STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345317	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD , CLAYTON, North Carolina, 27520

(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
F0000	INITIAL COMMENTS A complaint investigation was conducted from 6/30/25 through 7/3/25. The following intakes were investigated: NC00226390, NC00226576, NC00227231, NC00231733, NC00231986, and NC00232005. Event ID# R4V011 Three of the sixteen complaint allegations resulted in deficiency.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584	F584 Safe/Clean/Comfortable/Homelike Environment 1.Facility failed to have a system in place to ensure clean linens were available for bathing. Residents #7 & #8 suffered no ill effects related to this deficient practice. 2. All residents have the potential to be affected by this deficient practice; no other residents were identified as being negatively impacted after an audit initiated at 100% on all residents within the facility completed on July 14th, 2025, through interviews with residents BIMS 12 and up and RP interviews for BIMS less than 12). 3. All facility staff were educated on the requirements of F584; specifically, the facility staff on the importance of the availability of linen to be provided for ADL care. This education was completed on 07/17/2025. This in-service will be part of the orientation process for all newly hired staff and agency staff. The facility is completing daily linen availability audit by the Housekeeping Manager/designee. 4. The Housekeeping Manager or designee will monitor daily all linen in the facility to ensure there is sufficient linen to care for the residents on the floor.	07/21/2025

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

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

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F0584 SS = D	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with resident and staff, the facility failed to have a system in place to ensure clean linens were available for two (Resident 7 and Resident #8) of eight sampled residents who were interviewed and which resulted in Resident # 8 having no linens to bathe before leaving for an outside appointment. The findings included: Record review revealed Resident # 8 was admitted on 4/9/25 and her admission Minimum Data Set assessment, dated 4/15/25, coded Resident # 8 as cognitively intact. Record review revealed Resident # 7 was admitted on 4/7/25 and her admission Minimum Data Set assessment, dated 4/13/25, coded Resident # 7 as cognitively intact. During an interview on 6/30/25 at 12:22 PM with Resident #7, who was Resident # 8's roommate, Resident # 7 reported a problem with having enough linens at times. One of the problems had been that morning and her roommate (Resident # 8) had to leave for an appointment before washcloths were available for bathing. During an interview with Resident # 8 on 6/30/25 at 3:10 PM, Resident # 8 reported the following information. The facility did not have a washcloth or towel that morning for her to bathe before she left for	F0584	Continued from page 1 A linen availability audit tool was implemented and will be completed daily. This audit is given to the Administrator. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator for review monthly x 3 months or until substantial compliance is achieved then quarterly. Date of compliance: 7/21/25	

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F0584 SS = D	Continued from page 2 a morning appointment. It was a common problem that the facility would run out of linens. That morning she had used a wet incontinent wipe to wash her face and her private area before her appointment because that was all there was. Nurse Aide (NA) # 1 was interviewed on 6/30/25 at 3:40 PM and reported the following information. She had been assigned to care for Resident # 8 that day (6/30/25). She (NA # 1) had not had washcloths and towels from approximately 7:30 AM to 9:30 AM that morning (6/30/25). NA # 1 confirmed that there was no washcloth and towel for Resident # 8 before the resident needed to bathe and go to an appointment. She had assisted Resident # 8 with a wet wipe because there was no other choice given the resident needed to leave and could not wait on linens to be ready. Having enough linens was a problem about once every week, and she (NA # 1) did not know what happened to the linens. During a follow up interview with NA # 1 on 7/2/25 at 12:10 PM, NA # 1 reported she had also checked in the laundry department on 6/30/25 when she was in need of washcloths and towels and they had none to give her. NA # 2 was interviewed on 6/30/25 at 2:55 PM and reported the following information. She did not have washcloths or towels that morning (6/30/25) for about an hour when she came on duty at 7:00 AM. Having enough linens had delayed her being able to start bathing residents. Having enough linens was a problem about three times per week. During a follow up interview with NA # 2 on 7/2/25 at 12:00 PM, NA # 2 reported she had also checked in the laundry department on the morning of 6/30/25 for towels and washcloths and they had none to give her when she checked. NA # 3 was interviewed on 6/30/25 at 3:05 PM and reported the following information. It took a couple hours to have sufficient linens that morning (6/30/25). She had towels but she had only four washcloths that were passed along to her from the previous shift. During a follow up interview with NA # 3 on 7/2/25 at 12:00 PM, NA # 3 reported she had checked with laundry in the laundry department and there were no washcloths	F0584		

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F0584 SS = D	Continued from page 3 there either when she was in need of washcloths on 6/30/25. The Housekeeping Director (HD), who oversees the laundry department, was interviewed on 7/1/25 at 3:30 PM regarding the process of supplying linens for resident use. The HD reported the following information. He (the HD) staffs two employees in laundry each day. One employee starts at 7:00 AM and the second employee works from 2:00 PM to 7:00 PM. Prior to the second employee leaving at 7:00 PM, the second employee washes the linens and leaves them wet in the washing machines. There is no employee in the laundry department after 7:00 PM and therefore they cannot put the linens in the dryer and leave the dryers running without someone to attend to them. When the 7:00 AM laundry employee comes in the next morning, their first task is to remove the wet linens and dry them. The Nurse Aides bring their linen carts back to the laundry department around 8:30 AM for linens to be stocked on the carts. The laundry employees do not take the linen to the Nurse Aides. There should be enough linens left over from the day before on the linen carts to last until 8:30 AM when linens are dried again and able to be restocked. At times, he knew that some employees and residents hoarded linens in their rooms, and he periodically went through and removed the hoarded linens so there would be enough linens in rotation. This had been the process for years. The HD reported Resident # 8 should have had linens to take a bath on 6/30/25 before leaving for her appointment on 6/30/25. The Administrator was interviewed on 7/3/25 at 5:00 PM and reported the following information. She had just become employed in recent months and she had not been aware that the Nurse Aides had to go get their linens after they arrived at 7:00 AM or that the laundry employees were starting to work at the same time the dayshift Nurse Aides needed linens which still needed to be dried. The problems with this process had not been brought to her attention in order to resolve the issue.	F0584		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under	F0755	F755 Pharmacy 1-Residents # 2, #5, and #9 suffered no ill effects related to this deficient practice. Resident #2 verified that resident did not go without medication, as she was able to get a refill as needed. For Residents #5 and #9 the On-call Physician was notified that the medication had not been received from Pharmacy on 6/24/25. Orders received to hold medication until received and delivered from the pharmacy. The	07/21/2025

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F0755 SS = E	Continued from page 4 an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with resident, staff, Physician, Nurse Practitioner, and Pharmacist, the facility failed to provide services to ensure the accurate acquiring, dispensing, and administration of medications for three (Residents # 2, # 5, and #9) of five sampled residents whose medications were reviewed. For Residents # 5 and # 9 the facility failed to acquire and administer medications to newly admitted residents. For Resident # 2 the facility failed to ensure an effective system was in place for the accounting of a medication the resident supplied from home in order that unused medication be returned to the resident and that she not receive another resident's medication at discharge. The findings included: 1. Resident # 5 was admitted to the facility on 6/23/25. Review of hospital records revealed that prior to Resident # 5's facility admission she had been	F0755	Continued from page 4 Facility identified a lapse in communication between the pharmacy and the nursing staff. 2-All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted after an audit initiated at 100% on all residents within the facility completed on July 14th, 2025 by the Director of Nursing. 3-All licensed staff were educated on the requirements of F755; specifically, the nursing staff on the importance of the availability of medications and given as ordered, reconciling medication per policy if a readmission from a hospital or discharging to a home setting with current MD ordered medications, and clarifying orders from discharging facility. A process for checking in medications that must be brought from home. This education was completed by the DON/designee on 7/17/2025. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff. The facility is completing daily medication availability audit. The pharmacy has now added a third delivery to our facility to ensure that we are receiving medications in a timely manner. The pharmacy is completing a daily audit of their manifest to reconcile when the medications ordered, when the ordered was received at pharmacy and when the medications were delivered to the facility. A copy of the manifest is being sent to the Administrator of the facility daily as applicable, to ensure the reconciliation is completed and that there are no discrepancies. 4-The DON or designee will monitor daily all new orders for medication to ensure the medications have arrived in the facility and given as ordered. A medication availability audit tool was implemented and will be completed daily. This includes any medications which must be brought from home and checked in per our facility process. This audit is given to the Administrator. The pharmacy is completing a daily audit of their manifest to reconcile the medications ordered have been delivered. A copy of this manifest is being sent to the Administrator of the facility to ensure the reconciliation is being completed and that there are no discrepancies. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator for review monthly x 3 months or until substantial compliance is achieved then quarterly. Date of compliance: 7/21/25	

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F0755 SS = E	Continued from page 5 hospitalized from 6/10/25 to 6/19/25 and discharged home. On 6/20/25 Resident # 5 returned to the hospital ED (emergency department) where she stayed until her admission to the facility on 6/23/25. Resident # 5's diagnoses included the following. Chronic atrial fibrillation, diabetes, hypertension, osteoarthritis, systemic lupus erythematosus, essential tremor, chronic obstructive pulmonary disease, congestive heart failure, lymphedema, chronic kidney disease, intractable pain, neuropathy, hyperlipidemia, chronic sinusitis and hypothyroidism. A review of hospital ED records revealed Resident # 5 had last received the pravastatin on 6/22/25 at 9:10 PM and she was due for her 6/23/25 dose. Review of Resident # 5's admission nursing note revealed Resident # 5's admission time was documented to be 3:45 PM on 6/23/25. Review of Resident # 5's admission orders and Resident # 5's June 2025 MAR (Medication Administration Record) revealed the following information: - Pravastatin sodium 80 mg (milligrams) daily was ordered on 6/23/25 for hyperlipidemia. This pravastatin medication was scheduled on the facility MAR to be given at 9:00 PM on 6/23/25. According to the MAR Nurse # 1 documented a "9" rather than a check mark indicating the pravastatin sodium medication was not administered on 6/23/25 at 9:00 PM. - Apixaban 5 mg was ordered every twelve hours. (Apixaban is an anticoagulant used to treat atrial fibrillation.) This apixaban medication was initially scheduled on the MAR to start on 6/23/25 at 9 PM. According to the MAR Nurse # 1 documented a "9" rather	F0755		

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F0755 SS = E	Continued from page 6 than a check mark indicating the apixaban medication was not administered on 6/23/25 at 9:00 PM. - Duloxetine delayed release sprinkle 30 mg was ordered twice per day. (Duloxetine is used to treat depression.) This Duloxetine medication was scheduled on the MAR to initially be administered on 6/23/25 at 9:00 PM. According to the MAR Nurse # 1 documented a "9" rather than a check mark indicating the duloxetine medication was not administered on 6/23/25 at 9:00 PM. - Lantus Insulin 100 units/milliliters inject 21 units at morning and bedtime was ordered for diabetes. (Lantus Insulin is a long-acting insulin.) The evening dose of Lantus Insulin was scheduled on the MAR for 9 PM on 6/23/25. According to the MAR Nurse #1 documented a "9" rather than a check mark indicating the Lantus Insulin was not administered on 6/23/25 at 9:00 PM. Resident #5's blood sugar the next morning on 6/24/25 at 6:00 AM registered 241. (Resident # 5's blood sugar range throughout the remainer of June 2025 was documented as 106 to 331 when receiving her Lantus Insulin.) - Pregabalin 200 mg was ordered to be administered twice per day for neuropathy. The first dose of pregabalin was scheduled to initially be given on 6/23/25 at 9:00 PM. According to the MAR Nurse # 1 documented a "9" rather than a checkmark indicating the pregabalin was not administered on 6/23/25 at 9:00 PM. - Topiramate 25 mg was ordered to be given two times per day. (Topiramate is a medication used to treat	F0755		

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F0755 SS = E	Continued from page 7 migraine pain.) The first dose of topiramate was scheduled to initially be given on 6/23/25 at 9:00 PM. According to the MAR Nurse # 1 documented a "9" rather than a checkmark indicating the topiramate was not administered on 6/23/25 at 9:00 PM. - Ropinirole .25 mg three times per day was ordered. (Ropinirole is used to treat restless leg syndrome.) The first dose of ropinirole was scheduled to initially be given on 6/23/25 at 5:00 PM. According to the MAR Nurse # 1 documented a "9" rather than a checkmark indicating the ropinirole was not administered on 6/23/25 at 5:00 PM. On 6/24/25 at 12:03 AM Nurse # 1 documented Resident # 5 was a new admission, and she (Nurse # 1) was waiting on the pharmacy to deliver Resident # 5's medications. Nurse # 1 was interviewed on 7/1/25 at 4:10 PM and reported the following information. The date of 6/23/25 was her second day working at the facility. There was a back up emergency supply of medications located at the facility, but she did not have access to the system in order to sign out any medications. There had to be a regular staff nurse, who had emergency medication access, to help sign out the medications. She did not think that there was a nurse, who had emergency medication access, working on the evening of 6/23/25. She had stayed late that night (after midnight) thinking the medications would come from the pharmacy and she could administer them, but they never came. She had not administered any of Resident # 5's 6/23/25 medications because she could not access them. Although Resident # 5 did not have her pregabalin, the resident reported that she had something for pain before she left the hospital and was not in need of pain medication. Nurse # 7 was interviewed on 7/2/25 at 7:05 AM and reported the following information. She had cared for Resident # 5 on the shift which began at 11:00 PM on	F0755		

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F0755 SS = E	Continued from page 8 6/23/25 and ended at 7:00 AM on 6/24/25. When she (Nurse # 7) arrived at work on 6/23/25, she thought Resident # 5's orders were still cued in the electronic system and not activated. Resident # 5's medications did not arrive from the pharmacy at any time that night. The Unit Manager was interviewed on 7/3/25 at 1:25 PM and reported the following information. When new admissions were scheduled to arrive, their orders were placed in the computer system and "cued" for a time period. Then when a newly admitted resident arrives and the physician approves the orders and medications, the orders are activated in the computer system. At that point (when the orders are activated) the pharmacy should be able to automatically view the medication orders, fill, and dispense the medications to the facility. Resident # 5 was interviewed on 6/30/25 at 10:49 PM and reported the following information. When she first arrived at the facility, the facility staff did not have her medications to give her. One of the medications they did not have to give her was for her neuropathy. Her hands and feet were affected by neuropathy. One minute they would feel ice -cold and then they would be hot and burning. It took several days to get medication for her neuropathy. Continued review of Resident # 5's facility June 2025 MAR and MAR administration notes regarding the Pregabalin (ordered for neuropathy) revealed multiple missed doses following her admission date. The dates and times were as follows: 6/24/25 dose at 9:00 AM was blank 6/24/25 dose at 9:00 PM-- Nurse # 2 documented "9" indicating pregabalin was not administered. 6/25/25 dose at 9:00 AM-- Nurse # 3 documented "9" indicating pregabalin was not administered. 6/25/25 dose at 9:00 PM-- Nurse # 4 documented "9" indicating pregabalin was not administered.	F0755		

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F0755 SS = E	Continued from page 9 6/26/25 dose at 9:00 AM-- Nurse # 5 documented "9" indicating pregabalin was not administered. (Nurse # 5 documented an administration note at 9:25 AM on 9/26/25 noting the pregabalin was not available.) 6/26/25 dose at 9:00 PM-- Nurse # 4 documented "9" indicating pregabalin was not administered. (Nurse # 4 documented an administration note indicating he was awaiting the delivery from the pharmacy of the pregabalin.) 6/27/25 dose at 9:00 AM-Nurse # 6 documented the pregabalin was ordered from the pharmacy and not administered. An attempt was made on 7/2/25 at 3:46 PM to interview Nurse # 8, who had cared for Resident # 5 during part of the 7:00 AM to 3:00 PM shift on 6/24/25. The nurse could not be reached for interview. Nurse # 2, who had cared for Resident # 5 on the 6/24/25 shift from 3:00 PM to 11:00 PM, was interviewed on 7/1/25 at 5:05 PM and reported the following information. In order to get pregabalin from the pharmacy or from the facility's back up supply a prescription was needed from the physician because it was a controlled substance. On the evening shift of 6/24/25 she (Nurse # 2) had not administered Resident # 5's pregabalin. She had called the pharmacy. The pharmacy would not give her access to remove it from the emergency back up supply, which was located in the facility, because the pharmacy needed the prescription to give her authorization to remove it from the facility back up supply. There had been no prescription sent with the resident when she was admitted on 6/23/25 and therefore she could not access the medication in order to administer it. She had informed the Director of Nursing. Nurse # 3, who had cared for Resident # 5 on the 6/25/25 shift from 7:00 AM to 3:00 PM, was interviewed on 7/2/25 at 3:40 PM and reported the following information. She did not recall the specific details of 6/25/25 but stated if the medication was not available, she would have called the pharmacy. Nurse # 4, who had cared for Resident # 5 on the 3:00 PM to 11:00 PM shifts on the dates of 6/25/25 and	F0755		

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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
F0755 SS = E	Continued from page 10 6/26/25, was interviewed on 7/1/25 at 5:15 PM and reported the following information. He did not recall Resident # 5 complaining of pain on his shifts, but she asked about the pregabalin. He thought he had called one of the two days that he had worked with Resident # 5. As he recalled, the pharmacy said they would send it. He (Nurse # 4) was new and did not have access to the emergency supply of medications. Nurse # 6, who had cared for Resident # 5 on 6/27/25 from 7:00 AM to 3:00 PM, was not available for interview. On 6/27/25 a new order and prescription was obtained from the facility NP (Nurse Practitioner) for Resident # 5's pregabalin. The new order was for pregabalin 150 mg two times per day. The first pregabalin prescription was also written on this date by the NP. A review of Resident # 5's controlled drug records and Resident # 5's MAR revealed the first dose of pregabalin was administered on 6/27/25 at 9:00 PM following her admission date of 6/23/25. This indicated Resident # 5 had missed eight doses of pregabalin since her admission. Resident # 5's Physician and NP were interviewed together on 7/2/25 at 2:05 PM. The Physician reported the following information. Resident # 5 had been directly admitted from the ED and her discharge paperwork to the facility was not well organized. He saw Resident # 5 on 6/25/25 and Resident # 5 mentioned she at times had some pain. He had ordered her some Tramadol as needed. At the time he saw Resident # 5, she was not hurting. The NP reported she had written the first prescription for the pregabalin. She was in the facility daily during the weekdays and did not recall the staff mentioning they needed a pregabalin prescription before that time. The NP further reported if staff members call either her or the physician, then they (the NP or physician) can send the pharmacy the prescription electronically. A facility pharmacist was interviewed on 7/3/25 at 11:47 PM. During this time, the pharmacist reviewed the pharmacy records for dispensing of Resident # 5's medications and reported the following information. The pharmacy received Resident # 5's orders on 6/23/25 at 8:35 PM. The pharmacy had a cut off time of 7:30 PM	F0755		

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F0755 SS = E	Continued from page 11 every day because of less staff after that time. If new medication orders were received after 7:30 PM, then medications were sent the next day. Resident # 5's medications were sent and received by the facility the day following her admission (6/24/25 at 3:17 PM). If the facility needed her medications sooner than 6/24/25 then they should have called the pharmacy. Regarding the pregabalin, the pharmacist reported the following information. He did not see the admission order for 200 mg twice per day in their system. If the pharmacy had seen an order for the pregabalin on 6/23/25, then they would have called the facility and asked them to send the prescription. There was no prescription received by the pharmacy for pregabalin until 6/27/25. This would have been needed in order to have the medication sent by the pharmacy or doses removed from the emergency supply. On 7/2/25 12:15 PM Occupational Therapy Assistant # 1 was interviewed and on 7/2/25 at 12:35 PM Occupational Therapy Assistant # 2 was interviewed. Both of these Occupational Therapy Assistants reported they had worked with Resident # 5 during her first few days at the facility and she did not complain of pain that interfered with therapy. The facility Rehabilitation Director was interviewed on 7/2/25 at 12:25 PM and reported Resident # 5 had progressed in therapy since admission and neuropathy pain had not interfered with her progress. The Director of Nursing (DON) was interviewed on 7/1/25 at 4:40 PM and reported that medications are usually delivered to the facility between 10:00 PM and 2:00 AM daily. If a new admission arrives and evening medications are needed, then the nurses should call and order a stat delivery. They also maintain some medications in a back up supply. The DON was accompanied to view the facility's non-refrigerated back up supply of medications and review which nurses had access. It was observed that Nurse # 1, who had admitted Resident # 5, did not have electronic access to the non-refrigerated back up medications. It was observed that Insulin was stored in the refrigerator and signed out differently than the non-refrigerated medications which required electronic access. A slip of paper could be completed, and a new multi-dose of Lantus Insulin could be removed after the paper slip was completed.	F0755		

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F0755 SS = E	Continued from page 12 2. Resident # 9 was initially admitted to the facility on 5/5/25. According to facility records, Resident # 9 was transferred to the hospital on 5/14/25 for alteration in mental status and was hospitalized with a urinary tract infection. Resident # 9's facility record showed a readmission date of 6/10/25. Resident #9's diagnoses included hypertension. During an interview with the facility's Admission Director and facility Social Worker, the following information was reported. After Resident # 9's 5/14/25 hospitalization she was discharged from the hospital to another rehabilitation facility (Facility # 2) for a short stay. On the date of 6/10/25 she was readmitted to their facility (Facility # 1) and her admission orders would have come from the rehabilitation facility where she last resided (Facility # 2) rather than the hospital. She was readmitted late on 6/10/25. The Admission Director reported she left at 6:30 PM on 6/10/25 and Resident #9 still had not arrived from the other rehabilitation facility (Facility # 2). Facility # 2 sent orders on 6/10/25 with the resident and paperwork about her stay at Facility # 2. Resident # 9 did arrive sometime late on the evening of 6/10/25. During the next few days, Resident # 9's family member passed away soon following her readmission date of 6/10/25 and Resident # 9 was in and out of the facility on 6/11/25 and 6/12/25. She was in the facility on 6/13/25 with family present with her. According to Resident # 9's Medication Administration Record, Nurse # 3 signed as administering some medications to Resident # 9 on the evening of 6/10/25 when she was readmitted to the facility after being discharged from Facility # 2. Nurse # 3 initialed by orders which had originally been placed in the computer for Resident # 9 during her first residency at the facility and were still showing in the computer system as active from the order date of 5/5/25. Interview with Nurse # 3 on 7/3/25 at 4:15 PM revealed she did not recall getting new orders from Facility # 2 on the evening of 6/10/25 and had not realized Resident # 9 was a readmission with new transfer orders. She had not reconciled orders or ordered any medications that the resident might be in need of when she was readmitted.	F0755		

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F0755 SS = E	Continued from page 13 Review of the discharge orders from the rehabilitation facility who transferred Resident # 9 on 6/10/25 (Facility # 2) revealed an order for Benazepril 20 mg (milligrams) one time per day for blood pressure-Hold for systolic blood pressure less than 110 and diastolic blood pressure less than 55. Review of facility orders revealed this blood pressure medication (Benazepril) had been ordered while the resident had previously resided at the facility from 5/5/25 to 5/14/25 and still appeared on the June MAR for a 9 AM administration time on 6/11/25. The same dosage was reordered at the facility on 6/12/25. On 6/13/25 Medication Aide (MA) # 1 documented a "9" by the Benazepril indicating it was not administered. A review of Resident # 9's June MAR revealed other 9:00 AM medications were documented as administered on this date and time which indicated the resident was present in the facility and not absent at that time due to a family death. Interview with MA # 1 on 7/3/25 at 1:50 PM revealed she did not recall the details of Resident # 9's medications on 6/13/25. The Unit Manager made an entry on 6/13/25 at 12:32 PM noting that the pharmacy had provided an update on missing medications for Resident #9. One of the missing medications was Resident # 9's Benazepril. The Unit Manager documented the pharmacy reported it would be delivered that night. The first dose of Benazepril that was documented to be administered following Resident # 9's readmission date of 6/10/25 was on the date of 6/14/25. Also, a review of Resident #9's paperwork sent by the transferring rehabilitation facility (Facility # 2) on 6/10/25 revealed lab results showing a urine culture was collected on 6/5/25 at Facility # 2. The lab report showed a result of greater than 100,000 colonies of pseudomonas aeruginosa and greater than 100,000 colonies of enterococcus faecalis. Orders from the discharging facility (Facility # 2) included an order for an antibiotic. This was for Linezolid 600 mg every 12 hours for five days. Facility # 2's paperwork showed the Linezolid had begun at their facility on 6/9/25 and	F0755		

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F0755 SS = E	Continued from page 14 the course of treatment was not completed prior to her transfer from Facility # 2. According to facility orders (Facility # 1), an order was written on 6/11/25 at 9:00 PM for Resident # 5 to have Linezolid twice per day for five days. According to Resident # 9's June MAR, the Linezolid was scheduled to be administered at 8:00 AM and 8:00 PM. On 6/12/25 at 8:00 AM Nurse # 3 documented a "9" by the 8:00 AM MAR dose indicating it was not administered. Interview with Nurse # 3 on 7/3/25 at 1:35 PM revealed she did not recall the specific details of Resident # 9's medication administration. On 6/12/25 at 8:00 PM MA # 1 documented a "9" by the 8:00 PM MAR dose indicating it was not administered. MA # 1 documented a note on 6/12/25 at 8:44 PM noting the Linezolid was on order. Interview with MA # 1 on 7/3/25 at 1:50 PM revealed she did not recall the details of Resident #9's medication administration. MA # 1 reported it was her practice to report to a unit manager if a medication was missing. On 6/13/25 at 8:00 AM MA # 1 documented a "9" by the 8:00 AM MAR dose indicating it was not administered. MA # 1 documented a note on 6/13/25 at 12:18 PM noting the Linezolid was on order. On 6/13/25 at 12:29 PM the Unit Manager documented the pharmacy had provided an update about Resident # 9's missing Linezolid. Interview with the Unit Manager on 6/13/25 7/3/25 at 1:25 PM revealed the pharmacy had reported the Linezolid had been back ordered. A facility pharmacist was interviewed on 7/3/25 at 11:47 PM and reported the following information. Resident # 9's Linezolid order was received by them on 6/11/25 at 11:20 PM. It was not dispensed to the facility until 6/13/25 at 11:36 PM. Prior to that the pharmacy had called the facility twice because there	F0755		

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F0755 SS = E	Continued from page 15 was a possible interaction between the Linezolid and another one of Resident # 9's medications. They had to talk to a staff member prior to dispensing the medication. This had delayed the release of the antibiotic so that it could be administered. According to Resident # 9's June MAR (Medication Administration Record) Resident # 9 received her first dose of Linezolid on 6/13/25 for the 9:00 PM scheduled dose, which indicated she had missed three scheduled doses. The DON (Director of Nursing) was interviewed on 7/3/25 at 4:45 PM and reported the following information. When Resident #9 arrived her orders from 5/5/25 were still in the computer system. The nursing staff should have reconciled the orders from Facility # 2 with the orders that had been in the computer from Resident #9's 5/5/25 facility residency. The nurse should have then gotten readmission orders approved and needed medications ordered. She (the DON) had recognized this and did the reconciliation on 6/12/25. On 6/11/25 the NP reviewed Resident # 9's orders for antibiotics and ordered the continuation of the antibiotic Linezolid and the resident should have had it delivered from the pharmacy and administered starting on 6/12/25. Interview with Resident # 9's NP on 7/2/25 at 2:05 PM revealed Resident # 9 had no negative outcome from the delay in getting the antibiotic as ordered. The NP reported Resident # 9 had already received a number of doses prior to transferring from Facility # 2 to Facility # 1. Review of blood pressure readings revealed no negative outcome related to missed blood pressure medication. On 7/3/25 at 5:00 PM the Administrator was interviewed regarding the acquiring of medications from their pharmacy for administration by the nurses and reported the following information. She was aware that at times medications did not always come in on time, but no one had brought to her attention that it was a daily problem or the extent of any problem the nurses were having with acquiring medications. 3. Resident # 2 resided at the facility from 1/17/25 to 1/28/25. Resident # 2's diagnoses included a diagnosis of diabetes.	F0755		

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F0755 SS = E	Continued from page 16 On 1/17/25 Resident # 2 was ordered to receive Ozempic 2 mg (milligrams)/1.5 ml (milliliters) give 1 mg SQ (subcutaneous) every 7 days. (This medication is used for diabetes.) According to the January 2025 MAR, there were no doses of Ozempic administered while Resident # 2 resided at the facility. On 1/17/25 the order for Ozempic was discontinued and an order for Bydureon 2 mg/0.85 ml give 2 mg SQ every Monday was ordered. Interview with a facility Pharmacist on 7/3/25 at 11:47 AM revealed Bydureon is a medication automatically exchanged for an order for Ozempic. The exchange had been preapproved for all residents unless the pharmacy received different information for an individualized resident. There had been no information that Resident # 2 was to supply her own medication. Resident # 2's admission Minimum Data Set assessment, dated 1/23/25, included the assessment that Resident # 2 was cognitively intact. Resident # 2 was interviewed by phone on 6/30/25 at 12:45 PM and reported she had a problem with a medication while she resided at the facility. Resident # 2 reported the following information. She knew that Ozempic was an expensive medication, but she had obtained it at a lower cost for a monthly supply while at home. She had asked if the facility could use her Ozempic medication from home rather than ordering from the pharmacy when she was admitted and was told this was permissible. She was told to have the medication checked in when someone brought it to her. A friend brought a month's supply to the facility and it was given to Medication Aide # 2. She (Resident # 2) did not stay very long at the facility and she never received a dose of the Ozempic. When she was discharged from the facility she had asked for the Ozempic to be returned to her. At some point someone told her they could not find it. Then right before she left someone handed her friend, who had come to pick her up, a box of medication and reported to her that the medication was hers. She (Resident # 2) thought the facility staff had found her month's supply of Ozempic. When she arrived home, she realized that she had been handed someone else's box of medication. She had called the facility and reported the problem to a manager. She wanted to return the other resident's medication, and	F0755		

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F0755 SS = E	Continued from page 17 she wanted her Ozempic back. A facility staff member called and stated they would look into it and her Ozempic might have been thrown away. She continued to wait for follow- up and no one else called. She still had the other resident's medication at her home, and she wanted to return it. She also wanted her medication returned to her. During the interview, Resident # 2 was able to provide the surveyor with the name of the other resident (Resident # 13), whose medication she had, the name of the medication, and the prescription number. Resident # 2 stated the medication she had been given by error was for Resident # 13's headaches. A review of a patient profile report printed on 7/1/25 for Resident # 13 revealed it included the prescription numbers for Resident # 13's medications. The prescription number that was provided by Resident # 2 to the surveyor as the number on the medication she had erroneously been discharged home with was observed to coincide to Resident # 13's injectable headache medication on the report of Resident # 13's medications. This corroborated that Resident # 2 was discharged with someone else's medication. MA # 2 was interviewed on 7/2/25 at 4:07 PM and reported the following. She did recall Resident # 2's friend bringing a supply box of Ozempic from home to the facility when Resident # 2 resided at the facility. There was an agency nurse covering for her (MA # 2's) tasks that she was not licensed to do that day. She (MA # 2) did not recall which agency nurse was there. She (MA # 2) placed Resident # 2's home supply of Ozempic in the medication refrigerator and informed the agency nurse that the resident had her home Ozempic brought in for use. She was not licensed to administer Ozempic and she did not know what had happened to the box of medication. It was one Ozempic pen with multiple doses in the pen and there were multiple needles for the pen in the box. The DON (Director of Nursing) was interviewed on 7/3/25 at 10:20 AM and reported the following information. She had not been the DON when Resident # 2 resided at the facility and the nurse who had discharged Resident # 2 no longer worked at the facility. It was the facility's procedure that if a resident preferred to use some of their home medications, then in the computer system there was a place where the nurse could choose by the order for the medication that it was supplied by the family rather than the pharmacy. When the medication is brought in, there should be documentation in the record	F0755		

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F0755 SS = E	Continued from page 18 regarding what medication was brought into the facility from the family. At time of discharge, any remaining doses of a medication, which were supplied by the resident/ family should be accounted for and returned to a resident.	F0755		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Nurse Practitioner, and Pharmacist the facility failed to prevent significant medication errors for two (Residents # 5 and #9) of five sampled residents whose medications were reviewed. For Resident # 5 the facility failed to ensure her Insulin, anticoagulant, and neuropathy medications were administered on the evening of her admission. Following the missed neuropathy medication on Resident # 5's admission date, the facility failed to administer the neuropathy medication on seven more occasions during consecutive days for Resident # 5. The facility failed to obtain and administer an antibiotic to Resident # 9. The findings included: 1. Resident # 5 was admitted to the facility on 6/23/25. Resident # 5's diagnoses in part included chronic atrial fibrillation, diabetes, and neuropathy. Review of Resident # 5's admission nursing note revealed Resident # 5's admission time was documented to be 3:45 PM on 6/23/25. Review of Resident # 5's admission orders and Resident # 5's June 2025 MAR (Medication Administration Record) revealed the following information: - Apixaban 5 mg was ordered every twelve hours. (Apixaban is an anticoagulant used to treat atrial fibrillation.) This apixaban medication was initially scheduled on the	F0760	F760 Significant Medication Errors The facility failed to prevent significant medication errors for Residents #5 & #9. Both residents did not suffer any ill effects related to this deficient practice. All residents have the potential to be affected by this deficient practice. Nurse management/ designee audited all residents that have new medication orders on 7/11/2025, to ensure they were followed by physician orders and any concerns were reported to the physician and corrected immediately. Any issues were documented on medication error form with physician notification. All licensed nurses/ CMAs were in serviced by the Director of Nursing/ designee on following physician orders for new medications, new admission medications, and any concerns should be reported to the physician. This education was completed on 7/17/2025. Any newly hired licensed nurse/ CMA will be in serviced on following physician orders for new medications and any concerns reported to the physician during orientation by the Director of Nursing/ designee. Any agency licensed nurses or CMAs will receive education on following physician orders for new medications with any concerns reported to the physician prior to their first shift worked by the Director of nursing/ designee. A medication administration pass will be completed three times per week, twelve weeks to ensure physician orders for new medications are being followed and any concerns are reported to the physician by the Nurse Managers/ designee. An audit of new medications on the MARs will also be checked by the Director of Nursing/ designee to ensure licensed nurses/ CMAs are following physician orders for new medications and any concerns reported to the physician weekly times twelve. Any concerns will be documented on medication error forms with physician notification by the Director of Nursing/ designee. The results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee by the Administrator/ designee monthly times three.	07/21/2025

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F0760 SS = E	Continued from page 19 MAR to start on 6/23/25 at 9 PM. According to the MAR Nurse # 1 documented a "9" rather than a check mark indicating the apixaban medication was not administered on 6/23/25 at 9:00 PM. - Lantus Insulin 100 units/milliliters inject 21 units at morning and bedtime was ordered for diabetes. (Lantus Insulin is a long-acting insulin.) The evening dose of Lantus Insulin was scheduled on the MAR for 9 PM on 6/23/25. According to the MAR Nurse #1 documented a "9" rather than a check mark indicating the Lantus Insulin was not administered on 6/23/25 at 9:00 PM. Resident #5's blood sugar the next morning on 6/24/25 at 6:00 AM registered 241. (Resident # 5's blood sugar range throughout the remainer of June 2025 was documented as106 to 331 when receiving her Lantus Insulin.) - Pregabalin 200 mg was ordered to be administered twice per day for neuropathy. The first dose of pregabalin was scheduled to initially be given on 6/23/25 at 9:00 PM. According to the MAR Nurse # 1 documented a "9" rather than a checkmark indicating the pregabalin was not administered on 6/23/25 at 9:00 PM. On 6/24/25 at 12:03 AM Nurse # 1 documented Resident # 5 was a new admission, and she (Nurse # 1) was waiting on the pharmacy to deliver Resident # 5's medications. Nurse # 1 was interviewed on 7/1/25 at 4:10 PM and reported the following information. She confirmed she had not administered Resident # 5's Lantus Insulin, Apixaban, or pregabalin on the evening of 6/23/25 as ordered. She did not have access to the facility's back-up supply of medications. She had stayed late that night (after midnight) thinking the medications would	F0760	Continued from page 19 Date of compliance: July 21st, 2025.	

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F0760 SS = E	Continued from page 20 come from the pharmacy and she could administer them, but they never came. Although Resident # 5 did not have her pregabalin, the resident reported that she had something for pain before she left the hospital and was not in need of pain medication. Resident # 5 was interviewed on 6/30/25 at 10:49 PM and reported the following information. When she first arrived at the facility, the facility staff did not have her medications to give her. One of the medications they did not have to give her was for her neuropathy. Her hands and feet were affected by neuropathy. One minute they would feel ice -cold and then they would be hot and burning. It took several days to get medication for her neuropathy. Continued review of Resident # 5's facility June 2025 MAR and MAR administration notes regarding the Pregabalin (ordered for neuropathy) revealed multiple missed doses following her admission date. The dates and times were as follows: 6/24/25 dose at 9:00 AM was blank 6/24/25 dose at 9:00 PM-- Nurse # 2 documented "9" indicating pregabalin was not administered. 6/25/25 dose at 9:00 AM-- Nurse # 3 documented "9" indicating pregabalin was not administered. 6/25/25 dose at 9:00 PM-- Nurse # 4 documented "9" indicating pregabalin was not administered. 6/26/25 dose at 9:00 AM-- Nurse # 5 documented "9" indicating pregabalin was not administered. (Nurse # 5 documented an administration note at 9:25 AM on 9/26/25 noting the pregabalin was not available.) 6/26/25 dose at 9:00 PM-- Nurse # 4 documented "9" indicating pregabalin was not administered. (Nurse # 4 documented an administration note indicating he was awaiting the delivery from the pharmacy of the pregabalin.) 6/27/25 dose at 9:00 AM-Nurse # 6 documented the	F0760		

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F0760 SS = E	Continued from page 21 pregabalin was ordered from the pharmacy and not administered. An attempt was made on 7/2/25 at 3:46 PM to interview Nurse # 8, who had cared for Resident # 5 during part of the 7:00 AM to 3:00 PM shift on 6/24/25. The nurse could not be reached for interview. Nurse # 2, who had cared for Resident # 5 on the 6/24/25 shift from 3:00 PM to 11:00 PM, was interviewed on 7/1/25 at 5:05 PM and reported the following information. In order to get pregabalin from the pharmacy or from the facility's back up supply a prescription was needed from the physician because it was a controlled substance. On the evening shift of 6/24/25 she (Nurse # 2) had not administered Resident # 5's pregabalin. She had called the pharmacy. The pharmacy would not give her access to remove it from the emergency back up supply, which was located in the facility, because the pharmacy needed the prescription to give her authorization to remove it from the facility back up supply. There had been no prescription sent with the resident when she was admitted on 6/23/25 and therefore she could not access the medication in order to administer it. She had informed the Director of Nursing. Nurse # 3, who had cared for Resident # 5 on the 6/25/25 shift from 7:00 AM to 3:00 PM, was interviewed on 7/2/25 at 3:40 PM and reported the following information. She did not recall the specific details of 6/25/25 but stated if the medication was not available, she would have called the pharmacy. Nurse # 4, who had cared for Resident # 5 on the 3:00 PM to 11:00 PM shifts on the dates of 6/25/25 and 6/26/25, was interviewed on 7/1/25 at 5:15 PM and reported the following information. He did not recall Resident # 5 complaining of pain on his shifts, but she asked about the pregabalin. He thought he had called one of the two days that he had worked with Resident # 5. As he recalled, the pharmacy said they would send it. He (Nurse # 4) was new and did not have access to the emergency supply of medications. Nurse # 6, who had cared for Resident # 5 on 6/27/25 from 7:00 AM to 3:00 PM, was not available for interview.	F0760		

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F0760 SS = E	Continued from page 22 On 6/27/25 a new order and prescription was obtained from the facility NP (Nurse Practitioner) for Resident # 5's pregabalin. The new order was for pregabalin 150 mg two times per day. The first pregabalin prescription was also written on this date by the NP. A review of Resident # 5's controlled drug records and Resident # 5's MAR revealed the first dose of pregabalin was administered on 6/27/25 at 9:00 PM following her admission date of 6/23/25. This indicated Resident # 5 had missed a total of eight doses of pregabalin since her admission. Resident # 5's physician and NP were interviewed together on 7/2/25 at 2:05 PM. The physician reported the following information. Resident # 5 had been directly admitted from the ED and her discharge paperwork to the facility was not well organized. He saw Resident # 5 on 6/25/25 and Resident # 5 mentioned she at times had some pain. He had ordered her some Tramadol as needed. At the time he saw Resident # 5, she was not hurting. The NP reported she had written the first prescription for the pregabalin. She was in the facility daily during the weekdays and did not recall the staff mentioning they needed a pregabalin prescription before that time. The NP further reported If staff members call either her or the physician, then they (the NP or physician) can send the pharmacy the prescription electronically. A facility pharmacist was interviewed on 7/3/25 at 11:47 PM. During this time, the pharmacist reviewed the pharmacy records for dispensing of Resident # 5's medications and reported the following information. The pharmacy received Resident # 5's orders on 6/23/25 at 8:35 PM. The pharmacy had a cut off time of 7:30 PM every day because of less staff after that time. If new medication orders were received after 7:30 PM, then medications were sent the next day. Resident # 5's medications were sent and received by the facility the day following her admission (6/24/25 at 3:17 PM). If the facility needed her medications sooner than 6/24/25 then they should have called the pharmacy. Regarding the pregabalin, the pharmacist reported the following information. He did not see the admission order for 200 mg twice per day in their system. If the pharmacy had seen an order for the pregabalin on 6/23/25, then they would have called the facility and asked them to send the prescription. There was no prescription received by the pharmacy for pregabalin until 6/27/25. This would	F0760		

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F0760 SS = E	Continued from page 23 have been needed in order to have the medication sent by the pharmacy or doses removed from the emergency supply. On 7/2/25 12:15 PM Occupational Therapy Assistant # 1 was interviewed and on 7/2/25 at 12:35 PM Occupational Therapy Assistant # 2 was interviewed. Both of these Occupational Therapy Assistants reported they had worked with Resident # 5 during her first few days at the facility and she did not complain of pain that interfered with therapy. The facility Rehabilitation Director was interviewed on 7/2/25 at 12:25 PM and reported Resident # 5 had progressed in therapy since admission and neuropathy pain had not interfered with her progress. The Director of Nursing (DON) was interviewed on 7/1/25 at 4:40 PM and reported that medications are usually delivered to the facility between 10:00 PM and 2:00 AM daily. If a new admission arrives and evening medications are needed, then the nurses should call and order a stat delivery. The facility also maintained some medications in a back-up supply. 2. Resident # 9 was initially admitted to the facility on 5/5/25. According to facility records, Resident # 9 was transferred to the hospital on 5/14/25 for altered mental status and was hospitalized with a urinary tract infection. Resident # 9's facility record showed a readmission date of 6/10/25. During an interview with the facility's Admission Director and facility Social Worker, the following information was reported. After Resident # 9's 5/14/25 hospitalization she was discharged from the hospital to another rehabilitation facility (Facility # 2) for a short stay. On the date of 6/10/25 she was readmitted to their facility (Facility # 1) and her admission orders would have come from the rehabilitation facility where she last resided (Facility # 2) rather than the hospital. She was readmitted late on 6/10/25. The Admission's Director reported she left at 6:30 PM on 6/10/25 and Resident #9 still had not arrived from the other rehabilitation facility (Facility # 2). Facility # 2 sent orders on 6/10/25 with the resident and paperwork about her stay at Facility # 2. Resident # 9 did arrive sometime late on the evening of 6/10/25. During the next few days, Resident # 9's family member	F0760		

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F0760 SS = E	Continued from page 24 passed away. She was in and out of the facility on 6/11/25 and 6/12/25. She was in the facility with family on 6/13/25. A review of Resident #9's paperwork sent by the transferring rehabilitation facility (Facility # 2) on 6/10/25 revealed lab results showing a urine culture was collected on 6/5/25 at Facility # 2. The lab report showed a result of greater than 100,000 colonies of pseudomonas aeruginosa and greater than 100,000 colonies of enterococcus faecalis. Orders from the discharging facility (Facility # 2) included an order for an antibiotic. This was for Linezolid 600 mg every 12 hours for five days. Facility # 2's paperwork showed the Linezolid had begun on 6/9/25 and the course of treatment was not completed prior to her transfer from Facility # 2. According to Resident # 9's Medication Administration Record, Nurse # 3 signed as administering some medications to Resident # 9 on the evening of 6/10/25 when she was readmitted to the facility after being discharged from Facility # 2. Nurse # 3 initialed by orders which had originally been placed in the computer for Resident # 9 during her first residency at the facility and were still showing in the computer system as active from the order date of 5/5/25. Interview with Nurse # 3 on 7/3/25 at 4:15 PM revealed she did not recall getting new orders from Facility # 2 on the evening of 6/10/25 and had not realized Resident # 9 was a readmission with new transfer orders. She had not reconciled orders or seen new admission paperwork noting Resident # 9 needed an antibiotic. The DON (Director of Nursing) was interviewed on 7/3/25 at 4:45 PM and reported the following information. On 6/11/25 the NP reviewed Resident # 9's orders for antibiotics being administered at Facility # 2 and ordered the continuation of the antibiotic Linezolid. At that point the Linezolid became a valid order for Facility # 1. Nurse # 3 may not have realized Resident # 9 was a readmission with new orders for antibiotics because her orders from 5/5/25 had not been removed from the computer and therefore during medication pass, orders were showing up for administration on 6/10/25 based on her previous residency. According to facility orders (Facility # 1), an order	F0760		

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F0760 SS = E	Continued from page 25 was written on 6/11/25 at 9:00 PM for Resident # 5 to have Linezolid twice per day for five days. According to Resident # 9's June MAR, the Linezolid was scheduled to be administered at 8:00 AM and 8:00 PM starting on 6/12/25. On 6/12/25 at 8:00 AM Nurse # 3 documented a "9" by the 8:00 AM MAR dose indicating it was not administered. Interview with Nurse # 3 on 7/3/25 at 1:35 PM revealed she did not recall the specific details of Resident # 9's medication administration. On 6/12/25 at 8:00 PM MA # 1 documented a "9" by the 8:00 PM MAR dose indicating it was not administered. MA # 1 documented a note on 6/12/25 at 8:44 PM noting the Linezolid was on order. Interview with MA # 1 on 7/3/25 at 1:50 PM revealed she did not recall the details of Resident #9's medication administration. MA # 1 reported it was her practice to report to a unit manager if a medication was missing. On 6/13/25 at 8:00 AM MA # 1 documented a "9" by the 8:00 AM MAR dose indicating it was not administered. MA # 1 documented a note on 6/13/25 at 12:18 PM noting the Linezolid was on order. On 6/13/25 at 12:29 PM the Unit Manager documented the pharmacy had provided an update about Resident # 9's missing Linezolid. Interview with the Unit Manager on 6/13/25 7/3/25 at 1:25 PM revealed the pharmacy had reported the Linezolid had been back ordered. According to Resident # 9's June MAR (Medication Administration Record) Resident # 9 received her first dose of Linezolid on 6/13/25 for the night time dose scheduled at 9:00 PM, which indicated she had missed three scheduled doses on the MAR since it had been ordered at Facility # 1 on the night of 6/11/25. A facility pharmacist was interviewed on 7/3/25 at 11:47 PM and reported the following information.	F0760		

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F0760 SS = E	Continued from page 26 Resident # 9's Linezolid order was received by them on 6/11/25 at 11:20 PM. It was not dispensed to the facility until 6/13/25 at 11:36 PM. Prior to that the pharmacy had called the facility twice because there was a possible interaction between the Linezolid and another one of Resident # 9's medications. They had to talk to a staff member prior to dispensing the medication. This had delayed the release of the antibiotic so that it could be administered as ordered to the resident. Interview with Resident # 9's NP on 7/2/25 at 2:05 PM revealed Resident # 9 had no negative outcome from the delay in getting the antibiotic as ordered. The NP reported Resident # 9 had already received a number of doses prior to transferring from Facility # 2 to Facility # 1.	F0760		
F0925 SS = D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with resident, staff, and the facility's pest control company technician, the facility failed 1) to make sure holes to the exterior were repaired and sealed to prevent pests from entering in her room and 2) ensure multiple doors in common areas in the facility had weather stripping to seal gaps for one (Resident # 12) of one sampled resident who reported unresolved and repetitive pests issues in her room. The findings included: Resident # 12 was admitted to the facility on 9/18/24. A review of Resident # 12's quarterly Minimum Data Set assessment, dated 5/27/25, revealed Resident # 12 was cognitively intact. Resident # 12 was interviewed on 7/2/25 at 4:15 PM and reported the following information. Her room had been treated for roaches repetitively since she had arrived and the treatment did not make any difference. She continued to see roaches crawling on her walls and ceilings. They had just treated her room again that day. During the time of the interview, the following	F0925	F925 Maintains Effective Pest Control Program 1. The facility failed to make sure holes in the exterior of her room were repaired and sealed to prevent pests from entering her room and facility failed to ensure multiple doors in common areas in the facility had weather stripping to seal gaps. Resident #12 suffered no ill effects related to this deficient practice. Facility staff immediately cleaned the room, and sealed exterior holes noted on 7/2/25. This was completed by the Maintenance director. Maintenance director weather stripped all common area doors on 7/2/25. Facility has been diligently involving Ecolab to control pest issues since the beginning of April 2025. 2. All residents have the potential to be affected by this deficient practice. Each room and the outside of the facility was treated by Ecolab/Maintenance Director on or by 7/18/2025 weather permitting for deterrent of ants. If any pest issue was identified in a room the resident was moved out of the room for 3 days per the recommendation of Ecolab. All common area doors were weather stripped by 7/3/25 by the Maintenance Director. All rooms were assessed for exterior holes, and if found they were caulked to seal. 3. All facility staff were serviced on identification of pests, how, and who to report to, pest control, and proper follow-through by the Assistant Director of Nursing/ designee by 07/17/25 Any newly hired staff member will receive education on identification of pests, how and who to report to, pest control, and proper follow-through during orientation by the Assistant Director of Nursing/ designee.	07/21/2025

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F0925 SS = D	Continued from page 27 observations were made. Resident # 12's heating and air unit was a single unit built into the exterior wall below her window. Underneath the heating and air unit, there was a gap where the surveyor could visibly see the light from outside of the facility. There was missing caulk below the heating and air unit to seal the exterior from the interior. Resident # 12's bathroom also had a hole in the dry wall. The hole was around the water pipe which provided water to flush the toilet. The metal seal was pulled away leaving an open hole which had no caulk around it. On 7/2/25 at 5:10 PM a corporate consultant was accompanied to Resident # 12's room and also viewed where the exterior light could be seen from underneath the heating and air unit in Resident # 12's room and the hole in Resident # 12's bathroom. A review of the facility's maintenance pest log since 5/9/25 revealed Resident # 12's room was listed the following times with the following pests found. 5/9/25 ants 5/15/25 ants 5/19/25 ants 5/27/25 roaches and ants 5/29/25 roaches 6/9/25 roaches in Resident # 12's bathroom 6/24/25 ants 7/1/25 roaches and ants Review of the facility's contracting pest control company's logs revealed Resident # 12's room was serviced for pest control on the following service dates in 2025:	F0925	Continued from page 27 4. A weekly audit of the outside of the facility and each interior room to identify any issues with pests will be conducted 5 x week, X 12weeks by the Administrator/ Maintenance Director/ designee. Ecolab will provide deterrent treatment as needed and monthly times three. Room changes will be completed as needed after any identification of a pest concern. The Maintenance director or designee will audit the common area doors weekly x 12 weeks to ensure the weather stripping remains intact and will be corrected immediately if an issue noted. The outcome of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee three times monthly by the Administrator/ designee. 5. Date of compliance: July 21st, 2025	

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F0925 SS = D	Continued from page 28 1/7/25 1/24/25 2/4/25 4/4/25 6/9/25 6/27/25 Nurse Aide (NA) # 2 was interviewed on 7/3/25 at 9:50 AM and reported she had observed live roaches in the door jam of Resident # 12's bathroom "pretty much all the time" when she worked with Resident # 12. She would report the problem to the Maintenance Director or write it in his maintenance log. Nurse Aide (NA) # 1 was interviewed on 7/3/25 at 10:35 AM and reported she also saw both live and dead roaches in Resident #12's room. When interviewed how often this occurred, NA # 1 replied "a lot." NA # 1 reported Resident # 12 and another one of her neighbors would snack a lot in their rooms. The Maintenance Director was interviewed on 7/3/25 at 11:40 AM with a corporate consultant present. The Maintenance Director reported the following. The Administrator had pointed out to him (the Maintenance Director) that Resident # 12's room was a priority room and he checked it multiple times per day. Resident # 12 would tend to snack and leave open bags of food which would attract pests into the room. The facility had supplied zip lock bags for her to close her opened snacks and he would still find open snacks when he checked. They also tried to deep clean her room and other rooms to keep pests out. He was very busy and had not had the time to close all the holes by which pests might be entering. He was responsible for all of the maintenance at the facility with one other staff member who worked part time. Following the interview with the Maintenance Director,	F0925		

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F0925 SS = D	Continued from page 29 the Maintenance Director and Corporate Consultant were accompanied as some of the common area doors which led to the facility's exterior were observed. The following observations were made: There was light visible from the outside beneath 1) the door which was located by the rehabilitation room and conference room 2) the door which was located at the end of the 100 hall 3) the door located in the television room on the 400 hall 4) one of the doors located at the end of the 400 hall and 5) the door which was located in an activity room. The Maintenance Director reported that there were weather stripping seals that were worn or in need or replacing which was allowing an opening beneath these exit doors. According to the Maintenance Director these seals could be replaced and that would seal the holes beneath the exit doors. The facility's pest control company's technician, who routinely serviced the facility, was interviewed on 7/3/25 at 12:10 PM and reported the following information. He was aware that Resident # 12's room had a problem with American cockroaches. He had done seasonal treatment for the entire facility, and he had also treated Resident # 12's room on multiple occasions. He further reported effective pest control included a number of components. One was sanitation and he felt the facility did a good job with that. The second was that he do his job and treat the facility. He had been coming out regularly and when called. Effective pest control also entailed sealing up the exterior walls where pests could enter from the outside into the inside. He did feel as if the facility could do better with that. He routinely rounded with the Maintenance Director and would point out areas which needed to be sealed and he took pictures of areas and showed them to the Maintenance Director. He had let them know that it was a priority to seal gaps, which included the gaps in dry wall, below the heating and air units and underneath exit doors. An area where a water pipe led into a wall and there was a hole around the pipe was especially vulnerable to pests entering if there had been a water leak around the pipe in previous years. This was because the water made a soft chamber in the ground below making pests more susceptible to enter through the soft chamber of dirt and into the building. The Administrator was interviewed on 7/3/25 at 5:00 PM and reported the following information. She had just	F0925		

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F0925 SS = D	Continued from page 30 been employed in recent months. She did look at the pest control company's logs and the technician had not included in his reports all the areas which needed to be sealed. For the one area he had mentioned in the recent written reports since she had been employed, she had made sure it was sealed. The pest control technician did not verbally give her a report when he was finished each time for her to understand there needed to be more repair of holes and seals in the facility or she would have taken care of the problem.	F0925		