STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015422	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc Nursing Center	212 Ellen Street Oneonta, AL 35121

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of facility policies titled, Controlled Substances, Identifying Exploitation, Theft and Misappropriation of Resident Property, and Administering Medications, review of a Facility Reported Incident (FRI) received by the State Agency (SA) and review of the facility's investigative file, the facility failed to ensure Licensed Practical Nurse (LPN) #4 did not misappropriate resident property when she failed to follow facility procedures related to handling, storage, disposal, and documentation of controlled substances designed to prevent drug diversion and protect resident safety. Specifically, LPN #4 fabricated other nurses' signatures on Controlled Drug Records of Resident Identifier (RI) #99, #104 and #105, indicating they had observed her dispose of dropped controlled medications, when in fact they did not witness or co-sign controlled medication destruction. On 09/10/2025, LPN #4 forged Registered Nurse (RN) #3's signature on RI #99's Tramadol Controlled Drug Record. On 09/06/2025 LPN #4 forged LPN #7's signature on RI #104's Hydrocodone Controlled Drug Record. On 09/11/2025 LPN #4 forged LPN #6's signature on RI #105's Hydrocodone Controlled Drug Record. Further, LPN #4 signed out doses of the Oxycodone on RI #85's Controlled Substance Record in August for 08/01/2025, 08/04/2025, 08/11/2025, 08/15/2025, 08/18/2025 and 08/22/2025 and for September on 09/05/2025, 09/08/2025, and 09/10/2025 and failed to initial and record evidence of administration of the controlled medication, Oxycodone, on RI #85's August 2025 and September 2025 Medication Administration Record (MAR) for the doses she signed out.These deficient practices affected RI #85, #99, #104 and #105, four of nine residents sampled for misappropriation of resident property and one of five medication carts at the facility. This deficiency was cited as a result of the investigation of a facility reported incident/complaint/report number 2633979.Cross-reference F609.Findings Include: Review of a facility policy titled Identifying Exploitation, Theft and Misappropriation of Resident Property, effective 06/2024, revealed the following: Policy StatementAs part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to recognize exploitation of residents and misappropriation of resident property. Policy Interpretation and Implementation1. Exploitation, theft and misappropriation of resident property are strictly prohibited.4. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings .5. Examples of misappropriation of resident property include: . f. drug diversion (taking the resident's medication); . A facility policy titled Controlled Substances with a revised date of 11/2022, documented the following: Policy StatementThe facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications . Policy Interpretation and Implementation . Dispensing and Reconciling Controlled Substances . 2. The system of . disposition of controlled substances includes the following:a. Records of personnel access and usage;b. Medication administration records; .c. Declining inventory records; andd. Destruction, waste .7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witnes (witness) also signs the disposition sheet.9. Disposal methods are used to prevent diversion . On 10/01/2025 the SA received a FRI alleging misappropriation of resident property occurred on 09/11/2025 when the facility's Administrator (ADM) (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was made aware of an allegation of falsification of medication administration records after Registered Nurse (RN)#3 identified her signature on a controlled substance record for Tramadol, dated 09/10/2025, next to LPN #4's entry which noted the medication had been dropped. The FRI continued, two additional instances of dropped medications were identified, each accompanied by signatures from other nurses who, when questioned, confirmed they had not signed the entries. The Assistant Director of Nursing (ADON) also identified a resident (RI #85) who had received a PRN (as needed) medication nine times over the previous 40 days. The report indicated that RI #85 did not recall requesting the medication. The report indicated that LPN #4 was called into the facility for an interview regarding these findings and acknowledged she had entered other nurses' signatures and LPN #4 stated she administered RI #85's PRN medications based on her professional judgement that the resident needed it even though the resident had not requested it. LPN #4 was terminated and reported to the Alabama Board of Nursing. The report indicated that following the interview and a review of the available documentation, the leadership team and Human Resources concluded that LPN #4 had indeed falsified documentation by forging other nurses' signatures. The report indicated that LPN #4's conduct was determined to be a serious violation of facility policy, professional standards and the Nurse Practice Act. LPN #4 was terminated and reported to the Board of Nursing. The report indicated that the incident was categorized as Misappropriation of Resident Property. Contained within the facility's investigative file was an Employee Counseling/Disciplinary Action form for LPN #4 which documented the following: . Record of: Termination Employee Name: (name of LPN #4) Position: LPN Hall Nurse . Date 9/11/2025 Time: 04:00 p.m. Reason for counseling/disciplinary action: Group A Offense(s)1. Group A 15. Falsification of any facility record.Group B Offense(s): 1. Group B 22. Violating any policy or procedure established in this facility .Why is this unacceptable? Employee didn't follow policy when discarding medications. Employee forged another nurses signature on medication documentation.What is acceptable? Follow all facility policy and procedures. Never falsify documentation .Employee response: I signed a narcotic pill that was stated dropped but in turn to make the narcotic sheet correct I had (name of LPN #6) sign with me and (name of RN #3) sign as well . RI #99 was admitted to the facility 09/09/2025 and had diagnoses to include Vascular Dementia and Pain. RI #99's September 2025 Order Recap Report (Physicians Order) documented an order for Tramadol HCL (Hydrochloric Acid) Oral Tablet 100 mg (milligrams) two tablets by mouth two times a day for Pain. A review of RI #99's Controlled Drug Record for the Tramadol HCL 100 mg revealed on 09/10/2025 RN #3's signature indicating RN #3 had witnessed LPN #4 dispose of a dropped Tramadol tablet. On 03/11/2026 at 1:48 PM RN #3 was asked what she could tell the surveyor about her signature appearing on a controlled substance record. RN #3 said this occurred back in September of 2025 and she noticed when she was signing a controlled substance sheet the nurse on the previous shift had wasted a narcotic on that sheet and signed her name as a witness. RN #3 said, she started looking at other narcotic sheets and saw at least two other resident narcotic sheets with concerns. RN #3 said the proper procedure when making an entry on a controlled substance record that a medication had been dropped was to get another nurse to witness the medication being wasted and have the witness sign the controlled mediation record. RN #3 said she never signed as a witness with LPN #4 for disposal of a dropped controlled medication. RI #104 was originally admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Diabetes Mellitus with Diabetic Neuropathy, Muscle Spasms, and Pain. RI #104's September 2025 Order Recap Report documented an order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg one tablet by mouth three times a day for Pain. A review of RI #104's Controlled Drug Record for the Hydrocodone-APAP (Acetaminophen) 5-325 mg revealed on 09/06/2025 LPN #7's signature indicating that LPN #7 had witnessed LPN #4 dispose of a dropped Hydrocodone tablet. On 03/12/2025 at 5:53 PM an unsuccessful attempt was made to contact LPN #7. RI #105 was admitted to the facility 09/08/2025 and had diagnoses to include Fracture of Superior Rim of Left Pubis, Subsequent Encounter for Fracture with Routine Healing, Chronic Pain and Specified Fracture of Left Pubis, (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signatures for September 2025 indicating one pill was signed out on each of the following dates: 09/05/2025 with a handwritten 8 marked through with a 9. The next date listed was 8/8 instead of 9/8. The next date listed was 8/10 instead of 9/10. These entries were signed by LPN #4. A review of RI #85's August and September 2025 MAR revealed there were no entries initialed, as evidence on the MAR, to indicate the Oxycodone had been administered to RI #85 on the CDR dates. On 03/11/2026 at 1:48 PM RN #3 who initially discovered discrepancies on Controlled Drug Records involving LPN #4, said it would be considered misappropriation of the resident's medication when there was any type of discrepancy with the resident's controlled medication. When asked where there would be evidence that any medication had been administered, RN #3 said on the resident's MAR. On 03/12/2026 at 8:58 AM the ADON/Interim DON was asked about findings during the investigation of controlled medications involving LPN #4. The Interim DON said it was discovered Oxycodone had been signed out nine times in 40 days and all of the signatures after June belonged to LPN #4. The Interim DON said when RI #85 was interviewed the resident did not remember asking for or receiving any of the medication in August. The Interim DON said any type of discrepancy of a resident's controlled medication would be drug diversion and misappropriation. On 03/12/2026 at 3:41 PM a telephone interview was conducted with the Consultant Pharmacist (CP). When asked what it would be considered when there was any type of discrepancy of a resident's controlled medication, the CP said diversion. The CP said when a controlled medication was signed as administered on the Controlled Substance Record and there was no evidence it had been administered, it would be misappropriation of the resident's property. The CP also said it should be documented on the residents MAR that a resident had received their medication.**********The facility took the following corrective actions: ********** 09/10/2025: Controlled Drug Record (CDR) entry for Tramadol 100 mg for resident (RI #99) documented as dropped with dual signatures; one later determined not authentic. 09/11/2025: RN (RN #3) reported her signature appeared on CDR without her involvement. ADON initiated immediate review and identified two additional dropped-dose entries with forged cosignatories. 09/11-09/12/2025: ADON audited over 100 CDRs administered by nurse (LPN #4). No further discrepancies identified. One resident, (RI #85), noted to have received PRN medication 9 times in 40 days; resident did not recall requesting medication on most occasions. Midˆ[DATE]: (LPN #4) interviewed. admitted to entering other nurses' signatures after the fact. Voluntary drug screen completed and returned negative. 09/15/2025: Nursing leadership, including DON and ADON, conducted MAR and pharmacy audit; no evidence of diversion or missed medications found. 09/16/2025: Corporate nurse confirmed findings. Ad hoc QAPI meeting held; root cause analysis completed and monitoring/education recommended. 09/16-09/17/2025: Alert residents interviewed by Social Services. No reports of missed medications or concerns related to (LPN #4). 09/17/2025: Nursing staff education completed regarding narcotic documentation and PRN administration. 09/19/2025: Second ad hoc QAPI meeting confirmed termination for documentation falsification; no substantiation of diversion or resident harm. Late [DATE]: Independent pharmacy consultant audit completed; no diversion patterns identified. Controls are deemed effective. 10/01/2025: QAPI review of ADPH guidance. Leadership determined incident met threshold for credible allegation due to controlledˆsubstance documentation falsification. Allegation reported out of an abundance of caution. Ongoing: LPN #4 terminated and reported to Alabama Board of Nursing. Notifications completed. Continued audits, education, and QAPI monitoring implemented. ********** Upon review and verification of the information provided in the facility's corrective action plan, in-service/education records, the facility's investigation, staff interviews as well as performing narcotic medication match backs, the survey team determined the facility implemented corrective actions from 09/11/2025 - 10/01/2025, with on-going monitoring implemented; thus, past noncompliance was cited.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews, record review, review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, and review of a Facility Reported Incident (FRI) received by the State Agency (SA) on 10/01/2025 at 1:19 PM, the facility's Administrator (ADM) failed to ensure an allegation of misappropriation of resident property was reported to the SA in the required timeframe of 24 hours, when he was made aware on 09/11/2025 that Licensed Practical Nurse (LPN) #4 was falsifying residents' Controlled Drug Records (CDR) and failing to follow facility procedures related to handling, storage, disposal, and documentation of controlled substances designed to prevent drug diversion and protect resident safety. LPN #4 forged other nurses' signatures as witnesses of dropped medication disposal on Controlled Drug Records and LPN #4 signed out controlled medications on a Controlled Drug Record and failed to document them as administered on Medication Administration Records, per facility policy for evidence of administration.The facility failed to timely report one of three Facility Reported Incidents reviewed during the survey. This deficient practice had the potential to affect Resident Identifier (RI) #'s 99, 104, 105, and 85, four of 88 residents who resided at the facility.Findings Include:Cross-reference F602. Review of a facility policy titled Abuse, Neglect, Exploitation of or Misappropriation - Reporting and Investigating effective 06/2024 revealed the following: Policy StatementAll reports of resident abuse . or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current /regulations) . Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities .2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:a. The state licensing/certification agency responsible for surveying/licensing the facility;b. The local/state ombudsman; .e. Law enforcement officials; . 3. Immediately is defined as: .b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . On 10/01/2025 at 1:19 PM the SA received a FRI alleging the occurrence of misappropriation of resident property which the facility staff and Administrator became aware of on 09/11/2025 involving LPN #4.On 03/12/2026 at 8:58 AM an interview was conducted with the ADON/Interim DON. When asked how she was made aware of an incident where RI #4 had signed someone else's name by hers, indicating that narcotics for some residents had been dropped and the disposal was witnessed by other nurses, the Interim DON said she was first made aware when RN #3 notified her that morning. The Interim ADON said the affected residents were RI #99, RI #104 and RI #105. The Interim DON said the incident occurred back in September of 2025 and was reported to Alabama Department of Public Health (ADPH) on 10/01/2025. When asked, according to the facility's policy, what was the time frame for reporting incidents like this one to ADPH, the Interim DON said within 24 hours. The Interim DON said this incident was not reported in a timely manner. On 03/12/2026 at 10:52 AM an interview was conducted with the ADM. The ADM said one of his job responsibilities was to ensure the facility followed regulations. The ADM said he was made aware of an incident where LPN #4 signed someone else's name by hers indicating that narcotics for some residents had been dropped on 09/11/2025. When asked when the incident was reported to ADPH, the ADM said on 10/01/2025. The ADM said according to the facility's policy the time frame for reporting incidents like this one to ADPH was within 24 hours. When asked, according to regulations, if the incident was reported in a timely manner, the ADM said no. The ADM said, when a Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 10/01/2025 the leadership team made the decision to report the incident as an allegation of abuse. **********The facility took the following corrective actions: ********** 9/11/2025 Incident regarding a nurse forging signatures - determination - not reportable. No reportables to ADPH in September, 2025 10/1/2025 QAPI mtg re 9/11/25 nurse forgery incident - (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated determination - reportable as an allegation of abuse, potential misappropriation/drug diversion. No other reportables to ADPH in October, 2025 11/21/25 OCTOBER QAPI Meeting, Regulatory Compliance Monitoring began for reporting incidents to ADPH. No reportables in November, 2025 12/23/25 NOVEMBER QAPI Meeting, Continued Regulatory Compliance Monitoring for reportables to ADPH. No reportables in December, 2025 01/23/26 DECEMBER QAPI Meeting, Continued Regulatory Compliance Monitoring for reportables to ADPH. No reportables in January, 2026 02/19/26 January QAPI Meeting, Continued Regulatory Compliance Monitoring for reportables to ADPH. One (1) reportable in February, 2026 pertaining to abuse (misappropriation). Review revealed the incident was reported in a timely manner. 02/25/26 Ad hoc QAPI meeting re February reportable held, no concerns identified in reporting to ADPH in a timely manner. No other reportables at this time. ********** Upon review and verification of the information provided in the facility's corrective action plan, in-service/education records, the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 10/01/2025 to 02/25/2026, with on-going monitoring implemented; thus, past noncompliance was cited.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of Resident Identifier (RI) #81's hospital records, and review of a facility policy titled Medication Therapy, the facility failed to provide RI #81 care and treatment based on RI #81's hospital discharge orders, plan of care, and medications necessary to treat existing conditions and address significant risk. During record review surveyors discovered that on 02/20/2026 RI #81 was discharged from the hospital to the facility with discharge medications to include aspirin, 81 milligrams (mg) to be administered twice a day, recommended upon discharge for six weeks per orthopedic surgical consult following right femoral neck fracture and hemiarthroplasty (partial hip replacement). There was not any evidence that RI #81 received the aspirin as recommended. When RI #81 was readmitted to the facility, Licensed Practical Nurse (LPN) #9 notified the Medical Director (MD) who was RI #81's attending physician of RI #81's allergy to aspirin. The MD informed the nurse to discontinue the aspirin order, but he did not provide an order for alternate therapy. The MD and the facility failed to follow up with the surgeon for alternate medication therapy. There was not any evidence in RI #81's medical record of LPN #9's conversation with the MD and no evidence of determination of who was responsible for following up with the surgeon for an alternate to aspirin therapy.The facility failed to provide RI #81 alternate anticoagulant therapy for 20 days, until Eliquis was ordered on 03/12/2026 during the survey. This deficient practice affected RI #81, one of three residents reviewed for anticoagulant therapy. RI #81 not receiving anticoagulant therapy for 20 days, placed RI #81 at risk of developing a Deep Vein Thrombosis (DVT), a serious medical condition where a blood clot forms in a deep vein, usually in the legs and thighs, which could break loose and travel to the lungs causing Pulmonary Embolism (PE). Findings Include:Cross reference F710.The facility policy titled, Medication Therapy, with an effective date of 04/2024 included the following: Policy heading1.Each resident's medication regimen shall include . those medications necessary to treat existing conditions and address significant risk. 2. Medication use shall be consistent with an individual's conditions, prognosis .3. All medication orders will be supported by appropriate care processes and practices.Policy Interpretation and Implementation .5. The physician will identify situations where medications should be tapered, discontinued, changed to another medication, .RI #81 was originally admitted to the facility on [DATE] and was readmitted on [DATE] following hospital stay and a partial hip replacement after a Displaced Fracture of Base of Neck of Right Femur. A review of RI #81's hospital discharge summary with a discharge date of 02/17/2026 revealed the following: . Hospital Course with Significant Findings . Right Femoral Neck Fracture s/p (status post) Hemiarthroplasty . Orthopedic Surgery consulted: . recommend discharge on 6 (six) weeks of 81 mg aspirin twice daily . RI #81 was not discharged from the hospital until 02/20/2026.A review of RI #81's February 2026 Order Summary report (Physician orders) revealed RI #81's aspirin 81 mg, was to be given by mouth two times a day for DVT prevention for six weeks had been discontinued due to RI #81 being allergic to aspirin. RI #81's care plan with a focus area of anticoagulant therapy related to right femur fracture with an initiated date of 02/17/2026 documented an intervention to administer anticoagulant medication as ordered by the physician and monitor for side effects and effectiveness every shift. RI #81's physician order dated 03/12/2026 documented Eliquis oral tablet 2.5 mg (Apixaban), give one tablet by mouth two times a day had been confirmed by LPN #9.RI #81's February and March 2026 Medication Administration Records were reviewed and revealed no evidence RI #81 had received administration of anticoagulant medications or aspirin, from readmission on [DATE] until 03/12/2026. On 03/12/2026 at 12:01 PM the surveyor conducted an interview with LPN #9, regarding the care and treatment of RI #81. During the interview LPN #9 confirmed RI #81 had been prescribed aspirin 81 mg twice daily following discharge from the hospital for the purpose of DVT prevention. LPN #9 said the aspirin 81 mg was not administered because RI #81 had an allergy to aspirin. LPN #9 said she notified the physician who did not give her any new (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. LPN #9 said the importance of anticoagulant therapy was to prevent blood clots. LPN #9 said the potential harm of the resident not receiving anticoagulant therapy after surgery was stroke, heart attack, or pulmonary embolism that could lead to death. On 03/12/2026 at 2:46 PM the surveyor conducted a telephone interview with the attending physician /MD regarding the care and treatment of RI #81. The MD confirmed he had been notified by LPN #9 that RI #81 was readmitted to the facility on [DATE] with an order from the surgeon for aspirin. The MD said he did not give a new order for an anticoagulant because he needed to speak to the surgeon to see what the surgeon recommended. When asked if he spoke with the surgeon to see what was recommended, the attending physician said no, he thought the nurse was doing that. The MD said, when LPN #9 called him on 03/12/2026 was when he realized RI #81 was not on an anticoagulant and should have been. The MD said, not receiving anticoagulant therapy following surgery placed RI #81 at risk for complications, including the development of DVT below the surgical site, which could lead to pulmonary embolism. On 03/12/2026 at 3:34 PM the surveyor conducted an interview with the Interim Director of Nursing (IDON) regarding the care and treatment of RI #81. The IDON said the importance of obtaining a replacement anticoagulant medication for RI #81 was because of the hip fracture, and the risk was a blood clot. The IDON said aspirin being ordered after surgery would be to prevent a clot. The IDON said the concern with not receiving anticoagulant therapy after surgery was risk for DVT. On 03/31/2026 at 10:12 AM an interview was conducted with the Certified Nurse Practitioner (CRNP). When asked what the risk would be associated with a resident not receiving anticoagulant therapy for 20 days after surgery when it was recommended by the surgeon for six weeks, the CRNP said the risk to that would be DVT. The CRNP said with RI #81 in particular, if it was recommended by the Orthopedic Doctor it should have been carried out. On 03/31/2026 at 3:52 PM a follow-up interview was conducted with the IDON. When asked who identified that RI #81 was never on any type of anticoagulant therapy after his/her hip surgery was done, the IDON said she believed it was a state surveyor. The IDON said when it was identified that RI #81 was never on any type of anticoagulant therapy after his/her surgery, the nurse got in touch with RI #81's attending physician on 03/12/2026 and RI #81 was placed on anticoagulant therapy. When asked who else could or should have identified RI #81 was not receiving any type of anticoagulant therapy prior to the surveyor, the IDON said, the hall nurse. The IDON said everyone dropped the ball. The IDON said if it had been put in the nurses' note it would have been seen the next morning and could have received prompt follow up. The IDON said the facility failed to ensure continuity of care and medication changes were followed up with or documented so that RI #81 got the best care. On 03/31/2026 at 4:43 PM the surveyor conducted a telephone interview with the Clinical Pharmacist (CP). When asked what the risk could be for a resident not receiving anticoagulant therapy for 20 days after surgery, when it was recommended for six weeks, the CP replied, RI #81 could develop a DVT or PE. The CP said the resident would need to receive that therapy, especially if it was recommended. The CP said the resident could definitely develop a clot. On 04/01/2026 at 8:54 AM the surveyor conducted a telephone interview with RI #81's Orthopedic Surgeon. When asked what he would expect the facility staff to do if he ordered aspirin and the resident was allergic to aspirin, he replied, he expected the facility to call him or talk to the attending physician to get an alternate therapy. RI #81's Orthopedic Surgeon said he was never informed that RI #81 was allergic to aspirin. He further stated if he had been informed, he would have recommended RI #81 take Eliquis since RI #81 had an allergy to aspirin. When asked about the risk associated with not receiving anticoagulation therapy for 20 days after surgery when it was recommended for six weeks, he stated, increased risk for DVT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015422	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc Nursing Center	212 Ellen Street Oneonta, AL 35121

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of facility policies titled Medical Director and Medication Therapy, the facility failed to ensure Resident Identifier (RI) #81's attending physician/MD (Medical Director) provided orders to meet RI #81's medical needs upon discharge from the hospital post arthroplasty with partial hip replacement. On 02/20/2026, the facility's attending physician was notified that RI #81 was allergic to aspirin which had been ordered by the Orthopedic surgeon. The attending physician failed to provide an order for RI #81 to receive alternate anticoagulant therapy or follow-up to ensure the prescribing surgeon was notified of RI #81's allergy to aspirin and the need for alternate therapy. Because of this failure RI #81 did not receive aspirin or anticoagulant therapy for 20 days after readmission, from 02/20/2026 until 03/12/2026 during the survey. This deficient practice affected RI #81, one of three residents reviewed for anticoagulant therapy. Failure of the attending physician to ensure alternate anticoagulant therapy was provided at the time of RI #81's readmission placed RI #81 at risk for developing a Deep Vein Thrombosis (DVT), a serious medical condition where a blood clot forms in a deep vein, usually in the legs and thighs, which could break loose and travel to the lungs causing Pulmonary Embolism (PE). Findings Include: Cross reference F684. Review of a facility policy titled, Medical Director, with an effective date of 02/2024, revealed the following: Policy Statement Physician services shall be under the supervision of the medical director. Policy Interpretation and Implementation1. Physician services are under the general supervision of the medical director.2. The medical director . is responsible for:a. ensuring adequate and appropriate physician services; .e. participating in efforts to improve quality of care and services; .3.Medical director functions also include, but are not limited to: .c. helping assure that residents receive adequate services appropriate to meet their needs; . Another facility policy titled, Medication Therapy, with an effective date of 04/2024, revealed the following: . Policy Interpretation and Implementation .5. The physician will identify situations where medications should be tapered, discontinued, or changed to another medication . A review of RI #81's Discharge summary, dated [DATE], revealed it was recommended by RI #81's Orthopedic surgeon that RI #81 be discharged back to the facility on aspirin 81 mg (milligrams) twice a day for six weeks. RI #81 was discharged back from the hospital on [DATE] with a diagnosis of Displaced Fracture of Base of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. On 03/12/2026 at 12:01 PM an interview was conducted with Licensed Practical Nurse (LPN) #9. The LPN said on 02/20/2026 RI #81's aspirin order was discontinued because RI #81 was allergic to aspirin. LPN #9 said she was the one who called RI #81's attending physician and notified him of RI #81's allergy to aspirin. LPN #9 said RI #81's attending physician did not give her any other medication order. When asked what the potential harm of a resident not receiving an anticoagulant medication after surgery, LPN #9 said stroke, heart attack, pulmonary embolism which could lead to death. On 03/12/2026 at 2:46 PM a telephone interview was conducted with RI #81's attending physician. RI #81's attending physician said on 02/20/2026 LPN #9 did notify him that RI #81's Orthopedic surgeon had ordered aspirin and RI #81was allergic to aspirin. RI #81's attending physician said he did not order a new anticoagulant that day because he needed to speak to the surgeon to see what the surgeon recommend to replace the aspirin. RI #81's attending physician said he never spoke to the surgeon because he thought the nurse would notify the surgeon. RI #81's attending physician said it was an oversite, but RI #81 should have been on an anticoagulant. On 04/01/2026 at 8:54 AM a telephone interview was conducted with RI #81's Orthopedic surgeon. RI #81's Orthopedic surgeon said he was never notified RI #81 was allergic to aspirin. RI #81's Orthopedic surgeon said either the nurse or RI #81's physician could have notified him of the allergy. RI #81's Orthopedic surgeon said he probably would have ordered Eliquis. When asked what the risk would be for the resident not receiving anticoagulant therapy for 20 days after surgery when the recommendation was for anticoagulant therapy for six weeks, RI #81's Orthopedic surgeon said increased risk of DVT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015422	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of facility policies titled, Discontinued Medication and Charting and Documentation, the facility failed to maintain Resident Identifier (RI) #81's medical records in a manner to ensure the record was complete and accurately reflected RI #81's condition and consultation of RI #81's attending physician. Licensed Practical Nurse (LPN) #9 failed to document in RI #81's medical record when she notified the attending physician of RI #81's allergy to aspirin after RI #81 was readmitted on [DATE] from the hospital with an order for aspirin to be administered for six weeks. The facility failed to identify in RI #81's medical record what would be provided in place of the aspirin. This deficient practice affected RI #81, one of 18 residents for whom records were reviewed. LPN #9's failure to document in RI #81's medical records that RI #9's aspirin had been discontinued by RI #81's attending physician placed RI #81 at risk of not receiving continuity of care.Findings Include: Review of a facility policy titled Discontinued Medications with an effective date of 04/2024 revealed the following: . Policy Interpretation and Implementation1. A provider's order to discontinue a resident's medication is documented in the resident's clinical record .2. The nurse receiving the order to discontinue a medication is responsible for recording the information . A facility policy titled Charting and Documentation with an effective date of 01/2024 documented the following:Policy StatementAll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual, or a combination.3. Documentation in the medical record will be objective . complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including: .f. notification of . physician or other staff if indicated . RI #81 was admitted to facility on 02/12/2025 and readmitted to the facility on [DATE] with a diagnosis of Displaced Fracture of Base of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. A review of RI #81's February 2026 Order Summary Report (Physician Orders) revealed RI #81's aspirin, 81 mg to be given two times per day for DVT prevention, had been discontinued due to RI #81 being allergic to aspirin. On 03/12/2026 at 12:01 PM LPN #9 said she notified RI #81's attending physician that RI #81 was allergic to aspirin when RI #81 was readmitted on [DATE]. When asked if she documented in RI #81's medical chart or clinical records when she notified RI #81's physician, LPN #9 said she did not. When asked why she did not document in RI #81's medical chart that she had notified RI #81's attending physician of RI #81's allergy to aspirin, LPN #9 said, she had given report to another nurse. LPN #9 acknowledged the importance of documenting in the medical chart to make sure other nurses were aware of a resident's allergies and orders given by the physician. On 04/02/2026 at 1:16 PM Registered Nurse (RN) #3 was asked where it would be documented when the nurse communicated with the physician. RN #3 replied, in the chart (nurses notes). RN #3 said it would be important to document the nurse's notes because if it was not documented, it was not done. RN #3 said documenting in the nurses' notes was important for other nurses to see changes that were made. On 04/02/2026 at 1:41 PM an interview was conducted with RN #14. When asked where it would be documented when the nurse communicated with the physician, RN #14 replied documentation would be under the progress notes. When asked why it would be important to document the progress notes, RN #14 replied, so other nurses knew what was going on. RN #14 further stated supervisors read the progress notes every morning to see if there had been any change in conditions. On 04/02/2026 at 3:10 PM an interview was conducted with LPN #16. When asked where it would be documented when the nurse communicated with the physician, LPN #16 said, in the nurses' or progress notes. LPN #16 said it would be important to document the nurses' notes to show continuity of care for the resident