STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	**106 CAMERON STREET , LAKE WACCAMAW, North Carolina, 28450**

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E0000	Initial Comments An unannounced Complaint Investigation and Recertification survey was conducted from 06/22/2025 thruogh 06/26/2025. The facility was found in compliance with the requirement of CFR. 483.73 Emergency Preparedness. Event ID # RJJ111.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/22/2025 to 06/26/2025. Event ID# RJJ111. The following intakes were investigated: NC00225316, NC00223346, NC00230854, NC00228533, and NC 00223447. 4 of the 7 complaint allegations resulted in a deficiency.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services	F0550	The facility failed to ensure resident's right to maintain dignity for 1 of 1 residents reviewed for dignity. Resident rights were violated for Resident #35. Resident #35 was transported to a physician appointment in a urine soiled brief, wearing a hospital gown rather than her personal clothing as was her preference and without her hair brushed. This resulted in Resident #35 feeling embarrassed. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Social Worker or designee reviewed the facilities grievance records from the last 30 days to identify if any other resident may have experienced similar treatment. No additional residents were found to have been affected. This was completed by 07/14/2025. The Social Worker or designee placed a resident rights reminder poster in the employee breakroom and at the two nursing stations in the facility. This was completed by 07/14/2025. The facility's appointment checklist was updated to	08/15/2025

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F0550 SS = D	Continued from page 1 under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure resident's right to maintain dignity for 1 of 1 residents reviewed for dignity. Resident #35, a bedbound cognitively intact resident was transported to a physician appointment in a urine soiled brief, wearing a hospital gown rather than her personal clothing as was her preference and without her hair brushed. This resulted in the resident feeling bad and embarrassed. Findings included: Resident #35 was admitted on 12/6/23 with diagnosis of chronic pain, diabetes and muscle weakness. Review of Resident #35's significant change Minimum Data Set (MDS) assessment dated 12/9/24 revealed that resident was cognitively intact and exhibited no behaviors. Resident #35 required substantial/maximum assistance with toileting, was dependent for transfers and toileting, was incontinent of bowel and bladder and was non-ambulatory. Review of a grievance dated 3/10/25 filed by Resident #35 revealed that the resident reported she had an	F0550	Continued from page 1 include appointment preparation to ensure residents are appropriately dressed and groomed before leaving the facility for an appointment. This was completed by 07/14/2025. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all staff on resident rights and maintenance of resident dignity to include ensuring all residents are dressed appropriately, groomed, and provided with clean briefs before attending medical appointments. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will conduct routine audits and observations of the facility's transportation log to ensure compliance for 5 days a week x 4 weeks, 3 days a week x 4 weeks, then 2 days a week x 4 weeks. Beginning 07/14/2025, to prevent recurrence the Social Worker or designee will conduct an interview with 3 alert and oriented residents per week x 12 weeks to ensure resident rights are being followed by all staff members. If a resident has a concern the Social Worker or designee will file a grievance regarding the concern, investigate the concern, and implement an intervention to rectify the grievance. Beginning 07/14/2025, the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), or designee will ensure if a staff member is involved in a concern the staff member will be re-educated, and employee disciplinary action will be taken for staff who fail to comply with the facility's expectation that resident dignity be maintained. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0550 SS = D	Continued from page 2 appointment on 3/7/25, and she did not have her hair brushed and had on a soiled brief and a hospital gown. The findings of the grievance revealed that it was confirmed that Resident #35 was soiled and not dressed in personal clothing when she was taken out for the appointment. The response/resolution was that the Director of Nursing (DON) spoke with the staff member (Nursing Assistant #9) about making sure residents were ready for appointments in a timely manner. Review of Resident #35's medical record revealed that Resident #35 had presented at the orthopedic office on 3/7/25 at 11:30 AM for a follow up appointment. An interview with Resident #35 on 6/23/25 at 9:26 AM revealed she was taken to an appointment in March in a hospital gown, didn't have her hair brushed and was incontinent of urine. Resident #35 stated she was embarrassed and felt like people at the doctor's office were looking at her and it made her feel bad. She stated that the staff did not have time to get her ready for the appointment. An interview was conducted with the Business Office Manager (BOM) on 6/25/25 at 10:00 AM. The BOM stated that she arranged the appointments and the transportation for residents. The BOM stated the Transportation aide puts a schedule out at the nurses' station daily of the appointments. The nurses were to check the schedule daily to ensure that the residents were ready for the appointments each day. The BOM stated that Resident #35 was scheduled for an orthopedic appointment on 3/7/25 and ambulance transport was arranged. The BOM indicated that she was not informed that Resident #35 was not ready and the appointment needed to be rescheduled. An interview was conducted on 6/25/25 at 1:20 PM with Nurse #2. Nurse #2 was assigned to Resident #35 on 3/7/25 from 7:00 AM to 7:00 PM. Nurse # 2 stated that the Transportation Aide put out a schedule of appointments daily, so the staff knew which residents were going out and ensured they were ready. Nurse #2 stated that on 3/7/25 she checked the appointment schedule and informed NA #9 to have Resident #35 ready. Nurse #2 stated she was not sure what happened that morning but recalled that Resident #35 returned from the appointment and was upset about how she was sent. Nurse #2 stated she observed that Resident #35 was wearing a hospital gown and did not have her hair	F0550		

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F0550 SS = D	Continued from page 3 brushed when the ambulance transport arrived to take the resident to the doctor's appointment. Nurse #2 indicated that she should have rescheduled the appointment since Resident #35 was not ready instead of sending in a hospital gown instead of her personal clothing, without her hair brushed and without her brief checked for incontinence. Nurse #2 did not indicate that she was aware Resident #35's brief was soiled with urine when she transported to the appointment. An interview was conducted on 6/25/25 at 4:19 PM with the Transportation Aide. The Transportation Aide stated that she was responsible for transporting residents to appointments and prepared a schedule of residents with appointments each day. The Transportation Aide stated she gave a copy of the schedule of appointments to the nurses to ensure that the residents were ready for the appointments. The Transportation Aide stated that the nurses were responsible for ensuring that the residents received personal care, incontinence care and were dressed appropriately but she also tried to make sure the resident needs were met prior to transporting them to an appointment. The Transportation Aide stated on 3/7/25 she was assigned to work on the floor and Resident #35 was transported to the appointment by ambulance. Attempts were made to interview Nursing Assistant (NA) #9 on 6/25/25 at 9:40 AM, 6/25/25 at 4:30 PM and 6/26/25 at 12:50 PM were unsuccessful. Voice messages were left and text messages sent with no return call. A follow up interview was conducted with Resident #35 on 6/26/25 at 2:30 PM. Resident #35 stated that on the day of the appointment, the nursing assistant was very busy, that it was a heavy assignment and she (the NA) did not provide her personal care before she had to leave for the appointment. Resident #35 stated she was incontinent of urine and the NA did not come in to check on her, so she was unable to tell the NA that she required incontinence care. Resident #35 stated the ambulance arrived to take her to the appointment, and she was told by the nurse that she needed to go since it was too late to cancel the appointment. Resident #35 stated it was a 45-minute ride each way and the doctor's office was large and busy with a full waiting room that she was wheeled through on the gurney by the emergency personnel. Resident #35 stated she felt like everyone in the waiting room looked at her and she was embarrassed. Resident #35 stated that although she had	F0550		

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F0550 SS = D	Continued from page 4 a sheet over her, her chest and shoulders were exposed revealing she was wearing a hospital gown and she was afraid she smelled of urine. An interview with the DON on 6/26/25 at 3:45 PM revealed that she expected that residents would be treated with dignity and respect. The DON further stated that she expected that residents would receive personal care and were dressed appropriately when leaving the facility for an appointment. The DON stated that her investigation of the grievance filed by Resident #35 revealed that NA # 9 knew she had not provided care to the resident prior to her being transported to the appointment. The DON stated she counseled the NA and expected this would not occur again.	F0550		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Nurse Practitioner, Psychiatric Nurse Practitioner, and staff interviews, the facility failed to obtain consent and inform the resident or resident representative in advance of the risks and benefits of psychotropic medications prior to initiation of the antianxiety medication lorazepam (Resident #50) and the initiation of a medication used	F0552	The facility failed to obtain consent and inform the resident or resident representative (RP) in advance of the risks and benefits of psychotropic medications prior to initiation of the antianxiety medication lorazepam (Resident #50) and the initiation of a medication used to treat anxiety (Resident #23) for 2 of 5 residents reviewed for unnecessary medications (Resident # 50) All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Resident #50's RP was notified of resident use of lorazepam, reason for use, and risks versus benefits of lorazepam on 07/09/2025; the call was documented in the clinical record. Resident #23's RP was notified of the initiation of a medication used to treat anxiety, reason for use, and risks versus benefits of the medication on 07/14/2025; the call was documented in the clinical record. The Director of Nursing (DON) or designee reviewed all current residents who are prescribed psychotropic medications to ensure consent had been obtained and to inform the resident or resident representative (RP) of the risks and benefits of psychotropic medications. If it was identified that consent had not been obtained, then consent will be obtained by 07/16/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence. An Informed Consent for Psychotropic Medication form was obtained for facility use. The process for obtaining consent has been updated to the following steps. The resident or RP is	08/15/2025

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F0552 SS = D	Continued from page 5 to treat anxiety (Resident #23) for 2 of 5 residents reviewed for unnecessary medications (Resident # 50), Findings included: 1. Resident # 50 was admitted 2/1/24 with diagnoses of schizophrenia, history of traumatic brain injury and depressive disorder. Resident #50's quarterly Minimum Data Set (MDS) dated 4/24/25 indicated the resident received an antipsychotic medication on a routine basis. Resident #50 had moderate cognitive impairment with verbal behaviors and rejection of care was exhibited. A Psychiatric Nurse Practitioner progress note dated 6/11/25 indicated Resident #50 had delayed thought processes, confusion and forgetfulness with delusions and resident was oriented to person only. Resident #50 exhibited poor memory, concentration, attention, fund of knowledge and judgement and insight. The plan indicated a trial of lorazepam to be initiated for anxiety and the staff were to call Resident #50's responsible party to make aware of treatment and possible side effects. Resident #50's physician orders revealed an order dated 6/12/25 for the psychotropic medication lorazepam 0.5 milligram (mg) give 1 tablet by mouth three times per day for anxiety. Hold for sedation and notify the psychiatric service. A review of Resident # 50's medical record indicated no information whether Resident # 50's representative was informed in advance of the risks and benefits of initiating lorazepam. The Medication Administration Record (MAR) from 6/12/25 through 6/23/25 indicated Resident #50 was administered lorazepam as ordered. An interview with the Director of Nursing (DON) on 6/24/25 at 2:00 PM revealed that the facility had not been obtaining consents on psychotropic medications. The DON stated that she was looking for a consent form to use for psychotropic medications, but they did not	F0552	Continued from page 5 contacted. The resident or RP signs or gives verbal consent prior to medication administration. The Informed Consent for Psychotropic Medication form is now included in the facility's admission packet. As of 07/14/2025, the obtaining informed consent workflow has been updated to the following steps. The resident is seen by the Provider and orders for psychotropics remain pending until the DON or Nurse Manager obtains consent from the resident or RP. An explanation of medication use, why it is indicated, and risks versus benefits are reviewed with the resident or RP. The Informed Consent for Psychotropic Medication form consent is obtained. Then the medication order is activated. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff, the Social Worker, and the Admissions Coordinator on the regulatory requirements regarding obtaining consent and informing the resident or RP in advance of the risks and benefits of psychotropic medications prior to initiation of a psychotropic medication. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation that consent must be obtained, and the resident or RP must be informed in advance of the risks and benefits of psychotropic medications prior to initiation. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit new orders for psychotropic medications daily during the clinical morning meeting to ensure the resident or RP have been informed and consent has been obtained; this is an ongoing systemic change. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit psychotropic medications to ensure compliance as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting	

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F0552 SS = D	Continued from page 6 currently have one in place. The DON stated she thought that sometimes the psychiatric Nurse Practitioner obtained consent prior to the initiation or changes in psychotropic medications. An interview with the Nurse Practitioner on 6/25/25 at 10:30 AM revealed she deferred to the Psychiatric Nurse Practitioner regarding psychotropic medications and did not obtain consents for these medications from the resident or responsible party. An interview with the Psychiatric Nurse Practitioner on 6/25/25 at 4:00 PM indicated the nursing staff were supposed to call the responsible parties to discuss the treatment and the possible side effects when the medication was initiated. The Psychiatric Nurse Practitioner indicated that her discussion with Resident #50 consisted of asking the resident if she felt irritable and if she would like to take medication for this. A follow up interview with the DON on 6/26/25 at 3:45 PM revealed that she expected that consent including a discussion of the risks and benefits would be obtained prior to initiating or changing a psychotropic medication. 2. Resident #23 was admitted to the facility on 2/21/21 with diagnoses that included dementia, anxiety, anxiety disorder, and recurrent moderate depressive disorder. The physician's orders revealed an order dated 4/30/25 for the psychotropic medication Depakote tablet delayed release 125 mg. Give 1 tablet by mouth two times a day for generalized anxiety. The quarterly Minimum Data Set (MDS) for Resident #23 dated 5/10/25 revealed he was severely cognitively impaired and received an antidepressant on a regular basis. A review of Resident #23's electronic medical record (EMR) indicated no documentation that the resident representative was informed in advance of the risks or benefits of initiating Depakote.	F0552	Continued from page 6 for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0552 SS = D	Continued from page 7 The Medication Administration Record (MAR) from 4/30/25 through 6/25/25 indicated Resident #23 was administered Depakote as ordered. An interview with the Director of Nursing (DON) on 6/24/25 at 2:00 PM. Revealed the facility had not been obtaining consent for psychotropic medications. The DON stated she was looking for a consent form to be used for psychotropic medications, but they did not currently have one in place. The DON indicated that she thought sometimes the Psychiatric Nurse Practitioner (NP) obtained consent prior to initiation or changes in the psychotropic medications. She indicated that she expected consents, including a discussion of the risks and benefits would be obtained prior to initiating or changing the psychotropic medication An interview with the Psychiatric NP on 6/25/25 at 4:00 PM indicated that the nursing staff were supposed to call the Responsible Party to discuss the treatment and the possible side effects when the medication was initiated. The Psychiatric NP indicated that her discussion with Resident #23 involved counseling and adjustment of medications.	F0552		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident	F0580	The facility failed to notify the physician of pressure ulcers that were identified on admission and to notify the responsible party when a stage 2 pressure ulcer worsened to an unstageable pressure ulcer for 1 of 1 residents reviewed for pressure ulcers (Resident #64). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review records for all current residents with wounds to ensure that the physician and responsible party are aware of current ulcer status. This will be documented in the clinical record: to reflect time, method of notification, and name of the person notified. This will be completed by 08/15/2025. Beginning 07/14/2025, to prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on the following: promptly informing the attending physician of new or worsened pressure ulcers. Promptly notifying the resident (or their representative) when a significant change occurs, such as an ulcer's progression. Documentation of the above notifications is mandatory and should include who was notified, when	08/15/2025

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F0580 SS = D	Continued from page 8 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 Wound Care Physician interviews, the facility failed to notify the physician of pressure ulcers that were identified on admission and to notify the responsible party when a stage 2 pressure ulcer worsened to an unstageable pressure ulcer for 1 of 1 residents reviewed for pressure ulcers (Resident #64). Findings included: Resident #64 was admitted on 3/7/25. A nursing admission progress note completed by Nurse #2	F0580	Continued from page 8 they were notified, and by whom. Delayed physician involvement can postpone vital interventions (e.g., debridement, advanced wound care), raising infection risk and pain for the resident. Family or responsible parties left uninformed can't participate in care decisions or advocate effectively. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation of ensuring all parties are notified and the correct process is followed for notification. Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will audit 100% of wound assessments weekly x 3 weeks, 75% of wound assessments weekly x 3 weeks, 50% of wound assessments x 3 weeks, and 25% of wound assessments x 3 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET , LAKE WACCAMAW, North Carolina, 28450

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F0580 SS = D	Continued from page 9 on 3/7/25 at 3:43 PM indicated the resident had Stage 2 pressure ulcers (partial thickness skin loss) to the bilateral buttocks. The admission progress note did not indicate that the physician was notified of the pressure ulcers. A review of the admission skin assessment dated 3/7/25 by Nurse #2 revealed that Resident #64 was noted with the following areas on the skin: - left buttock pressure ulcer 1 centimeter (cm) length with 2 cm width - right buttock pressure ulcer 2 cm length with 2 cm width The admission skin assessment did not indicate that the physician was notified of the pressure ulcers. The assessment did not indicate that the physician was consulted regarding treatment of the Stage 2 pressure ulcers. A physician order in Resident #64's electronic health record dated 3/7/25 indicated to apply house barrier cream to the peri area after each incontinence episode and as needed. An interview was conducted with Nurse #2 on 6/24/25 at 3:00 PM. Nurse #2 stated that the floor nurse was responsible for completion of the admission assessment including a full body audit when a resident was admitted or readmitted. Nurse #2 stated that she completed the initial admission skin assessment for Resident #64, and she recalled that the resident had Stage 2 wounds. Nurse #2 indicated she did not notify the physician of the 2 Stage 2 wounds. Nurse #2 stated she didn't think she needed to notify the physician. A review of an undated facility Standing Treatment Orders for Wounds revealed that Stage 2 wounds were to be cleansed with normal saline, calcium alginate and an island dressing was to be applied. The physician and the Wound Care Physician were to be notified. A review of Resident #64's electronic health record revealed that the standing treatment order for Stage 2	F0580		

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F0580 SS = D	Continued from page 10 ulcers to cleanse the area with normal saline, apply calcium alginate and cover with an island dressing was not initiated until 3/13/25. The first Wound Care Physician note for Resident #64 was dated 3/13/25. The note indicated Resident #64 was evaluated due to a pressure ulcer to the right buttock. Resident #64 was noted to have an unstageable deep tissue injury to the right buttock measuring 6.5 cm x 5.3 cm. The wound care physician note did not indicate that Resident #64's responsible party was notified of the wound and did not indicate a pressure ulcer was observed on the left buttock. An interview was conducted with the Wound Care Physician on 6/26/25 at 12:30 PM. The Wound Care Physician stated he evaluated Resident #64's unstageable deep tissue wound on 3/13/25. The Wound Care Physician stated he did not notify Resident #64's responsible party of the wound. The Wound Care Physician stated that the nursing staff should have informed Resident #64's responsible party of the wound. The Wound Care Physician stated that the Stage 2 pressure ulcer noted on admission should have been treated with a foam dressing for protection and the physician should have been notified to implement orders to prevent worsening of the ulcer. A pressure injury assessment dated 3/13/25 signed on 3/18/25 by Nurse #4 indicated Resident #64's responsible party and physician were notified of resident's unstageable deep tissue injury to the right buttock measuring 6.5 cm x 5.3 cm. An interview was conducted with Nurse #4 on 6/25/25 at 3:49 PM. Nurse #4 stated she was assigned to accompany the Wound Care Physician on 3/13/25 and to document the pressure injury assessments for each resident that was evaluated. Nurse #4 stated that she did not notify Resident #64's responsible party of the pressure ulcer to the right buttock since she assumed they already knew about it since it. Nurse #4 stated the information documented on the pressure injury assessment dated 3/13/25 was from the Wound Care Physician's evaluation and she did not know that the wound was a stage 2 on admission. Nurse #4 stated that she documented in error on the Wound Assessment dated 3/13/25 that she had notified Resident #64's responsible party.	F0580		

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F0580 SS = D	Continued from page 11 A physician order dated 3/13/25 indicated to apply calcium alginate and cover with an island dressing every day to the right buttock. The electronic Treatment Administration Record for March 2025 indicated the entry to apply calcium alginate and cover with an island dressing every day to the right buttock was signed as completed. Resident #64's admission Minimum Data Set (MDS) assessment dated 3/14/25 indicated the resident had a severe cognitive impairment and had 2 Stage 2 pressure ulcers present on admission. The first physician progress note dated 3/19/25 indicated Resident #64 had an open area on the buttock managed by the Wound Care Physician. A Wound Care Physician note dated 3/27/25 indicated Resident #64 was evaluated and noted with a Stage 4 full thickness pressure ulcer to the right buttock measuring 1.9 cm x 3.2 cm x 0.1 cm. The note indicated that a surgical incision debridement procedures to remove necrotic (dead) tissue and establish margins of viable tissue was completed. A post debridement assessment of the wound indicated that the previously unstageable necrotic wound revealed underlying deep tissue at the muscle/fascia level which had been obscured by the necrotic tissue. With the removal of the necrotic tissue the wound now presented as a Stage 4 wound. A pressure injury assessment completed by Nurse #4 on 3/27/25 indicated the responsible party was notified of Resident #64's Stage 4 full thickness pressure ulcer to the right buttock. An interview was conducted with Nurse #4 on 6/25/25 at 3:49 PM. Nurse #4 stated she was assigned to accompany the Wound Care Physician on 3/27/25 and to document the pressure injury assessments for each resident that was evaluated. Nurse #4 stated that she did not notify Resident #64's responsible party of the pressure ulcer to the right buttock. Nurse #4 stated that she documented in error on the Wound Assessment dated 3/27/25 that she had notified Resident #64's responsible party.	F0580		

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F0580 SS = D	Continued from page 12 A review of a grievance form dated 3/31/25 indicated a concern was filed by Resident #64's responsible party with the previous Social Worker. The grievance form indicated that Resident #64's responsible party called with a concern that she was not made aware that the resident had wounds upon discharge from the facility on 3/27/25. The summary of corrective action taken revealed that a plan of correction was implemented for responsible party notification of wounds. An interview was conducted with the previous Social Worker (SW) on 6/24/25 at 3:45 PM. The previous SW stated she left the position at the facility one month ago. The previous SW recalled that Resident #64's responsible party called the facility a few days after discharge and stated they were not aware that the resident had a pressure ulcer. The previous SW stated that Resident #64 was seen by the wound care specialist so she would have thought that he would have informed the family. The previous SW stated she did not know how the responsible party was informed of wounds. An interview with the Director of Nursing on 6/26/25 at 3:45 PM revealed that she expected that the responsible party would be informed of a pressure ulcer and the physician would be notified on admission of a pressure ulcer so treatment orders could be initiated. The facility provided a corrective action plan that was not acceptable to the State Agency due to no evidence that a monitoring system was implemented. The corrective action plan did not address notification of the physician regarding pressure ulcers.	F0580		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600	The facility failed to protect a resident's right to be free from neglect when the Nurse Practitioner failed to provide a pain management treatment for Resident #62 who was reporting pain and demonstrating signs and symptoms of pain after he was assessed for pain on 03/17/2025 and 06/16/2025. This failure occurred for 1 of 1 resident reviewed for neglect. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Resident #62 was assessed immediately upon discovery of unaddressed pain complaints. The physician was notified, and new pain medication orders were implemented on 06/26/2025. The resident's pain was	08/15/2025

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F0600 SS = G	Continued from page 13 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff and Nurse Practitioner interviews the facility failed to protect a resident's right to be free from neglect when the Nurse Practitioner failed to provide a pain management treatment for a resident (Resident #62) who was reporting pain and demonstrating signs and symptoms of pain after he was assessed for pain on 03/17/25 and 06/16/25. This failure occurred for 1 of 1 resident reviewed for neglect. Findings included: This tag is cross referenced to: F697: Based on observations, record review, staff, and Nurse Practitioner and Physician interviews the facility failed to provide pain management to include medications or non-pharmacological interventions for a resident who was observed by the Nurse Practitioner, the Nursing Aides and Occupational Therapist Assistant to have signs and symptoms of pain. This was for 1 of 1 resident (Resident #62) reviewed for pain. An interview was conducted with the Nurse Practitioner on 06/25/25 at 9:05 AM. The Nurse Practitioner stated in hindsight she should have ordered something for Resident #62's pain when she assessed him on 03/17/25. She stated he continued to demonstrate signs of pain on 06/16/25 according to her progress note and she should have ordered pain medication then as well. The Nurse Practitioner stated Resident #62 did not always demonstrate signs and symptoms of pain when she inquired with the nursing staff, but she did neglect to treat his pain when she observed it. An interview with the Director of Nursing on 06/26/25 at 10:25 AM revealed Resident #62's pain was neglected and he should have had pain medications ordered to treat his pain to help with his activities of daily living care and to participate in therapy.	F0600	Continued from page 13 reassessed and documented at a zero. The Director of Nursing (DON) or designee reviewed all current residents who are prescribed PRN pain medication or scheduled pain medication by 07/14/2025. Any residents found with unmet needs were reassessed, the physician was notified, new orders were received as indicated, and the resident care plans were updated. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has implemented a stop and watch early warning form for all staff to complete if they become aware of a resident having a change in their condition. Any resident changes noted will require further assessment and intervention by the physician. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on the facility pain management policy and procedures, timely assessment and documentation of resident pain, and reporting to physician for treatment as indicated. This will be completed by 08/15/2025. After 08/15/2025 newly hired licensed nursing staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee, will educate all staff on the stop and watch early warning form that are to be utilized when they become aware of a resident having a change in their condition so that the noted changes can be reported to the physician. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation to protect a resident's right to be free from neglect. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit resident charts who are prescribed PRN pain medication or scheduled pain medication to ensure compliance as follows: 12 charts weekly x 4 weeks, 6 charts weekly x 4 weeks, 3 charts weekly x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of	

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F0600 SS = G		F0600	Continued from page 14 the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate.	F0627	The facility failed to implement an effective discharge plan by failing to inform the responsible party of a pressure wound and provide wound care instructions before discharging a resident home for 1 of 1 residents reviewed for discharge (Resident #64). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review the last 30 days of resident discharges to ensure reconciliation of medication and treatment orders were provided to the appropriate discharging party. This will be completed by 08/15/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has revised its discharge policy to include mandatory identification of all wounds and a checklist item for “responsible party notification and education.” The facility has also updated the discharge summary template to add a “Wound Care Instructions” section. The facility will implement a sign-off sheet for responsible parties to acknowledge receipt of wound information. This will be completed by 08/15/2025. Beginning 07/14/2025, to prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on the resident discharge policy and template. They will also be educated on proper wound documentation and communication techniques. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation of ensuring there is an effective discharge plan in place for discharging residents.	08/15/2025

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F0627 SS = D	Continued from page 15 §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0627	Continued from page 15 Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will conduct weekly audits for the next three months, then monthly audits thereafter. These audits will be focused on completion of the “Wound Care Instructions” section in discharge summaries and documentation of responsible party notification and acknowledgment. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0627 SS = D	Continued from page 16 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F0627		

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F0627 SS = D	Continued from page 17 (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record,	F0627		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET , LAKE WACCAMAW, North Carolina, 28450

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F0627 SS = D	Continued from page 18 the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Wound Care Physician, and Nurse Practitioner interviews, the facility failed to implement an effective discharge plan by failing to inform the responsible party of a pressure wound and provide wound care instructions before discharging a resident home for 1 of 1 residents reviewed for discharge (Resident #64). Findings: Resident #64 was admitted on 3/7/25 with diagnosis which included femur fracture (a fracture of the long thigh bone), multiple myeloma (a cancer of the white blood cells), Covid, pneumonia and encephalopathy. A nursing admission progress note completed by Nurse #2 on 3/7/25 at 3:43 PM indicated Resident #64 was admitted with Stage 2 pressure ulcers to bilateral buttock. A care plan dated 3/7/25 indicated Resident #64's family preferred short term placement with a goal for	F0627		

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F0627 SS = D	Continued from page 19 resident to return home after completion of rehabilitation. The care plan indicated that Resident #64 will require 24 hour care upon discharge. Interventions indicated that the Social Worker will coordinator with family and all disciplines related to Resident #64's progress and care. A Wound Care Physician note dated 3/13/25 indicated Resident #64 was evaluated due to a wound to the right buttock. Resident #64 was noted to have an unstageable deep tissue injury (a pressure injury where the full extent of the tissue damage cannot be determined due to necrotic or dead tissue) to the right buttock. The Wound Care Physician note did not indicate that Resident #64's responsible party was notified of the wound and did not indicate a pressure ulcer was observed on the left buttock. A pressure injury assessment dated 3/13/25 signed on 3/18/25 by Nurse #4 indicated Resident #64's responsible party was notified of resident's unstageable deep tissue injury to the right buttock. An interview conducted with Nurse #4 on 6/25/25 at 3:49 PM revealed she documented in error that she notified Resident #64's responsible party of the unstageable deep tissue injury to the right buttock. A physician order dated 3/13/25 indicated to apply calcium alginate and cover with an island dressing every day to right buttock. Resident #64's admission Minimum Data Set (MDS) assessment dated 3/14/25 indicated the resident had a severe cognitive impairment and had 2 Stage 2 pressure ulcers present on admission. The treatments included a pressure-reducing device to the chair and the bed, a turning and repositioning program, nutrition to promote wound healing, and pressure injury care. The MDS indicated the overall goal was to discharge the community and active discharge plan in place for return to the community was coded No. A review of Resident #64's electronic Treatment Administration Record revealed an entry for right buttock wound care cleanse with normal saline and apply calcium alginate and cover with an island dressing every day was completed daily from 3/14/25 through	F0627		

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F0627 SS = D	Continued from page 20 3/27/25. Review of an Admission Summary note completed by the previous Social Worker dated 3/15/25 indicated Resident #64 had severe cognitive impairment and was dependent for all activities of daily living including bathing, dressing, transfers, toileting and eating. The note indicated Resident #64 was admitted for short term rehabilitation. Resident #64's responsible party expressed concerns due to the resident not progressing and unable to return to prior level of care. Resident #64 will require 24-hour care. The note indicated the Social Worker will follow up as needed. A review of a Nurse Practitioner discharge note dated 3/26/2025 at 9:29 AM indicated Resident #64 was seen regarding discharge. The note indicated Resident #64 was admitted for rehabilitation therapy following a femur fracture, made little progress with therapy and was dependent on others for activities of daily living. Resident #64 will be discharged home on 03/27/2025 with Home Health, Nursing, nurse aide and physical and occupational therapy. The Nurse Practitioner discharge note did not indicate that Resident #64 had a wound that required daily wound care treatments. A Wound Care Physician note dated 3/27/25, the day of discharge, indicated Resident #64 was evaluated and a surgical debridement procedure to remove necrotic tissue and establish margins of viable (healthy) tissue was completed. Adherent black, necrotic eschar or dead tissue was removed from the wound bed. A post debridement assessment of the wound indicated that the previously unstageable necrotic wound revealed underlying deep tissue at the muscle/fascia level which had been obscured by the necrotic tissue. With the removal of the necrotic tissue the wound now presented as a Stage 4 (the most severe stage of a pressure ulcer characterized by full thickness tissue loss with exposed bone, tendon or muscle). An interview was conducted with the Wound Care Physician on 6/26/25 at 12:30 PM. The Wound Care Physician stated he evaluated Resident #64's unstageable deep tissue wound on 3/13/25. The Wound Care Physician stated he did not notify Resident #64's responsible party of the wound. The Wound Care Physician stated that the nursing staff should have informed Resident #64's responsible party of the wound. The Wound Care Physician stated he debrided, removed	F0627		

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F0627 SS = D	Continued from page 21 necrotic or dead tissue from Resident #64's wound on 3/27/25 the day of discharge and the nursing staff should have instructed Resident #64's responsible party on wound care upon discharge with instructions to observe for increased bleeding or pain. A review of the Home Discharge Plan of Care form completed by the previous Social Worker dated 3/27/25 indicated Resident #64 was to receive home health nursing, physical, occupation and speech therapy and home health aide services. Resident #64 had an appointment with her primary care physician on 4/7/25 at 3:40 PM and her medications were called into the pharmacy. The section of the form titled Medications and Treatments had a line drawn through it and indicated to see attached. A printed copy of the Resident's medication orders was attached. There was no indication on the form that Resident #64 had a pressure wound and required daily wound care to the wound on her right buttock. There was no documentation of precautions or potential complications to observe for including bleeding, increased pain or fever related to the surgical debridement procedure performed on Resident #64's wound earlier that day. A nursing progress note written by Nurse #5 on 3/27/25 at 3:42 PM indicated Resident #64's responsible party arrived at facility at 2:05 PM for resident's discharge home. The note indicated Nurse #5 reviewed the discharge form that was prepared by the Social Worker with the responsible party who stated understanding. Resident #64 exited the facility at 2:29 PM with the responsible party for discharge home. The progress note did not indicate that the wound or the required wound care was reviewed with Resident #64's responsible party. An interview with Nurse #5 on 6/25/25 at 12:10 PM revealed that she was assigned to Resident #64 on 3/27/25 and discharged the resident home with her responsible party. Nurse #5 stated she did not discuss Resident #64's wound or the required daily wound care with the responsible party when she discussed her discharge home that day. Nurse #5 stated there was nothing on the discharge form that the Social Worker prepared about wound care so she did not think about discussing it. A discharge note dated 3/27/2025 at 3:01 PM by the previous Social Worker stated Resident #64 was	F0627		

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F0627 SS = D	Continued from page 22 discharged home with the responsible party via family car. Discharge instructions were reviewed by the nurse and sent with the resident. The note indicated that the Social Worker met with Resident #64's responsible party on admission and 2 other times to discuss the resident's care. An interview was conducted with the previous Social Worker on 6/24/25 at 3:45 PM. The previous SW stated she left the position at the facility one month ago. The previous SW stated when a resident was discharged, she sent the referral to the home health agency if ordered and completed the Home Discharge Plan of Care form. The previous SW stated she prepared the Home Discharge Plan of Care form for Resident #64 and did not include information regarding the resident's pressure wound or daily wound care instructions. She stated that she prepared the discharge form and gave it to the nursing staff prior to a resident's discharge. She stated she did not know how the resident or responsible party was informed of wounds or wound care upon discharge as this was not information that she included when she completed the Discharge Plan of Care form. She stated that she just assumed that the nursing staff would know to review wound care with the resident or responsible party prior to discharge and that no one had reported to her that Resident #64 had a Stage 4 wound that required daily care. The previous SW recalled that Resident #64's responsible party called the facility a few days after discharge and stated they were not aware that the resident had a pressure wound or that daily wound care was required. A review of a grievance form dated 3/31/25 indicated a concern was received by the previous Social Worker from Resident #64's responsible party. The grievance form indicated that Resident #64's responsible party called with a concern regarding not being made aware that resident had a wound upon discharge from the facility on 3/27/25. The finding of the grievance form indicated that a discussion of Resident #64's wound was not reviewed with the resident's responsible party upon discharge. The summary of corrective action taken revealed that a new plan of correction was implemented for responsible party notification of wounds upon discharge. Nursing staff education was provided. An interview with the current Social Worker (SW) was conducted on 6/24/25 at 1:00 PM. The SW stated she was in the position for one month. The SW stated she had a process she completed when a resident was discharged	F0627		

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F0627 SS = D	Continued from page 23 home to ensure that all orders were obtained and the resident had the equipment and services required. The SW stated that prior to discharge, she discussed the resident care needs with the interdisciplinary team including therapy, nurses, wound care nurse and the Nurse Practitioner. The SW stated she checked the last skin assessment and wound care assessments prior to discharge to obtain care for the resident upon discharge and to ensure this information was included on the discharge paperwork that she prepared for the nurse to review with the resident and the responsible party. An interview was conducted with the Nurse Practitioner on 6/25/25 at 10:30 AM. The Nurse Practitioner indicated she completed Resident #64's discharge summary progress note on 3/26/25, the day prior to discharge. The Nurse Practitioner stated she was not aware that Resident #64's wound was debrided by the Wound Care Specialist on 3/27/25 and that if she was aware of the debridement and the changes to the wound, she would have ensured that the discharge orders were updated and listed on the discharge paperwork that was reviewed with the responsible party. An interview with the Director of Nursing (DON) on 6/26/25 at 3:45 PM revealed that she expected that wounds and wound care would be discussed with the resident and responsible party upon discharge. The DON stated it was important for the resident and responsible party to receive wound care instructions to ensure a safe discharge, and the facility was planning on working on improving the discharge process to ensure this did not occur again.	F0627		
F0637 SS = B	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F0637	The facility failed to complete the required Significant Change in Status Assessment (SCSA) for 1 of 19 residents (Resident #32) reviewed for assessments. Resident #32 required a SCSA due to changes in activities of daily living (ADL). Resident #32 was admitted to the facility on03/29/24. Diagnoses included major joint replacement with right femur fracture. Resident #34s had a significant change assessment scheduled on 06/26/2025. Assessment has been closed and submitted to IQUIES. Resident #34 care plan has been updated as of 06/26/2025 to reflect current status and needs. All residents residing in the facility have been identified as having the potential to be affected by	08/15/2025

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F0637 SS = B	Continued from page 24 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete the required Significant Change in Status Assessment (SCSA) for 1 of 19 residents (Resident #32) reviewed for assessments. Resident #32 required a SCSA due to changes in activities of daily living (ADL). Findings included: Resident #32 was admitted to the facility on 03/29/24. Diagnoses included major joint replacement with right femur fracture. The Minimum Data Set (MDS) quarterly assessment dated 03/24/25 revealed Resident #32 was moderately cognitively impaired and required extensive assistance with two staff physical assistance with bed mobility, supervision with one staff physical assistance with transfers, and eating, and extensive assistance with one staff physical assistance with toileting. Resident #32 used a wheelchair, had no impairments and was always incontinent of bowel and bladder. A progress note written on 04/11/25 by Nurse #10 revealed Resident #32 had a fall and an order was obtained to send Resident #32 to the Emergency Room for further evaluation. A nursing progress note written on 04/11/25 by Nurse #10 revealed Resident #32 was admitted to the hospital for fracture of right femur. An admission summary note written by the Director of Nursing on 04/15/25 revealed that the resident arrived at the facility via Emergency Medical Services, had a right femur fracture and had an open reduction internal fixation (a type of surgical procedure used to repair a bone break or facture) done on 04/14/25. The MDS admission assessment dated 04/22/25 revealed Resident #32 was moderately cognitively impaired, and was dependent with bed mobility and toileting, and had no transfers out of bed due to a medical condition (femur fracture). Resident #32 was coded as having no impairment to the lower extremity, which was not	F0637	Continued from page 24 the alleged deficient practice. As of 07/14/2025, The VP of MDS Services for Broad River Rehab reviewed all current residents in facility to determine any significant change in status. It was determined that 6 residents have had a significant change in status. All 6 will have a SCSA scheduled within 14 days of identification. As of 07/14/2025, systemic changes have taken place to prevent recurrence. Daily communication with the remote MDS staff and nursing services will occur to review patient status changes. The VP of MDS Services for Broad River Rehab has educated MDS nurse on identification SCSA and care planning for those residents with a change in condition on 07/01/2025. Beginning 07/14/2025, to prevent recurrence the VP of MDS Services for Broad River Rehab will review resident status changes weekly x 12 week to ensure significant changes are identified. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0637 SS = B	Continued from page 25 accurate due to having a fractured femur. A review of the MDS assessments for Resident #32 indicated that a Significant Change in Status Assessment was not completed within 14 days of the identification of changes in two or more activities of daily living (ADL) including increased assistance with bed mobility and toileting, a change in transfer status and an impairment to the lower extremity. An interview with the Vice President of MDS Services Nurse on 06/25/25 at 4:00 PM revealed that she was aware of the Long-Term Care Facility Resident Assessment Instrument user's manual indications regarding identifying and completing significant change assessments. She stated that the significant change assessment for Resident #32 should have been completed based on a comparison of the current status to the prior assessment and that she would modify the assessment. The MDS nurse indicated that she did not know why the SCSA MDS assessment was not completed as a significant change assessment An interview with the Administrator on 06/26/25 at 3:35 PM revealed that it was her expectation that all MDS assessments were completed accurately and timely per the Long-Term Care Facility Resident Assessment Instrument User's manual to reflect the resident's care needs.	F0637		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion	F0641	The facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 19 residents (Resident #4, Resident #32,Resident #62) reviewed. Resident #4 Admitted on 2/14/25 under hospice services for hypertensive heart disease with heart failure. Admission MDS dated 2/24/25 did not reflect hospice status. Resident #32 Admitted on 3/29/24 with right femur fracture following a fall. Admission MDS dated 4/22/25 failed to reflect lower	08/15/2025

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F0641 SS = D	Continued from page 26 of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 19 residents (Resident #4, Resident #32, Resident #62) reviewed. Findings included: 1. Resident #4 was admitted on 2/14/25 under Hospice services with medical diagnoses which included hypertensive heart disease with heart failure. Review of Resident #4's admission Minimum Data Set (MDS) dated 2/24/25 did not indicate Hospice services had been received while a resident. A late entry admission summary note by the Social Worker dated 2/26/25 indicated Resident #4 was admitted from home with Hospice services. An interview was conducted with the Nurse Practitioner (NP) on 6/26/25 at 9:00 AM who stated Resident #4 was admitted on Hospice services. An interview was conducted with the Vice President of MDS Services Nurse on 6/26/25 at 1:00 PM. The MDS Nurse	F0641	Continued from page 26 extremity impairment. Resident #62 Admitted on 1/26/25 with stroke-related right-side weakness and contracture. Admission MDS dated 1/23/25 lacked assessment for activities of daily living (ADLs). As of 07/14/2025, systemic changes have taken place to prevent recurrence. Daily communication with the remote MDS staff and nursing services will occur to review patient status changes. The VP of MDS Services for Broad River Rehab has educated MDS nurse on correct MDS coding, identification of status 07/01/2025 Beginning 07/14/2025, to prevent recurrence the VP of MDS Services for Broad River Rehab will audit a random sample of 5 MDS assessments and care plans to ensure accuracy weekly x 12 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0641 SS = D	Continued from page 27 reviewed the admission MDS, stated it had been completed by the Corporate MDS Nurse Consultant, and Hospice should have been coded yes. The MDS Nurse stated that it was an error due to an oversight, and it was important to accurately complete the MDS assessments. An interview with the Director of Nursing on 6/26/25 at 3:45 PM revealed that she expected that residents MDS assessments would be accurate and reflect the resident care needs. An interview with the Administrator on 6/26/25 at 4:00 PM revealed that it was important that MDS assessments were completed accurately and that was her expectation. 2. Resident #32 was admitted to the facility on 03/29/24. Diagnoses included major joint replacement with right femur fracture. A progress note written on 04/11/25 by Nurse #10 revealed Resident #32 had a fall and an order was obtained to send Resident #32 to the Emergency Room for further evaluation. A nursing progress note written on 04/11/25 by Nurse #10 revealed Resident #32 was admitted to the hospital for right femur fracture. An admission summary note written by the Director of Nursing on 04/15/25 revealed that the resident arrived at the facility via Emergency Medical Services, had a right femur fracture and had an open reduction internal fixation (a type of surgical procedure used to repair a bone break or facture) done on 04/14/25. The Minimum Data Set (MDS) admission assessment dated 04/22/25 revealed Resident #32 was moderately cognitively impaired and she had no impairments to her lower extremities. An interview with Resident #32 on 06/22/25 at 1:10 PM revealed she had a right femur fracture in April and she was getting therapy for strengthening.	F0641		

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F0641 SS = D	Continued from page 28 An interview with the Vice President of MDS Services Nurse on 06/25/25 at 4:00 PM revealed Resident #32 was coded inaccurately on the MDS admission assessment and that she should have been coded to reflect a lower extremity impairment due to her femur fracture. She stated it was an oversight. An interview with the Administrator on 06/26/25 at 3:35 PM revealed that it was important that MDS assessments were completed accurately to reflect the residents' care. 3. Resident #62 was admitted to the facility on 01/26/25. Diagnoses included stroke with right side weakness and contracture to right elbow. The Minimum Data Set (MDS) admission assessment dated 01/23/25 revealed there was no assessment completed for activities of daily living. The documentation indicated "not assessed / no information." An interview with the Vice President of MDS Services Nurse on 06/25/25 at 4:00 PM revealed Resident #62 was receiving therapy services per her documentation and stated that the MDS consulting nurse should have completed the assessment since there was information to support he was participating in activities of daily living. She stated this was a comprehensive assessment and should have been completed in its entirety. An interview with the Administrator on 06/26/25 at 3:35 PM revealed that it was important that MDS assessments were completed accurately to reflect the residents' care.	F0641		
F0656 SS = B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan	F0656	The facility failed to develop a comprehensive person-centered care plan for the focus area of hospice in the initial care plan for 1 of 19 residents (Resident # 4) reviewed for comprehensive care plans. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Resident #4 care plan was reviewed and updated on 05/26/2025 to include hospice services. No further updates were needed. Resident #4s MDS was modified on 06/26/2025 to include	08/15/2025

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F0656 SS = B	Continued from page 29 must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, staff and Nurse Practitioner interviews the facility failed to develop a comprehensive person-centered care plan for the focus area of hospice in the intial care plan for 1 of 19 residents (Resident # 4) reviewed for comprehensive care plans. Findings included:	F0656	Continued from page 29 hospice and submitted to IQUIES. The VP of MDS Services for Broad River Rehab reviewed all care plans for residents receiving hospice services to ensure that hospice was included in comprehensive care plan. As of 07/14/2025 all care plans are in compliance to include hospice services. As of 07/14/2025, systemic changes have taken place to prevent recurrence. Daily communication with the remote MDS staff and nursing services will occur to review patient status changes. The VP of MDS Services for Broad River Rehab has educated MDS nurse on identification of hospice residents and care planning for those residents receiving hospice services on 07/01/2025. Beginning 07/14/2025, to prevent recurrence the VP of MDS Services for Broad River Rehab will audit new MDS assessments and care plans for residents receiving hospice services to ensure accuracy. All residents indicated to be receiving hospice services will be audited weekly x 12 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0656 SS = B	Continued from page 30 Resident # 4 was admitted on 2/14/25 with diagnosis of hypertensive heart disease with congestive heart failure. A review of Resident #4's census information in the electronic health record revealed that the resident was admitted on 2/14/25 on hospice services. Review of Resident #4's admission Minimum Data Set (MDS) dated 2/24/25 indicated hospice while a resident was coded No. Review of Resident #4's care plan revealed that a hospice care plan was added to the care plan on 5/26/25. The hospice care plan dated 5/26/25 indicated Resident #4 received Hospice services due to terminal prognosis with diagnosis of hypertensive heart disease with heart failure. Interventions included: give resident/family a working knowledge of diagnosis, prognosis & plan of care, provide resource materials on death and dying, assess resident's experience of pain, administer pain medication as ordered, provide environment conducive to comfort, reposition for comfort, encourage resident to be as active as able, monitor for skin issues and provide treatment to contain drainage, provide mouth care as needed, provide care with all activity of daily living tasks as needed. Review of Resident #4's quarterly MDS dated 5/23/25 indicated hospice while a resident was coded as Yes. An interview was conducted with the Nurse Practitioner (NP) on 6/26/25 at 9:00 AM. The NP stated that Resident #4 was admitted on 2/14/25 on hospice services. An interview was conducted with the Minimum Data Set (MDS) Supervisor on 6/26/25 at 1:00 PM. The MDS Supervisor reviewed Resident #4's care plan and acknowledged that the resident was admitted on 2/14/25 on hospice services and hospice was not added to the care plan until 5/26/25. The MDS Supervisor stated that hospice should have been included in the initial care plan and that it was important that resident care plans were accurate and person centered. An interview with the Director of Nursing on 6/26/25 at	F0656		

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F0656 SS = B	Continued from page 31 3:45 PM revealed that she expected that resident care plans would be person centered and accurate An interview with the Administrator on 6/26/25 at 4:00 PM revealed that resident care plans were to be person centered and address resident care needs including hospice services.	F0656		
F0684 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 care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 2.) Resident #38 was admitted to the facility on 4/3/25 with diagnoses of Parkinson's disease and dementia. A new diagnosis of a wedge compression fracture of the third thoracic vertebra was added on 6/23/25. A care plan dated 4/14/25 revealed Resident #38 had an extensive history of falls prior to admission and had injuries from falls. She was at risk for further falls with injury related to impaired balance, weight bearing issues, medication use, and a history of falls. Interventions included in part; to have no further falls with injury. The Minimum Data Set (MDS) quarterly assessment dated 5/19/25 revealed Resident #38 was severely cognitively impaired and had no falls. A progress note dated 6/21/25 at 5:30 AM documented by Nurse #11 revealed Resident #38 was heard yelling from her bedroom. Resident #38 was found on the floor by the nurse and nurse aide. She had a laceration on her right eye which was bleeding. Resident #38 was confused and stated she was looking for her pillow. Resident #38 was transferred to the hospital with Emergency Medical Services.	F0684	The facility failed to follow the physician's order to obtain an x-ray of a resident's right wrist and lower arm due to swelling and signs and symptoms of pain and failed to acknowledge recommendations on the x-ray results for further diagnostic reviews indicating a fracture could not be excluded for Resident #62. The facility failed to provide a TLSO (thoraco-lumbo-sacral orthosis, a type of spinal brace that supports the spine from the thoracic region down to the sacrum. It is used to limit movement, provide support and stabilization to the spine, and promote healing after injury) which was ordered by the hospital following a T3 (third thoracic vertebra) compression fracture for Resident #38 who experienced a fall in the facility. The facility failed to administer the full course of antibiotic therapy prescribed to Resident #48 for the treatment of a urinary tract infection. The above failures occurred for 3 of 3 residents reviewed for quality of care (Residents #62, #38 and #48). Resident #62 received 2 subsequent x-rays on 06/25/2025 and a CT scan on 06/26/2025. On 06/25/2025 there was an x-ray ordered for Resident #62 for the right upper extremity, right hand, right wrist, right forearm, and right elbow due to pain. The results were as follows: The examination is limited. The elbow is apparently contracted. No fracture or dislocation is seen. No joint effusion is seen. There is an osteophyte on the olecranon process of the ulna. Mild osteoarthritis is seen in the elbow. Conclusion: Limited study. There is mild osteoarthritis in the right elbow. On 06/25/2025 Resident #62 was sent to the Emergency Department for an x-ray of his right side due to pain. The results were as follows: AP and lateral of right humerus obtained - Osseous demineralization. No evidence of acute fracture or dislocation. No focal soft tissue abnormalities. Suspected: Hill-Sachs	08/15/2025

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F0684 SS = E	Continued from page 32 A hospital admission note dated 6/21/25 at 6:43 AM revealed Resident #38 was evaluated for an unwitnessed fall with an abrasion to the right temple. Resident #38 was at the nursing facility and was walking and slipped on a mat and fell onto her right cheek. There was no loss of consciousness, or blood thinner use, and no other pain or trauma reported during the evaluation. Resident #38 had a normal neurological exam and was stable to return to the nursing home. An order will be written for a TLSO brace. The discharge diagnoses included T3 (third thoracic vertebra) compression fracture. A written order dated 6/21/25 signed by the hospital physician for Resident #38 revealed TLSO for T3 compression fracture. An order dated 6/21/25 signed by the hospital physician for Resident #38 revealed Ultracet 37.5 milligrams (mg)/325 mg oral tablets. Give one tablet every six hours for 5 days as needed for pain. A progress note dated 6/21/25 at 11:18 AM documented by Nurse #4 revealed Resident #38 returned from the hospital this morning at approximately 11:00 AM following a fall during the night. Resident #38 was noted to have hit the right side of her head while walking in her room in the dark per report from the night shift nurse. Dried blood and bruising was noted above the right eye. Resident #38 was assisted into bed and was currently lying in bed with her eyes closed at this time. Resident #38 rated her pain as 6 out of 10 and pain medication was given. A new order was written for a TLSO brace for a 60% T3 compression fracture. The TLSO order was brought to the facility by Emergency Medical Services (EMS). The Director of Nursing (DON) was notified of the order. A phone interview was conducted on 6/26/25 at 3:30 PM with Nurse #4. She stated she was the admitting nurse when Resident #38 returned to the facility on Saturday 6/21/25 around 11:00 AM after a fall during the night. Nurse #4 stated the hospital sent the TLSO order with Emergency Medical Services (EMS) personnel. Nurse #4 stated she called the Director of Nursing (DON) once she received the order, and the DON instructed her to call the hospital to clarify the order. Nurse #4 called the hospital at that time and stated the hospital personnel did not communicate to her very well	F0684	Continued from page 32 deformity of the humeral head. On 06/26/2025 a STAT CT scan without contrast was ordered for Resident #62 for the right shoulder to rule out fracture. The results were as follows: Has suspected Hill-Sachs deformity, previous fall, related to pain right shoulder. Has contracture of RUE. Results: No acute fracture or dislocation. The Director of Nursing (DON) or designee will review the last 90 days of diagnostic test results for all current residents residing in the facility to ensure no follow-up studies were indicated. This will be completed by 07/18/2025. All current residents residing in the facility will have a pain assessment completed by 07/18/2025. The Director of Nursing (DON) or designee will review the pain assessments to ensure all resident pain is being managed. If pain is identified, then it will be reported to the physician for further treatment as indicated. Resident #38 was discharged from the hospital with a prescription for a TLSO brace on 06/21/2025 which occurred over the weekend. Due to limited vendor availability, obtaining the brace was delayed. Resident #38 was sent back to the Emergency Department per the Medical Director on 06/25/2025 until the hospital could get the resident fitted for the TLSO brace. The Director of Nursing (DON) or designee will review the last 90 days of durable medical equipment (DME) orders for all current residents residing in the facility to ensure all residents have the appropriate DME. If DME orders were missed, then it will be reported to the physician for further treatment as indicated. This will be completed by 07/18/2025. Resident #48 received 10 of 14 doses of antibiotic therapy prescribed for the treatment of a urinary tract infection. The medication was not available in the facility and nursing staff were waiting on the pharmacy to send the medication. The Director of Nursing (DON) or designee will review the last 90 days of antibiotic therapy prescriptions to ensure all medication orders were completed for all current residents residing in the facility by 07/18/2025. If antibiotic therapy prescription orders were missed, then it will be reported to the physician for further treatment as indicated. Beginning 07/14/2025, to prevent recurrence, the	

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F0684 SS = E	Continued from page 33 regarding who provided the TLSO but stated to her that they did not provide it indicating it was the responsibility of the facility. The hospital personnel instructed Nurse #4 that the TLSO was to be worn 24 hours a day and to follow up with the Orthopedist. Nurse #4 stated she notified the DON after speaking with the hospital and indicated they didn't know how to get the TLSO. Nurse #4 stated Resident #38 did return from the hospital with a pain medication order which she received during her shift on 6/21/25 and had also required pain medication during the week. She stated the pain medication administered for Resident #38 was effective in managing her pain. A progress note dated 6/23/25 at 10:37 AM written by the Nurse Practitioner revealed Resident #38 was evaluated for follow up after an emergency room visit on 6/21/25. Resident #38 was sent to the hospital after an unwitnessed fall. Staff entered the room after hearing Resident #38 yelling. She was found on the floor at the foot of her roommate's bed. She had bleeding from an area lateral to her right eye. Resident #38 told staff she was looking for her pillow. She was observed lying in bed this morning with a large ecchymosed (bruised) area surrounding the right eye with swelling, and a small abrasion on the right cheek. Resident #38 was at baseline regarding mentation, and was confused, and oriented to self only. Resident #38 denied pain. Diagnostics at the hospital showed a 60% T3 compression fracture of the spine with mild compromise to the adjacent spinal canal. The examination revealed Resident #38 was able to move all extremities without verbal or non-verbal indicators of pain. Resident #38 is at high risk for falls due to dementia and Parkinson's disease. Resident #38 was stable and denied pain at this time. She has Ultracet (pain medication) every 6 hours as needed for pain. Follow up with neurosurgery. TLSO brace to be worn while out of bed. During an observation on 6/26/25 at 9:30 AM Resident #38 was observed sitting up on the side of her bed. She was oriented to person. She was observed with a large, bruised area around her right eye with facial grimacing. There was no TLSO in place. When the surveyor asked her if she had pain, Resident #38 stated yes her back and her head hurt. During an interview on 6/26/25 at 9:35 AM Nurse #2 stated she was the assigned nurse. Nurse #2 stated Resident #38 had pain medication ordered after having	F0684	Continued from page 33 administration dates and times of ordered medication that is not in the facility should be extended in the electronic medical record. When the ordered medication is received in the facility the licensed nurse on duty should account for the missed doses of the ordered medication and extend the discontinue date on the Medication Administration Record (MAR) to ensure the full course of antibiotic treatment is administered to the resident. The licensed nurse on duty should call the pharmacy if an ordered medication is not in the facility and utilize the facilities backup pharmacy. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on reviewing resident diagnostic testing results in their entirety and reporting the diagnostic testing results as recommended to the physician to be followed up on. The documentation of this is to be entered into the clinical record as well as any new orders from the physician related to follow-up studies. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator, Registered Nurse (RN) or designee will educate all licensed nursing staff on what to do if a resident has a need for DME outside of normal business hours. Beginning 07/14/2025, to prevent recurrence, the facility will send out any resident in the future to the Emergency Department for DME equipment to be supplied or remain in holding and observation at the hospital until the appropriate DME is available and the resident can receive quality care and have their medical needs met at the skilled nursing facility level of care. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator, Registered Nurse (RN) or designee will educate all licensed nursing staff on timely medication administration including the importance of following physician orders without delay, physician/responsible party notification when medications are unavailable or delayed. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator, Registered Nurse (RN) or designee will educate all licensed nursing	

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F0684 SS = E	Continued from page 34 the fall on 6/21/25 and she continued to receive the pain medication as needed. Nurse #2 stated Resident #38 had complaints of back pain or pain all over at times, but the medication was effective in relieving her pain. She stated she would administer pain medication at this time. Nurse #2 stated Resident #38 did not have a TLSO that she was aware of, and she did not know the reason she didn't have the brace. During an interview on 06/26/25 at 10:33 AM the Rehabilitation Director stated she was surprised that Resident #38 came back from the hospital without the TLSO which was a brace that covered the entire torso. The Rehabilitation Director stated therapy was not equipped to fit Resident #38 for the TLSO and that would have to be done from an outside service and required proper fitting. She stated the TLSO for Resident #38 was discussed in the Monday morning meeting on 6/23/25 following the fall over the weekend and the Director of Nursing was informed during the meeting that the therapy department could not provide the TLSO. The Rehabilitation Director stated Resident #38 was seen by the Orthopedist yesterday 6/25/25 and she thought maybe they would fit her there, but they didn't. She reported therapy services had been held for Resident #38 pending the results from the Orthopedist appointment to clear her for further services. During an interview on 06/26/25 at 1:24 PM the Nurse Practitioner stated she evaluated Resident #38 on Monday 6/23/25 following the fall over the weekend. She stated she was aware that the hospital wrote an order for the TLSO but thought the facility had obtained it. The Nurse Practitioner stated she was not aware Resident #38 still did not have the TLSO but stated she should have had it in place by now because it had been 5 days without one. During a phone interview on 06/26/25 at 2:00 PM the Physician stated he was made aware today of Resident #38's fall with compression fracture that occurred on 6/21/25. He indicated the Nurse Practitioner would have followed up with Resident #38 following the fall on 6/21/25 and therefore he was not aware of the fall or the order for the TLSO. The Physician stated he spoke with the DON today and ordered Resident #38 to be sent back to the hospital today due to having continued complaints of pain and until the hospital could get the TLSO placed. He stated the order for the TLSO should have been obtained sooner than 5 days following hospitalization. The Physician stated the TLSO was used	F0684	Continued from page 34 staff on the procedures for contacting the pharmacy and or backup pharmacy to ensure prescribed medication availability or pending medication delivery to the facility. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator, Registered Nurse (RN) or designee will educate all licensed nursing staff on documentation standards for missed or late medication doses. The nurse discontinues or re-orders the prescribed order when the medication is available to ensure the correct number of doses are administered to the resident. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, DON or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation of meeting resident quality of care needs. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit diagnostic test results to ensure the results have been reviewed and are followed up as the diagnostic test order indicates. To ensure compliance the audit will be completed as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit DME orders to ensure DME equipment has been obtained. To ensure compliance the audit will be completed as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit antibiotic administration daily. To ensure compliance the audit will be completed as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance	

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F0684 SS = E	Continued from page 35 for stabilization of the spine and Resident #38 should have had one provided upon return from the hospital or sent back to the hospital until she could get one. The Physician indicated that once the facility realized they could not obtain the TLSO upon return from the hospital they should have sent Resident #38 back to the hospital at that time. During an interview on 6/26/25 at 3:00 PM the Director of Nursing (DON) stated Nurse #4 notified her of the TLSO for Resident #38 upon return from the hospital on 6/21/25. She stated she had Nurse #4 call the hospital back, but they did not get clear information as to how to get the TLSO. She stated on Monday 6/23/25 the Nurse Practitioner was notified and evaluated Resident #38. The DON stated Resident #38 had a follow up appointment scheduled on Thursday 6/25/25 and the Orthopedist wrote to continue the TLSO and follow up with neurosurgery. She stated she just spoke with the facility Physician and was instructed to call a medical supply company today to come out and fit for the brace and if the medical supply company could not get there today to send Resident #38 back to the hospital. She indicated she was awaiting a call back from the medical supply company and would know something soon and if they could not come out today they would send Resident #38 back to the hospital until she could get the TLSO placed. 3.) Resident #48 was admitted to the facility on 2/7/24 with diagnoses of a gastrostomy tube placement and a history of urinary tract infections. The Minimum Data Set (MDS) quarterly assessment dated 2/28/25 revealed Resident #48 was severely cognitively impaired. She received medications through the gastrostomy tube and received antibiotics. A care plan revised 3/20/25 for Resident #48 included a history of urinary tract infections and Resident #48 remained at risk for further urinary tract infections. A nursing progress note dated 3/20/25 at 2:05 AM documented by the Unit Manager revealed a report was given from the off going nurse that Resident #48 had foul smelling urine and vaginal discharge. A urine sample was obtained per standing orders. The urine sample was sent to the lab for urinalysis with culture and sensitivity (a urine test obtained to identify the presence of bacteria. A urine culture identifies the	F0684	Continued from page 35 under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0684 SS = E	Continued from page 36 presence and type of bacteria causing an infection. Sensitivity tests determine which antibiotics are effective against the bacteria per standing orders). A physician's order with a start date of 3/22/25 at 9:00 PM for Resident #48 revealed Sulfamethoxazole-Trimethoprim (antibiotic) oral suspension 800-160 milligrams per 20 milliliters (ml). Give 20 milliliters via gastrostomy tube two times a day for urinary tract infection for 7 days (Total of 14 doses). A progress note dated 3/23/25 at 5:27 PM documented by the Nurse Practitioner revealed Resident #48 was evaluated to follow up on a urinary tract infection. The recent culture and sensitivity grew greater than 100,000 cfu/mls (colony forming units per milliliter- a measurement used to quantify the number of viable bacteria in a sample. Greater than 100,000 is indictive of a urinary tract infection). Review of the Medication Administration Record (MAR) for Resident #48 dated March 2025 revealed Sulfamethoxazole-Trimethoprim (antibiotic) oral suspension was scheduled for administration at 9:00 AM and 9:00 PM. Resident #48 received only 10 of the 14 doses. The dates and times of when the medication was not given were as follows: 3/22/25 at 9:00 PM the medication was documented as not administered by the Unit Manager. 3/23/25 at 9:00 AM the medication was documented as not administered by Nurse #8. 3/23/25 at 9:00 PM the medication was documented as not administered by the Unit Manager. 3/26/25 at 9:00 PM the medication was documented as not administered by Nurse #9. Review of Resident #48's progress notes from 3/22/25 through 3/26/25 revealed no documentation as to why the Sulfamethoxazole-Trimethoprim was not administered.	F0684		

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F0684 SS = E	Continued from page 37 During an interview on 06/26/25 at 1:07 PM the Unit Manager stated the antibiotic was not administered to Resident #48 on 3/22/25 at 9:00 PM or 3/23/25 at 9:00 PM due to waiting for the liquid suspension to come from the pharmacy. She stated the liquid form was needed to administer through the gastrostomy tube and the liquid suspension would not have been available in the Omnicell (the medication dispensing system in the facility). The Unit Manager stated she he had a resident assignment on 3/22/25 and 3/23/25 on night shift and indicated she did not call the pharmacy regarding the medication due to it being after hours. She did not attempt to get the medication from the back up pharmacy. She indicated that she did not notify the Nurse Practitioner or the Physician that the antibiotic was not available. Attempts were made on 06/27/25 at 1:15 PM to contact Nurse #9. There was no response. During a phone interview on 6/26/25 at 5:00 PM Nurse #8 stated the antibiotic was not administered to Resident #48 by her on 3/23/25 at 9:00 AM due to waiting for the medication to come from the pharmacy. Nurse #8 stated she did not recall reaching out to the pharmacy regarding the medication. She stated the medication would not have been available in the Omnicell and indicated she did not try to get it from the back up pharmacy. Nurse #8 confirmed she did not notify the Nurse Practitioner or the Physician regarding not having the medication available for administration. During a phone interview on 6/26/25 at 3:30 PM the Nurse Practitioner stated she was not aware that the full course of the antibiotic Sulfamethoxazole-Trimethoprim was not administered to Resident #48. She stated Resident #48 had a history of urinary tract infections and should have received the full course totaling 14 doses. The nursing staff had not reported any further signs or symptoms of a urinary tract infection to her since that time. The Nurse Practitioner stated there had been no significant outcome from not receiving the missed doses but indicated it was important that she received the full course of treatment to effectively treat the infection. During an interview on 06/26/25 at 3:08 PM the Director of Nursing (DON) stated she was not aware that Resident #48 did not receive the full course of the prescribed antibiotic (Sulfamethoxazole-Trimethoprim). The DON	F0684		

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F0684 SS = E	Continued from page 38 stated when it was realized that the medication was not available in the facility and nursing staff were waiting on the pharmacy to send the medication, the administration dates and times should have been extended in the electronic medical record so that the order wouldn't have been discontinued after 7 days. The nurse on duty when the medication was received in the facility should have accounted for the missed doses and extended the discontinue date on the MAR and that did not occur and that was why the full course of treatment was not administered. She stated education would be provided on ensuring the full course of antibiotic therapy was administered. The DON stated she expected the nurses to call the pharmacy if the medication was not delivered or utilize the backup pharmacy and that did not occur. Based on observations, record review, and staff, Nurse Practitioner and Physician interviews the facility failed to 1.) follow the physician's order to obtain an x-ray of a resident's right wrist and lower arm due to swelling and signs and symptoms of pain and failed to acknowledge recommendations on the x-ray results for further diagnostic reviews indicating a fracture could not be excluded for Resident #62. 2.) provide a TLSO (thoraco-lumbo-sacral orthosis, a type of spinal brace that supports the spine from the thoracic region down to the sacrum. It is used to limit movement, provide support and stabilization to the spine, and promote healing after injury) which was ordered by the hospital following a T3 (third thoracic vertebra) compression fracture for a resident (Resident #38) who experienced a fall in the facility. 3.) administer the full course of antibiotic therapy prescribed to a resident (Resident #48) for the treatment of a urinary tract infection. This occurred for 3 of 3 residents reviewed for quality of care (Residents #62, #38 and #48). Findings included: 1.) Resident #62 was admitted to the facility on 01/26/25. Diagnoses included stroke with right side weakness, aphasia (loss of ability to express speech), cognition deficit, vascular dementia, contracture to right elbow, anxiety, and depression. The Minimum Data Set (MDS) quarterly assessment dated 02/06/25 revealed Resident #62 and was moderately cognitively impaired.	F0684		

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F0684 SS = E	Continued from page 39 A review of Resident #62's care plan dated 02/06/25 revealed a plan of care was in place for at risk for alteration in musculoskeletal status related to stroke with right side weakness with a goal that the resident would remain free of injuries or complications through next review. Interventions included, in part, to monitor/document/report as needed signs or symptoms of complications related to joint pain, joint stiffness, usually worse on wakening, swelling, decline in self-care ability, contracture formation or changes, and pain after exercise. A nursing progress note written by Nurse #3 on 03/07/25 at 12:54 revealed this nurse was called to Resident's room by staff at 7:30 AM. Resident was observed lying on the floor beside his bed, on his right side, possibly trying to transfer without assistance from staff. A head to toe assessment was completed and there were no injuries, bruising, or bleeding noted. The Nurse Practitioner was notified at 7:35 AM with a new order to send Resident to the Emergency Room for evaluation. The Emergency Room (ER) note dated 03/07/25 at 8:46 AM revealed in part, per Emergency Medical Services, the resident arrived due to an unwitnessed fall. Resident reportedly was trying to get out of bed and falling and demonstrated actual or suspected pain (headache but no other pain). A Computed Tomography (CT) Scan (medical imaging technique used to obtain detailed internal images of the body) of the head was conducted and showed an old left stroke. Resident #62 was discharged back to facility on 03/07/25. A Nurse Practitioner (NP) note dated 03/17/25 revealed she was seeing Resident #62 due to complaints of right arm pain. Resident had fallen on 03/07/25 from the bed to the floor landing on his right side and refused an initial assessment becoming very agitated and swung at the staff with his left arm and yelled loudly. Resident was sent to the hospital where he was evaluated. A CT scan was taken of his head which was negative for any new findings and he was returned to the facility. The NP note indicated the staff have reported the resident was having increased pain when any manipulation of his right arm was attempted during care. When the NP attempted to examine his right arm, resident pulled away and resisted any attempt at inspection and/or movement. He was noted to have mild edema of his right wrist and the top of the right hand. Resident has had	F0684		

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F0684 SS = E	Continued from page 40 an increase of pain since his fall. The Nurse Practitioner's plan was noted as "pain in right arm - uncontrolled. Will obtain x-rays 2 views of right arm to include hand, wrist and lower arm. Treatment as indicated after results obtained." A physician's order entered by the Nurse Practitioner was written 4 days later on 03/22/25 for x-ray of right extremity 2 views to rule out fracture due to increased pain on movement to include right hand, wrist and lower arm due to increased pain since fall on 03/07/25 and swelling for 2 days. There was no x-ray ordered for the right shoulder. Review of the physician orders revealed there were no medications ordered to manage or treat pain. An interview was conducted with the Nurse Practitioner (NP) on 06/25/24 at 11:00 AM. The NP stated she saw Resident #62 him on 03/17/25 related to his recent fall on 03/07/25. She stated Resident #62 was guarding his right arm and pushing her arm away and replied "yes" when asked if his right arm was in pain. The NP stated he was noted to have some swelling on his right wrist and hand and that was why she ordered the x-ray. The Nurse Practitioner stated she did not realize the order was not carried out to include Resident #62's right wrist and lower arm and she did not know why the x-ray included the right shoulder when she did not order that. The NP stated she did not follow through with the recommendations because she did not read the result of the x-ray in its entirety. She stated her eyes stopped at where the result read "no gross fracture or dislocation." The NP stated she would get another x-ray today at the hospital. The NP stated the reason the x-ray was done 4 days after she originally ordered it on 03/17/25, was because she realized she had entered the order in the electronic record the wrong way and the nurses could not see the order. The NP stated when she realized the x-ray was not done, she reentered the order on 03/22/25 the correct way in the electronic record so the nurses could view the order and obtain the x-ray. The x-ray results for Resident #62's right shoulder dated 03/24/25 was reviewed. The findings indicated no gross fracture or dislocation. The osseous (bone) structures appeared grossly intact. The conclusion of the x-ray indicated no gross osseous abnormality, limited study for which a fracture is not excluded and recommend repeat study with diagnostic views.	F0684		

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F0684 SS = E	Continued from page 41 The x-ray results for Resident #62's right hand dated 03/24/25 was reviewed. The findings indicated no gross fracture or dislocation. The osseous structures appear grossly intact. The conclusion of the x-ray indicated no gross osseous abnormality, limited study for which a fracture is not excluded and recommend repeat study with diagnostic views. There were no x-ray results for Resident #62's right wrist or lower arm per the physician order on 03/22/25. The MDS quarterly assessment dated 04/11/25 revealed Resident was rarely or never understood and moderately cognitively impaired. He exhibited rejection of care behavior 1 to 3 days during this assessment. A progress note written by the Nurse Practitioner written on 06/16/25 revealed Resident has a contracture of his right arm and complaints of pain when right arm was moved or manipulated. A follow up interview was conducted with the Nurse Practitioner on 06/25/25 at 9:05 AM. She stated she agreed that another x-ray should be taken today to rule out any kind of fracture and it should have been done when the x-ray resulted on 03/24/25. A Nurse Practitioner order was written on 06/25/25 to be sent to the Emergency Room for x-rays of the lower right arm due to pain and contracture. The Emergency Room note dated 06/25/25 revealed, in part, resident presented to the ER via EMS for right arm pain from contracture. The Medical Decision Making note revealed the physician was able to extend the resident's right arm a little bit further down the chest so that it is was not in the way of neck and face after Baclofen (a medication to treat muscle spasms) and Diazepam (an antianxiety medication) were administered. The note indicated he would be sent back to the facility with a prescription for Baclofen for muscle spasticity. Review of the x-ray of the right humerus (arm) revealed bone demineralization (reduction of minerals in tissue) and no evidence of acute fracture of dislocation. X-ray result of the right elbow and lower arm revealed a contracted elbow with no fracture or dislocation and mild osteoarthritis.	F0684		

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F0684 SS = E	Continued from page 42 An interview with the Director of Nursing (DON) on 06/26/25 at 2:35 PM revealed she did not read the x-ray result from 03/24/25 in its entirety and she stopped reading the x-ray when she read no fracture or dislocation. She stated she should have read the entire result of the x-ray and notified the physician to obtain an order to complete the recommendations for further diagnostic views. An interview with the facility's Physician was conducted via phone on 06/26/25 at 2:15 PM. The Physician stated he would have expected the nursing staff and the Nurse Practitioner to read any and all x-rays results in their entirety. The Physician stated although the result of the x-rays were not indicative of any fractures, there would be no way of knowing this for sure without obtaining the additional diagnostic views that were recommended.	F0684		
F0686 SS = G	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 observations, record reviews, staff interviews, and Wound Care Physician interviews, the facility failed to obtain orders, and to provide treatment on admission for a Stage 2 pressure ulcer wound that progressed to an unstageable wound for 1 of 1 residents (Resident # 64) reviewed for pressure ulcers.	F0686	The facility failed to obtain orders, and to provide treatment on admission for a Stage 2 pressure ulcer wound that progressed to an unstageable wound for 1 of 1 residents (Resident # 64) reviewed for pressure ulcers. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review admission documentation and Braden scores for all residents admitted in the last 30 days. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. The Director of Nursing (DON) or designee will audit current residents with Braden scores of 12 or less to confirm wound assessments were completed on admission. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. The Director of Nursing (DON) or designee perform a facility-wide skin inspection within one week to detect any undocumented pressure injuries. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record.	08/15/2025

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F0686 SS = G	Continued from page 43 Finding included: A review of Resident #64's hospital discharge summary dated 3/7/25 revealed no order for treatment to the right and left buttock and no documentation regarding the condition of the resident's skin upon discharge. Resident #64 was admitted to the facility from the hospital on 3/7/25 with diagnoses which included aftercare following femur (the long thigh bone) fracture, anemia, multiple myeloma (a severe form of cancer), and history of stroke. A nursing admission progress note completed by Nurse #2 on 3/7/25 at 3:43 PM indicated the resident had Stage 2 pressure ulcers (partial thickness skin loss) to the bilateral buttocks. The admission progress note did not indicate that the physician was notified of the pressure ulcers or that the physician was consulted for wound care treatment orders. A review of the admission skin assessment dated 3/7/25 by Nurse #2 revealed that Resident #64 was noted with the following areas on the skin: - left buttock pressure ulcer 1 centimeter (cm) length with 2 cm width - right buttock pressure ulcer 2 cm length with 2 cm width The admission skin assessment did not indicate that the physician was notified of the pressure ulcers or consulted regarding treatment of the Stage 2 pressure ulcers. A physician order in Resident #64's electronic health record dated 3/7/25 indicated to apply house barrier cream to the peri area after each incontinence episodes and as needed. A review of Resident #64's March 2025 electronic Medication and Treatment Administration Record revealed no entry for house barrier cream to the peri area after	F0686	Continued from page 43 This will be completed by 07/21/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has revised its Admission Policy to require nursing staff to complete a full skin assessment and Braden scoring upon admission and obtain and carry forward all wound care orders before end of shift. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has revised it's nursing policies to have licensed nurses conduct a comprehensive wound assessment with documentation of size, depth, tissue type, and exudate being entered in the electronic health record when a resident admits to the facility. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has revised its nursing policies to ensure that the physician and wound care specialist orders are obtained and entered into the electronic health record, within 24 hours of assessment for appropriate dressing changes, offloading, and support surfaces. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has revised its nursing policies to monitor wound progress with weekly measurements; update the care plan and notify the physician of any deterioration. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on early pressure injury identification and staging and timely physician order acquisition procedures. They will also be educated on the admissions checklist that includes “Wound Assessment Completed” and “Orders Obtained” sign-off fields. This will be completed by 08/15/2025. After 08/15/2025 newly hired licensed nursing staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, Director of Nursing (DON), or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation to obtain orders, and to provide treatment on admission to residents. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit 100% of admission records weekly for 3 weeks, 75 % for 3 weeks, 50% x 3 weeks, then 25% x3 weeks. Audit tool will track time from admission to skin assessment,	

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F0686 SS = G	Continued from page 44 incontinence episodes and as needed. An interview was conducted with Nurse #2 on 6/24/25 at 3:00 PM. Nurse #2 stated that the floor nurse was responsible for completion of the admission assessment including a full body audit when a resident was admitted or readmitted. Nurse #2 stated that she completed the initial admission skin assessment for Resident #64, and she recalled that the resident had Stage 2 wounds to bilateral buttocks that did not have dressings covering them on admission. Nurse #2 indicated she did not think she needed to notify the physician of the 2 Stage 2 wounds and did not need to consult the physician for a wound care treatment orders. Nurse #2 indicated that she did not think the wounds were that serious, so she did not think she needed to do anything further other than the order for barrier cream. Nurse #2 stated she did not alert anyone that Resident #64 should be evaluated by the Wound Care Physician and was unaware that Resident #64's wound on the right buttock progressed to an unstageable wound that required debridement. A skin observation tool dated 3/8/25 completed by Nurse #5 indicated Resident #64 had Stage 2 pressure wounds to the right and left buttock. A review of an undated facility Standing Treatment Orders for Wounds revealed that Stage 2 wounds were to be cleansed with normal saline, calcium alginate and an island dressing was to be applied. The physician and the Wound Care Physician were to be notified. A review of Resident #64's electronic health record revealed that the standing treatment order for Stage 2 ulcers to cleanse the area with normal saline, apply calcium alginate and cover with an island dressing was not initiated until 3/13/25. A review of Resident # 64's nursing progress notes from 3//8/25 through 3/13/25 revealed there was no entry noting that the right buttock wound was an unstageable deep tissue wound (a wound where the full extent of tissue damage cannot be determined due to eschar or dead tissue). There was no further entry regarding the left buttock wound. The first Wound Care Physician note for Resident #64	F0686	Continued from page 44 presence of physician orders within 24 hours, and wound treatment initiation date. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0686 SS = G	Continued from page 45 dated 3/13/25 indicated Resident #64 was evaluated at the request of the physician due to a wound on the right buttock. The note indicated a thorough assessment and evaluation was performed with the wound exam revealing an unstageable deep tissue injury to the right buttock measuring 6.5 cm x 5.3 cm. The wound care physician note did not indicate a pressure ulcer was observed on Resident #64's left buttock. An interview was conducted with the Wound Care Physician on 6/26/25 at 12:30 PM. The Wound Care Physician stated he evaluated Resident #64 on 3/13/25 due to a wound on the right buttock and his exam revealed that the resident had an unstageable deep tissue wound. The Wound Care Physician stated that the nursing staff had assessed the wound as a Stage 2 on admission however when he evaluated it the wound was unstageable due to necrotic or dead tissue. The Wound Care Physician stated the nursing staff should have informed Resident #64's physician of the Stage 2 pressure ulcer noted on admission to implement orders to prevent worsening of the ulcer. A pressure injury assessment dated 3/13/25 signed on 3/18/25 by Nurse #4 indicated Resident #64 had an unstageable deep tissue injury to the right buttock measuring 6.5 cm x 5.3 cm. The assessment indicated this was the first pressure injury assessment with no other assessments to compare to evaluate the progress of the wound. An interview was conducted with Nurse #4 on 6/25/25 at 3:49 PM. Nurse #4 stated there was not currently a Wound Care Nurse for the facility. Nurse #4 stated she was assigned to accompany the Wound Care Physician on 3/13/25 on rounds and to document the pressure injury assessments for each resident that was evaluated. Nurse #4 stated Resident #64 was on the list to be evaluated on 3/13/25 but she did not know who added the resident to the list. An interview was conducted with the Nurse Practitioner (NP) on 6/25/25 at 10:30 AM. The NP stated that she evaluated Resident #64's skin but was unable to recall on what date. The NP stated that she recalled that Resident #64's skin was broken with pressure areas on bilateral buttock. The NP stated that the treatment of barrier cream was a prevention for a Stage 1 wound but once the skin was broken as in Stage 2, 3 or 4 wounds, a dressing was required. The NP indicated that if a	F0686		

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F0686 SS = G	Continued from page 46 topical treatment such as barrier cream was used, it must be applied after each incontinence episode and must be recorded on the Treatment Administration Record. The nurses must apply the barrier cream and assess the skin if it was used for a pressure ulcer treatment. The NP stated that given Resident #64's overall condition and boney body habitus, she would have expected a wound care treatment other than barrier cream. The Stage 2 area on the buttock that Resident #64 was admitted with could have progressed due to not obtaining an order for a wound care treatment. A cushioned foam island dressing would have been a more appropriate order and could have prevented the wound from progressing. The NP stated that she expected that wounds would be thoroughly assessed and appropriate wound care orders implemented. A physician order written by the Wound Care Physician dated 3/13/25 indicated to apply calcium alginate and cover with an island dressing every day to the right buttock. Resident #64's admission Minimum Data Set (MDS) assessment dated 3/14/25 indicated the resident had a severe cognitive impairment and had 2 Stage 2 pressure ulcers present on admission. Skin observation tools completed on 3/15/25 and 3/22/25 indicated Resident #64 had no new areas of concern. A Wound Care Physician note dated 3/27/25 indicated Resident #64 was evaluated and a surgical debridement procedure to remove necrotic tissue and establish margins of viable tissue was completed. A post debridement assessment of the wound indicated that the previously unstageable necrotic wound revealed underlying deep tissue at the muscle/fascia level which had been obscured by the necrotic tissue. With the removal of the necrotic tissue the wound now presented as a Stage 4 full thickness pressure wound measuring 1.9 cm length by 3.2 cm width and 0.1 cm depth. An interview with the Director of Nursing (DON) on 6/26/25 at 3:45 PM revealed that she expected that the physician would be notified on admission of a pressure ulcer and appropriate treatment orders would be initiated. The DON indicated that the facility had an interdisciplinary team daily morning meeting that reviewed new admissions and changes in resident	F0686		

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F0686 SS = G	Continued from page 47 conditions from the previous day. The DON indicated that Resident #64 was reviewed in the meeting following her admission and a referral was made for the resident to be evaluated by the Wound Care Physician. The DON indicated it was an oversight that the appropriate wound treatment orders were not initiated on admission and education of the nursing staff was required.	F0686		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff, the Registered Dietitian, Nurse Practitioner, and Physician interviews the facility failed to provide an enteral tube feeding (nutrition provided directly into the digestive system through a tube inserted through the nose, stomach, or small intestine) according to the physician's order. This occurred for 1 of 2 residents reviewed for nutrition (Resident #48). Findings included. Resident #48 was admitted to the facility on 2/7/24 with diagnoses including cerebral vascular accident, dysphagia (difficulty swallowing), and gastrostomy tube	F0693	The facility failed to provide an enteral tube feeding (nutrition provided directly into the digestive system through a tube inserted through the nose, stomach, or small intestine) according to the physician's order for Resident #48. This occurred for 1 of 2 residents reviewed for nutrition (Resident #48). All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. Resident #48 had a change in condition. The Director of Nursing (DON) or designee will review all current residents who receive enteral tube feedings to ensure they are receiving the correct ordered enteral tube feedings. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 07/18/2025. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on enteral tube feedings. The education will include how to correctly set up, program, and monitor enteral tube feeding pumps. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee will conduct hands-on competency validation for all licensed nursing staff on continuous feeding administration. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff that when sending a resident out to the Emergency Department for treatment as indicated, the nurse should call the triage nurse at the Emergency Department and explain why the resident is being sent to the hospital document the name of the nurse spoken to and	08/15/2025

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F0693 SS = D	Continued from page 48 placement (tube placed into a surgically created opening in the stomach). A care plan dated 9/19/24 revealed Resident #48 required tube feedings. Interventions included to maintain adequate nutrition and hydration status and provide the diet as ordered. A physician's order dated 1/6/25 for Resident #48 revealed enteral feeding in the evening for nutrition. Infuse the fortified nutritional supplement at 55 milliliters (ml) per hour for 10 hours for nocturnal (during the night) feeding. The order was scheduled on the Medication Administration Record (MAR) for infusion nightly at 9:00 PM. The Minimum Data Set (MDS) annual assessment dated 4/4/25 revealed Resident #48 was severely cognitively impaired. She received tube feedings and had no rejection of care. A progress note dated 6/25/25 at 11:00 PM documented by Nurse #7 revealed Resident #48 was noted to have gastrostomy tube leakage during routine care. The site was leaking with no visible dislodgement. The on- call physician was notified and ordered Resident #48 to be sent to the hospital for evaluation. A hospital admission note dated 6/25/25 at 11:48 PM revealed Resident #48 was sent to the emergency department (ED) for a clogged feeding tube, there were concerns of leaking around the stoma. The gastrostomy tube was easily unclogged by the ED nurse. The tube was flushed and the plunger retracted. There was no leaking around the stoma with testing. The dirty bandage was changed, and Resident #48 was discharged back to the nursing facility. Review of Resident #48's progress notes from 6/25/25 through 6/26/25 revealed no documentation of when Resident #48 returned to the facility or the status of the gastrostomy tube. During an observation on 6/26/25 at 9:45 AM Resident #48 was observed lying in bed in her room. She was oriented to self but due to aphasia (difficulty speaking) she could not voice her needs. She was able	F0693	Continued from page 48 information relayed. When a resident returns from the hospital the nurse must document the return in the clinical record, and document any new orders as indicated. If paperwork does not come back with the resident, the nurse is to call the Emergency Department for clarification, and document it in the clinical record. All residents transferred to and from the hospital will have a clinical disposition reported to the on-coming nurse at shift change to ensure quality of care is received. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation of ensuring ordered enteral tube feedings are completed for any resident who receives enteral tube feedings. Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will audit daily enteral tube feedings. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. The audit will be completed as follows to ensure compliance: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will audit daily enteral tube feedings to ensure resident has received the prescribed amount of nutrition. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. The audit will be completed as follows to ensure compliance: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0693 SS = D	Continued from page 49 to respond to yes or no questions by nodding her head. When asked if she received her tube feeding during the night or this morning she nodded no. When asked if she was hungry she nodded yes. A 1000 milliliter (ml) bag of the fortified nutritional supplement dated 6/24/25 was hanging at the bedside with 500 milliliters of the nutritional supplement that remained in the bag. During an interview on 6/26/25 at 9:50 AM Nurse #2 stated she was Resident #48's assigned nurse today. She stated according to the report she received from Nurse #7 the night shift nurse, Resident #48 was sent to the hospital around 11:00 PM last night (6/25/25) due to the gastrostomy tube being clogged and returned to the facility shortly after around midnight with no new orders. Nurse #2 stated she had not administered any tube feeding to Resident #48 since she arrived for her shift this morning at 7:00 AM. She was not certain if Nurse #7 had given Resident #48 any of the tube feeding supplement after returning from the hospital. When Nurse #2 was asked, shouldn't the nutritional supplement be infusing at this time if it was to run for 10 hours and Resident #48 returned from the hospital around midnight. Nurse #2 stated she did not realize that the tube feeding was not infusing. Nurse #2 observed the old bag of the fortified nutritional supplement dated 6/24/25 hanging at the bedside. She stated that was the bag from two nights ago and should not be hanging there. Nurse #2 stated she would notify the Nurse Practitioner immediately. During a phone interview on 6/26/25 at 10:0 AM Nurse #7 the night shift nurse stated Resident #48 was sent to the hospital at 10:50 PM last night on 6/25/25 due to her gastrostomy tube leaking. Resident #48 retuned to the facility around 12:50 AM two hours later with no new orders. Nurse #7 stated emergency medical services (EMS) personnel reported that the hospital was able to unclog and flush the gastrostomy tube. Nurse #7 stated she did not administer the order for the fortified nutritional supplement to infuse 55 milliliters over 10 hours even though the gastrostomy tube flushed fine, but she did administer Resident #48's pain medications through her gastrostomy after returning from the hospital. When asked why she didn't infuse the fortified nutritional supplement according to the physician's order to Resident #48 after returning from the hospital Nurse #7 stated she didn't because she thought since the tube had leaked requiring Resident #48 having to go to the hospital she thought it was okay not to give the tube feeding continuously over 10 hours. She later stated she did give Resident #48 a	F0693		

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F0693 SS = D	Continued from page 50 bolus of 237 milliliters of the fortified nutritional supplement around 1:30 AM instead of the continuous feeding. Review of Resident 48's physician orders revealed no order to provide a 237-milliliter bolus of the fortified nutritional supplement to Resident #48 in place of the continuous infusion of the nutritional supplement over 10 hours during the night. Review of Resident #48's electronic medical record from 6/25/25 through 6/26/25 revealed no documentation that Nurse #7 administered a 237-milliliter bolus feeding of the fortified nutritional supplement to Resident #48. During a phone interview on 6/26/25 at 11:30 AM the Registered Dietitian (RD) stated she last evaluated Resident #48 on 5/22/25. The RD reported that Resident #48 had weight loss over the last few months. They had started pleasure feedings of 4 ounces of pudding at breakfast and at lunch and to provide a bolus feeding after breakfast and lunch only if Resident #48 did not consume the 4 ounces of pudding. The RD stated an order was in place for a fortified nutritional supplement to infuse at 55 milliliters continuous over night to meet Resident #48's dietary needs of 1600 kilocalories (measurement of the energy content of food) per day and there were no orders to replace the continuous feeding over 10 hours with a bolus feeding. The RD indicated Resident #48 should have received the continuous infusion of the nutritional supplement after returning from the hospital. During a phone interview on 06/26/25 at 2:00 PM the Physician stated Resident #48 should have received the continuous infusion of the fortified nutritional supplement through the gastrostomy tube according to the order after returning from the hospital on 6/26/25. He stated Resident #48 should have received the continuous infusion and not a bolus feeding. The Physician stated that Resident #48 would have no significant outcome from not receiving one feeding of the fortified nutritional supplement, but he expected the order to be followed. During an interview on 6/26/25 at 3:00 PM the Director of Nursing (DON) stated Nurse #7 should have provided Resident #48 with the fortified nutritional supplement to be infused over 10 hours after returning from the	F0693		

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F0693 SS = D	Continued from page 51 hospital on 6/26/25. The DON stated there was no order in place to provide a bolus feeding in place of the continuous feeding over 10 hours each night. She stated the fortified nutritional supplement should have been administered according to the physician's order.	F0693		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, Nurse Practitioner and Physician interviews, the facility failed to provide pain management to include medications or non-pharmacological interventions for a resident who was observed by the Nurse Practitioner, the Nursing Aides and Occupational Therapist Assistant to have signs and symptoms of pain. This was for 1 of 1 resident (Resident #62) reviewed for pain. Findings included: Resident #62 was admitted to the facility on 01/26/25. Diagnoses included stroke with right side weakness, aphasia (loss of ability to express speech), cognition deficit, vascular dementia, contracture to right elbow, anxiety, and depression. The Minimum Data Set (MDS) quarterly assessment dated 02/06/25 revealed Resident #62 was moderately cognitively impaired, exhibited no behaviors, and was coded as not receiving any scheduled or as needed pain medication. A review of Resident #62's care plan dated 02/06/25 revealed a plan of care was in place for at risk for alteration in musculoskeletal status related to stroke with right side weakness with a goal that the resident would remain free of injuries or complications through next review. Interventions included, in part, to monitor/document/report as needed signs or symptoms of	F0697	The facility failed to provide pain management to include medications or non-pharmacological interventions for a resident who was observed by the Nurse Practitioner, the Nursing Aides and Occupational Therapist Assistant to have signs and symptoms of pain. This was for 1 of 1 resident (Resident #62) reviewed for pain. Resident #62 was reassessed by the Nurse Practitioner and attending physician. Pain medications and non-pharmacological interventions (e.g., repositioning, heat/cold therapy) were initiated per the updated care plan. Resident's care plan was revised to include specific pain management goals, interventions, and monitoring frequency. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review all residents for signs/symptoms of pain and proper documentation of pain management interventions. Staff interviews and observations will be conducted to identify gaps in recognition and response to pain indicators. This will be completed by 08/15/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has implemented standardized pain assessment tools (e.g., PAINAD, Numeric Rating Scale) during admission, shift changes, and therapy sessions. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has established direct reporting pathways between therapy staff and nursing for pain-related observations. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility has implemented a stop and watch early warning form for all staff to complete if they become aware of a resident having a change in their condition. Any resident changes noted will require further assessment and intervention by the physician. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on	08/15/2025

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F0697 SS = G	Continued from page 52 complications related to joint pain, joint stiffness, usually worse on wakening, swelling, decline in self-care ability, contracture formation or changes, and pain after exercise. Review of an Occupational Therapist Assistant (OTA) note written on 02/10/25 revealed, in part, the therapist provided passive range of motion to the right upper extremity to reduce contracture and prevent loss of range of motion. Resident tolerated well with extra time required due to pain. An Occupational Therapist Assistant note written on 02/26/25 revealed resident agreed to passive range of motion to right upper extremity but was very limited due to pain response causing resident to pull away during light passive range of motion. A nursing progress note written by Nurse #3 on 03/07/25 at 12:54 PM revealed this nurse was called to Resident's room by staff at 7:30 AM. Resident observed lying on the floor beside his bed, on his right side, possibly trying to transfer without assistance from staff. A head to toe assessment was completed and there were no injuries, bruising, or bleeding noted. The Nurse Practitioner was notified at 7:35 AM with a new order to send Resident to the Emergency Room for evaluation. The Emergency Room (ER) note dated 03/07/25 at 8:46 AM revealed in part, per Emergency Medical Services (EMS), the resident arrived to the emergency room due to an unwitnessed fall. Resident reportedly was trying to get out of bed and falling and demonstrated actual or suspected pain (headache but no other pain). A Computed tomography (CT) Scan (medical imaging technique used to obtain detailed internal images of the body) of the head was conducted and showed an old left stroke. The ER note indicated Resident #62 was discharged back to facility. A review of the Occupational Therapist Assistant's note written on 03/11/25 revealed Resident was seen today following a fall on 03/07/25. The note revealed the therapist provided passive range of motion to the right upper extremity to reduce contracture and protect skin integrity, but resident only tolerated less than 10 minutes before refusing to continue.	F0697	Continued from page 52 the facility pain management policy and procedures, timely assessment and documentation of resident pain, and reporting to physician for treatment as indicated. This will be completed by 08/15/2025. After 08/15/2025 newly hired licensed nursing staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee, will educate all staff on the stop and watch early warning form that are to be utilized when they become aware of a resident having a change in their condition so that the noted changes can be reported to the physician. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, Director of Nursing (DON), or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation to provide appropriate pain management for residents. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will conduct daily MAR audits to ensure pain medications are administered as ordered. To ensure compliance the audit will be completed as follows: 12 charts weekly x 4 weeks, 6 charts weekly x 4 weeks, 3 charts weekly x 4 weeks. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will conduct resident interviews to assess satisfaction with pain control. To ensure compliance the audit will be completed as follows: 12 alert and oriented residents weekly x 4 weeks, 6 alert and oriented residents weekly x 4 weeks, 3 alert and oriented residents weekly x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET , LAKE WACCAMAW, North Carolina, 28450

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F0697 SS = G	Continued from page 53 A Nurse Practitioner (NP) note dated 03/17/25 revealed she was seeing Resident #62 due to complaints of right arm pain. Resident had fallen on 03/07/25 from the bed to the floor landing on his right side and refused an initial assessment and became very agitated and swung at the staff with his left arm and yelled loudly. Resident was sent to the hospital where he was evaluated. A CT scan was taken of his head which was negative for any new findings and he was returned to the facility. The note indicated the staff have reported the resident was having increased pain when any manipulation of his right arm was attempted during care. When the NP attempted to examine his right arm, resident pulled away and resisted any attempt at inspection and/or movement. He was noted to have mild edema of his right wrist and the top of his right hand. Resident has had an increase of pain since his fall. The plan was noted as "pain in right arm - uncontrolled. Will obtain x-rays 2 views of right arm to include hand, wrist and lower arm. Treatment as indicated after results obtained." A physician's order was written 4 days later on 03/22/25 for x-ray of right extremity 2 views to rule out fracture due to increased pain on movement to include right hand, wrist and lower arm due to increased pain since fall on 03/07/25 and swelling for 2 days. There was no x-ray ordered for the right shoulder. Review of the physician orders for Resident #62 revealed there were no medications ordered to manage or treat pain. The facility had no standing orders in place to administer pain relievers. Review of the nursing progress notes since 03/07/25 revealed there were no non pharmacological interventions done to treat Resident #62's pain. The x-ray results for Resident #62's right shoulder dated 03/24/25 were reviewed. The findings indicated no gross fracture or dislocation. The osseous (bone) structures appeared grossly intact. The conclusion of the x-ray indicated no gross osseous abnormality, limited study for which a fracture is not excluded and recommend repeat study with diagnostic views. The x-ray results for Resident #62's right hand dated	F0697		

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F0697 SS = G	Continued from page 54 03/24/25 was reviewed. The findings indicated no gross fracture or dislocation. The osseous structures appear grossly intact. The conclusion of the x-ray indicated no gross osseous abnormality, limited study for which a fracture is not excluded and recommend repeat study with diagnostic views. There were no x-ray results for Resident #62"s right wrist or lower arm per the physician order. The MDS quarterly assessment dated 04/11/25 revealed Resident was rarely or never understood and moderately cognitively impaired. He exhibited rejection of care behavior 1 to 3 days during this assessment. Resident had impairment to one side to upper extremity and no impairment to lower extremity. Resident #62 was not receiving scheduled or as needed pain medication. A progress note written by the Nurse Practitioner written on 06/16/25 revealed Resident has a contracture of his right arm and complaints of pain when right arm was moved or manipulated. An interview with Nurse Aide (NA) #1 on 06/23/25 at 3:45 PM revealed Resident #62 did not like to get out of bed and he would get very angry when she tried to get him out of bed. She stated when she repositioned him he would favor his right contracted arm and show signs of pain such as moaning and groaning and grimacing and guarding. She stated she had noticed that he used to keep his arm / elbow bent and rest across his abdomen but since the fall on 03/07/25 he has it raised (like drawn up) laying over his chest. NA #1 stated Resident #62 showed signs of pain whenever she would get him dressed and it was hard to put on his hospital gown; he would groan and pull away whenever she tried to put on his gown and she had to be very careful and ease it on his arm and shoulder very carefully. NA #1 stated he would refuse care a lot, but she did not know if that was because he was in pain. She stated as far as she knew he did not get pain medication and she did not tell the nurse that he was having pain during care because she thought it was related to the contracture and the nurses were already aware. NA #1 stated she had reported the observation of pain to the Nurse Practitioner a couple of times since his falls on 03/07/25 and 04/10/25 but she could not remember the exact dates.	F0697		

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F0697 SS = G	Continued from page 55 An interview with Nurse #3 on 06/24/25 at 2:30 PM revealed Resident #62 revealed Resident #62 was refusing to get out bed and did not want to be bothered since admission. She stated he wanted to be left alone. She stated he was cognitively aware and even though he was aphasic he could make his needs known by saying yes or no when asked and pointing to items/things. She stated he did not complain of pain and she would ask when she gave him his medications. Nurse #3 stated none of the Nurse Aides ever reported to her that Resident #62 was having pain. Nurse #3 stated on 03/07/25 at the beginning of the shift, she was notified that Resident #62 had a fall and was on the floor. Upon entering the room, she stated he was lying on the floor and she attempted to do a head to toe neurological assessment, but he was being very uncooperative and swung his arm at her and would not allow her to assess him. She stated she did not know if he was in pain or not, but he did not want to be touched. Nurse #3 stated it was an unwitnessed fall and since she could not do a neurological assessment she reported that to the EMS team and a CT scan of his head was done while he was at the hospital. Nurse #3 stated prior to the fall and after the fall she did not notice him having signs or symptoms of pain to his arm, but she knew that his right arm was contracted. An interview with the Rehabilitation (Rehab) Manager who was also the Occupational Therapist Assistant (OTA) on 06/24/25 at 4:00 PM revealed Resident #62 was nonverbal but he could make his need known with yes or no questions. She stated he was very difficult to evaluate since admission as he did not want to be touched and wanted to be left alone and would not allow her to do range of motion. She stated contractures can be very painful especially with movement, but not doing range of motion would cause more pain due to the joint and muscle stiffness that can occur with non-movement. The Rehab Manager/OTA stated Resident #62 refused care due to pain. The Rehab Manager/OTA stated the resident's refusal with therapy was discussed at the morning meetings and the nursing staff was made aware of his refusals due to pain. The Rehab Manager/OTA stated he demonstrated signs and symptoms of pain by wincing, groaning and pulling away and also verbally answering "yes" when asked if he was in pain. An interview with Nurse Aide #2 at 9:45 AM on 06/25/25 at 9:30 AM revealed since his admission, Resident #62 would refuse care often and would not allow her to touch him or change him at times. She stated whenever she would try to provide care, he would be combative	F0697		

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F0697 SS = G	Continued from page 56 and wince especially when trying to put on his hospital gown or getting him dressed. She stated his right arm was very tight and it was very difficult to get his gown on and he would try to pull away. NA #2 stated she did not report Resident #62's pain to the nurse because she thought the nurses were aware since he had a contracture to that right arm. An interview was conducted with the Nurse Practitioner (NP) on 06/25/25 at 11:00 AM. The NP stated she saw him on 03/17/25 related to his recent fall on 03/07/25. She stated Resident #62 was guarding his right arm and pushing her arm away and replied "yes" when asked if his right arm was in pain. The NP stated he was noted to have some swelling on his right wrist and hand and that was why she ordered the x-ray. The NP stated his pain could have been the reason he was refusing care and in hindsight she should have ordered something sooner for his pain. She stated up until 03/17/25, she had not been made aware he was having pain until NA #1 informed her that he was having pain whenever he was being provided care and was refusing to get up. The NP stated as far as she knew he always had that baseline pain due to his contracture since admission and it could have been the reason he was resistant to care and not participating in therapy, and that he did not want to be touched. It was reported to her again in June by NA #1 that Resident #62 was having pain and again she stated she should have ordered something for pain. The Nurse Practitioner stated she would start him right away on scheduled Tylenol (pain reliever). The Nurse Practitioner stated she would get another x-ray today on Resident #62's right arm to make sure a fracture could be ruled out. The Emergency Room note dated 06/25/25 revealed, in part, resident presented to the ER via EMS for right arm pain from contracture. The Medical Decision Making note revealed the physician was able to extend the right arm a little bit further down the chest so that it is was not in the way of neck and face after the baclofen and the diazepam (an antianxiety medication) were administered. The note indicated he would be sent back to the facility with a prescription for baclofen for muscle spasticity. Review of the x-ray of the right humerus (arm) revealed bone demineralization (reduction of minerals in tissue) and no evidence of acute fracture of dislocation. X-ray result of the right elbow and lower arm revealed a contracted elbow with no fracture or dislocation and mild osteoarthritis.	F0697		

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F0697 SS = G	Continued from page 57 A follow up interview was conducted with the Nurse Practitioner on 06/26/25 at 9:05 AM. The NP stated Resident #62 was sent to the ER on 06/25/25 to get an x-ray of his arm since the last x-ray did not get a full picture of his wrist and arm as ordered on 03/22/25 and that there was a recommendation for further diagnostic views. She stated when Resident #62 was sent back to the facility on 06/25/25 from the ER, the ER physician had ordered Baclofen (a medication to treat muscle spasticity) which she felt was a good idea for Resident #62. The Nurse Practitioner stated the Baclofen and the Tylenol may help him to be able to participate in therapy and be able to move his right arm more with less pain and he may not refuse care as much. An interview with the facility's Physician was conducted via phone on 06/26/25 at 2:15 PM. The Physician stated if Resident #62 was demonstrating signs and symptoms of pain when the Nurse Practitioner assessed him, then he would have expected the Nurse Practitioner to order a pain reliver for this resident and for the pain to be assessed. He stated 3 months or possibly longer of not getting pain medication was a long time and perhaps the resident would have been participating in his therapy and ADLS if he were medicated for his pain. The Physician also stated he would have expected the Nurse Aides to communicate with the Nurses of the signs and symptoms or pain they observed on this resident during care and for the Nurse to complete an assessment. An interview with the Director of Nursing (DON) on 06/26/25 at 2:35 PM revealed she was not made aware Resident #62 was having any pain. The DON stated she would have expected the Nurse Aides to report the pain to the Nurses and for the Nurses to assess the resident, document the assessment and notify the Physician for any new orders if there was pain. The DON stated she knew that Resident #62 was refusing care, but she did not remember the Rehab Manager/OTA reporting pain.	F0697		
F0756 SS = E	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 licensed pharmacist.	F0756	The Consultant Pharmacist failed to identify and report a medication irregularity during the monthly medication regimen review for Resident #62. Resident #62 received the anticonvulsant medication Depakote 250 milligrams after the order was written for a gradual dose reduction and to discontinue after 14 days.	08/15/2025

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F0756 SS = E	Continued from page 58 §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 interviews, the Consultant Pharmacist failed to identify and report a medication irregularity during the monthly medication regimen review. Resident #62 received the anticonvulsant medication Depakote 250 milligrams after the order was written for a gradual dose reduction and to discontinue after 14 days. Resident #62 received 25 additional tablets of Depakote and the wrong dose. There was no significant outcome. This occurred for 1 of 5 residents reviewed for medication administration. Findings included.	F0756	Continued from page 58 Resident #62 received 25 additional tablets of Depakote and the wrong dose. There was no significant outcome. This occurred for 1 of 5 residents reviewed for medication administration. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review the last three months of pharmacist review reports to identify any missed irregularities. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. The Director of Nursing (DON) or designee will update each affected resident’s medical record with a clear rationale for each medication continued, modified, or discontinued. This will be completed by 07/25/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility will revise the Drug Regimen Review policy to include: a standardized checklist of common medication irregularities (e.g., duplications, contraindications, dosing errors). A requirement for the consultant pharmacist to sign off on each checklist item. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility will implement a clear escalation protocol: any irregularity flagged by nursing staff or direct care staff must be communicated to the pharmacist within 24 hours. The Staff Development Coordinator Registered Nurse (RN) or designee will educate the Consultant Pharmacist on the updated checklist and escalation protocol described above. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff nursing staff on how to pre-screen medication administration records and submit potential concerns. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee	

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F0756 SS = E	Continued from page 59 Resident #62 was admitted to the facility on 1/16/25 with diagnoses including major depressive disorder. The Minimum Data Set (MDS) quarterly assessment dated 4/11/25 revealed Resident #62 had moderately impaired cognition. He received anticonvulsant and antidepressant medications. A Psychiatrist's order dated 5/14/25 for Resident #62 revealed Depakote 250 milligrams (mg). Give one tablet by mouth twice a day for mood disorder. The Psychiatrist's note dated 5/29/25 for Resident #62 revealed to start a gradual dose reduction and discontinue Depakote for mood due to Resident #62 was currently receiving Keppra (an anticonvulsant) following recent hospitalization. The Psychiatrist's order dated 5/29/25 for Resident #62 revealed to start Depakote 125 milligram tablets. Give 1 tablet by mouth two times a day for recurrent major depressive disorder for 14 days then discontinue due to taking Keppra (discontinue 6/12/25). Review of the Medication Administration Record (MAR) dated 5/29/25 through 6/25/25 revealed Resident #62 was administered Depakote 125 milligram tablets twice a day. Resident #62 continued to receive the medication twice a day from 6/13/25 through the morning dose administered on 6/25/25. Review of Resident #62's electronic medical record revealed the order for Depakote 125 milligram tablets was entered by the Director of Nursing on 5/29/25 at 4:36 PM. There was no 14 day stop date entered on the order. The Consultant Pharmacist's medication regimen review note dated 6/18/25 documented that Resident #62 had medication changes. On 5/29/25 Depakote was decreased to 125 milligrams twice a day due to recently starting Keppra. There were no recommendations made regarding the Depakote order.	F0756	Continued from page 59 disciplinary action is taken for staff who fail to comply with the expectation of identifying and reporting any medication irregularities. Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will audit 5 random pharmacist reviews weekly and verify completion of the checklist and documentation of follow-up actions. Then after an initial 8-week period, the audit will shift to monthly audits for an additional 3 months to ensure sustained compliance. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0756 SS = E	Continued from page 60 An attempt was made on 6/26/25 at 1:50 PM to contact the Consultant Pharmacist, with no response. The Director of Nursing reported the Pharmacist was on leave and unavailable for interview. A phone interview was conducted on 6/25/25 at 2:00 PM with the Psychiatrist who ordered Depakote. She stated the Depakote order dated 5/29/25 for Resident #62 should have been discontinued after 14 days. She stated Resident #62 was prescribed Keppra during a recent hospitalization due to seizure activity so therefore the Depakote dose was to be decreased to 125 milligrams for a 14-day period and then discontinued. She stated she was in the facility today and evaluated Resident #62 and there had been no outcome from continuing to receive the additional doses or the increased dose of the medication. She stated that a 250-milligram dose was considered a low dose, and it was prescribed to Resident #62 for mood and behaviors. The potential outcome would be increased sedation, and no adverse symptoms had been reported to her. She stated she would send an order to discontinue the Depakote today. She indicated the facility should have identified the medication error and she would continue to monitor Resident #62. During an interview on 06/26/25 at 3:04 PM the Director of Nursing (DON) stated she entered the Depakote order on 5/29/25 and did not enter a 14 day stop date. Therefore, the order continued to remain active after the 14-day period. She stated the Consultant Pharmacist's monthly medication review was a part of their oversight to catch medication discrepancies. She stated the Consultant Pharmacist had completed her medication review for the facility for the month of June 2025 and there were no recommendations made regarding the Depakote order for Resident #62. She stated the medication error was missed by the staff and by the Consultant Pharmacist. During a phone interview on 06/26/25 at 3:15 PM the Physician stated the Depakote order for Resident #62 should have been entered correctly and then discontinued according to the Psychiatrist's order. He stated potential adverse symptoms would include increased sedation and there had been no reports of any adverse signs or symptoms reported to him. He indicated that the medication error should have been identified by the facility staff and the Consultant Pharmacist.	F0756		
F0760 SS = E	Residents are Free of Significant Med Errors	F0760	The facility failed to discontinue the anticonvulsant	08/15/2025

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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
F0760 SS = E	Continued from page 61 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 observations, record review, the Psychiatrist, Nurse Practitioner, the Physician, and the dispensing pharmacy Quality Assurance Representative interviews, the facility failed to discontinue the anticonvulsant medication Depakote prescribed to a resident (Resident #62) for mood disorder. This resulted in the resident receiving 25 additional tablets of Depakote and the wrong dose. There was no significant outcome. This occurred for 1 of 5 residents reviewed for medication administration. Findings included. Resident #62 was admitted to the facility on 1/16/25 with diagnoses including major depressive disorder. The Minimum Data Set (MDS) quarterly assessment dated 4/11/25 revealed Resident #62 had moderately impaired cognition. He received anticonvulsant and antidepressant medications. A Psychiatrist's order dated 5/14/25 for Resident #62 revealed Depakote 250 milligrams (mg). Give one tablet by mouth twice a day for mood disorder. The Psychiatrist's note dated 5/29/25 for Resident #62 revealed to start a gradual dose reduction and discontinue Depakote for mood due to Resident #62 was currently receiving Keppra (an anticonvulsant) following recent hospitalization. The Psychiatrist's order dated 5/29/25 for Resident #62 revealed to start Depakote 125 milligram tablets. Give 1 tablet by mouth two times a day for recurrent major depressive disorder for 14 days then discontinue due to taking Keppra. (discontinue 6/12/25)	F0760	Continued from page 61 medication Depakote prescribed to a resident (Resident #62) for mood disorder. This resulted in the resident receiving 25 additional tablets of Depakote and the wrong dose. There was no significant outcome. This occurred for 1 of 5 residents reviewed for medication administration. Resident #62 who received the incorrect medication dose was assessed by nursing staff and the physician was notified. No adverse effects were identified. The error was documented, and the responsible staff member was counseled, and a process was put in place to prevent reoccurrence for Resident #62 and all other residents who could be affected. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee will review any prescribed orders from the psychiatric provider for all current residents in the last 90 days to ensure the medication orders were transcribed correctly. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. Beginning 07/14/2025, to prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on how to appropriately transcribe medication orders from medical providers. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation of ensuring residents receive their proper medication. Beginning 07/14/2025, to prevent recurrence and to ensure compliance the Director of Nursing (DON) or designee will conduct weekly medication audits on 10% of residents for 8 weeks, then monthly for 3 months. If any irregularities are found during the audit the physician will be notified immediately, Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality	

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F0760 SS = E	Continued from page 62 During a medication pass observation on 6/25/25 at 10:00 AM Nurse #3 administered one Depakote 250 milligram oral tablet to Resident #62. During an observation on 6/25/25 at 10:00 AM Resident #62 was observed lying in bed with his eyes closed. He aroused when his name was called. He was able to respond with yes or no appropriately. Review of the Medication Administration Record (MAR) dated 5/29/25 through 6/25/25 revealed Resident #62 was administered Depakote 125 milligram tablets twice a day. Resident #62 continued to receive the medication twice a day from 6/13/25 through the morning dose administered on 6/25/25. Review of Resident #62's electronic medical record revealed the order for Depakote 125 milligram tablets was entered by the Director of Nursing on 5/29/25 at 4:36 PM. There was no 14 day stop date entered on the order. During an interview on 6/25/25 at 12:00 PM Nurse #3 stated Resident #62 was aphasic (difficulty with speech) due to a history of stroke, but he could communicate his needs to staff. She stated she was not aware the Depakote should have been discontinued. She stated she administered the 250-milligram tablet in error although the order on the MAR was to administer 125 milligrams. She stated she was routinely assigned to Resident #62, and she was uncertain how long the 250 milligram tablets had been available for use on the medication cart. She stated Resident #62 had not had any symptoms such as increased sedation from receiving the additional doses including the wrong dose of Depakote. A phone interview was conducted on 6/25/25 at 2:00 PM with the Psychiatrist who ordered Depakote. She stated the Depakote order dated 5/29/25 for Resident #62 should have been discontinued after 14 days. She stated Resident #62 was prescribed Keppra during a recent hospitalization due to seizure activity so therefore the Depakote dose was to be decreased to 125 milligrams for a 14-day period and then discontinued. She stated she was in the facility today and evaluated Resident #62 and he had no outcome from continuing to receive the additional doses or the increased dose of the medication. She stated a 250-milligram dose was	F0760	Continued from page 62 Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0760 SS = E	Continued from page 63 considered a low dose and there were no Depakote levels ordered during the time he received the medication because he was not Bipolar (a mental health condition causing severe mood swings) and she was not trying to reach a therapeutic range. It was prescribed to Resident #62 for mood and behaviors. She stated potential outcome would be increased sedation and no adverse symptoms had been reported to her. She stated she would send an order to discontinue the Depakote today and there would be no need to check his Depakote level at this time due to him being on a low dose. She stated she would continue to monitor Resident #62. A phone interview was conducted on 6/25/25 at 2:30 PM with the facility's dispensing Pharmacy Quality Assurance Representative. She stated the pharmacy dispensed 60 tablets of Depakote 250 milligrams on 5/14/25 and 28 tablets of Depakote 125 milligrams (14-day supply) on 5/29/25. She stated no other Depakote tablets had been dispensed since that time. During an interview on 6/25/25 at 3:00 PM Nurse #1 stated she routinely provided care to Resident #62. She stated she had administered Depakote to Resident #62 daily and had never split the tablet therefore he received the full 250 milligram dose that was currently on the medication cart. She was not certain of how long he had been receiving the 250 milligram tablets. During an interview on 6/26/25 at 9:20 AM the Nurse Practitioner stated she was in the facility daily Monday through Friday. She was not aware the Depakote order should have been discontinued for Resident #62. The Nurse Practitioner stated Resident #62 was followed by the Psychiatrist who wrote the order. During the last evaluation on 6/16/25, her note included that Resident #62 had no signs of sedation. She stated there had been no reports of Resident #62 having any adverse symptoms from receiving the additional doses or the wrong dose of Depakote. An attempt was made on 6/26/25 at 1:50 PM to contact the Consultant Pharmacist, with no response. The Director of Nursing reported the Pharmacist was on leave and unavailable for interview. During an interview on 06/26/25 at 3:04 PM the Director of Nursing (DON) stated she entered the Depakote order on 5/29/25 and did not enter a 14 day stop date.	F0760		

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F0760 SS = E	Continued from page 64 Therefore, the order continued to remain active after the 14-day period. She stated the 250 milligram tablets from the previous order on 5/14/25 should have been returned to the pharmacy when the new order was written on 5/29/25 for the lower dose. This would have prevented the 250-milligram dose being available for administration on the medication cart. She stated the order entry was done in error and education would be provided to all nursing staff. During a phone interview on 06/26/25 at 3:15 PM the Physician stated the Depakote order for Resident #62 should have been entered correctly and then discontinued according to the Psychiatrist's order. He stated potential adverse symptoms would include increased sedation. He stated there had been no reports of any adverse signs or symptoms reported to him.	F0760		
F0761 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 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 manufacturer instructions, observations and	F0761	The facility failed to record an opened date on a multi-dose oral inhaler that had a shortened expiration date on 1 of 3 medication carts (300 hall) and to discard expired medications on 2 of 2 wound treatment carts (100/200 hall, 400/500 hall) and in 1 of 2 medication storage rooms (400/500 hall) and maintain a locked wound treatment cart (100/200 hall) that were reviewed for medication storage. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) or designee reviewed all medication carts, medication storage rooms, and wound treatment carts to ensure all medications were labeled and dated appropriately. If any medications were found to not have an opened date they were immediately dated and labeled. This was completed on 07/14/2025. The Director of Nursing (DON) or designee reviewed all medication carts, medication storage rooms, and wound treatment carts to ensure all medications were not expired. If any medications were found to be expired they were immediately removed and properly discarded. This was completed on 07/14/2025. The Director of Nursing (DON) or designee reviewed the wound treatment carts to ensure they were locked. If the wound treatment carts were not locked they were immediately locked. This was completed on 07/14/2025. To prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff and pharmacy staff	08/15/2025

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F0761 SS = E	Continued from page 65 staff interviews the facility failed to record an opened date on a multi-dose oral inhaler that had a shortened expiration date on 1 of 3 medication carts (300 hall) and to discard expired medications on 2 of 2 wound treatment carts (100/200 hall, 400/500 hall) and in 1 of 2 medication storage rooms (400/500 hall) and maintain a locked wound treatment cart (100/200 hall) that were reviewed for medication storage. Findings included. a.) An observation of the 300-hall medication cart on 6/23/25 at 1:00 PM revealed the following medications: Trelegy Ellipta oral inhaler 200 micrograms with no opened date. The manufacturer's instructions listed on the label read to discard 6 weeks after opening. During an interview on 06/23/25 at 1:03 PM Nurse #2 stated all nurses were responsible for checking the medication carts for expired medications. She indicated that she had not administered the Trelegy Ellipta inhaler today and had not checked for an expiration date. She stated the inhaler should have been labeled with a date when it was opened. b.) An observation of the 100/200 hall wound treatment cart on 6/23/25 at 1:30 PM revealed the following: The wound treatment cart was observed on the 100 hallway and was noted with the lock out which indicated the cart was unlocked. There were no staff members observed using the cart. An observation of the wound treatment cart on the 100 hallway revealed the following: Biofreeze pain relief spray with an expiration date of March 2025. During an interview on 06/23/25 at 1:35 PM Nurse #6 stated the nurses were responsible for wound care and for checking the treatment cart for expired medications. Nurse #6 stated she had not used the wound treatment cart and was uncertain who left the cart unlocked. She stated she was not aware of the expired medication on the cart.	F0761	Continued from page 65 on the requirements for dating multi-dose products. All opened vials or inhalers are to be discarded within 28 days unless the manufacturer specifies otherwise. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. To prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff and pharmacy staff on the procedures for daily check and removal of expired items from all medication areas. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. To prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff and pharmacy staff on the proper labeling standards, including resident name, dose, strength, expiration date, and opened date of all medications. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. To prevent recurrence, the Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff and pharmacy staff on the importance of ensuring wound treatment carts remain locked when not in use. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, the Director of Nursing (DON) or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation that all medications be stored and labeled properly. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will audit 100 percent of medication carts, medications storage rooms, and wound treatment cards for dated multi-dose products, absence of expired items, and proper storage will audit psychotropic medications to ensure compliance as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks.	

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F0761 SS = E	Continued from page 66 During an interview on 6/23/25 at 1:40 PM Nurse #1 the 100/200 hall assigned nurse stated she had not used the wound treatment cart. Nurse #1 reported she was uncertain who left the cart unlocked. She stated all nurses were responsible for checking expiration dates and she had not checked the cart today (06/23/25). c.) An observation of the 400/500 hall wound treatment cart on 6/23/25 at 1:50 PM revealed the following: Minerin cream (used to treat skin irritations) with instructions on the label to discard after 6/17/23. During an interview on 06/23/25 at 1:35 PM Nurse #6 stated the nurses were responsible for wound care and for checking the treatment cart for expired medications. Nurse #6 stated she was not aware of the expired Minerin cream on the cart. d.) An observation of the 400/500 hall medication storage room on 6/23/25 at 2:00 PM revealed the following expired medications: Potassium Chloride 20 milliequivalents (used to treat low potassium levels) 1000 milliliter intravenous (IV) solution with an expiration date of May 2025. 2 vials of Gentamicin (antibiotic) 80 milligrams per 2 milliliters for injection with an expiration on each vial of May 2025. One Normal Saline Syringe (used for flushing IV catheters) 10 milliliters with an expiration date of September 2024. Lisinopril (an antihypertensive) 2.5 milligram oral tablets labeled to discard after 4/29/25. During an interview on 6/23/25 at 2:15 PM Nurse #1 stated the IV supplies currently being used for residents were located in the medication storage room. Nurse #1 was not aware of any expired medications. She stated all nurses were responsible for checking expiration dates in the medication storage rooms.	F0761	Continued from page 66 Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0761 SS = E	Continued from page 67 During an interview on 6/23/25 at 2:30 PM Nurse #6 stated all nurses were responsible for checking expiration dates as well as the Unit Manager who was responsible for restocking the medication storage room. Nurse #6 was not aware there were expired medications in the storage room. Nurse #6 stated there were currently no residents with orders for IV fluids. During an interview on 6/23/25 at 3:30 PM the Unit Manager stated she was also responsible for checking the medication storage rooms for expired medications. She stated she checked the medications rooms weekly. The Unit Manager was not aware of the expired medications and indicated it was an oversight. During an interview on 06/23/25 at 4:00 PM the Director of Nursing (DON) 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 nursing staff including the Unit Manager were responsible for checking the medication storage rooms for expired medications. The assigned nurse performed wound care and should check the cart daily for expired medications, or creams prior to doing wound treatments, and ensuring the wound treatment cart was locked when not in use.	F0761		
F0812 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.	F0812	The facility failed to remove expired food items stored for use in the reach-in refrigerator, the dry storage room, and the walk-in refrigerator. The facility failed to remove dented cans that were stored in stock rotation for use in the dry storage room. The facility failed to maintain cold food temperatures at 41-degree Fahrenheit or less. The alleged deficient practices had the potential to affect the food served to all residents residing in the facility. All dietary staff were instructed to implement proper food storage practices by 06/27/2025. The Dietary Manager or designee audited all food items in the reach-in refrigerator, the dry storage room, and the walk-in refrigerator to ensure the items were not expired. All food items found in improper storage were	08/15/2025

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F0812 SS = E	Continued from page 68 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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 record review, observations and staff interviews, the facility failed to remove expired food items stored for use in the reach-in refrigerator, the dry storage room and the walk-in refrigerator, failed to remove dented cans that were in stock rotation stored for use in the dry storage room, and failed to maintain cold food temperatures at 41 degree Fahrenheit or less. This deficient practice had the potential to affect the food served to residents residing in the facility. Findings included: 1. An observation in the kitchen on 06/22/25 at 10:00 AM with the Dietary Aide revealed the following items were in the reach-in refrigerator: - an opened carton of honey thick tea with no opened date. - two cartons of honey thick tea with an open date of 05/29/25. - two cartons of thickened tea with an opened date of 05/19/25 and 05/29/25. The manufacturer label for the honey thick tea indicated the products were good for 10 days after they were opened if stored in the refrigerator. The manufacturer label for the thickened tea indicated the products were good for 7 days after they were opened if stored in the refrigerator. An interview was conducted with the Dietary Aide on 06/22/25 at 10:00 AM. The Dietary Aide stated the	F0812	Continued from page 68 discarded immediately to prevent the risk of foodborne illness. This was completed by 06/27/2025. The Dietary Manager or designee audited all cans that were stored in stock rotation for use in the dry storage room. All cans found in improper storage were discarded immediately to prevent the risk of foodborne illness. This was completed by 06/27/2025. The Dietary Manager or designee audited the cold food temperatures that were in the kitchen to ensure the cold food temperatures were at 41-degree Fahrenheit or less. All food items found in improper temperatures were discarded immediately to prevent the risk of foodborne illness. This was completed by 06/27/2025. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all dietary staff on the importance of removing expired food items stored for use in the reach-in refrigerator, the dry storage room, and the walk-in refrigerator. This will be completed by 08/15/2025. After 08/15/2025 newly hired dietary staff will be educated by the Dietary Manager or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all dietary staff on the importance of removing dented cans that are stored in stock rotation for use in the dry storage room. This will be completed by 08/15/2025. After 08/15/2025 newly hired dietary staff will be educated by the Dietary Manager or Designee during their new hire employee orientation. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all dietary staff on the importance of maintaining cold food temperatures at 41-degree Fahrenheit or less. This will be completed by 08/15/2025. After 08/15/2025 newly hired dietary staff will be educated by the Dietary Manager or Designee during their new hire employee orientation. Beginning 07/14/2025, to prevent recurrence the Dietary Manager or designee will audit the reach-in refrigerator, the dry storage room, and the walk-in refrigerator weekly x 12 weeks to ensure there are no expired food items stored for use. If food items are found in improper storage they will be discarded immediately to prevent the risk of foodborne illness. The appropriate staff will be educated by the Dietary Manager or designee, and employee disciplinary action will be taken for staff who fail to comply with the food safety practices.	

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F0812 SS = E	Continued from page 69 opened carton of honey thick tea should have been dated and she did not realize the thickened teas were only good for 7 or 10 days after opening. She stated she had never seen the instruction on the carton. The Dietary Aide removed the honey thick products from the reach-in refrigerator. An interview with the Dietary Manager on 06/22/25 at 10:30 AM revealed she did not realize about the instruction on the box that the product was only good for 7 or 10 days after opening. She also stated that the process in the kitchen was that anytime a packaged item was opened, it should be dated. An interview was conducted with the Administrator on 06/26/25 at 4:00 PM. The Administrator indicated that she expected that all food items in the kitchen to be labelled and dated properly and that the kitchen staff should be reading all the food containers carefully for storage instructions. 2. An observation of the dry storage room was conducted with the Dietary Aide on 06/22/25 at 10:15 AM and then with the Dietary Manager at 10:30 AM. The following expired items were in the dry storage room: -8 boxes of creamy wheat 28 ounces. There was no expiration on the box and there was a handwritten label indicating the opened date was 01/02/24 and the use by date was 01/03/25. - 15 - 16 ounce boxes of rice with an expiration date of 02/26/24 - 6 - 12 ounce bottles of tartar sauce with an expiration date of 09/26/24 - 6 - 16 ounce cans vanilla pudding delivered on 10/19/23 with no expiration date An interview with the Dietary Manager on 06/22/25 at 11:07 AM revealed she would need to call the manufacturer to see what the expiration was for the creamy wheat boxes and the vanilla pudding. The Dietary Manager stated the other items were expired and should have been removed from the stock rotation. She stated	F0812	Continued from page 69 Beginning 07/14/2025, to prevent recurrence the Dietary Manager or designee will audit all cans that are stored in stock rotation for use in the dry storage room weekly x 12 weeks to ensure there are no dented cans stored for use. If cans are found in improper storage they will be discarded immediately to prevent the risk of foodborne illness. The appropriate staff will be educated by the Dietary Manager or designee, and employee disciplinary action will be taken for staff who fail to comply with the food safety practices. Beginning 07/14/2025, to prevent recurrence the Dietary Manager or designee will audit food storage temperatures daily. Food storage temperatures will be checked at the beginning and end of each shift and logged in the temperature logbook daily x 12 weeks. Any food items found in improper temperature will be discarded immediately to prevent the risk of foodborne illness. The appropriate staff will be educated by the Dietary Manager or designee, and employee disciplinary action will be taken for staff who fail to comply with food safety practices. Beginning 07/14/2025, to prevent recurrence the Dietitian or designee will conduct weekly audits x 12 weeks to ensure compliance with nutritional standards and food safety practices. Beginning 07/14/2025, to prevent recurrence the Licensed Nursing Home Administrator (LNHA) or designee will conduct a monthly audit of the kitchen for compliance with food safety practices x 3 months. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = E	Continued from page 70 she would have expected her dietary aides to ensure all the products on the shelf were within their expiration date and remove the items that were expired each week when the aides were putting the weekly truck delivery away. The Dietary Manager stated she had a lot of new staff and more education needed to be given A follow up interview with the Dietary Manager on 06/23/25 at 9:27 AM revealed she spoke with the manufacturer of the creamy wheat boxes and the vanilla pudding and the representative informed her that if the product did not have an expiration date, the product was good for one year. The Dietary Manager stated she would make sure to inquire about expiration dates upon delivery and label the products with the expiration date. An interview with the Administrator on 06/22/25 at 4:00 PM revealed she would have expected the Dietary Manager and the Dietary Aides to ensure all items that are in stock are within their expiration date and stored safely for use. She stated those expired items were over a year expired and should have been noticed. The Administrator stated more education needed to be given to the kitchen staff. 3. An observation of the dry storage room was conducted with the Dietary Manager on 0/22/25 at 10:30 AM and revealed the following: " 4 - significantly dented cans in rotation for use included 2 / 6lbs. (pounds)/10 ounce cans of fruit cocktail, 1 6 lbs./10 ounce can of pineapple chunks, and 1 6 lbs./10 ounce can of sausage gravy. The Dietary Manager stated she should have removed the dented cans from the stock rotation. The Dietary Manager removed all the dented cans out of stock rotation. The Dietary Manager stated she would set up an area for dented cans to be placed until she discarded them or returned them back to the manufacturer.	F0812		

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F0812 SS = E	Continued from page 71 An interview was conducted with the Administrator on 06/22/25 at 4:00 PM. The Administrator stated she would have expected a system to be in place to store all dented cans and to not have the dented cans in stock rotation. 4. An observation of the walk-in refrigerator was conducted with the Dietary Manager at 11:10 AM and revealed the following: " 1-12 pound box of bacon was noted to be opened and there was no opened date. An interview with the Dietary Manager on 06/22/25 at 11:10 AM revealed whichever dietary aide opened the box of bacon should have put an opened date. She stated she did not serve bacon today and removed the product from the shelf. The Dietary Manager stated she would conduct in services with all her dietary staff again regarding dating products when they are opened. The Dietary Manager stated she had a lot of new staff members which she had provided training to during orientation, but she needed to provide more training. 5. An observation of the tray line was conducted on 06/24/25 at 11:30 AM. The steam table and cold tables were prepared for the lunch meal. The Dietary Manager was asked if the food was ready to be served to the residents and she replied "yes." Temperatures were taken at this time with the Dietary Manager. The menu consisted of ham and cheese sandwiches, beets, potato salad, tossed salad, fruit cup and hot vegetable soup. The potato salad was prepared to be served in a small bowl with a covered lid and placed on a cold tray with ice. The potato salad temperature was taken by the Dietary Manager and noted to be recorded at 48 degrees Fahrenheit. The Dietary Manager checked the temperature of two more prepared potato salads from the same cold tray and the temperature both times was recorded at 47 degrees Fahrenheit. An interview with the Dietary Manager on 06/24/25 at	F0812		

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F0812 SS = E	Continued from page 72 11:30 AM stated the potato salad temperature should be 41 degrees or below. The Dietary Manager reported the dietary staff had prepared the potato salad this morning, put it on ice and left it in the walk in refrigerator until lunch. She stated the food delivery truck came just before lunch and the staff pulled the cold tray out to put away their delivery. The Dietary Manager stated the potato salad cold tray must have been left out too long, and added, she could not serve the potato salad. She removed the entire potato salad cold tray from the food line and three potato salad bowls that were on residents' trays to be served. An interview was conducted with the Administrator on 06/26/25 at 4:00 PM. The Administrator stated she expected food temperatures to be within the regulated guidelines at all times to prevent from any food born illnesses that could possibly occur.	F0812		
F0842 SS = E	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. (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,	F0842	The facility failed to maintain accurate medical records by 1.) not documenting the administration of narcotic pain medications (Hydrocodone-Acetaminophen 5-325 milligrams (mg) and oxycodone 10 mgs) on the residents Medication Administration Record (MAR). 2.) not accurately documenting notification of the resident's responsible party and the physician of a pressure wound. This occurred for 2 of 5 residents reviewed for medication administration, pressure wounds, and medical record review (Resident #40, Resident #64). For Resident #40 the MAR has been reviewed for the last 30 days, and no issues were identified. For Resident #64 the home health agency involved was contacted to provide the missing treatment order. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The Director of Nursing (DON), or designee will review all current residents receiving narcotic pain medications to ensure documentation is complete.. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. The Director of Nursing (DON) or designee perform a facility-wide skin inspection within one week to detect any undocumented pressure injuries. If any irregularities are found during the audit the physician	08/15/2025

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F0842 SS = E	Continued from page 73 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 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	F0842	Continued from page 73 will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 07/21/2025. The Director of Nursing (DON), or designee will review the last 30 days of all discharges to home health agencies to verify that discharge summaries and treatment orders were sent and acknowledged by the receiving agency if applicable. If it is found that a discharge summary or treatment order was not sent and acknowledged by the receiving agency then the DON or designee will reach out to the agency immediately. This will be completed by 08/15/2025. The Staff Development Coordinator Registered Nurse (RN) or designee will educate all licensed nursing staff on proper documentation procedures, including medication administration and communication protocols. This will be completed by 08/15/2025. After 08/15/2025 newly hired licensed nursing staff will be educated by the Staff Development Coordinator Registered Nurse (RN) or Designee during their new hire employee orientation. Beginning 07/14/2025, Director of Nursing (DON), or designee will ensure re-education and employee disciplinary action is taken for staff who fail to comply with the expectation to maintain accurate medical records. Beginning 07/14/2025, to prevent recurrence the Director of Nursing (DON) or designee will conduct daily MAR audits and progress note audits to ensure pain medications are administered as ordered. To ensure compliance the audit will be completed as follows: 12 charts weekly x 4 weeks, 6 charts weekly x 4 weeks, 3 charts weekly x 4 weeks. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

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F0842 SS = E	Continued from page 74 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: 2.) Resident #64 was admitted on 3/7/25. A nursing admission progress note completed by Nurse #2 on 3/7/25 at 3:43 PM indicated the resident had Stage 2 pressure wounds (partial thickness skin loss) to the bilateral buttocks. The admission progress note did not indicate that Resident #64's responsible party or physician was notified of the pressure wounds. An interview was conducted with Nurse #2 on 6/24/25 at 3:00 PM. Nurse #2 stated she did not notify Resident #64's responsible party or physician of resident's 2 Stage 2 pressure wounds to the bilateral buttocks. A pressure injury assessment dated 3/13/25 signed on 3/18/25 by Nurse #4 indicated Resident #64's responsible party and physician were notified of resident's unstageable deep tissue injury to the right buttock measuring 6.5 cm x 5.3 cm. A pressure injury assessment dated 3/27/25 completed by Nurse #4 indicated Resident #64's responsible party and physician were notified of resident's Stage 4 full thickness pressure wound to the right buttock. An interview was conducted with Nurse #4 on 6/25/25 at 3:49 PM. Nurse #4 stated she was assigned to accompany the Wound Care Physician on 3/13/25 and 3/27/25 and to document the pressure injury assessments for each resident that was evaluated. Nurse #4 stated that she did not notify Resident #64's responsible party, or the physician of the pressure wound to the right buttock since she assumed they already knew about it. Nurse #4 stated that she documented in error on the Wound Assessments dated 3/13/25 and 3/27/25 that she had notified Resident #64's responsible party and the physician. An interview with the Director of Nursing on 6/26/25 at 3:45 PM revealed that she expected that documentation in the medical record would be accurate and that included notification of the responsible party regarding pressure ulcers.	F0842		

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F0842 SS = E	Continued from page 75 Based on record review, and staff interviews the facility failed to maintain accurate medical records by 1.) not documenting the administration of narcotic pain medications (Hydrocodone-Acetaminophen 5-325 milligrams (mg) and oxycodone 10 mgs) on the residents Medication Administration Record (MAR). 2.) not accurately documenting notification of the resident's responsible party and the physician of a pressure wound. This occurred for 2 of 5 residents reviewed for medication administration, pressure wounds, and medical record review (Resident #40, Resident #64). Findings included. 1.) Resident #40 was admitted to the facility on 10/6/23 with diagnoses including chronic pain. A physician's order for Resident #40 dated 9/20/24 with an end date of 11/15/24 read Hydrocodone/Acetaminophen 5-325 milligrams three times a day as needed for pain. The Minimum Data Set (MDS) quarterly assessment dated 10/7/24 revealed Resident #40 was cognitively intact. He received scheduled and as needed opioid pain medications. Review of the controlled drug record declining count sheet dated October 2024 revealed Hydrocodone/Acetaminophen 5-325 milligrams was signed off on the declining count sheet on the following dates and times: 10/2/24 at 5:00 PM by Medication Aide #1 10/3/24 at 10:00 PM by Medication Aide #2 10/8/24 at 9:40 AM by Medication Aide #1 10/8/24 at 6:35 PM by Medication Aide #1 10/8/24 at 11:00 PM by Medication Aide #2	F0842		

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F0842 SS = E	Continued from page 76 10/11/24 at 10:30 AM by Medication Aide #1 10/12/24 at 10:00 AM by Medication Aide #1 10/12/24 at 6:40 PM by Medication Aide #1 10/13/24 at 9:30 AM by Medication Aide #1 10/13/24 at 6:00 PM by Medication Aide #1 10/14/24 at 10:00 AM by Medication Aide #1 10/14/24 at 7:15 PM by the Unit Manager 10/22/24 at 6:33 PM by Medication Aide #1 10/26/24 at 6:30 PM by Medication Aide #1 Review of Resident #40's Medication Administration Record (MAR) dated October 2024 revealed no documentation that Hydrocodone/Acetaminophen 5-325 milligrams was signed off as administered on the dates listed above from 10/2/24 through 10/26/24 that correlated with the controlled drug record declining count sheet. A physician's order for Resident #40 dated 4/22/25 read oxycodone 5 milligram tablets. Take one tablet by mouth every four hours as needed for pain. Take two tablets every four hours as needed for severe pain. Review of the controlled drug record declining count sheet dated May 2025 revealed oxycodone 5 milligrams was signed off on the declining count sheet on the following dates and times: 5/1/25 at 6:20 PM 1 tablet was signed out by Nurse #6 5/7/25 at 5:35 PM 2 tablets were signed out by Nurse #3	F0842		

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F0842 SS = E	Continued from page 77 5/13/25 at 6:45 PM 2 tablets were signed out by Nurse #3 5/21/25 at 2:51 PM 2 tablets were signed out by Nurse #6 5/28/25 at 4:30 PM 2 tablets were signed out by Nurse #3 Review of Resident #40's Medication Administration Record (MAR) dated May 2025 revealed no documentation that oxycodone 5 milligrams was signed off as administered on the dates listed above from 5/1/25 through 5/28/25 that correlated with the controlled drug record declining count sheet. Review of the controlled drug record declining count sheet dated June 2025 revealed oxycodone 5 milligrams was signed off on the declining count sheet on the following dates and times: 6/13/25 at 11:00 AM 2 tablets were signed out by Medication Aide #1. 6/23/25 at 4:30 PM 2 tablets were signed out by Medication Aide #1. Review of Resident #40's Medication Administration Record (MAR) dated June 2025 revealed no documentation that oxycodone 5 milligrams was signed off as administered on the dates listed above from 6/13/25 through 6/23/25 that correlated with the controlled drug record declining count sheet. During an interview on 06/24/25 at 1:57 PM Medication Aide #1 stated she did administer the Hydrocodone/Acetaminophen 5/325 mg tablets during the month of October 2024 and the oxycodone 5 mg tablets during the month of June 2025 to Resident #40 after signing the medications out on the controlled drug record declining count sheet. The Medication Aide stated she was only allowed to pull the medication from the locked medication storage box on the medication cart and sign the declining count sheet and administer the medication to the resident, but she was not	F0842		

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F0842 SS = E	Continued from page 78 supposed to sign the medications off on the Medication Administration Record (MAR). Medication Aide #1 reported that signing the MAR was the responsibility of the overseeing nurse on duty and she has had to remind the nurses to sign off the controlled medications for her on the MAR. Attempts were made to contact Medication Aide #2 on 6/24/25. She was no longer employed by the facility, and there was no response. During an interview on 06/25/25 at 3:58 PM Nurse #3 stated she administered the oxycodone 5 milligram tablets to Resident #40 after signing it out on the declining count sheet but just didn't remember to sign it off on the MAR. Nurse #3 stated the hall she was typically assigned to was a busy assignment and it was done in error. An attempt was made to contact Nurse #6 on 6/24/25 with no response. During an interview on 06/26/25 at 5:00 PM the Director of Nursing (DON) stated the Medication Aides were allowed to sign the controlled medications that they administer to residents on the Medication Administration Record, and they did not have to get the nurse to sign the MAR for them. She stated Medication Aide #1 was aware of this, but education would be provided. The DON stated the nurses get in a hurry at times and just forget to follow through and sign the controlled medications off on the MAR. The DON reported education would be provided and she expected that the controlled medications were accurately documented on the controlled count sheet and on the MAR.	F0842		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F0851	The facility failed to submit payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) for federal fiscal year Quarter 1 (October through December 2024) and Quarter 2 (January through March 2025). This was for 2 of 3 quarters reviewed. No specific resident harm was identified. However, due to inaccurate PBJ reporting, CMS could not validate staffing levels for the affected quarters. A corrected PBJ file will be uploaded to CMS by 08/15/2025. All residents residing in the facility have been identified as having the potential to be affected by	08/15/2025

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F0851 SS = F	Continued from page 79 §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.	F0851	Continued from page 79 the alleged deficient practice due to the inaccurate representation of staffing levels. A full audit of staffing coverage during the reporting periods was conducted to ensure that actual care delivery met resident needs. No missed shifts or gaps in direct care were identified. This was completed by 07/14/2025. It was identified by the Licensed Nursing Home Administrator (LNHA) that the previous Human Resource Coordinator was responsible for obtaining these files and sending them to the LNHA for submission. The LNHA had last reported what was given to her in November 2024. However, there had been multiple changes to the Human Resource Coordinator position since December 2024, and this reporting had not been completed. The LNHA was locked out of the system to submit the PBJ reports and was unable to log in to the PBJ system. The LNHA had reached out for assistance with her log-in, however, had not received a response to correct the system lockout. The LNHA is aware that PBJ reporting must be completed but due to lack of facility resources she had tried her best. The PBJ submission process now includes a 3-step review as follows: the initial data entry is completed by the Staffing Scheduler. The Human Resources Coordinator reviews and completes a reconciliation in which a report is sent to her from the payroll company for each payroll cycle. Lastly, final approval and upload of the PBJ file is submitted by the LNHA or designee. The LNHA has implemented systemic changes to prevent recurrence. The LNHA or designee will educate the new Human Resources Coordinator and Staffing Scheduler will be trained on PBJ requirements, including daily documentation, classification of staff by job code, and accurate reporting hours by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the LNHA or designee during their new hire employee orientation. Beginning 07/14/2025, to prevent recurrence the LNHA has implemented a PBJ tracking log which audits the payroll tasks including staffing data. The PBJ tracking log is to be verified weekly by the LNHA or designee to monitor hours worked and ensure accuracy. The audit will be completed weekly x 8 weeks then monthly x for 6 months to ensure PBJ requirements are met according to CMS regulations. Any discrepancies will be addressed immediately and reported during weekly facility at risk meetings and quarterly QAPI meetings.	

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F0851 SS = F	Continued from page 80 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) for federal fiscal year Quarter 1 (October through December 2024) and Quarter 2 (January through March 2025). This was for 2 of 3 quarters reviewed. Findings included: A review of the PBJ Staffing Data Report for Quarter 1 for the reporting period October 1, 2024, through December 31, 2024, revealed that the staffing data report identified an area of concern triggered for failed to submit data for the quarter. A review of the PBJ Staffing Data Report for Quarter 2 January 1, 2025, through March 31,2025 revealed that the staffing data report identified an area of concern triggered for failed to submit data for the quarter. An interview was conducted with the Administrator on 6/24/25 at 10:00 AM. The Administrator stated she was responsible for submitting the payroll-based data on the PBJ report to CMS. The Administrator stated the last time she submitted data was November 2024. The Administrator stated that after that, she was unable to log in to the PBJ system and did not know how to correct this. The Administrator indicated that she had reached out for assistance with her log-in but did not receive a response and she had not followed up on this. The Administrator stated she knew she was required to submit PBJ data and she had not done so.	F0851	Continued from page 80 Beginning 07/14/2025, to prevent recurrence the Human Resources Coordinator or designee will ensure that the quarterly PBJ submissions will be cross verified with payroll records prior to CMS upload. This audit will be completed monthly x 6 months. Any discrepancies will be addressed immediately and reported during weekly facility at risk meetings and quarterly QAPI meetings. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or designee, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	
F0867 SS = E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F0867	The facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program established and implemented effective systems to monitor and evaluate action plans previously developed to correct identified deficiencies. This failure resulted in the facility being unable to sustain compliance for F686, F761, and F842. During the recertification and complaint investigation survey of 07/02/2024 the facility failed to obtain and implement physician orders for treatment of pressure ulcers (F686), discard expired medications and record an opened date on medication (F761), and accurately document the administration of medications on the Medication Administration Record (MAR). During	08/15/2025

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F0867 SS = E	Continued from page 81 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety	F0867	Continued from page 81 the revisit survey of 08/21/2024 the facility again failed to record an opened date on medication (F761). On the current recertification and complaint investigation survey these identical deficient practices were repeated. The continued failure to sustain compliance during three surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The facility identified the lack of a fully developed and effectively implemented QAPI program due to the turnover of Medical Director's and Nurse Practitioner's in the facility since the surveys in 2024 and the current survey in 2025. The facility attributes this turnover to the clinical leadership in the facility being a deterrent as to why compliance in the identified areas has not been sustained. The facility has utilized the minimal resources they have had access to and did implement weekly at-risk meetings. An official QAPI meeting had not been held since November 2024 due to conflicting schedules and challenging communications with medical professionals. However, the QAPI committee has been immediately re-engaged, and the facility will hold an emergency meeting on 07/17/2025 during the facility's weekly at-risk meeting. All current adverse events, incidents, and trends (falls, pressure ulcers, infections, weight loss, etc.) will be reviewed and addressed. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented. To ensure compliance is sustained for F686, the Director of Nursing (DON) or designee will review admission documentation and Braden scores for all residents admitted in the last 30 days. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. To ensure compliance is sustained for F686, the Director of Nursing (DON) or designee will audit current residents with Braden scores of 12 or less to confirm wound assessments were completed on admission. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025.	

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F0867 SS = E	Continued from page 82 problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F0867	Continued from page 82 To ensure compliance is sustained for F686, the Director of Nursing (DON) or designee perform a facility-wide skin inspection within one week to detect any undocumented pressure injuries. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 07/21/2025. To ensure compliance is sustained for F761, the Director of Nursing (DON) or designee reviewed all medication carts, medication storage rooms, and wound treatment carts to ensure all medications were labeled and dated appropriately. If any medications were found to not have an opened date they were immediately dated and labeled. This was completed on 07/14/2025. To ensure compliance is sustained for F761, the Director of Nursing (DON) or designee reviewed all medication carts, medication storage rooms, and wound treatment carts to ensure all medications were not expired. If any medications were found to be expired, they were immediately removed and properly discarded. This was completed on 07/14/2025. To ensure compliance is sustained for F761, the Director of Nursing (DON) or designee reviewed the wound treatment carts to ensure they were locked. If the wound treatment carts were not locked, they were immediately locked. This was completed on 07/14/2025. To ensure compliance is sustained for F842, the Director of Nursing (DON), or designee will review all current residents receiving narcotic pain medications to ensure documentation is complete. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 08/15/2025. To ensure compliance is sustained for F842, the Director of Nursing (DON) or designee will perform a facility-wide skin inspection within one week to detect any undocumented pressure injuries. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented in the clinical record. This will be completed by 07/21/2025. To ensure compliance is sustained for F842, the Director of Nursing (DON) or designee will review the last 30 days of all discharges to home health agencies to verify that discharge summaries and treatment orders were sent and acknowledged by the receiving agency if	

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F0867 SS = E	Continued from page 83 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program established and implemented effective systems to monitor and evaluate action plans previously developed to correct identified deficiencies. This failure resulted in the facility being unable to sustain compliance at F686, F761, and F842. During the recertification and complaint investigation survey of 7/2/24 the facility failed to obtain and implement physician orders for treatment of pressure ulcers (F686), discard expired medications and record an opened date on medication (F761), and accurately document the administration of medications on the Medication Administration Record (MAR). During the revisit survey of 8/21/24 the facility again failed to record an opened date on medication (F761). On the current recertification and complaint investigation survey these identical deficient practices were repeated. The continued failure to sustain compliance during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: a. On the current recertification and complaint investigation survey the facility failed to obtain orders and to provide treatment on admission for a Stage 2 pressure ulcer wound that progressed to an unstageable wound. During the complaint investigation and recertification survey of 7/2/24, the facility failed to obtain and implement physician orders for treatment of a pressure ulcer. b. On the current recertification and complaint investigation survey the facility failed to record an opened date on a multi-dose inhaler and discard expired medications on the wound treatment carts and in the medication storage room. During the complaint and recertification survey of 7/2/24, the facility failed to record an opened date on a tube eye ointment and discard expired medications on medication carts. During the revisit survey of 8/21/24, the facility failed to record an opened date on medication.	F0867	Continued from page 83 applicable. If it is found that a discharge summary or treatment order was not sent and acknowledged by the receiving agency then the DON or designee will reach out to the agency immediately. This will be completed by 08/15/2025. As of 07/14/2025, systemic changes have taken place to prevent recurrence regarding F686, F761, and F842 to sustain compliance. The facility's QAPI Plan has been revised to ensure it meets federal requirements. This includes specific performance indicators for resident care, safety, and services. Clear documentation processes for identifying and analyzing problems. Action plans with measurable goals, responsible staff, and timelines. As of 07/14/2025, systemic changes have taken place to prevent recurrence and sustain compliance. The QAPI Committee has been restructured to include: The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Medical Director, Infection Preventionist, Consultant Pharmacist, and department heads. In the absence of the Medical Director the Nurse Practitioner will attend and communicate with the Medical Director. If the Medical Director or Nurse Practitioner cannot attend the QAPI meeting the minutes will be sent to the Medical Director via email and discussion will take place if needed. The LNHA oversees QAPI implementation and compliance. The DON leads clinical quality initiatives and performance improvement plans. Ad hoc meetings will take place as needed. The LNHA, or designee will re-educate the QAPI Committee described above on the importance of a fully developed and effectively implemented QAPI program so that compliance can be sustained. The education will include the purpose, scope, and responsibilities related to QAPI. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the LNHA or Designee during their new hire employee orientation. Beginning 07/14/2025, to prevent recurrence and sustain compliance for F686 the Director of Nursing (DON) or designee will audit 100% of admission records weekly for 3 weeks, 75 % for 3 weeks, 50% x 3 weeks, then 25% x3 weeks. Audit tool will track time from admission to skin assessment, presence of physician orders within 24 hours, and wound treatment initiation date. Beginning 07/14/2025, to prevent recurrence and sustain compliance for F761 the Director of Nursing (DON) or designee will audit 100% of medication carts,	

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F0867 SS = E	Continued from page 84 c. On the current recertification and complaint investigation survey the facility failed to maintain an accurate medical record in the area of documentation of medication. During the recertification and complaint survey of 7/2/24, the facility failed to accurately document medication administration. During an interview with the Administrator on 6/26/25 at 4:30 PM she indicated she was responsible for the QAPI program in the facility and that she was the Administrator at the facility during the previous recertification and complaint investigation survey of 7/2/24. She revealed that the facility had not conducted quarterly QAPI meetings for review of audits, systems and procedures. She explained when the Medical Director was not able to attend the QAPI meetings she cancelled the meetings. She further revealed that she had attempted to implement previous plans of correction, however, due to not following through with the QAPI process, the plans were not successful. The Administrator spoke about the repeat deficiencies related to pressure ulcers, medication labeling/storage, and complete/accurate medical records. She stated that the facility had undergone changes in the Director of Nursing (DON), Medical Director, and both administrative nursing positions and direct care nurse positions in the past year which contributed to the facility's inability to sustain compliance.	F0867	Continued from page 84 medications storage rooms, and wound treatment cards for dated multi-dose products, absence of expired items, and proper storage will audit psychotropic medications to ensure compliance as follows: 5 days a week x 4 weeks, 3 days a week x 4 weeks, 2 days a week x 4 weeks. Beginning 07/14/2025, to prevent recurrence and sustain compliance for F842 the Director of Nursing (DON) or designee will conduct daily MAR audits and progress note audits to ensure pain medications are administered as ordered. To ensure compliance the audit will be completed as follows: 12 charts weekly x 4 weeks, 6 charts weekly x 4 weeks, 3 charts weekly x 4 weeks. Beginning 07/14/2024, to prevent recurrence and sustain compliance the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	
F0868 SS = F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F0868	The facility Quality Assurance and Performance Improvement (QAPI) committee failed to meet at least quarterly to fulfill the responsibilities of the committee to identify and correct deficient practices in the facility effectively for 2 quarters and failed to have the Medical Director attend the meeting for 1 quarter. This deficient practice was observed for 3 of 3 quarters reviewed. All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice. The facility identified the lack of a fully developed and effectively implemented QAPI program due to the turnover of Medical Director's and Nurse Practitioner's in the facility since the surveys in 2024 and the current survey in 2025. Therefore, the QAPI committee failed to meet at least quarterly. The facility has utilized the minimal resources they have had access to and did implement weekly at-risk meetings. An official	08/15/2025

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F0868 SS = F	Continued from page 85 (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility Quality Assurance and Performance Improvement (QAPI) committee failed to meet at least quarterly to fulfill the responsibilities of the committee to identify and correct deficient practices in the facility effectively for 2 quarters and failed to have the Medical Director attend the meeting for 1 quarter. This deficient practice was observed for 3 of 3 quarters reviewed and had the potential to impact all facility residents. Findings included: A review of the facility Quality Assurance and Performance Improvement Program (QAPI) policy last revised January 2025 revealed that the following individuals serve on the committee: Administrator or designee Director of Nursing (DON)	F0868	Continued from page 85 QAPI meeting with the QAPI committee had not been held since November 2024 due to conflicting schedules and challenging communications with medical professionals. However, the QAPI committee has been immediately re-engaged, and the facility will hold an emergency meeting on 07/17/2025 during the facility's weekly at-risk meeting. All current adverse events, incidents, and trends (falls, pressure ulcers, infections, weight loss, etc.) will be reviewed and addressed. If any irregularities are found during the audit the physician will be notified immediately, and their clinical decisions will be documented. The Director of Nursing (DON) or designee will review all resident care areas potentially impacted by the lack of active QAPI oversight. Key risk areas to be reviewed include infection control, falls, medication errors, and care plan compliance. This will be completed by 07/17/2025 at the facility's weekly at-risk meeting. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The facility's QAPI Plan has been revised to ensure it meets federal requirements. This includes specific performance indicators for resident care, safety, and services. Clear documentation processes for identifying and analyzing problems. Action plans with measurable goals, responsible staff, and timelines. As of 07/14/2025, systemic changes have taken place to prevent recurrence. The QAPI Committee has been restructured to include: The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Medical Director, Infection Preventionist, Consultant Pharmacist, and department heads. In the absence of the Medical Director the Nurse Practitioner will attend and communicate with the Medical Director. If the Medical Director or Nurse Practitioner cannot attend the QAPI meeting the minutes will be sent to the Medical Director via email and discussion will take place if needed. The LNHA oversees QAPI implementation and compliance. The DON leads clinical quality initiatives and performance improvement plans. Ad hoc meetings will take place as needed. The LNHA, or designee will re-educate the QAPI Committee described above on the importance of a fully developed and effectively implemented QAPI program. The education will include the purpose, scope, and responsibilities related to QAPI. This will be completed by 08/15/2025. After 08/15/2025 newly hired staff will be educated by the LNHA or Designee during their new hire employee orientation.	

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F0868 SS = F	Continued from page 86 Medical Director Infection Preventionist Representatives of the following departments as requested by the Administrator: pharmacy, Social Services, Activity Services, Environmental Services, Human Resources and medical records. The policy stated that the committee meets at least quarterly. A review of the facility QAPI meeting minutes revealed the following: A review of the quarterly QAPI meeting minutes dated 11/12/24 at 10:30 AM revealed the following staff members were in attendance: Administrator, Rehabilitation Director, DON, Social Worker, Assistant Director of Nursing, Dietary Manager, Activities Services and Staff Development Coordinator. The Medical Director and Pharmacist were not listed in attendance. 1st Quarter 2025 the QAPI meeting did not take place. 2nd Quarter 2025 the QAPI meeting did not take place. An interview was conducted with the Nurse Practitioner (NP) on 6/25/25 at 10:30 AM. The NP indicated that she was not involved in the QAPI program and had not been invited to attend a QAPI meeting. The NP stated the Medical Director was not involved in the QAPI program. An interview with the Administrator on 6/26/25 at 4:30 PM revealed that the previous Medical Director that was in the position until the beginning of June 2025, worked remotely in another state and was unable to attend QAPI meetings on site. The Administrator stated that she did not extend an invitation to the Nurse Practitioner that worked on site daily to attend the QAPI meetings in the Medical Director's absence. The Administrator indicated she did not attempt to have the Medical Director attend the meetings virtually, instead	F0868	Continued from page 86 Beginning 07/14/2025, to prevent recurrence and to ensure compliance the LNHA and DON will audit QAPI effectiveness by reviewing QAPI minutes, action plans, and results quarterly x 12 months to ensure follow-through on identified areas and to ensure the QAPI committee meets at least quarterly. Beginning 07/14/2024, to prevent recurrence the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed quarterly in the Quality Assurance and Performance Improvement (QAPI) Meeting for 3 quarters. The QAPI Committee will review the audits and make recommendations as necessary to ensure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 08/15/2025 and the audits will continue for the specified timeframe as described in this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0868 SS = F	Continued from page 87 she cancelled the meetings, and the committee had not met since November. The Administrator indicated the facility held a weekly "at risk" meeting of the interdisciplinary team. The Administrator revealed that the facility had not met expectations regarding weights, falls and grievances. She stated she had attempted to implement plans of correction in these areas however due to not following through in these areas with the QAPI process, the plans were not successful. The Administrator indicated she was responsible for the QAPI program in the facility and moving forward, she will make sure the Medical Director or his designee is present at all the QAPI committee meetings. The facility provided a corrective action plan that was not acceptable to the State Agency due to no evidence that education or a monitoring system was implemented prior to the entrance of the survey team for the recertification survey on 6/22/25.	F0868		