrition. Resident #1 admitted on 3/8/25. Weights were obtained on 3/13, 3/28, 4/3, 4/11, 4/16, and 4/22. All residents have the potential to be affected by this practice. IDT met and discussed Admission/Readmission weight communication tool which was revised to ensure that weights are being obtained as ordered or at least weekly x 4 weeks. Beginning the week of 4/28/25, the Director of Nursing or Assistant Director of Nursing in collaboration with the restorative aide will monitor weights 5 times weekly to ensure they are being obtained as ordered or at least weekly x 4 weeks for new admissions/readmissions. Any deficient practice found during the audit will be corrected immediately and education/corrective action done by the Director of Nursing as appropriate. The audit findings will be reported by the Director of Nursing during the monthly QAPI meeting for 3 months to determine if	

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F 692	Continued From page 49 During an interview on 04/03/25 at 9:59 AM the Registered Dietitian stated the facility policy was to weigh new admissions weekly for 4 weeks then monthly if there were no concerns. She stated the facility process in obtaining weights was that after the weekly weight meeting the Director of Nursing (DON) gave her a copy of the current weight orders and then sent the orders out to the staff. She stated the Restorative Aide was the primary staff member who was assigned to obtain the weights. She indicated Resident #1 was to receive weekly weights due to being a new admission and receiving tube feedings. She indicated it was important to obtain weekly weights to determine her nutritional status to ensure she was receiving adequate intake. She stated the weekly weights should have been obtained. During an interview on 04/03/25 at 10:35 AM the Restorative Aide stated that she was responsible for obtaining all resident weights. She stated she attended the weekly care plan meetings. During the weekly meetings, the DON will give her a list to let her know what the weight orders were, and which residents needed daily or weekly weights. She stated new admissions were to receive weekly weights and if there was a resident observed on the hall that was new to the facility and not on her list she would obtain the weight. She stated she was also assigned as a nurse aide on the floor some days and assigned to transport residents to appointments at times which made it difficult to do weights and she was unable to get the weights done at times. She stated she would weigh Resident #1 today. During a follow up interview on 4/3/25 at 1:00 PM the Restorative Aide stated she obtained	F 692	changes need to be made.	

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F 692	Continued From page 50 Resident #1's weight today and it was 89 pounds. During an interview on 04/03/25 at 2:00 PM Nurse #2 stated she was routinely assigned to Resident #1. She stated the Restorative Aide was responsible for obtaining the weights. She indicated she had not obtained weights on Resident #1. An interview was conducted on 04/03/25 at 3:33 PM with the Director of Nursing (DON) along with the Administrator. The DON stated the facility policy included to obtain weekly weights for all new admissions and the Restorative Aide was responsible for obtaining weights. She stated the Restorative Aide attended the weekly weight meetings and she was given a list of residents that needed daily or weekly weights. She indicated that if the Restorative Aide was not available to get the weight for a resident the assigned nurse was responsible for making sure the weights were done. She indicated that a weight should have been obtained on day of admission then weekly. She stated they would review their process for obtaining weights and provide staff education. During a phone interview on 04/03/25 at 5:11 PM the Physician indicated Resident #1 required weekly weights as a new admission receiving tube feedings. She stated weekly weights should have been obtained.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		4/23/25

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F 756	Continued From page 51 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician and Consultant Pharmacist's interviews, the Pharmacist failed to identify and address during	F 756	Based on record review, and staff, Physician and Consultant Pharmacist's interviews, the Pharmacist failed to	

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F 756	Continued From page 52 the monthly medication regimen reviews that a resident's Midodrine 10 mg (milligrams) prescribed for hypotension was administered outside of the set parameters 38 times during January 2025, 44 times in February 2025 and 15 times in March 2025 when the Consultant Pharmacist completed her monthly March review on 03/14/25. This occurred for 1 of 1 resident (Resident #95) reviewed for medication administration. Resident #95 experienced no significant outcome. Finding included: Resident #95 was admitted to the facility on 04/12/24 with diagnoses that included hypotension. Record review revealed the following active orders: Midodrine 10 mg give 1 tablet by mouth one time a day every Monday, Wednesday, Friday for hypotension hold if sys (systolic) > (greater than) 120 or dys (diastolic) > 80; Start date 01/08/25. Midodrine 10 mg give 1 tablet by mouth three times a day every Tuesday, Thursday, Saturday, and Sunday for hypotension hold if sys > 120 or dys > 80; Start date 01/08/25. Review of the January 2025 Medication Administration Record (MAR) revealed that the medication Midodrine was given in error a total of 38 times, in February 2025 the medication Midodrine was given in error a total of 44 times and in March 2025 the medication Midodrine was given in error a total of 35 times to Resident #95.	F 756	identify and address during the monthly medication regimen reviews that a resident's Midodrine 10 mg (milligrams) prescribed for hypotension was administered outside of the set parameters 38 times during January 2025, 44 times in February 2025 and 15 times in March 2025 when the Consultant Pharmacist completed her monthly March review on 03/14/25. This occurred for 1 of 1 resident (Resident #95) reviewed for medication administration. Resident #95 experienced no significant outcome. Resident #95 was assessed by NP in house with no significant effects noted. NP ordered to discontinue Midodrine as resident’s blood pressure had been stable. The pharmacy consultant completed the required monthly drug regimen review and noted on a nursing recommendation in February that it had been administered outside of parameters. The pharmacy consultant report did not identify this as a medication error. All residents have the potential to be affected by this deficient practice. An audit was conducted on 4/1/25 of all pharmacy recommendations from the month of February with all recommendations being addressed and scanned into the documents section of the medical record with the exception of the one for resident #95. Discussion with Pharmacy Consultant, Administrator, and Director of Nursing took place on 4/14/25 regarding facility expectations along with	

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F 756	Continued From page 53 Review of the Pharmacist Recommendations to the Nursing Staff dated 02/14/25 revealed the pharmacist noted the medication Midodrine had been administered when the systolic blood pressure was >120 on 2/1/25, 2/2/25, 2/4/25, 2/6/25, 2/8/25, 2/13/25 and 2/20/25 in relation to the Midodrine order for Tuesday, Thursday, Saturday and Sunday. The Monday, Wednesday, Friday Midodrine order was not acknowledged in the report. There were no recommendations made to nursing regarding Midodrine medication errors in January 2025 or March 2025 for Resident #95. The Consultant Pharmacist Summary dated as of 1/13/2025 provided to the facility documented, "Medication errors were not noted during my review this month." The Consultant Pharmacist Summary dated as of 2/10/2025 provided to the facility documented, "Medication errors were not noted during my review this month." The Consultant Pharmacist Summary dated as of 3/10/2025 provided to the facility documented, "Medication errors were not noted during my review this month." A telephone interview was conducted with the facility Consultant Pharmacist on 04/01/25 at 10:18 AM. She stated she had not notified the facility that the Midodrine had been given in error in January 2025 because she had not seen a trend and didn't think that giving this medication to Resident #95 when his blood pressure was outside of the parameters was of clinical significance. She reported that she had recommended to the nursing staff on 02/14/25	F 756	regulatory expectations. The Administrator and Director of Nursing expect that they be notified by separate email of any observations noted by the pharmacist of medications being administered outside of parameters. The Pharmacy Consultant will also draft a new separate document of any recommendations not addressed from the previous month. The administrator will review the individual resident recommendations from the monthly drug regimen review as well as the summary to validate whether there were observations of medications being administered outside of ordered parameters, beginning with the April 2025 Consultant Pharmacy Summary. The administrator will report the findings to QAPI monthly x 3 months to determine if there are any additional training opportunities identified.	

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that the medication had been administered in error when the systolic blood pressure was >120 but only listed a small sample of dates, just enough to show a trend, but not all the dates that the medication was given in error in February 2025. She stated she did not alert the facility that errors continued to occur in March 2025 because she had been told that the nurses had been educated (when she followed up with the facility regarding the February recommendation on March 10, 2025) and she thought the re-education would "take a while."

An interview was conducted with the Director of Nursing on 04/02/25 at 11:30 AM. She stated that she received the monthly pharmacy recommendations and distributed them to the Unit Manager. She noted no medication errors were documented on the monthly summary reports. She explained she had not seen the February 2025 Pharmacy Recommendation to Nursing Staff that listed a portion of the medication errors. She was not aware of any medication errors in January 2025, February 2025, or March 2025. She stated that the facility should have been notified by the pharmacist if even one medication error had been discovered during the monthly reviews. She noted she was shocked when she found out about the Midodrine medication administration errors. She was not aware of any education that had been provided to the nursing staff related to medication parameters. She stated she had not told the Consultant Pharmacist that the nursing staff had received education for this issue.

An interview was conducted with the Unit Manager on 04/02/25 at 12:23 PM. She acknowledged that she received the pharmacy

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reports each month and acted on the recommendations. She stated she had never seen the February 2025 Pharmacy Recommendation to Nursing Staff that listed a portion of the medication errors. She explained no medication errors had been noted between January 2025 through March 2025. She stated she never told the Consultant Pharmacist that nursing staff had been educated regarding medication errors or parameters.

An interview was conducted with the Staff Development Nurse on 04/02/25 at 1:23 PM. She stated she had not provided any education to the nursing staff regarding medication parameters and had not been asked to do so. She had not been aware of the medication errors prior to today. She stated she had not told the Consultant Pharmacist that education had been provided to the nursing staff regarding the administration of medication with parameters.

An interview was conducted with the facility Administrator on 04/02/25 at 10:00 AM. She stated she was not aware of any medications errors that had occurred in the facility between January 2025 and March 2025. She explained because she signed off on all medication error reports and/or reprimands that occurred and would have known. She stated that she was surprised when she learned today of the number of medication errors that had occurred. She explained that the Consultant Pharmacist had documented on the monthly pharmacy summary reports for January 2025, February 2025, and March 2025 that there had been no medication errors. She stated the facility should have been made aware even if only one medication error had been discovered during the monthly

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F 756	Continued From page 56 pharmacy medication reviews. A telephone interview was conducted with the Medical Director on 04/03/25 at 4:36 PM. She stated she would have expected the Consultant Pharmacist to report the medication errors to the facility beginning in January 2025. She concluded that the Consultant Pharmacist should have reported any medication error to the facility when it was discovered. She noted Resident #95 had no significant outcome related to the medication errors.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Physician, and the Consultant Pharmacist interviews, the facility failed to hold the medication Midodrine when Resident #95 's systolic blood pressure was above 120 mm Hg (millimeters of mercury) or give the medication when the systolic blood pressure was less than 120 mm Hg. Resident #95 experienced no significant outcome. This occurred for 1 of 1 resident reviewed for medication administration. Findings included: Resident #95 was admitted to the facility on 04/12/24 with diagnoses that included hypotension. Record review revealed the following active	F 760	The facility failed to hold the medication Midodrine when Resident # 95s systolic blood pressure was above 120mmHg or give the medication when the systolic blood pressure was less than 120 mmHg. MD was notified immediately. Resident #95 suffered no ill effect from receiving the medication. The medication has been discontinued due to resident #95 having stable blood pressures. Education on the use of Midodrine was initiated on 4/3/25 to licensed nurses and certified medication aides. All residents who are ordered Midodrine have the potential to be affected by this deficient practice. On 4/1/25, current residents with orders for Midodrine were	4/23/25

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F 760	Continued From page 57 orders: Midodrine 10 MG (milligrams) give 1 tablet by mouth one time a day every Monday, Wednesday, Friday for hypotension hold if sys (systolic) > (greater than) 120 or dys (diastolic) > 80; Start date 01/08/25. Midodrine 10 MG (milligrams) give 1 tablet by mouth three times a day every Tuesday, Thursday, Saturday, and Sunday for hypotension hold if sys > 120 or dys > 80; Start date 01/08/25. Review of the Medication Administration Records revealed Resident #95 received 10 MG of Midodrine with a blood pressure reading > 120 mm Hg and did not receive Midodrine with a blood pressure reading < 120 mm Hg on Monday, Wednesday, and Friday on the following dates: 01/08/25 at 7:30 AM blood pressure 118/61 mm Hg, 10 mg of Midodrine was held by Medication Aide (MA) #1 01/08/25 at 7:30 AM blood pressure 114/55 mm Hg, 10 mg of Midodrine was held by MA #1 01/13/25 at 7:30 AM blood pressure 113/51 mm Hg, 10 mg of Midodrine was held by MA #1 01/15/25 at 7:30 AM blood pressure 153/74 mm Hg, 10 mg of Midodrine was given by MA #1 01/17/25 at 7:30 AM blood pressure 131/65 mm Hg, 10 mg of Midodrine was given by MA #1 01/22/25 at 7:30 AM blood pressure 136/72 mm Hg, 10 mg of Midodrine was given by MA #1 01/24/25 at 7:30 AM blood pressure 128/56 mm Hg, 10 mg of Midodrine was given by MA #1 01/27/25 at 7:30 AM blood pressure 130/64 mm Hg, 10 mg of Midodrine was given by MA #1 01/29/25 at 7:30 AM blood pressure 124/66 mm Hg, 10 mg of Midodrine was given by MA #1 02/03/25 at 7:30 AM blood pressure 121/54 mm Hg, 10 mg of Midodrine was given by MA #1 02/07/25 at 7:30 AM blood pressure 135/69 mm	F 760	reviewed with no additional issues found. All licensed nurses and certified medication aides have been re-educated on the use of Midodrine as well as significant medication error discovered during survey. Newly hired licensed nurses and certified medication aides will be educated on the use of Midodrine as well as administering medications with parameters during orientation. Beginning the week of 4/28/25, the Director of Nursing, Assistant Director of Nursing, or Staff Development Nurse will audit MARs for administration of medications with parameters 5 times weekly with re-education occurring as necessary. Additionally, medication administration observation of the residents receiving medications with parameters will randomly be conducted 2 times weekly. The Director of Nursing will report these findings to the Quality Assurance Performance Improvement meeting monthly x 3 months to determine if additional changes are necessary.	

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Hg, 10 mg of Midodrine was given by MA #1
02/14/25 at 7:30 AM blood pressure 129/70 mm
Hg, 10 mg of Midodrine was given by MA #1
02/17/25 at 7:30 AM blood pressure 159/87 mm
Hg, 10 mg of Midodrine was given by MA #1
02/19/25 at 7:30 AM blood pressure 129/64 mm
Hg, 10 mg of Midodrine was given by MA #1
02/21/25 at 7:30 AM blood pressure 129/64 mm
Hg, 10 mg of Midodrine was given by MA #1
02/24/25 at 7:30 AM blood pressure 140/70 mm
Hg, 10 mg of Midodrine was given by MA #1
03/03/25 at 7:30 AM blood pressure 140/55 mm
Hg, 10 mg of Midodrine was given by MA #1
03/07/25 at 7:30 AM blood pressure 130/74 mm
Hg, 10 mg of Midodrine was given by MA #1
03/10/25 at 7:30 AM blood pressure 123/67 mm
Hg, 10 mg of Midodrine was given by MA #1
03/12/25 at 7:30 AM blood pressure 147/73 mm
Hg, 10 mg of Midodrine was given by MA #1
03/14/25 at 7:30 AM blood pressure 132/72 mm
Hg, 10 mg of Midodrine was given by MA #1
03/17/25 at 7:30 AM blood pressure 121/57 mm
Hg, 10 mg of Midodrine was given by MA #1
03/19/25 at 7:30 AM blood pressure 134/79 mm
Hg, 10 mg of Midodrine was given by MA #1
03/21/25 at 7:30 AM blood pressure 127/73 mm
Hg, 10 mg of Midodrine was given by MA #1
03/24/25 at 7:30 AM blood pressure 136/62 mm
Hg, 10 mg of Midodrine was given by MA #1
03/26/25 at 7:30 AM blood pressure 130/72 mm
Hg, 10 mg of Midodrine was given by MA #1
03/28/25 at 7:30 AM blood pressure 132/71 mm
Hg, 10 mg of Midodrine was given by MA #1
03/31/25 at 7:30 AM blood pressure 127/60 mm
Hg, 10 mg of Midodrine was given by MA #1

Review of the Medication Administration Records revealed Resident #95 received 10 MG of Midodrine with a blood pressure reading > 120

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mm Hg and did not receive Midodrine with a blood pressure reading < 120 mm Hg on Tuesday, Thursday, Saturday, and Sunday on the following dates:
01/09/25 at 7:30 AM blood pressure 112/59 mm Hg, 10 mg of Midodrine was held by MA #1
01/09/25 at 12:00 PM blood pressure 116/58 mm Hg, 10 mg of Midodrine was held by MA #1
01/09/25 at 7:00 PM blood pressure 122/82 mm Hg, 10 mg of Midodrine was given by MA #5
01/11/25 at 12:00 PM blood pressure 128/60 mm Hg, 10 mg of Midodrine was given by MA #1
01/11/25 at 7:00 PM blood pressure 144/68 mm Hg, 10 mg of Midodrine was given by MA #1
01/12/25 at 7:30 AM blood pressure 139/73 mm Hg, 10 mg of Midodrine was given by MA #3
01/12/25 at 12:00 PM blood pressure 139/73 mm Hg, 10 mg of Midodrine was given by MA #3
01/14/25 at 7:30 AM blood pressure 124/72 mm Hg, 10 mg of Midodrine was given by MA #1
01/14/25 at 12:00 PM blood pressure 136/66 mm Hg, 10 mg of Midodrine was given by MA #1
01/14/25 at 7:00 PM blood pressure 126/62 mm Hg, 10 mg of Midodrine was given by MA #1
01/16/25 at 7:30 AM blood pressure 147/72 mm Hg, 10 mg of Midodrine was given by Nurse #1
01/16/25 at 12:00 PM blood pressure 140/76 mm Hg, 10 mg of Midodrine was given by Nurse #1
01/16/25 at 7:00 PM blood pressure 122/67 mm Hg, 10 mg of Midodrine was given by MA #6
01/18/25 at 7:30 AM blood pressure 132/66 mm Hg, 10 mg of Midodrine was given by MA #4
01/18/25 at 12:00 PM blood pressure 132/66 mm Hg, 10 mg of Midodrine was given by MA #4
01/19/25 at 7:30 AM blood pressure 116/60 mm Hg, 10 mg of Midodrine was held by MA #4
01/19/25 at 7:00 PM blood pressure 140/80 mm Hg, 10 mg of Midodrine was given by MA #4
01/21/25 at 7:30 AM blood pressure 130/62 mm

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F 760	Continued From page 60 Hg, 10 mg of Midodrine was given by MA #1 01/21/25 at 12:00 PM blood pressure 130/68 mm Hg, 10 mg of Midodrine was given by MA #1 01/21/25 at 7:30 PM blood pressure 136/72 mm Hg, 10 mg of Midodrine was given by MA #1 01/23/25 at 12:00 PM blood pressure 136/68 mm Hg, 10 mg of Midodrine was given by MA #1 01/26/25 at 7:30 AM blood pressure 125/65 mm Hg, 10 mg of Midodrine was given by MA #1 01/26/25 at 12:00 PM blood pressure 132/74 mm Hg, 10 mg of Midodrine was given by MA #1 01/28/25 at 7:30 AM blood pressure 127/67 mm Hg, 10 mg of Midodrine was given by MA #1 01/28/25 at 12:00 PM blood pressure 138/74 mm Hg, 10 mg of Midodrine was given by MA #1 01/28/25 at 7:00 PM blood pressure 103/52 mm Hg, 10 mg of Midodrine was held by MA #2 01/30/25 at 7:30 AM blood pressure 147/62 mm Hg, 10 mg of Midodrine was given by MA #1 01/30/25 at 12:00 PM blood pressure "X", 10 mg of Midodrine was held by MA #2 01/30/25 at 7:00 PM blood pressure 118/58 mm Hg, 10 mg of Midodrine was held by MA #2 02/01/25 at 7:30 AM blood pressure 158/80 mm Hg, 10 mg of Midodrine was given by MA #4 02/01/25 at 12:00 PM blood pressure 147/77 mm Hg, 10 mg of Midodrine was given by MA #4 02/01/25 at 7:00 PM blood pressure 147/77 mm Hg, 10 mg of Midodrine was given by MA #4 02/02/25 at 12:00 PM blood pressure 134/80 mm Hg, 10 mg of Midodrine was given by MA #4 02/02/25 at 7:00 PM blood pressure 157/75 mm Hg, 10 mg of Midodrine was given by MA #4 02/04/25 at 7:30 AM blood pressure 130/70 mm Hg, 10 mg of Midodrine was given by MA #1 02/04/25 at 12:00 PM blood pressure 160/80 mm Hg, 10 mg of Midodrine was given by MA #4 02/04/25 at 7:00 PM blood pressure 112/58 mm Hg, 10 mg of Midodrine was held by MA #2	F 760		

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F 760	Continued From page 61 02/06/25 at 7:30 AM blood pressure 135/69 mm Hg, 10 mg of Midodrine was given by MA #1 02/06/25 at 12:00 PM blood pressure 138/72 mm Hg, 10 mg of Midodrine was given by MA #1 02/06/25 at 7:00 PM blood pressure 128/78 mm Hg, 10 mg of Midodrine was given by MA #2 02/08/25 at 7:30 AM blood pressure 128/66 mm Hg, 10 mg of Midodrine was given by MA #1 02/08/25 at 12:00 PM blood pressure 136/74 mm Hg, 10 mg of Midodrine was given by MA #1 02/09/25 at 12:00 PM blood pressure 128/76 mm Hg, 10 mg of Midodrine was given by MA #1 02/09/25 at 7:00 PM blood pressure 142/83 mm Hg, 10 mg of Midodrine was given by MA #3 02/11/25 at 7:30 AM blood pressure 139/75 mm Hg, 10 mg of Midodrine was given by MA #1 02/13/25 at 7:30 AM blood pressure 138/76 mm Hg, 10 mg of Midodrine was given by MA #1 02/13/25 at 12:00 PM blood pressure 136/74 mm Hg, 10 mg of Midodrine was given by MA #1 02/15/25 at 7:30 AM blood pressure 138/76 mm Hg, 10 mg of Midodrine was given by MA #4 02/15/25 at 12:00 PM blood pressure 1139/67 mm Hg, 10 mg of Midodrine was given by MA #4 02/15/25 at 7:00 PM blood pressure 105/60 mm Hg, 10 mg of Midodrine was held by MA #4 02/16/25 at 12:00 PM blood pressure 105/60 mm Hg, 10 mg of Midodrine was held by MA #4 02/16/25 at 7:00 PM blood pressure 130/79 mm Hg, 10 mg of Midodrine was given by MA #4 02/18/25 at 7:30 AM blood pressure 132/72 mm Hg, 10 mg of Midodrine was given by Nurse #2 02/18/25 at 12:00 PM blood pressure 132/72 mm Hg, 10 mg of Midodrine was given by MA #1 02/18/25 at 7:00 PM blood pressure 136/74 mm Hg, 10 mg of Midodrine was given by MA #1 02/20 25 at 7:30 AM blood pressure 123/68 mm Hg, 10 mg of Midodrine was given by MA #1 02/20/25 at 7:00 PM blood pressure 123/68 mm	F 760		

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F 760	Continued From page 62	F 760		

Hg, 10 mg of Midodrine was given by MA #3
02/22/25 at 12:00 PM blood pressure 124/66 mm
Hg, 10 mg of Midodrine was given by MA #1
02/22/25 at 7:00 PM blood pressure 146/82 mm
Hg, 10 mg of Midodrine was given by MA #6
02/23/25 at 7:30 AM blood pressure 144/70 mm
Hg, 10 mg of Midodrine was given by MA #5
02/23/25 at 12:00 PM blood pressure 124/61 mm
Hg, 10 mg of Midodrine was given by MA #5
02/23/25 at 7:00 PM blood pressure 136/72 mm
Hg, 10 mg of Midodrine was given by MA #7
02/25/25 at 7:30 AM blood pressure 142/68 mm
Hg, 10 mg of Midodrine was given by MA #1
02/25/25 at 12:00 PM blood pressure 136/72 mm
Hg, 10 mg of Midodrine was given by MA #1
02/25/25 at 7:00 PM blood pressure 113/60 mm
Hg, 10 mg of Midodrine was held by MA #2
02/27/25 at 7:30 AM blood pressure 122/65 mm
Hg, 10 mg of Midodrine was given by MA #1
03/01/25 at 7:30 AM blood pressure 118/70 mm
Hg, 10 mg of Midodrine was held by MA #4
03/01/25 at 12:00 PM blood pressure 129/65 mm
Hg, 10 mg of Midodrine was given by MA #4
03/01/25 at 7:00 PM blood pressure 113/60 mm
Hg, 10 mg of Midodrine was held by MA #4
03/02/25 at 7:30 AM blood pressure 133/62 mm
Hg, 10 mg of Midodrine was given by MA #4
03/02/25 at 12:00 PM blood pressure 135/69 mm
Hg, 10 mg of Midodrine was held by MA #4
03/04/25 at 7:00 PM blood pressure 139/77 mm
Hg, 10 mg of Midodrine was given by MA #3
03/06/25 at 12:00 PM blood pressure 136/74 mm
Hg, 10 mg of Midodrine was given by MA #1
03/06/25 at 7:30 PM blood pressure 136/74 mm
Hg, 10 mg of Midodrine was given by MA #3
03/08/25 at 7:30 AM blood pressure 125/70 mm
Hg, 10 mg of Midodrine was given by MA #1
03/11/25 at 7:30 AM blood pressure 132/70 mm
Hg, 10 mg of Midodrine was given by MA #1

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F 760	Continued From page 63 03/11/25 at 12:00 PM blood pressure 139/63 mm Hg, 10 mg of Midodrine was given by MA #1 03/11/25 at 7:00 PM blood pressure 132/66 mm Hg, 10 mg of Midodrine was given by MA #1 03/13/25 at 7:30 AM blood pressure 138/74 mm Hg, 10 mg of Midodrine was given by MA #1 03/13/25 at 12:00 PM blood pressure 136/68 mm Hg, 10 mg of Midodrine was given by MA #1 03/15/25 at 7:30 AM blood pressure 112/60 mm Hg, 10 mg of Midodrine was held by MA #4 03/15/25 at 12:00 PM blood pressure 141/80 mm Hg, 10 mg of Midodrine was given by MA #4 03/15/25 at 7:00 PM blood pressure 130/60 mm Hg, 10 mg of Midodrine was given by MA #4 03/16/25 at 12:00 PM blood pressure 141/70 mm Hg, 10 mg of Midodrine was given by MA #4 03/18/25 at 7:30 AM blood pressure 136/68 mm Hg, 10 mg of Midodrine was given by MA #1 03/18/25 at 12:00 PM blood pressure 132/66 mm Hg, 10 mg of Midodrine was given by MA #1 03/18/25 at 7:00 PM blood pressure 129/67 mm Hg, 10 mg of Midodrine was given by MA #1 03/20/25 at 7:30 AM blood pressure 136/76 mm Hg, 10 mg of Midodrine was given by MA #1 03/20/25 at 12:00 PM blood pressure 128/68 mm Hg, 10 mg of Midodrine was given by MA #1 03/22/25 at 7:30 AM blood pressure 122/68 mm Hg, 10 mg of Midodrine was given by MA #1 03/23/25 at 7:30 AM blood pressure 138/76 mm Hg, 10 mg of Midodrine was given by MA #1 03/25/25 at 7:30 AM blood pressure 132/74 mm Hg, 10 mg of Midodrine was given by MA #1 03/25/25 at 12:00 PM blood pressure 122/70 mm Hg, 10 mg of Midodrine was given by MA #1 03/25/25 at 7:00 PM blood pressure 130/72 mm Hg, 10 mg of Midodrine was given by MA #1 03/27/25 at 7:30 AM blood pressure 134/72 mm Hg, 10 mg of Midodrine was given by MA #1 03/27/25 at 12:00 PM blood pressure 141/86 mm	F 760		

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F 760	Continued From page 64	F 760		

Hg, 10 mg of Midodrine was given by MA #1 03/27/25 at 7:00 PM blood pressure 138/72 mm Hg, 10 mg of Midodrine was given by MA #1 03/29/25 at 7:00 PM blood pressure 110/60 mm Hg, 10 mg of Midodrine was held by MA #4 03/30/25 at 12:00 PM blood pressure 101/70 mm Hg, 10 mg of Midodrine was held by MA #4 04/01/25 at 7:30 AM blood pressure 128/72 mm Hg, 10 mg of Midodrine was given by MA #1 04/01/25 at 12:00 PM blood pressure 133/66 mm Hg, 10 mg of Midodrine was given by MA #1

Review of the progress notes from 01/08/25 through 04/01/25 for Resident #95 revealed no documentation that the medication Midodrine was correctly held or given on the dates listed.

An interview was conducted with MA #1 on 04/01/25 at 2:50 PM. She stated she worked full time on the 100 hall and cared for Resident #95. She acknowledged that this medication order had parameters attached to it because the parameters popped up automatically. She confirmed if there was a check mark on the Medication Administration Record (MAR) it meant that she had administered the medication. She stated she did not know what had happened that caused her to give the medication in error.

An interview was conducted with Nurse #2 on 04/01/25 at 3:00 PM. She stated she was familiar with Resident #95. She noted she was familiar with the medication Midodrine and knew it was used to increase the blood pressure. She stated she had made a medication error because she had not noticed the parameters when she administered the medication.

An interview was conducted with MA #4 on

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04/01/25 at 3:11 PM via phone. She stated she worked on the weekends and was familiar with Resident #95. She stated she knew the medication Midodrine was used to treat low blood pressure by raising the blood pressure. She knew the medication had parameters. She confirmed that if she documented a check mark on the MAR that she had administered the medication. She thought she may have documented incorrectly.

A telephone interview was conducted with MA #6 on 04/02/25 at 10:28 AM. She stated that she had worked at the facility for 4 years and was familiar with Resident #95. She explained that she understood that the medication Midodrine was used for orthostatic hypotension and would bring up his blood pressure. She stated she was aware of the parameters and would hold the medication if the systolic blood pressure was > 120. She concluded she must have made a documentation error because she also had to also pass medications on the 500 hall which made the assignment chaotic.

An interview was conducted with MA #5 on 04/02/25 at 11:10 AM. She stated that she usually worked on the 300 hall but was occasionally pulled to pass medications on the 100 hall. She stated she had administered the medication to Resident #95 in error.

An interview was conducted with MA #3 on 04/02/25 at 4:17 PM. She stated she had worked at the facility for 2 years and was familiar with Resident #95. She indicated that if she signed off the medication on the MAR that she had administered the drug. She stated she had not looked at the parameters as closely as she should have and gave the medication in error.

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A phone interview was conducted with MA #2 on 04/02/25 at 4:39 PM. She stated that she had worked at the facility for 3 years and was familiar with Resident #95. She noted she usually worked as a nurse aide but did pass medications occasionally. She recalled the parameters on the Midodrine order for Resident #95 and stated she had always taken his blood pressure before administering the drug. She stated she may have misunderstood the order and had given the medication in error.

A telephone interview was conducted with Nurse #1 on 04/02/25 at 4:52 PM. She stated that she was familiar with Resident #95. She explained that the medication Midodrine was used for hypotension. She was not sure why she gave the medication when the systolic blood pressure was > 120. She thought she may have interpreted the order to instruct her to hold the medication if the systolic reading was < 120. She confirmed that if there was a check mark on the MAR that she had given the medication.
An interview was conducted with the Staff Development Coordinator (SDC) Nurse on 04/03/25 at 8:59 AM. She stated she was familiar with the medication Midodrine and that it was used to bring up a low blood pressure. She explained she had not noticed the order had parameters set and had given the medication in error.

A telephone interview was conducted with MA #7 on 04/03/25 at 11:15 AM. She stated she was familiar with Resident #95 but usually did not work the 100 hallway. She explained she did not know why she gave the medication in error. She assumed she had not seen the parameters and

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gave the medicine to the resident. She noted the 100 hall was very busy and the whole time she passed medication on the 100 hall she was constantly being interrupted by residents approaching her for pain medications. She described the assignment as hectic.

Unsuccessful attempts to contact Nurse #3 were made on 04/02/25 at 10:40 AM, 04/03/25 at 9:15 AM and 04/03/25 at 4:22 PM. A message was left on each attempt.

An interview was conducted with the Assistant Director of Nursing on 04/01/25 at 4:30 PM. She stated she was familiar with Resident #95 and had administered the medication Midodrine to him in error. She stated she had been a dialysis nurse in the past and knew that dialysis would not be given if the diastolic blood pressure was too low, so she had given the Midodrine on 01/27/25 in the morning in an effort to raise his diastolic pressure and wasn't paying attention to the parameters that had been ordered. She had thought the diastolic pressure of 68 was too low. She stated she had misunderstood the order and thought it read "dys hold if < 80" when it actually read "dys hold if > 80" and she was trying to raise the diastolic blood pressure up to 80 mm Hg by giving the medication. She had not noticed the systolic parameter was >120 mm Hg when she gave it either because she was focused on her previous dialysis experience.

A telephone interview was conducted with the facility Consultant Pharmacist on 04/01/25 at 10:18 AM. She stated she had not notified the facility that the Midodrine had been given in error in January 2025 because she had not seen a trend and didn't think that giving this medication

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to Resident #95 when his blood pressure was outside of the parameters was of clinical significance. She reported that she had recommended to the nursing staff on 02/14/25 that the medication had been administered in error when the systolic blood pressure was >120 but only listed a small sample of dates, just enough to show a trend, but not all the dates that the medication was given in error in February 2025. She stated she did not alert the facility that errors continued to occur in March 2025 because she had been told that the nurses had been educated (when she followed up with the facility regarding the February recommendation on March 10, 2025) and she thought the re-education would "take a while."

An interview was conducted with the Unit Manager on 04/02/25 at 12:23 PM. She acknowledged that she received the pharmacy reports each month and acted on the recommendations. She stated she had never seen the February 2025 Pharmacy Recommendation to Nursing Staff that listed the medication errors. She explained she was not aware that any medication errors had occurred.

An interview was conducted with the SDC Nurse on 04/02/25 at 1:23 PM. She stated she had not provided any education to the nursing staff regarding medication parameters, and she had not been aware of any medication errors.

An interview was conducted with the Director of Nursing on 04/02/25 at 11:30 AM. She stated she had not been aware of any medication errors.

An interview was conducted with the facility Administrator on 04/02/25 at 10:00 AM. She

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F 760	Continued From page 69 stated she was not aware of any medications errors that had occurred in the facility between January 2025 and March 2025. She explained she signed off on all medication error reports and/or reprimands that occurred and would have known. She stated that she was surprised when she learned today of the number of medication errors that had occurred. A telephone interview was conducted with the Medical Director on 04/03/25 at 4:36 PM. She stated that she expected the nursing staff to administer medications according to the ordered parameters. She reported that she had not been notified of the medication errors. She noted Resident #95 had no significant outcome related to the medication errors even though the number of errors was significant.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/25/25

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F 761	Continued From page 70 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired medications, record an opened date on a multi-dose oral inhaler that had a shortened expiration date, and refrigerate unopened ophthalmic drops according to the manufacturer's guidelines on 2 of 5 medication carts (400 hall, 800 hall) and in 2 of 2 medication storage rooms (300 hall, 400 hall) that were reviewed for medication storage. Findings included. 1.) An observation of the 400-hall medication cart on 04/02/25 at 11:19 AM revealed the following medications: One bottle of Latanoprost .005% ophthalmic drops that was unopened and not refrigerated. Review of the manufacturers guidelines for Latanoprost ophthalmic solution instructed to store unopened bottles under refrigeration at 2° to 8°C (36° to 46°F). Once a bottle was opened for use, it may be stored at room temperature up to 25°C (77°F) for 6 weeks. Fluticasone propionate salmeterol (Advair diskus)100 micrograms (mcg)/50mcg that was in use with no opened date labeled on the inhaler.	F 761	The facility failed to discard expired medications, record an opened date on a multi-dose oral inhaler that had a shortened expiration date, and refrigerate unopened ophthalmic drops according to the manufacturer’s guidelines on 2 of 5 medication carts and in 2 of 2 medication storage rooms that were reviewed for medication storage. All medications discovered to be out of compliance were discarded and replaced as necessary. No residents suffered any ill effects related to this practice. All residents have the potential to be affected by this deficient practice. All licensed nurses were educated by the Administrator, Director of Nursing, Assistant Director of Nursing, and Staff Development Nurse on 4/17/25 on medication storage and labeling. All newly hired licensed nurses will be educated during orientation on medication storage and labeling. The facility has identified a medication cart champion who has organized each	

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F 761	Continued From page 71 Fluticasone propionate salmeterol inhaler (Advair diskus)100 micrograms (mcg)/50mcg with an opened date of 1/09/25. Review of the manufacturers guidelines for Fluticasone propionate salmeterol inhaler instructed to discard one month after opening the foil pouch. One box of Hemorrhoidal suppositories that were house stock with an expiration date of 11/2023. Clobetasol 0.5% topical ointment with an expiration date of 9/2024. Imvexxy vaginal suppositories 10mcg with an expiration date of 10/2024. During an interview on 04/02/25 at 11:30 AM Nurse #2 stated all nurses were responsible for checking the medication carts for expired medications. She indicated she had not checked the cart so far today due to being busy with the morning medication pass. She stated the medications should have been discarded and an opened date labeled on the inhaler. She indicated she was not aware that the Latanoprost ophthalmic drops had to be refrigerated if not opened. 2.) An observation of the 800-hall medication cart on 04/02/25 at 11:45 AM revealed the following medications: One bottle of Latanoprost .005% ophthalmic drops that was opened and in use with no opened date recorded.	F 761	cart to promote consistency and compliance with medication storage and labeling. Beginning the week of 4/28/25, the medication cart champion will audit all medication carts one to two times weekly and provide immediate feedback to the assigned nurse responsible for the medication cart at the time of the audit. A reference document of medications with shortened expiration dates will be laminated and placed on each cart for quick reference. Additionally, each medication cart will be taken to the Director of Nursing's office once weekly at a scheduled time to be audited by the Director of Nursing. Any identified areas of concern will be addressed immediately with re-education given as necessary. The Assistant Director of Nursing will be responsible for auditing all medication storage rooms weekly. The audits will be conducted x 12 weeks. The Director of Nursing will present the findings of the audits to the QAPI committee monthly for a minimum of 3 months to determine if additional audits/training are required. The Director of Nursing will be responsible for ensuring compliance as of 4/25/25.	

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F 761	Continued From page 72	F 761		

One bottle of Lansoprazole 3 milligrams per milliliter suspension with a use by date of 3/31/25.

Review of the manufacturer's instructions for Lansoprazole suspension instructed to discard after 30 days and store in the refrigerator.

During an interview on 04/02/25 at 11:45 AM Nurse #4 stated all nurses were responsible for checking the medication carts for expired medications and to ensure medications with short expiration dates were labeled with an opened date. She stated this was an oversight.

3.) An observation of the 300-hall medication storage room on 04/02/25 at 12:30 PM revealed the following:

Two bottles of wound cleanser (antiseptic) with an expiration date of 4/30/24 and 9/2023.

During an interview on 04/02/25 at 12:30 PM Unit Manager #1 stated she thought she had checked the storage room for expired medications. She stated it was an oversight.

4.) An observation of the 400-hall medication storage room on 04/02/25 at 11:55 AM revealed the following:

Lansoprazole suspension 3 mgs with an expiration date of 03/01/25.

During an interview on 04/02/25 at 11:55 AM Nurse #2 stated that central supply staff, the Assistant Director of Nursing and the nurses were all responsible for checking the medication storage rooms for expired medications. She stated this was an oversight.

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F 761	Continued From page 73 During an interview on 04/03/25 at 3:53 PM Central Supply staff member #1 stated she routinely checked the medication storage rooms for expired medications. She stated she was responsible for over-the-counter medications not prescription medications. An interview was conducted on 04/03/25 at 3:01 PM with the Director of Nursing (DON) along with the Administrator. The Administrator stated the assigned nurse was responsible for checking medication carts for expired medications and to ensure all medications were labeled with an opened date. She stated the central supply staff member was responsible for checking the medication storage rooms for expired medications. She stated education regarding medication storage would be provided to nursing staff.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		4/23/25

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F 812	Continued From page 74 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and date an opened food item in 1 of 1 walk-in refrigerator and failed to remove expired containers of milk from 2 of 3 nourishment rooms (Secured Unit and East Wing). These practices had the potential to affect food service for the residents. The findings included: a. The initial tour of the kitchen with the Dietary Manager on 3/31/2025 at 10:50 AM revealed an open package of sliced turkey in the walk-in refrigerator that was not labeled and dated. An interview with the Dietary Manager was conducted on 3/31/2025 at 11:00 AM. The Dietary Manager stated that all open food in the kitchen was supposed to be labeled with an opened date and an expiration date. She further stated she was going to discard the package of turkey because it was not labeled and dated. b. A tour of the East Wing nourishment room with the Dietary Manager on 3/31/2025 at 11:05 AM revealed a container of 2% milk with the expiration date of 3/29/2025. c. A tour of the Secured Unit nourishment room with the Dietary Manager on 3/31/2025 at 11:08 revealed 2 containers of 2% milk with the expiration date of 3/29/2025.	F 812	Based on observations and staff interviews, the facility failed to label and date an opened food item in 1 of 1 walk-in refrigerator and failed to remove expired containers of milk from 2 of 3 nourishment rooms (Secured Unit and East Wing). These practices had the potential to affect food service for the residents. a. The initial tour of the kitchen with the Dietary Manager on 3/31/2025 at 10:50 AM revealed an open package of sliced turkey in the walk-in refrigerator that was not labeled and dated. An interview with the Dietary Manager was conducted on 3/31/2025 at 11:00 AM. The Dietary Manager stated that all open food in the kitchen was supposed to be labeled with an opened date and an expiration date. She further stated she was going to discard the package of turkey because it was not labeled and dated. b. A tour of the East Wing nourishment room with the Dietary Manager on 3/31/2025 at 11:05 AM revealed a container of 2% milk with the expiration date of 3/29/2025. c. A tour of the Secured Unit nourishment room with the Dietary Manager on 3/31/2025 at 11:08 revealed 2 containers of 2% milk with the expiration date of 3/29/2025. No residents were affected. The undated turkey and expired milk were immediately	

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F 812	Continued From page 75 An interview with the Dietary Manager was completed on 3/31/2025 at 11:10 AM. The Dietary Manager stated that the dietary staff were responsible for stocking the nourishment rooms and removing expired items. She indicated the expired milk containers should have been removed from the nourishment rooms. An interview with the Administrator was completed on 4/3/2025 at 1:20 PM. The Administrator stated she expected opened food items to be labeled and dated correctly. She further stated that the milk expired on the weekend and no one was assigned to check the nourishment rooms on the weekend.	F 812	discarded. All residents had the potential to be affected. 100% of dietary staff were immediately reeducated. Dairy products will be relocated to the kitchen fridge accessible to floor staff 24/7. Starting 4/28/25, the dietary manager or designee will check the walk-in fridge and pantry rooms 5 times a week for 12 weeks to ensure food is stored and labeled properly. Any deficiencies found with the audits will be corrected immediately and re-education done as necessary by the dietary manager. The findings of the audits will be taken to QAPI meeting monthly x 3 months by the Dietary Manager to determine if changes need to be made.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-	F 825		4/23/25

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F 825	Continued From page 76 §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and Nurse Practitioner interviews, the facility failed to provide rehabilitation services per the resident's plan of care. This was for 1 of 2 residents (Resident # 93) reviewed for rehabilitation services. Findings included Review of Resident #93's hospital discharge summary dated 3/17/25 indicated the resident was hospitalized from 3/6/25 through 3/17/25. The discharge summary indicated Resident #93 remained functionally dependent and required skilled nursing facility placement upon discharge from the hospital due to mobility and activity of daily living (bathing, dressing, and toileting) limitations. Physical and occupational therapy was recommended to continue at the skilled nursing facility with possible transition to long-term care. The discharge summary indicated it was important that Resident #93 continued with range of motion exercises. Resident #93 was admitted to the facility on 3/17/25 with diagnoses of sacral pressure ulcer and stroke.	F 825	The facility failed to provide ordered physical and occupational therapy services to a resident admitted from the hospital with therapy orders. Therapy services were delayed due to a pending order for a PRAFO (pressure-relieving ankle-foot orthosis). Physical therapy and Occupational Therapy have been initiated for Resident #93 since identification of the deficiency. Resident #93 was reassessed to determine any missed therapy needs and compensatory sessions were provided as appropriate. The resident was notified of the delay in services and updated regarding the correction plan. PRAFO has been ordered – fitting appointment is scheduled the week of 4/28/25. All residents have the potential to be affected by this practice. A review was conducted of all residents admitted within the past 30 days with orders for PT/OT from the hospital. Any identified residents with a delay in the initiation of therapy services were	

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F 825	Continued From page 77 Resident #93's physician orders revealed orders dated 3/17/25 for speech, occupational and physical therapy to evaluate and treat as indicated. A therapy screening form dated 3/18/25 completed by the Rehabilitation Director revealed the reason for the screen was admission to the facility. The form was not completed and the justification for "no evaluation" indicated Resident #93 was total care, required a mechanical lift for transfers and needed a PRAFO boot before therapy. The form indicated the facility was in the process of obtaining the PRAFO boot. Resident #93's physician orders revealed no order for a PRAFO boot (Pressure Reduction Ankle Foot Orthosis used to manage ankle/foot anomalies by keeping the ankle and foot aligned and relieves pressure off the heel) to be applied to resident's left lower extremity. A Nurse Practitioner note dated 3/18/25 indicated physical and occupational therapy was consulted in the hospital and recommendation was written in the discharge summary for skilled nursing due to activity of daily living limitations and sacral wound. Physical and occupation therapy was recommended with possible transition to long-term care, however the resident reported she would like to return home to family. On assessment Resident #93 was in the room with family members who confirmed the resident would be returning home. The assessment and plan indicated that Resident #93 was to receive physical and occupational therapy to address mobility and activities of daily living with the goal of returning home with family.	F 825	immediately addressed, with services initiated or resumed. A new interdisciplinary therapy initiation protocol has been implemented: Upon admission, therapy referrals will be reviewed within 24 hours by the rehab department. Therapy services will be initiated regardless of pending equipment, if clinically indicated. Therapy personnel have been re-educated by the Regional Director of Rehab on the expectation that OT and PT must be initiated as ordered, even if equipment is delayed. Rehab director or designee will conduct daily reviews of all new admissions to ensure timely therapy initiation. Beginning the week of 4/28/25, a weekly audit of new admissions with PT/OT orders will be completed by the Director of Rehab or designee for 4 weeks. If no further concerns are identified after 4 weeks, audits will be reduced to monthly for an additional 2 months. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) Committee by the Rehab Director monthly x 3 months to determine if additional audits/training are required.	

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Resident #93's care plan dated 3/18/25 indicated the resident required assistance with activities of daily living related to stroke with right sided weakness, impaired mobility, and history of an ankle fracture. Interventions included to provide assistance with activities of daily living tasks and therapy as ordered.

Resident #93's admission Minimum Data Set (MDS) dated 3/23/25 indicated the resident was cognitively intact with no rejection of care. Resident #93 required extensive to total assistance with activities of daily living. Resident #93 did not receive occupational, physical or speech therapy services since admission.

A physician progress note dated 3/24/25 at 12:37 PM indicated Resident #93 had a history of a left ankle fracture and underwent surgery approximately 2 years ago. The physician note indicated Resident #93 needed to start putting weight on the left ankle since now she had decreased strength and movement in her lower extremity. The physician's assessment indicated Resident #93 had decreased strength and movement in the right upper and lower extremities.

An interview was conducted with Resident #93 on 3/31/25 at 2:41 PM. Resident #93 stated she was still waiting to get on therapy services, and she did not know why she could not receive therapy. Resident #93 stated she thought she was supposed to receive therapy services, and she wanted to work with therapy to improve her mobility.

An interview was conducted with Nurse #4 on 4/2/25 at 9:30 AM. Nurse #4 was assigned to

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Resident #93 on the day shift from 7:00 AM to 3:00 PM Monday through Friday. Nurse #4 indicated that residents were usually evaluated by therapy when they were admitted to the facility. Nurse #4 stated she did not know whether Resident #93 had been evaluated by therapy or if she was receiving therapy or not.

An interview was conducted with the Therapy Director on 4/2/25 at 1:05 PM. The Therapy Director stated Resident #93 was screened by therapy and was determined to require total assistance with all activities of daily living and therefore was not a priority to receive therapy services. The Therapy Director stated they were waiting to obtain a PRAFO boot for the resident due to the resident's history of an ankle fracture. The Therapy Director stated Resident #93 was required to pay for part of the cost of the PRAFO boot. The Therapy Director stated he spoke with the resident regarding her portion of the cost of the PRAFO boot and Resident #93 stated she was not financially able to do so. The Therapy Director stated Resident #93 was not able to receive therapy services until she was able to pay for the PRAFO. The Therapy Director stated that he was working on recoding the information to submit to the insurance copy for the PRAFO boot however these things can take a while. The Therapy Director was unable to explain why Resident #93 could not receive occupational therapy services that concentrated on upper body movement until the PRAFO boot for the lower body was obtained.

A follow up interview with the Therapy Director on 4/2/25 at 2:50 PM revealed he was aware that physical therapy and occupational therapy were recommended by the hospital and by the medical

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F 825	Continued From page 80 providers however the resident was not able to receive therapy services until she had the PRAFO boot. An interview with the Nurse Practitioner on 4/3/25 at 3:00 PM revealed that Resident #93 was admitted with orders for physical, occupational and speech therapy. The Nurse Practitioner indicated that the expectation was that the facility evaluated residents with orders for therapy services. The Nurse Practitioner stated there was not an order for the PRAFO boot and it was not required for participation in therapy. An interview was conducted with the Administrator on 4/3/25 at 8:15 AM. The Administrator stated the facility had an influx of new admissions all at once that were truly here for short-term rehabilitation. The Administrator stated she understood, from a prior admission to the facility, that Resident #93 was admitted for long-term care and therapy services were not started upon admission due to not being a short-term patient. The Administrator indicated the facility did not require the resident to pay for the PRAFO boot but the facility preferred that she or her insurance paid for the equipment, rather than the facility. The Administrator stated she was not aware that the resident was asked to pay for the PRAFO boot and did not know why the Therapy Director indicated that the resident was responsible for it.	F 825		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		4/24/25

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(ii) The facility may release information that is resident-identifiable to an agent only in 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.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§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-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(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.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 82 unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Physician interviews, the facility failed to maintain a complete medical record by 1.) not documenting a pulse (heart rate) prior to the administration of the medication for a resident with an order for hydralazine, a medication to treat high blood pressure, with a parameter to hold the medication for a heart rate less than 60 beats per minute (Resident #24). 2.) maintain an accurate medical record for weight monitoring (Resident #17). This was observed for 2 of 6 residents whose medical record was reviewed. Findings included:	F 842	The facility failed to document a heart rate in the medical record prior to the administration of the medication for a resident with an order for hydralazine, a medication to treat high blood pressure, with a parameter to hold the medication for a heart rate less than 60 beats per minute (resident #24) and failed to maintain an accurate medical record for weight monitoring for resident #17. The order for hydralazine for resident #24 was updated to include documentation of a heart rate on the MAR. Nurse #7 was verbally counseled on not obtaining the weights that she documented on the	

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(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
F 842	Continued From page 83 1.) Resident #24 was admitted to the facility on 4/13/23 with diagnoses which included stroke and hypertension. Resident #24's physician orders revealed an order entered by the Director of Nursing (DON) dated 3/4/25 for hydralazine 25 milligrams (mg) every 8 hours for hypertension. Hold the medication for systolic blood pressure (the top number in the blood pressure) less than 100 or diastolic blood pressure (the bottom number) less than 50 or heart rate less than 60. Resident #24's electronic Medication Administration Record (eMAR) revealed that the entries for hydralazine 25 mg three times per day at 6:00 AM, 2:00 PM and 10:00 PM with the parameter to hold for systolic blood pressure less than 100 or diastolic blood pressure less than 50 or heart rate less than 60 were electronically signed as given. The blood pressure was recorded for each dose administered. The record revealed there was no pulse or heart rate recorded. Review of Resident #24's electronic health record revealed there were no pulse or heart rate results recorded at 6:00 AM, 2:00 PM or 10:00 PM in the vital sign record for March 2024. An interview was conducted with Nurse #5 on 4/2/25 at 10:20 AM. Nurse #5 reviewed the order for hydralazine and the parameters to hold the medication. Nurse #5 stated that the computer required blood pressure to be recorded but a pulse was not required when documenting the administration of the medication hydralazine. Nurse #5 stated that it was an error when the order for hydralazine was entered that it did not	F 842	MAR. All residents have the potential to be affected by this same deficient practice. An audit was conducted of current residents MARs who have orders for blood pressure medications with hold parameters to ensure the MAR reflected a space to document the necessary parameters. Any MARs that did not include a space to document the necessary parameters were updated to allow for accurate documentation. All licensed nurses were educated on 4/17/25 by the Administrator, Director of Nursing, Assistant Director of Nursing, and Staff Development Nurse on maintaining accurate medical records, medication administration and documentation. Education to include maintaining accurate medical records, medication administration and documentation will be included in orientation of all newly hired licensed nurses. Beginning the week of 4/28/25, the Director of Nursing or Assistant Director of Nursing will audit the MARs of residents with new orders for blood pressure medications with parameters to ensure the MAR has space to allow for documentation of necessary parameters, as well as all residents with daily weights. This audit will be conducted five times	

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	345234	A. BUILDING _____ B. WING _____	C 04/10/2025

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F 842	Continued From page 84 require the pulse to be documented. Nurse #5 stated that she used an automatic blood pressure cuff to obtain a blood pressure prior to administering Resident #24's hydralazine and that the cuff also displayed a pulse. Nurse #5 stated she checked the blood pressure and pulse prior to administering the medication per order but there wasn't a place on the eMAR to record the pulse. An interview was conducted with Nurse #9 on 4/2/25 at 4:30 PM. Nurse #9 stated she was assigned to Resident #24 from 3:00 PM to 11:00 PM Monday through Friday. Nurse #9 reviewed the order for hydralazine and the parameters to hold the medication. Nurse #9 stated that the order did not require the pulse (heart rate) to be recorded but she obtained a pulse prior to administering the medication. Nurse #9 stated it was an error that the order did not require the pulse to be documented. An interview was conducted with Nurse #8 on 4/3/25 at 10:35 AM. Nurse #8 stated she was assigned to Resident #24 from 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. Nurse #8 stated she checked Resident #24's pulse (heart rate) prior to administering the hydralazine but she did not record it. The eMAR did not require that a pulse be recorded but she obtained it prior to administering the medication. Nurse #8 stated she was aware there was a parameter for holding the medication based on the pulse reading. Nurse #8 stated that the pulse should have been recorded but she did not correct the documentation or ask anyone about correcting it. An interview was conducted with Nurse #7 on 4/3/25 at 12:35 PM. Nurse #7 stated that she	F 842	weekly x 12 weeks. Any discrepancies will be corrected immediately with re-education being done by the Director of Nursing to the party responsible. The audit findings will be reported by the Director of Nursing to the QAPI committee monthly for a minimum of three months.	

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F 842	Continued From page 85	F 842		

was a nurse that worked Saturdays and Sundays from 7:00 AM to 7:00 PM. Nurse #7 indicated she recalled administering Resident #24's hydralazine as ordered and was aware there were parameters for holding the medication based on the blood pressure and pulse readings. Nurse #7 stated she obtained a pulse prior to administering Resident #24's hydralazine after checking to ensure that it was within the parameter. Nurse #7 stated the eMAR did not require the pulse to be recorded and she had not asked anyone about correcting it.

Attempts were made on 4/2/25 and 4/3/25 to interview Nurse #3 with messages left and no return call received. Nurse #3 was assigned to Resident #24 on Saturdays and Sundays from 7:00 AM to 3:00 PM.

An interview with the Director of Nursing and Administrator on 4/3/25 at 2:50 PM revealed that they expected that medication orders would be transcribed correctly and would be documented appropriately. The DON stated it was an error when she transcribed the order for hydralazine that she did not enter the requirement to record the pulse or heart rate when the medication was administered.

An interview with the Nurse Practitioner on 4/3/25 at 3:00 PM revealed that when an order had parameters to hold a medication for a blood pressure or pulse reading, the readings obtained prior to administering the medication should be recorded. The Nurse Practitioner stated that the pulse not being recorded prior to administering Resident #24's hydralazine was an error.

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F 842	Continued From page 86	F 842		

2.) Resident #17 was admitted to the facility on 1/3/25 with diagnosis including congestive heart failure and chronic kidney disease.

A physician's order dated 3/1/25 for Resident #17 was to obtain daily weights due to congestive heart failure.

Review of the Medication Administration Record (MAR) dated March 2025 for Resident #17 revealed the following weights recorded:

3/01/25 weight 318.6 pounds (lbs.) documented by Nurse #7
3/02/25 weight 318.6 lbs. documented by Nurse #7
3/08/25 weight 292 lbs. documented by Nurse #7
3/09/25 weight 292 lbs. documented by Nurse #7
3/15/25 weight 292 lbs. documented by Nurse #7
3/16/25 weight 292 lbs. documented by Nurse #7
3/17/25 weight 292 lbs. documented by Nurse #7
3/22/25 weight 292 lbs. documented by Nurse #7
3/23/25 weight 292 lbs. documented by Nurse #7

During a phone interview on 04/03/25 at 1:19 PM Nurse #7 stated that when she recorded Resident#17's weights on the Medication Administration Record (MAR) she used the previous weight that she found in the medical record. She stated that she did not obtain the daily weights that she recorded on the MAR from 3/01/25 through 3/23/25. She stated she had not obtained any weights on Resident #17 because she was not sure how the Restorative Aide obtained Resident #17's weight and whether the Restorative Aide used the wheelchair or the mechanical lift to get the weight. She stated she knew that was wrong and she should have obtained the weight and documented accurate

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F 842	Continued From page 87 weights. An interview was conducted on 04/03/25 at 3:33 PM with the Director of Nursing (DON) along with the Administrator. The DON and Administrator both stated that Nurse #7 should have obtained the daily weights and recorded accurate weights in Resident #17's medical record.	F 842		