STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105128	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morton Plant Rehabilitation Center	400 Corbett St Belleair, FL 33756

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review, interview, and review of the facility's policy titled Pre-Admission Screening for Mental Disorders (MD)/Intellectual Disability (ID) Patients, the facility failed to ensure Level I Preadmission Screening and Resident Review (PASARRs) were accurate upon admission for three Residents (#27, #75, and #297) of six residents sampled for PASARRs. Findings included: 1. Review of the Admission record showed Resident #75 was admitted to the facility on [DATE] with diagnoses that included but not limited to anoxic brain damage, not elsewhere classified, major depressive disorder (4/11/24), moderate, cognitive communication deficit, obsessive compulsive disorder, bipolar disorder and generalized anxiety disorder. Review of the Preadmission Screening and Resident Review (PASARR) dated 10/29/24 revealed Section 1 A. MI [Mental Illness] or suspected MI check all that apply showed Anxiety Disorder, Bipolar Disorder and Depressive Disorder was checked. Section 1 B. ID [Intellectual Disability] or suspected ID check all that apply had no selections checked. Review of Section II: Other indications for PASARR Screen Decision-Making showed all selections were check marked No. During an interview on 02/05/25 at 12:09 p.m. the Nursing Home Administrator (NHA) stated Resident # 75's diagnosis of Anoxic Brain was not a common diagnosis, so it was missed on the PASARR dated 10/29/24. The Administrator stated that the facility reviewed all the PASARRs the survey team requested yesterday at morning meeting today. The NHA stated after reviewing Resident #75's PASARR the facility found that anoxic brain damage should have been included under section 1 B in the Other column indicting an intellectual disability and when updating section II correctly the revisions resulted in a PASARR level II being required. 50732 2. Review of the Admission Record showed Resident #297 was admitted to the facility on [DATE] with diagnoses including major depressive disorder. Review of Resident #297's Level 1 PASARR, dated 01/28/2025, Section 1:PASARR Screen Decision-Making, Section A revealed a blank PASARR, and qualifying diagnoses were not checked. 37999 (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #27s Admission Record revealed the resident was admitted on [DATE]. The record showed the resident was admitted with a diagnosis of unspecified anxiety disorder. Review of Resident #27s Behavioral Health note, dated 1/7/25, showed the resident was seen for initial evaluation to assess adjustment issues secondary to medical status, presented with a history of anxiety, and voiced mild sleep issues with frustration. Review of Resident #27s PASARR dated 1/3/25 showed the resident did not have a mental illness (MI) or intellectual disability (ID) and a level II was not required. The PASARR was blank, and qualifying diagnoses were not checked. During an interview on 2/5/25 at 12:03 p.m. with the Nursing Home Administrator (NHA) stated the facility had reviewed Resident #27s meds that morning and did not correct the PASARR as it was determined the screening was correct. The NHA reviewed the current PASARR and stated it needed to be reviewed to show anxiety disorder. An interview was conducted on 2/5/25 at 11:50 a.m. with the Nursing Home Administrator (NHA). The NHA stated the Social Service department was responsible for ensuring new admissions had a PASARR and if any corrections were needed the Social Worker would go through the appropriate agency. The Interdisciplinary Team (IDT) reviews the PASARR of every new admission. The IDT reviews History & Physical (H&P) from hospital, medications, and follows instructions on the PASARR form. The NHA stated the PASARR process was an ongoing issue with PASARR's. The audit included date of admission, name of resident, if the PASARR was correct of not, if not correct the IDT reviewed the originating location, who reviewed the PASARR and the reason it was incorrect. Review of the policy - Pre-Admission Screening for Mental Disorders (MD)/Intellectual Disability (ID) Patients, revised 3/2021 revealed This Pre-admission Screening for Mental Disorders (MD) / Intellectual Disability (ID) patients policy applies to the facilities listed above. - To ensure that all individuals are screened for a MD and/or ID prior to admission. - To ensure that individuals identified with MD or ID are evaluated and received care and services in the most integrated setting appropriate to their needs. The policy revealed the facility staff will assure that all patients with Mental Disorders (MD) and/or Intellectual Disability (ID) receive appropriate pre-admission screenings according to federal and/ or state regulations. The practice standards showed: 1. Social Services will coordinate and/ or inform the appropriate agency to conduct the evaluation and obtain results if: a. it is learned after admission that the pre-admission screening and resident review (PASARR) well it's not completed or is incorrect, or b. there is significant change in status that results in new evidence of possible mental disorder, intellectual disability, or a related condition. 2. Social services will review to determine appropriate care needs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Refer to the appropriate state designated authority when a patient is identified as having an evident or possible MD, ID, or related condition. b. Incorporate recommendations into the patient's assessment, care planning, and transitions of care. 3. The PASARR will be placed in the admissions or legal section of the patient's medical record. 4. Social Services will be responsible for: a. coordinating updates as needed and per state requirements. b. Notifying the state mental health authority or state intellectual disability authority, as applicable, prompting after a significant change in mental or physical condition of a patient who has a MD or ID for a patient review.

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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** 37999 Based on observation record review and interview the facility failed to assess and obtain physician orders for a skin injury for one (#7) of one resident sampled for non-pressure related skin conditions, failed to remove a topical pain patch per documentation for one (#149) of two residents observed during medication administration receiving topical patches, and failed to obtain blood pressure measurement for one (#20) of one observed resident receiving anti-hypotensive medication per physician ordered parameters. Findings included: 1. An observation was made on 2/3/25 at 3:23 p.m. of Resident #7 sitting in resident room with spouse. A 1.5 x 1.5-inch foam dressing had been applied to the area below the resident's right elbow. The dressing was not dated, and the dressing appeared to have a dried-looking brown discoloration. The spouse notified the resident of the dressing then resident stated the dressing had been applied 4 days ago. An observation was made on 2/5/25 at approximately 10:30 a.m. of Resident #7 sitting by self in the facility driveway. A clean pink foam dressing was applied to the area below the right elbow, dated 2/4/25. The resident stated the facility had changed it yesterday. An interview was conducted with Staff D, Registered Nurse/Nurse Manager (RN/NM) on 2/6/25 at 8:52 a.m. Staff D reviewed Resident #7's physician orders and reported the resident did not have a physician order for a dressing to the right elbow. The staff member stated there should be documentation related to how the injury occurred and a physician order for a dressing. An observation was conducted on 2/6/25 at 9:02 a.m. with Staff D of Resident #7's right elbow. The dressing was dated 2/4/25 and the staff member removed the dressing the area had red fresh blood with scabbed area. The resident reported the injury occurred prior to admission to the facility and had reopened. The sheepskin covering the resident's wheelchair armrests (in which the resident was sitting) was stained with brown discoloration corresponding with the right elbow area. Review of Resident #7's admission record showed the resident had been admitted on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of Resident #7's Treatment Administration Record (TAR) did not reveal an order to apply or change the resident's right elbow skin injury. Review of Resident #7's February 2025 TAR did not reveal a physician order to apply or change the resident's right elbow skin injury prior to Staff D's observation on 2/6/25. The order to cleanse right arm near elbow with normal saline, apply foam dressing, and change twice weekly and as needed (prn) every day shift every Tuesday (Tue) and Thursday (Thu) for skin tear was to start on 2/11/25 at 7:00 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's progress notes dated 1/30/25 at 1:17 a.m. to 2/6/25 at 9:14 a.m. (12 minutes after Staff D's observation) did not reveal any assessment of the resident's right elbow skin injury. A note on 2/6/25 at 9:14 a.m. revealed a new skin tear to the right elbow measuring 2 centimeters (cm) x 1 cm with light sanguineous exudate. The exudate revealed active bleeding. Review of Resident #7's care plan revealed the resident had a potential for impairment to skin integrity and for infections secondary to admitted with skin tears, impaired mobility, use of anticoagulant, and antiplatelet medications. Patient prefers to sit outside in the sun, is aware of risk, and apply sunscreen daily. Enhanced Barrier Precautions as indicated suprapubic catheter (and) pressure injury areas. History of pressure injury (PI) at bilateral heels, 2/6/25 skin tear to right arm near elbow and right outer thigh skin tear. The interventions instructed staff to report to physician (MD) for location, size, and treatment of skin injury, abnormalities, failure to heal, signs or symptoms (s/s) of infection, (and) maceration etcetera (etc.) See MD orders for current skin treatments, initiated on 9/16/24. During an interview on 2/6/25 at 8:59 a.m. the Interim Director of Nursing (DON) stated the dressings should be dated, dressings should have an order and should have documentation that the area has reopened, and wound care was provided. Review of the policy/procedure - Altered Skin Integrity Guidelines, revised 6/2024, revealed This policy is developed as a guideline to address general circumstances. There may be certain instances in which the exercise of professional judgment and/or discretion by the health care provider warrants taking other actions. The evaluation - Skin Inspection instructs staff to: - Observe all skin surfaces for tissue tolerance and signs of alterations in skin integrity on admission/re-admission, weekly, and as needed. - Document in the Medical Record (COMS) skin evaluation. The Wound Care Guidelines showed the Basic Principles of Wound Management was to protect the wound bed from further trauma, contamination, or dying, promote the removal of necrotic tissue and exudate, and provide moist healing environment to support tissue growth (and) keep surrounding skin dry. The Care for All Wounds revealed: - Cleanse wound initially and with each dressing change. Use sterile, normal saline with appropriate pressure or wound cleanser (if ordered practitioner) for cleansing. - Evaluate wound for signs of increasing bioburden and/or infection. Notify physician/mid-level provider of observations and recommendations. Initiate treatment order. Signs may include: - Purulent, foul drainage - Increasing redness and/or warmth beyond wound borders - Fever, elevated white blood count, and/or abnormal blood sugars if diabetic patient - Deteriorating mental and/or functional status (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Increasing drainage, friable bloody base, and/or deteriorating wound - Increasing of new wound pain The policy instructed staff to monitor the outcome of the plan of care through consistent observation, documentation, and review. Caregivers are to observe patients' skin daily to identify potential changes in skin condition. Weekly skin inspections are to be documented as completed and outcome in electronic medical record. Staff are to inspect daily for any new complications (i.e. dressings not intact, excess drainage, new erythema, (and) new pain). 2. An observation of medication administration with Resident #149 was conducted on 2/5/25 at 9:51 a.m. with Staff C, Registered Nurse (RN). The staff member dispensed oral medications with one 5% Lidocaine topical patch. Staff C entered the resident room, spoke with Resident #149's roommate, then placed the medication cup with oral medications on the over-bed table. The staff member placed eye drops in each eye, then assisted in repositioning the resident's shirt to expose the right shoulder. The observation revealed Staff C removed a white filmy patch from the resident's shoulder and threw it away in bedside garbage. Staff C applied the observed dispensed Lidocaine patch to the right shoulder, in the same area as the removed patch. Review of Resident #149's February 2025 Medication Administration Record (MAR) included an order for Lidocaine External Patch 5% (Lidocaine) - Apply to right shoulder topically one time a day for pain and remove per schedule, started on 1/21/25. The MAR revealed a schedule to apply at 9:00 a.m. and remove at 9:00 p.m. The MAR revealed staff had documented the removal of the Lidocaine patch at 9:00 p.m. on 2/4/25, the night before the observation of Staff C removing the topical patch from the resident's right shoulder. Review of Resident #149's admission record revealed the resident was admitted to the facility on [DATE] with diagnoses not limited to unspecified Alzheimer's Disease and unspecified site unspecified osteoarthritis. During an interview on 2/6/25 at 9:36 a.m. the DON stated staff had documented Resident #149's (lidocaine) patch had been removed at 9 p.m. the night before observation of medication administration. Review of the policy - Documentation Nursing Care, revised 1/2025, revealed Team members involved in the medical documentation process have a personal obligation to complete accurate documentation. Inaccurate and/ or incomplete documentation may lead to legal sanctions under federal health care rules and regulations including repayment of monies, fines, exclusion from participating in a federal health care program, and imprisonment for criminal actions. The nurse will document under the eMAR module for medication and the (TAR) treatment administration each shift as orders indicate. 3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of medication administration with Resident #20 was conducted on 2/4/25 at 5:13 p.m. with Staff A, Licensed Practical Nurse (LPN). The staff member dispensed one tablet of 325 milligram (mg) of Ferrous Sulfate, one 3 mg tablet of Coumadin, and one 10 mg of Midodrine. Staff A entered the resident room and handed the medication cup to the resident who swallowed the three tablets at one time. Immediately following the observed administration on 2/4/25 with Resident #20, Staff A documented the resident's blood pressure as 102/63. The staff member stated the blood pressure was taken this morning and there was no order to take it prior to the administration of Midodrine. Review of Resident #20's admission record showed the resident was readmitted to the facility on [DATE]. The record included diagnoses not limited to chronic peripheral venous insufficiency and unspecified hypotension. Review of Resident #20's January 2025 Medication Administration Record (MAR) revealed an order for the resident to receive Midodrine 10 mg's by mouth with meals for hypotension and to hold if blood pressure (BP) was greater than (>) 160. The MAR showed Midodrine was scheduled at 8:00 a.m., 1:00 p.m., and 6:00 p.m. and did not include documentation of blood pressure. The review of the MAR did not reveal an area in which blood pressures had been documented. The MAR showed the resident's Midodrine had been administered three times a day during the month of January 2025. Review of Resident #20's February 2025 MAR revealed an order for Midodrine 10 mg's by mouth with meals for hypotension and to hold if blood pressure (BP) was greater than (>) 160. The MAR showed the medication was scheduled at 8:00 a.m., 1:00 p.m., and 6:00 p.m. and did not include documentation of blood pressure. The review of the MAR did not reveal an area in which a blood pressure had been documented. The review of the MAR did not reveal an area in which blood pressures had been documented. The MAR showed the resident had been administered Midodrine three times a day from 2/1/25 to 2/4/25 and twice on 2/5/25. Review of Resident #20's blood pressure summary from 1/1/25 to 2/5/25 showed staff documented one blood pressure daily except for 1/29/25 which did not show a blood pressure had been documented in vitals summary or progress notes. Review of Resident #20's progress notes from 1/1 to 2/4/25 revealed staff had documented additional blood pressures on 1/30/25 at 2:21 p.m. of BP 111/69; on 1/26 at 7:01 p.m. of 102/68 and on 1/16/25 at 2:26 p.m. of 115/72. During an interview on 2/6/25 at 8:59 a.m. Staff D stated a blood pressure should be taken prior to administration and reported if a resident was taking blood pressure medications twice a day, the expectation was a blood pressure to taken at the time of administration and (prior to) each dose. During an interview on 2/6/25 at 9:32 a.m. the DON reported being aware of Staff A not obtaining Resident #20's blood pressure prior to the administration of Midodrine as she heard the interview from the next room. The DON sated the order needed to be revised to instruct staff to obtain a blood pressure prior to administration per the parameter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy - Medication Administration, issued 11/2024, revealed the purpose was To provide a safe, effective medication administration process . A licensed nurse will administer medication to patients/residents per state regulations. Accepted standards of practice will be followed. The policy did not address obtaining vital signs prior to medication administration per physician ordered parameters.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on observation, interview and record review the facility failed to ensure posting of cautionary and safety signs indicating the use of oxygen in resident rooms for eight residents (#298, #33, #4, #56, #80, #81, #147 and #148) out of ten residents reviewed for oxygen use. Findings included: On 02/03/2025 at 10:02 AM Resident #298 was observed in her room with an oxygen concentrator sitting next to the wall on the opposite side of the bed. Upon exiting the resident's room an observation was made and there was no oxygen in use sign on the outside of the resident's room door. On 02/03/2025 at 3:09 PM an observation was made of the outside of Resident #298's room door and there was no oxygen in use sign posted on the door. Review of the admission record showed Resident #298 was admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, pulmonary fibrosis, dyspnea, emphysema and chronic obstructive pulmonary disease (COPD). Review of a physician order dated 02/04/2025 showed Resident #298 was to use oxygen at 2L (liters) via nasal canula to maintain oxygen saturation above 92% every shift. 46498 During an observation made on 2/5/2025 at 10:00am and at 3:00 pm., Resident #33 was observed with an oxygen concentrator placed next to her bed. There was no oxygen signs posted outside of the resident's room. Review of Resident # 33's Order Summary Report dated 02/06/2025 showed an active order with start date 3/2/2024 for Oxygen via nasal cannula at 2 liters continuously every day shift. 37999 On 2/3/25 at 11:18 a.m. Resident #4's doorway was observed without a sign posting the use of oxygen. The observation showed an emergency oxygen tank (e-tank) in holder next to the privacy curtain of the resident. Review of Resident #4's admission record revealed admitted s of 5/13/24 and 12/18/24 with diagnoses including but not limited to (adult) (pediatric) obstructive sleep apnea, unspecified organism pneumonia (onset date 1/23/25), and angina pectoris. Review of Resident #4's physician orders revealed - Oxygen 2 liters via nasal cannula (NC) as needed (prn). Keep O2 (oxygen) saturation (sat) 92% or above if 92% on room air (RA) may discontinue prn order as needed for hypoxemia. Start date 1/30/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's Admission Record revealed the resident was admitted on [DATE]. The record included diagnoses not limited to unspecified chronic obstructive pulmonary disease, unspecified emphysema, and unspecified diastolic (congestive) heart failure. Review of Resident #56's physician order revealed orders - Oxygen at 1 lpm nasal cannula prn, discontinue (dc) if oxygen saturation 92% or above on RA as needed. Resident #56's doorway was observed without an oxygen in use sign. 5. Review of Resident #80's Admission Record revealed the resident was admitted on [DATE] and included diagnoses not limited to unspecified combined systolic (congestive) and diastolic (congestive) heart failure, unspecified cardiomyopathy, and unspecified uncomplicated asthma. Review of Resident #80's physician orders revealed the resident was to be administered O2 via nasal cannula at 2 lpm prn. Resident #80's doorway was observed without an oxygen in use sign. Review of Resident #81's Admission Record revealed the resident was admitted on [DATE] and included diagnoses of unspecified paroxysmal atrial fibrillation and (chronic) (peripheral) venous insufficiency. Review of Resident #81's physician orders revealed the resident was ordered O2 at 2 liter/minute NC continuously. Resident #81's doorway was observed without an oxygen in use sign. During observations on 2/5/25 at 1:45 p.m. Resident #147 was observed in room wearing oxygen cannula. There was no posting related to the use of oxygen. Review of Resident #147's admission record revealed the resident was admitted on [DATE] with diagnoses to include acute respiratory failure with hypoxia. Review of Resident #147's physician orders revealed the resident was to receive O2 2 liters via nasal cannula continuously every shift. During observations on 2/5/25 at 1:45 p.m. Resident #148 was observed lying in bed wearing oxygen via a nasal cannula. The doorway to the resident room revealed there was no posting related to the use of oxygen. Review of Resident #148's Admission Record revealed the resident was admitted on [DATE] and included diagnoses of paroxysmal atrial fibrillation, chronic diastolic (congestive) heart failure, and nonrheumatic mitral (valve) insufficiency. Review of Resident #148's physician order revealed the resident was to be administered O2 2L via nasal cannula PRN to maintain SPO2 92% or greater as needed PRN. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff D, Registered Nurse/Nurse Manager on 2/6/25 at 8:55 a.m. The staff member stated oxygen use should be posted at the doorway. An interview was conducted with the Director of Nursing (DON) on 2/6/25 at 9:14 a.m. The DON stated rooms should be posted for oxygen use and she had identified the issue the day before. Review of the policy - Oxygen Delivery Systems, revised 9/2024, revealed the purpose was To ensure [name of facility] patients/residents receive adequate oxygen delivery and to relieve hypoxia/hypoxemia. The policy revealed the E-cylinder procedure included O2 In Use/No Smoking Sign will be placed on door to room entrance. Photographic Evidence Obtained.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 46498 Based on observation interview and policy review, the facility failed to ensure federal staff posting dates were accurate for two (02/03/25 and 02/04/25) of four days of survey. Findings included: During a facility tour on 02/03/25 at 9:00 a.m. and on 02/04/25 at 8:32 a.m. an observation was made of the federal staff posting located outside of the front entrance door dated 02/02/25. During an interview on 02/05/25 at 2:00p.m., with the Interim Director of Nursing (DON). She stated the Unit Managers on the night shift are supposed to ensure the staffing numbers are correct and posted daily. She stated she was not aware the federal staff posting on the front entrance door had the wrong date for two days. Review of the facility policy titled, Staffing Data dated 12/5/2023 showed Policy: To provide guidelines and outlines responsibilities for maintaining compliance with State and Federal mandated staffing data. This includes the completion of the AHCA Staffing Compliance Form, the posting of daily staffing information, and submission of Payroll Based Journal (PBJ) data. Procedure: Posting of the Daily Staffing information is the responsibility of the 2nd shift Nurse Supervisor/ Designee. The information posted is reviewed by the Director of Patient Services/ Weekend Nurse Supervisor/ Designee for accuracy and compliance. Information must be posted in a clear and readable format, and in a prominent place readily accessible to residents and visitors. The Center will post the following information on a daily basis: 1. Facility Name 2. Current Date Photographic Evidence obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105128	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morton Plant Rehabilitation Center	400 Corbett St Belleair, FL 33756

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37999 Based on observation record review and interview the facility failed to ensure the medication error rate was less than 5.00%. Thirty-seven medication administration opportunities were observed, and 15 errors were identified for three residents (#56, #43, and #45) of six residents observed. These errors constituted a 40. 54% medication error rate. Findings included: 1. On 2/4/25 at 4:55 p.m. an observation was made of Staff A, Licensed Practical Nurse (LPN) obtain a capillary blood glucose level of Resident #56. The staff member cleansed the resident's left ring finger with an alcohol pad, lanced the finger, and obtained a level of 116. The staff member returned to the medication cart and reported the resident's sliding scale of Humalog insulin was not needed, however, the resident would receive the scheduled dosage of Humalog (Insulin Lispro). Staff A uncapped the Insulin Lispro Kwikpen, wiped the end with an alcohol pad, a needle was placed and uncapped, the staff member dialed the dosage selector to 2 units and depressed with insulin seen from end of needle. Staff A dialed the insulin pen to 5 units, re-entered the room, cleaned the resident's abdomen with an alcohol pad and injected the insulin into the left abdomen. Review of Resident #56's February Medication Administration Record (MAR) revealed the order: Humalog KwikPen Solution Pen-Injector 100 unit/milliliter (mL) (Insulin Lispro) - Inject 5 unit subcutaneously before meals related to Type 2 Diabetes Mellitus without complications. Hold if capillary blood glucose (CBG) less than (<) 120. An interview was conducted on 2/6/25 at 9:28 a.m. with the Interim Director of Nursing (DON). The DON reviewed the MAR and stated a checkmark (on MAR) did show the medication had been administered. 2. On 2/5/25 at 9:26 a.m. an observation was made of Staff B, Registered Nurse (RN) dispense the following medications for Resident #43: - Carbidopa-levodopa 25-100 milligram (mg) - 2 tablets - Vitamin D3 125 mcg (5000 international unit (iu) over-the counter (OTC) tablet - Losartan Potassium 25 mg tablet - Memantine 10 mg tablet - Potassium Extended Release (ER) 10 milliequivalents (meq) - 2 tablets (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The observation showed the medication profile for the Carbidopa-levodopa was colored red. Staff B confirmed dispensing 7 tablets and entered the resident room at 9:30 a.m. The resident was asleep, and the staff member had difficulty waking up the resident. The resident sat at edge of bed and began taking medications at 9:43 a.m. After the administration the staff member reported Carbidopa was late due to the resident would not wake up earlier and had to go back. Review of Resident #43s February Medication Administration Record (MAR) revealed the following: - Carbidopa-Levodopa Oral Tablet 25-100 mg - Give 2 tablets by mouth three times a day for Parkinsons. This order was scheduled for 8:00 a.m., 12:00 p.m., and 4:00 p.m. - Carbidopa-Levodopa Extended Release (ER) tablet 50-200 mg - Give 1 tablet by mouth at bedtime related to Parkinson's disease with dyskinesia without mention of fluctuations. The order was scheduled for 8:00 p. m. Review of Resident progress notes including administration notes, on 2/5/25 at 11:25 a.m. did not reveal the physician had been notified of the late medication, administered 1 hour and 43 minutes after the scheduled time and 2 hours and 15 minutes prior to the next scheduled time of administration. 3. On 2/5/25 at 10:09 a.m. Staff B Registered Nurse (RN) reported medications were late. The observation was made of Staff B, Registered Nurse (RN) dispense the following medications for Resident #45: - Allopurinol 100 milligram tablet - Aspirin 81 mg chewable tablet - Vitamin D3 25 mcg (1000iu) - 2 tablets - Clopidogrel 75 mg tablet - Furosemide 20 mg tablet - Isosorbide Mono Extended Release (ER) 120 mg tablet - Kerendia 10 mg tablet - Lamotrigine 100 mg tablet - Metoprolol Tartrate 50 mg tablet - Ranolazine ER 1000 mg tablet - Vascepa 1 gram (gm) capsule - Acetaminophen 325 mg - 2 tablets. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The observation revealed the medication profiles other than the as needed (PRN) dosage of Acetaminophen was colored red, showing the medications were late. The staff member reported not having the residents Lisinopril available and would have to contact the pharmacy. Staff B confirmed dispensing 14 tablets, entered the resident's room, and watched the resident swallow the medications. Immediately following the administration, Staff B stated the reason for being late was due to extra time taken with Resident #43. Review of Resident #45's February Medication Administration Record (MAR) revealed Allopurinol, Aspirin, Vitamin D3, Clopidogrel, Finerenone (Kerendia), Furosemide, Isosorbide, Lamotrigine, and Lisinopril were due at 9:00 a.m. The medications of Icosapent Ethyl (Vascepa), Metoprolol, and Ranolazine was due at 9:00 a.m. and 9:00 p.m. The MAR showed the resident was to receive 2 capsules of Vascepa versus the one capsule given. Review of Resident #45s progress notes completed on 2/6/25 at 12:44 p.m. showed Staff B had documented 99 (per chart codes 99=Other/See Nurse Notes) for the administration of the residents' Lisinopril. The nurses' note for Lisinopril, 2/5/25 at 10:21 a.m. read Will follow up with pharmacy. The progress notes did not reveal if pharmacy was notified of the unavailable medication, and the notes did not reveal if the physician had been notified of the unadministered medication. An interview was conducted with Staff D, Registered Nurse/Nurse Manager (RN/NM) on 2/6/25 at 8:59 a.m. Staff D stated there was an electronic medication dispenser on each unit, if (medication) was not available, pharmacy was notified, and the medication was STAT'd (meaning immediately ordered) out, then the physician was notified the resident did not get the medication. The staff member stated the physician was to be notified at the time the nurse was working with that resident. An interview was conducted with the DON on 2/6/25 at 8:59 a.m. The DON stated the physician is to be notified of late meds when the medications are identified as late. Review of the policy - Medication Administration Time Delivery Guideline, revised 8/2023, revealed the purpose was The initial start time for medication administration to residents/patients for routine medications are the same daily. Medication administration must be completed within 2 hours, 1 hour prior to the scheduled time and one hour past the scheduled time. Review of the policy - Medication Administration, issued 11/2024, revealed the purpose was To provide a safe, effective medication administration process. The policy was for A licensed nurse will administer medication to patients/residents per state regulations. Accepted standards of practice will be followed. The practice standards included: a. If medication(s) is not available, the nurse will: 1) Coordinate with the pharmacy to procure the medication(s) as soon as possible and discuss possible substitution options with the pharmacist, if applicable. 2) Notify the physician/ practitioner of the unavailability of the medication(s). 3) Discuss substitution options for the ordered medication(s) with the physician/ practitioner, if applicable. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) If unable to provide medication(s) or substitution(s) within one hour of prescribed time, notify supervisor.