Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105613	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Suwan	1620 Helvenston St SE Live Oak, FL 32064

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40559 Based on observation, interview, and record review, the facility failed to ensure residents' right to live in a manner that promoted their quality of life for 1 of 57 residents sampled, Resident #135. Findings include: Review of Resident #135's admission record showed the resident was admitted on [DATE] with diagnoses including type 2 diabetes mellitus, major depressive disorder, unspecified mood (affective) disorder, and acquired absence of left leg below knee. Review of Resident #135's Service Dog Card showed it read, The Americans with Disabilities Act of 1990 mandates the handler and their service dog shall have full access to all public places. It is Federal law. Handler: [Resident #135's Name], Dog Name: [Resident #135's dog's name], Breed: Mixed, ID Number: [Service Dog ID]. The card contained a photo of the service dog. Review of Resident #135's Minimum Data Set (MDS) assessment dated [DATE] under Section GG-Functional Abilities for self-care showed the resident was independent for eating, oral hygiene, toileting hygiene, self-showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. For mobility, the resident was independent for rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. During an interview on 2/6/2025 at 3:32 PM, Resident #135 stated, Not having my service animal has caused me great distress. I get depressed and very agitated. The facility says they have 24-hour monitoring, but that is not the case. The dog was a rescue, and I had to nourish it back to health. I took it to training so now he is my diabetes dog. Since 11/19/2024, I have been trying to get permission to bring it. They said no it's not going to happen. The options they gave me were to pay for a private room or a sitter, but I cannot afford it. I am afraid to lose him. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #135's Advanced Registered Nurse Practitioner (ARNP) visit note dated 12/27/2024 showed it read, HPI [History of Present Illness] General . Patient seen today for an initial psych evaluation to rule out symptoms of depression and anxiety given recent medical hospitalization , current physical functioning, and reduced mobility. Patient is seen and examined, sitting up at bedside finishing lunch, in no acute apparent distress . Her mood is euthymic; affect is appropriate. Mood is congruent to affect . She voices her depression is managed at this time but her anxiety is not . She voices her frustration with not being allowed to have her service dog with her at bedside. Review of Resident #135's Advanced Registered Nurse Practitioner (ARNP) visit note dated 1/17/2025 showed it read, HPI General . The patient is being seen today for a follow up visit . Patient seen and examined, at bedside, in no acute apparent distress . She shares a recent issue that caused her increased stress at facility Review of Systems: Depression: depressed mood and insomnia, Anxiety: Excessive anxiety and worry, Not able to control worry . Aggravating factors: Ongoing medical problems and life stressors and being in the facility. During an interview on 2/6/2025 at 4:10 PM, the Administrator stated that he has had no interactions or met Resident #135 prior to about 10 minutes ago when he went to her room to discuss the direction the facility was going to take regarding her service animal. During an interview on 2/7/2025 at 2:25 PM, Resident #135's ARNP stated, I did initial evaluation when we first encounter together. She has a long history of mental history, psychosocial history and anxiety. She has pretty severe history of anxiety, but has nothing to do with the dog. She has suicidal ideation. It is not about the dog just has a lot of coping to do. She is going to have a lot of future adjustments. She is not sleeping well and other underlying health conditions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47275 Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 1 of 4 residents reviewed for discharge, Resident #150. Findings include: Review of Resident #150's admission record showed the resident was admitted to the facility on [DATE]. Review of Resident #150's physician order dated 1/13/2025 showed it read, Discharge home with [Name of Home Care Provider]- SN [skilled Nursing] for wound care to left heel, scrotum, left ischium, left plantar, right elbow, right ischium, and sacrum. PT [Physical therapy] to evaluate and treat. Review of Resident #150's Discharge Return not Anticipated MDS assessment dated [DATE] showed the resident was discharged to short-term general hospital. During an interview on 2/5/2025 at 10:37 AM, the MDS Coordinator confirmed that Resident #150's discharge status was coded as short-term general hospital. The MDS Coordinator stated, It has been coded wrong. The patient was not discharged to a hospital. The patient was discharged home. When requested a policy for MDS assessments, the MDS Coordinator stated, We use the RAI [Resident Assessment Instrument] specified by the State.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on record review and interview, the facility failed to develop a comprehensive care plan for 1 of 3 residents reviewed for behaviors, Resident #48. Findings include: Review of Resident #48's admission record showed the resident was admitted on [DATE] with diagnoses including encephalopathy, seizures, major depressive disorder, pseudobulbar affect, schizoaffective disorder and mood disorder due to known physiological condition. Review of Resident #48's physician order dated 10/11/2024 showed it read, Nuedexta Oral Capsule 20-10 mg [milligrams] (Dextromethorphan HBr-Quinidine Sulfate), Give 1 capsule via G-tube [gastric tube] two times a day for PBA [Pseudobulbar Affect: a neurological condition characterized by involuntary and uncontrollable episodes of laughing or crying, often in inappropriate situations]. Review of Resident #48's care plan did not reveal a focus for care and services related to pseudobulbar affect. During an interview on 2/6/2025 at 4:15 PM, the MDS Coordinator stated, After reviewing [Resident #48's name] care plan, I do not see that he is care planned for Pseudobulbar Affect. Review of the facility policy and procedure titled Nursing-Care Plans-Comprehensive-Person Centered with the last review date of 1/13/2025 showed it read, Purpose: To ensure the development and implementation of a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents' physicals , psychosocial and functional needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49846 Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with currently accepted professional principles for 2 of 6 residents reviewed for medication administration, Residents #6 and #87. Findings include: 1) During an observation on 2/5/2025 at 9:00 AM, Resident #87 was eating breakfast in her room. There was a small plastic cup containing medications on top of her bedside. During an interview on 2/5/2025 at 9:00 AM, Resident #87 stated, I take my medication with food and not on an empty stomach. Review of Resident #87's physician orders revealed no orders for self-administering medications. During an interview on 2/6/2025 at 8:24 AM, Staff L, Registered Nurse (RN), stated, I left the medication at bedside. [Resident #87's name] likes to take her medication with food. I know this is not normal practice and is wrong. During an interview 2/6/2025 at 9:09 AM, the Director of Nursing (DON) stated, It is not protocol to leave the medication at bedside and maybe we can get the order changed for her [Resident #87], so she gets her medication when breakfast is served and staff not leave the medication at bedside. Medication should not be left unattended. 51447 2) During an observation on 2/4/2025 at 3:08 PM, there was a white oval pill sitting on Resident #6's shirt. During an interview on 2/4/2025 at 3:09 PM, Staff U, Licensed Practical Nurse (LPN), confirmed there was a medication on Resident #6's shirt and stated the nurse should stay until the medication was taken. Review of the facility policy and procedure titled Medication Dispensing System with the last review date of 1/13/2025 showed it read, Policy: All medications will be prepared (blister cards, vials, Artromick box) and administered in a manner consistent with the general requirements outlined in this policy. Procedure . J. Medication Administration . 8. Ensure that the customer swallows all the medication(s).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51447 Based on observation, interview, and record review, the facility failed to ensure the residents who are unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal and oral hygiene for 2 of 4 residents reviewed for ADL care, Residents #88, and #131. Findings include: 1) During an observation on 2/4/2025 at 9:24 AM, Resident #88 was lying in bed. The resident's face was oily, her lips were dry and cracked with a dried crusty substance on them, and her mouth was dry when she tried to talk. During an observation on 2/4/2025 at 10:52 AM, Resident #88's lips were dry and cracked with a dried crusty substance on them, and her mouth was dry when she tried to talk. Review of Resident #88's admission record showed the resident was admitted on [DATE] with the diagnoses including encephalopathy, muscles weakness, and failure to thrive. Review of Resident #88's MDS dated [DATE] showed the resident was dependent for performing personal hygiene (oral hygiene) under Section GG- Functional Abilities. During an interview on 2/7/2025 at 8:39 AM, Staff P, CNA, confirmed Resident #88 did not receive ADL care and stated, On average, the CNAs will have 16 to 18 residents in their assignments. I feel like I can meet the needs of my residents because I have a lot of experience being a CNA, but other CNAs who are newer tend to have difficulty getting the tasks done. 2) During an observation on 2/3/2025 at 2:30 PM, Resident #131's lips were cracked and had a buildup on them. His teeth were discolored with a thick film on them and his mouth was dry. During an observation on 2/4/2025 at 8:46 AM, Resident #131's teeth had a thick film substance on them. His mouth was dry, and his lips were cracked and had a substance buildup on them. During an observation on 2/5/2025 at 10:55 AM, Resident #131's lips were dry and had a substance caked on them. His teeth were discolored with a thick film on them and his mouth was dry. During an interview on 2/5/2025 at 10:55 AM, Resident #131 stated that he had not had any (ADL) care so far today and if they provided care to him like oral care, he would be a lot more comfortable and would like to have it done. Review of Resident #131's admission record showed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, muscle weakness, polyosteoarthritis and dorsalgia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #131's Minimum Data Set (MDS) dated [DATE] showed the resident was dependent for performing oral hygiene, showering/bathing and personal hygiene under Section GG- Functional Abilities. During an interview on 2/5/2025 at 11:12 AM, Staff B, Certified Nursing Assistant (CNA), stated, I have not been able to care for [Resident #131's name] yet today because I have been taking care of the other residents in the assignment. It is hard to meet the needs of all residents in an assignment because there are so many residents, and the residents tend to require a lot of care. During an interview on 2/6/2025 at 9:08 AM, the Director of Nursing stated that her expectation for the staff would be to provide each resident with the ADL care they need based on their care plan. During an interview with the Administrator on 2/7/2025 at 2:00 PM, when a policy on ADL assistance was requested, no policy was provided.

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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. 46523 Based on record review and interview, the facility failed to ensure residents received blood pressure medications following parameters for 1 of 6 residents reviewed for medication administration, Resident #136. Findings include: Review of Resident #136's physician order dated 6/8/2024 showed it read, Amlodipine Besylate Oral Tablet 5 mg [milligram] (Amlodipine Besylate), Give 1 tablet by mouth one time a day for hypertension, Hold for systolic less than 110 or pulse less than 60. Review of Resident #136's Medication Administration Record (MAR) for January 2025 showed the resident received Amlodipine 5 mg on 1/2/2025 at 9:00 AM when systolic blood pressure was 102 and pulse was 59 and on 1/12/2025 at 9:00 AM when pulse was 58. Review of Resident #136's physician order dated 6/8/2024 showed it read, Losartan Potassium Oral Tablet 100 mg (Losartan Potassium), Give 1 tablet by mouth one time a day for hypertension, Hold for systolic less than 110 or pulse less than 60. Review of Resident #136 MAR for January 2025 showed the resident received Losartan Potassium 100 mg on 1/2/2025 at 9:00 AM when systolic blood pressure was 102 and pulse was 59 and on 1/12/2025 at 9:00 AM when pulse was 58. Review of Resident #136's physician order dated 8/8/2024 showed it read, Propranolol HCl Oral Tablet 40 mg (Propranolol HCl), Give 1 tablet by mouth two times a day for hypertension, Hold for systolic less than 110 or pulse less than 60. Review of Resident #136's MAR for January 2025 showed the resident received Propranolol HCl 40 mg on 1/2/2025 at 9:00 AM when systolic blood pressure was 102 and pulse was 59, on 1/12/2025 at 9:00 AM when pulse was 58, on 1/14/2025 at 9:00 AM and at 9:00 PM when pulse was 49, on 1/17/2025 at 9:00 AM and at 9:00 PM when pulse was 59, on 1/22/2025 at 9:00 AM and at 9:00 PM when systolic blood pressure was 109 and pulse was 51, on 1/27/2024 at 9:00 PM when pulse was 55, and 1/28/2025 at 9:00 AM and at 9:00 PM when systolic blood pressure was 109 and pulse was 51. During an interview on 2/5/2025 at 9:02 AM, the Director of Nursing (DON) stated, Nurses are to follow the parameters that the doctor puts in place. If they have any questions or need to clarify an order, they should contact the provider. During an interview on 2/6/2025 at 9:25 AM, the Advance Practice Registered Nurse (APRN) #1 stated, I expect if an order has parameters, the nursing staff should follow the orders. [Resident #136's name] has not had any recent medical concern. (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 facility policy and procedure titled Administering Medications with the last review date of 1/13/2025 showed it read, Purpose: To ensure that medications are administered in a safe and timely manner, and as prescribed. General Guidelines . 3. Medications are administered in accordance with prescriber orders, and current standards of practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50695 Based on observation, record review, and interview, the facility failed to ensure residents received oxygen as prescribed by physician for 1 of 8 residents sampled for oxygen therapy, Resident #28. Findings include: During an observation on 2/3/2025 at 9:47 AM, Resident #28 was in bed. The resident was not receiving oxygen. The oxygen tubing was no dated. During an observation on 2/4/2025 at 10:34 AM, Resident #28 was lying in bed with eyes closed and glasses on. Resident #28 was receiving oxygen via nasal cannula at 3.5 liters per minute. There was no date on the canula or humidification bottle. During an observation on 2/5/2025 at 12:18 PM, Resident #28 was receiving oxygen via nasal cannula at 4.5 liters per minute. Review of Resident #28's admission record showed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses including metabolic encephalopathy, acute and chronic respiratory failure with hypercapnia (abnormally elevated carbon dioxide levels in the blood), acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues), chronic obstructive pulmonary disease, obstructive sleep apnea, acute pulmonary edema, unspecified systolic (congestive) heart failure, muscle weakness, need for assistance with personal care, and morbid (severe) obesity due to excess calories. Review of Resident #28's physician orders showed an order dated 1/3/2025 for administration of oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath. Review of Resident #28's Treatment Administration Record (TAR) for February 2025 showed the resident received oxygen at the rate of 2 liters per minute on 2/3/2025 on both twelve-hour shifts, 2/4/2025 on both twelve-hour shifts, and on 2/5/2025 on the first twelve-hour shift. During an interview on 2/5/2025 at 12:25 PM, Staff D, Registered Nurse (RN), stated, I signed off on [Resident #28's name] oxygen this morning. We are supposed to check that he has O2 [oxygen] on, and I think we just have to check his O2 [oxygen saturation] level. I didn't know that the rate was there too when I signed it. It does say he is supposed to be on 2 liters [per minute]. I didn't look [at the oxygen concentrator], I just assumed it was at the right rate. During an interview on 2/5/2025 at 12:40 PM, the Respiratory Therapist stated, He [Resident #28] is supposed to be on 2 liters of oxygen [per minute]. I don't know who is changing the rates. I don't think it is him. I don't think he can reach it. I changed the tubing and water bottle yesterday. I wasn't here last week and someone else was changing the tubing for me. I am not sure where she put the dates. During an interview on 2/5/2025 at 12:50 PM, the East Wing Unit Manager stated, I expect the nurses to confirm the order for all residents who are on oxygen. That includes the rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 2:50 PM, the Director of Nursing (DON) stated, I expect the nurses to confirm all the rights, including the right rate and the number of hours they are receiving oxygen. Review of the facility policy and procedure titled Nursing- Oxygen Administration with the last review date of 1/13/2025 showed it read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Process . 6. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute . Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record . 3. The rate of oxygen flow, route, and rationale.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40559 Based on observation and interview, the facility failed to ensure the nurse staffing data was posted on a daily basis. Findings include: During an observation upon entrance to the facility on [DATE] at 9:00 AM, the nurse staffing information in the reception area was dated Friday 1/31/2025. During an interview on 2/3/2025 at 9:05 AM, the Administrator confirmed the nurse staffing data posted was for 1/31/2025 and not 2/3/2025. During an interview on 2/5/2025 at 2:00 PM, when a policy on posting of nurse staffing information was requested, the Administrator stated the facility did not have a policy and he expected it to be posted accurately daily.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40559 Based on record review and interview, the facility failed to ensure the attending physician documented their rationale related to pharmacy recommendations and failed to ensure to implement the physician's agreed changes for 3 of 5 residents reviewed for drug regimen, Residents #23, #101, and #124. Findings include: 1) Review of the Drug Regimen Review for Resident #23 dated 3/22/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Lamotrigine (Lamictal) for Mood without recent attempt to taper. Please evaluate and consider an attempt at gradual dose reduction with eventual discontinuation or document inability to do so. Please note: abrupt cessation not recommended. Consider a slow taper over 4 weeks then discontinue. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #23 dated 4/24/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Alprazolam 0.25 mg [milligram] daily without recent attempt to taper. Please evaluate current need. Consider taper to 0.25 mg every other day with eventual discontinue or document inability to do so. There was no physician response documented on recommendation. Review of the Drug Regimen Reviews for Resident #23 dated 8/16/2024 and 11/12/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Trazodone 100 mg at bedtime for insomnia without recent attempt to taper. Please evaluate, consider trial taper 50 mg at bedtime or document inability to do so. There was no physician response documented on recommendation. Review of the Drug Regimen Reviews for Resident #23 dated 12/13/2024 and 1/29/2025 showed it read, Consultant Pharmacist Recommendations: Currently receiving Alprazolam which can increase risk of dizziness and falls. Per clinical record, with recent falls. Please evaluate, consider tapering dose or implementing alternative treatment if necessary . Currently receiving Aripiprazole (Abilify) which can increase risk of falls. Per clinical record, with recent falls. Please evaluate, consider tapering dose or implementing alternative treatment if necessary. There was no physician response documented on recommendation. Review of the Drug Regimen Reviews for Resident #23 dated 1/29/2025 showed it read, Consultant Pharmacist Recommendations: Currently receiving Gabapentin which has potential for dizziness and drowsiness, increasing the risk of falls. Per clinical record, with recent falls. Please evaluate possible causal relationship. Consider trial taper to discontinue Gabapentin, if appropriate. There was no physician response documented on recommendation. Review of Resident #23's Medication Regimen Review for Resident #23 dated 6/10/2024 showed the physician agreed with Consultant Pharmacist's recommendation for adding pain parameters to avoid misuse for Oxycodone. The physician signed off on 6/17/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Bedrock Rehabilitation and Nursing Center at Suwan		STREET ADDRESS, CITY, STATE, ZIP CODE: 1620 Helvenston St SE Live Oak, FL 32064	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's physician orders showed no order to implement the physician's agreed changes on 6/17/2024. Review of Resident #23's Medication Regimen Review for Resident #23 dated 9/19/2024 showed the physician agreed with the Consultant Pharmacist's recommendation for evaluation of current need and discontinuation of Lactulose by ordering to change the order to PRN (as needed) and agreed with the Consultant Pharmacist's recommendation for adding pain parameters for Oxycodone. The physician signed off on 10/3/2024. Review of Resident #23's physician orders showed no order to implement the physician's agreed changes on 10/3/2024. 2) Review of the Drug Regimen Review for Resident #101 dated 3/22/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Tramadol which has potential for dizziness and drowsiness, increasing the risk of falls. Per clinical record, with recent falls. Please evaluate possible causal relationship. Consider trial discontinue Tramadol and start alternate therapy (i.e. Ibuprofen or Acetaminophen), if necessary. The physician disagreed with the recommendation on 3/26/2024, but no reason was documented. Review of the Drug Regimen Review for Resident #101 dated 5/9/2024 showed it read, Consultant Pharmacist Recommendations: Currently with routine fingerstick blood sugar monitoring. Please consider add order to notify MD [Medical Doctor] if results <70 or > 300, if appropriate, There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #101 dated 6/10/2024 showed it read, Consultant Pharmacist Recommendations: Currently with active order for sliding scale insulin coverage without order for long-acting or basal insulin. Long term use not recommended due to higher risk of hypoglycemia without improvement in hyperglycemia management. Consider discontinue insulin coverage and taper fingerstick order to two times a week, AM and PM, notify MD if results below 70 or greater than 250, if appropriate. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #101 dated 7/10/2024 showed it read, Consultant Pharmacist Recommendations: Currently with active order for Senna prn which has not been used in greater than 30 days. Please evaluate current need and discontinue if appropriate . Currently has an active order for Acetaminophen prn for fever which has not been used in greater than thirty days. Please consider discontinue unused order at this time. (Please also note that any new use of acetaminophen for fever at this time would require your notification of a change in medical status, making the presence of a prn order for acetaminophen unnecessary.) There was no physician response documented on recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Drug Regimen Reviews for Resident #101 dated 8/16/2024 and 9/19/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Oxcarbazepine. Per order, use is for a diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this mediation for an approved use such as Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions or discontinuing at this time . Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. Please evaluate and consider discontinue Lorazepam prn, if appropriate. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #101 dated 10/22/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Loratadine without a stop date. Please evaluate. Consider add stop date now if appropriate . Currently receiving Simvastatin (Zocor) for dyslipidemia. Unable to located recent serum lipid profile in chart. Recommended 3 months after start then annually. Please consider ordering . Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. Please evaluate and consider discontinue Lorazepam prn, if appropriate . Currently receiving Oxcarbazepine. Per order, use is for a diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this mediation for an approved use such as Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions or discontinuing at this time. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #101 dated 11/12/2024 showed it read, Consultant Pharmacist Recommendations: Currently with active order for Guaifenesin LA [long acting] (Mucinex) prn which has not been used recently. Please evaluate current need and discontinue if appropriate . Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. Please evaluate and consider discontinue Lorazepam prn, if appropriate . Currently receiving Oxcarbazepine. Per order, use is for a diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this mediation for an approved use such as Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions or discontinuing at this time. There was no physician response documented on recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Drug Regimen Review for Resident #101 dated 12/13/2024 showed it read, Consultant Pharmacist Recommendations: Currently has active order for Hydrocodone/APAP [Acetaminophen] without a stop date. Emerging data highlights an association between opioid administration and delirium. Please evaluate duration of therapy. Consider add stop date of 14 days, if appropriate . Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. Please evaluate and consider discontinue Lorazepam prn, if appropriate . Currently receiving Oxcarbazepine. Per order, use is for a diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this mediation for an approved use such as Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions or discontinuing at this time. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #101 dated 1/29/2025 showed it read, Consultant Pharmacist Recommendations: Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders for PRN psychotropics on medication profiles. Please evaluate and consider discontinue Lorazepam prn, if appropriate . Currently receiving Oxcarbazepine. Per order, use is for a diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this mediation for an approved use such as Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reductions or discontinuing at this time. There was no physician response documented on recommendation. 46523 3) Review of the Drug Regimen Review for Resident #124 dated 4/23/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Megestrol (Megace) for appetite stimulation and weight gain. Long term use not recommended due to increased thromboembolic risk with use. Please evaluate. Consider add stop date x [times] 14 days, if appropriate . Currently with active order for sliding scale insulin coverage without standing order medication for diabetes. Long term use not recommended due to higher risk of hypoglycemia without improvement in hyperglycemia management. Consider discontinue insulin coverage and taper fingerstick order to two times a week, AM and PM, notify MD if results below 70 or greater than 250, if appropriate There was no physician response documented on recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Drug Regimen Review for Resident #124 dated 5/9/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Lansoprazole (Prevacid) for GI [Gastrointestinal] prophylaxis. Long term use for this indication is not recommended due to increased risk of pneumonia, fractures and C. difficile [Clostridium difficile], and development of vitamin B12 deficiency. Please evaluate continued need. Consider trail taper to every other day for 14 days then discontinue, if appropriate . Currently with active order for Ondansetron (Zofran) prn which has not been used in over 30 days. Please evaluate current need and discontinue if appropriate . Currently with active order for sliding scale insulin coverage without standing order medication for diabetes. Long term use not recommended due to higher risk of hypoglycemia without improvement in hyperglycemia management. Consider discontinue insulin coverage and taper fingerstick order to two times a week, AM and PM, notify MD if results below 70 or greater than 250, if appropriate . Currently receiving Mirtazapine (Remeron) for anorexia which can increase risk of dizziness and falls with recent documented falls. Please evaluate risk versus benefit and discontinue, if appropriate . Per clinical record resident with recent falls, recommended to check 25-hydorxyvitamin D levels in those with advanced age and recent falls. Please consider ordering and if necessary initiating vitamin D3 50,000IU capsule once weekly for 6 weeks then monthly thereafter. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #124 dated 9/19/2024 showed it read, Consultant Pharmacist Recommendations: Currently receiving Mirtazapine (Remeron) which can increase risk of dizziness and falls, with recent documented falls, Please evaluate risk versus benefit and discontinue, if appropriate . Currently with active order for Hydrocodone /APAP which can increase risk of falls with recent documented falls per clinical record. Please evaluate possible causal relationship. Consider tapering dose or implementing alternative treatment, if appropriate. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #124 dated 10/22/2024 showed it read, Consultant Pharmacist Recommendations: Per clinical record resident with recent falls. A daily intake of 800-1,000 IU [International Unit] of Vitamin D is currently recommended in the elderly to maintain bone health and reduce the risk of falls and factures. Please evaluate. Consider adding Vitamin D3 1000IU once daily, if appropriate. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #124 dated 11/12/2024 showed it read, Consultant Pharmacist Recommendations: Currently has an active order for Lorazepam prn without a specified stop date. Please note that CMS guidelines do not allow maintaining open ended orders or prn psychotropics on medication profiles. Please evaluate and consider discontinuing Lorazepam prn, if appropriate. There was no physician response documented on recommendation. Review of the Drug Regimen Review for Resident #124 dated 12/13/2024 showed it read, Consultant Pharmacist Recommendations: Currently with active order for Hydrocodone /APAP which can increase risk of falls with recent documented falls per clinical record. Please evaluate possible causal relationship. Consider tapering dose or implementing alternative treatment, if appropriate . Currently receiving Mirtazapine (Remeron) which can increase risk of dizziness and falls, with recent documented falls, Please evaluate risk versus benefit and discontinue, if appropriate . Currently receiving Quetiapine (Seroquel) which can increase risk of falls. Per clinical record, with recent falls. Please evaluate, consider tapering dose or implementing alternative treatment, if necessary. There was no physician response documented on recommendation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Drug Regimen Review for Resident #124 dated 1/28/2025 showed it read, Consultant Pharmacist Recommendations: Currently receiving Hydroxyzine (Atarax) as an anxiolytic. Please note: hydroxyzine is NOT recommended for use as an anxiolytic. Consider taper to prn for one week and discontinue, or document inability to do so . Currently receiving Quetiapine (Seroquel). Per order, use is for diagnosis other than an approved psychiatric condition. Please evaluate accuracy of diagnosis. If the diagnosis is inaccurate and the resident currently is using this medication for an approved use such as Schizophrenia, Bipolar Disorder, or other chronic enduring psychiatric condition, please update the medication order accordingly. If no approved chronic enduring psychiatric diagnosis exists, please consider implementing gradual dose reduction and discontinues at this time. There was no physician response documented on recommendation. During an interview on 2/6/2025 at 10:15 AM, the Director of Nursing (DON) confirmed the pharmacist recommendations had not been reviewed by physicians and that the recommendations that were agreed upon had not been implemented Residents #23, #101, and #124. The DON further confirmed when the physician disagreed, they did not document a reason. She stated her expectation was that the recommendations were printed, presented to the physicians and then any agreed upon changes recorded in the resident's medical records.

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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. 46523 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not 5 percent or greater. The medication error rate was 10.81 percent. Findings include: 1) Review of Resident #11's physician order dated 10/18/2023 showed it read, Trazodone HCl Oral Tablet 150 mg [milligram] (Trazodone HCl), Give 150 mg by mouth two times a day for depression. Review of Resident #11's physician order dated 1/2/2025 showed it read, Tizanidine HCl Oral Tablet 4 mg (Tizanidine HCl), Give 2 tablet by mouth four times a day for muscle spasms. During an observation on 2/3/2025 at 11:12 AM, Staff E, Licensed Practical Nurse (LPN), began to pour Resident #11's medications into a medication cup. Staff E poured one tablet of Tizanidine 4 mg. Staff E did not pour Trazodone 150 mg (milligram). Staff E began to pour water into a medication cup and was getting ready to give the medications to Resident #11. Staff E was asked to review the medications that were in her medication cup. During an interview on 2/3/2025 at 11:15 AM, Staff E, LPN, stated, I am missing the Trazodone and Tizanidine should be two tablets instead of one. During an interview on 2/7/2025 at 10:37 AM, the Advanced Practice Registered Nurse (APRN) #1 stated, One time missed dose of medication does not have an impact to the patient. The nurses have not contacted me recently for any complaints of discomfort or pain. 2) During an observation on 2/4/2025 at 8:03 AM, Staff F, LPN, entered Resident #206's room and handed him a medication cup that contained medications. Resident #206 asked Staff F what the medications were in his cup. Staff F stated she did not know because she was training and Staff G, LPN, was the one to prepare the medication. Staff F and Resident #206 went outside of the room. Staff G was standing next to the medication cart. Resident #206 asked Staff G what the medication were in his cup. Staff G stated what was in the medication cup and asked Resident #206 if he wanted his multivitamin. Resident #206 stated he would take the multivitamin. Staff G opened the medication cart and poured the multivitamin into the medication cup that was originally given to Resident #206. Staff G handed the medication cup back to Resident #206. During an interview on 2/6/2025 at 9:36 AM, Staff G, LPN, stated, I normally put all his [Resident #206] medications in the medication cup. I overlooked the multivitamin. It was just so hectic. Review of Resident #206's physician order dated 12/25/2024 showed it read, Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ [with] Minerals), Give 1 tablet by mouth one time a day for at risk for malnutrition. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) During an observation on 2/5/2025 at 11:30 AM, Staff H, Registered Nurse (RN), began to prepare Resident #116's medications. Staff H placed a Lansoprazole Delayed Release 30 mg capsule into a medication cup. Staff H donned a pair of gloves and opened Lansoprazole Delayed Release capsule. Staff H asked a certified nursing assistant to grab him some warm water in a Styrofoam cup. Staff H proceeded to walk to Resident #116's room. Staff H placed Resident #116's feeding on hold and proceeded to check gastric tube for placement. Staff H was getting ready to premix the medications with water. Staff H was requested to check the delayed released medication. During an interview on 2/5/2025 at 11:49 AM, Staff H, RN, stated, [Resident #116's name] has a gtube [gastric tube]. She should not have an order for delayed release medication. The medication should be in liquid form. During an interview on 2/5/2025 at 5:00 PM, Staff H, RN, stated, I got clarification and the doctor changed the medication to the liquid due to the size of her tubing because it could clog the tubing due to the size. Review of Resident #116's physician order dated 8/22/2024 showed it read, Lansoprazole Oral Capsule Delayed Release 30 mg (Lansoprazole), Give 1 capsule via G-tube in the morning for GERD [Gastro-Esophageal Reflux Disease]. During an interview on 2/6/2025 at approximately 10:15 AM, the Director of Nursing stated, Delayed release medication should not be administered via gastric tube. If a nurse sees an order that is questionable, they should contact the provider for notification. The nurses should be validating all the medications against the MAR [Medication Administration Record] before giving. Review of the facility policy and procedure titled Administering Medications with the last review date of 1/13/2025 showed it read, Purpose: To ensure that medications are administered in a safe and timely manner, and as prescribed. General Guidelines . 3. Medications are administered in accordance with prescriber orders, and current standards of practice . 8. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication . 19. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall enter the correct code into the bos [Sic.] on eMAR [electronic Medication Administration Record] followed by nursing note if indicated. 20. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Review of the facility policy and procedure titled Medication Dispensing System with the last review date of 1/13/2025 showed it read, Policy: All medications will be prepared (blister cards, vials, Artromick box) and administered in a manner consistent with the general requirements outlined in this policy. Procedure . G. Prior to Medication Administration: 1. Verify each medication preparation that the medication is the right drug, at the right dose, the right route, at the right rate, at the right time, for the right customer. (continued on next page)

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	105613	A. Building B. Wing	02/07/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure titled Administering Medications Through an Enteral Tube with the last review date of 1/13/2025 showed it read, Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . General Guidelines . 5 . c . Do not crush enteric coated, sustained release, buccal, sub-lingual, or enzyme-specific medications. Notify physician and obtain guidance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47275 Based on observation, interview, and record review, the facility failed to ensure food items were labeled in 1 of 3 nourishment rooms. Findings include: During an observation on 2/3/2025 at 9:25 AM while conducting a tour of the nourishment rooms with the Certified Dietary Manager (CDM), there were one unlabeled and undated grocery bag containing Chicken BLT salad bowl, one unlabeled and undated Chef salad bowl, and one unlabeled and undated clear plastic container of blackberries on the bottom shelf of the refrigerator in Nutrition room [ROOM NUMBER] located on the 300 hallway. During an interview on 2/3/2025 at 9:30 AM, the CDM stated, All foods brought in must be labeled with the residents' name, when it was brought in, and the expiration date of 7 days after it was brought in. Review of the facility policy and procedure titled Food: Safe Handling for Foods from Visitors with the last review date of 1/13/2025 showed it read, Procedures . 4. When food items are intended for later consumption, the responsible facility staff member will . Label foods with the resident name and the current date.

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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 - Some	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** 40559 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 of 6 residents reviewed for blood pressure medication, residents reviewed for medication, Residents #40 and #122, 1 of 3 residents reviewed for dialysis care, Resident #80, 1 of 10 residents reviewed for advance directives, Resident #127, and 1 of 8 residents sampled for oxygen therapy, Resident #28. Findings include: 1) Review of Resident #80's admission record showed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses including end stage renal disease, sepsis, and anemia. Review of Resident #80's Dialysis Hand Off Communication Report dated [DATE] showed no information documented for presence of bruit/thrill, catheter dressing, signs/symptoms of infection upon his return to the facility. Review of Resident #80's Dialysis Hand Off Communication Report dated [DATE] showed no information documented for presence of bruit/thrill, catheter dressing, signs/symptoms of infection upon his return to the facility. Review of Resident #80's Admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident as being on dialysis. Review of Resident #80's physician orders showed no current order for dialysis. During an interview on [DATE] at 10:53 AM, the Director of Nursing (DON) stated, He [Resident #80] does not have a current order for dialysis. He goes to the dialysis center each day during the week unless he refuses. 2) Review of Resident #127's health records showed a Do Not Resuscitate Order signed on [DATE]. Review of Resident #127's physician order dated [DATE] showed it read, Full code. Review of Advance Directive Discussion form for Resident #127 dated [DATE] showed the resident wished to withhold cardiopulmonary resuscitation. During an interview on [DATE] at 11:05 AM, Resident #127 stated, I do not want CPR [cardiopulmonary resuscitation] at all. During an interview on [DATE] at 11:10 AM, Staff A, Licensed Practical Nurse (LPN), stated, He [Resident #127] is a full code. I would instruct staff to start CPR. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Suwan		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 Helvenston St SE Live Oak, FL 32064	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:13 AM, the DON confirmed the full code status in the electronic health record system was incorrect and stated, [Resident #127's name] has a DNR [Do not resuscitate order]. 46523 3) Review of Resident #40's physician order dated [DATE] showed it read, Amlodipine Besylate Oral Tablet 5 mg [milligram] (Amlodipine Besylate), Give 1 tablet by mouth one time a day for HTN [hypertension]. Review of Resident #40's Medication Administration Record (MAR) for [DATE] showed code 4 (vitals outside of parameters for administration) was documented on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of Resident #40's physician order dated [DATE] showed it read, Isosorbide Mononitrate Oral Tablet (Isosorbide Mononitrate), Give 30 mg by mouth in the morning for hypertension. Review of Resident #40's MAR for [DATE] showed code 4 (vitals outside of parameters for administration) was documented on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During an interview on [DATE] at 9:00 AM, the DON stated, I reached out to the provider and order needs to include parameters to hold if systolic blood pressure is less than 110. Nurses communicate with the provider. They should document the notification in the system. During an interview on [DATE] at 9:22 AM, the Advanced Practice Registered Nurse (APRN) #1 stated, Usually staff do communicate with me about parameters and holding medications. I would not be able to remember the dates. All my blood pressure medications have parameters. I usually have hold parameters for systolic blood pressure less than 110 and heart rate less than 60. 4) Review of Resident #122's physician order dated [DATE] showed it read, Insulin Glargine Subcutaneous Solution Pen-Injector 100 UNIT/ML [milliliters] (Insulin Glargine), Inject 20 units subcutaneously two times a day for DM [Diabetes Mellitus], Hold for BS<70 [Blood Sugar less than 70] and notify MD [Medical Doctor]. Review of Resident #122's MAR for [DATE] showed code 9 (other/see progress notes) was documented on [DATE] at 6:30 AM for blood glucose level of 100, code 13 (no insulin required) was documented on [DATE] at 6:30 AM for blood glucose level of 102, code 5 (hold/see progress notes) was documented on [DATE] at 4:30 PM for blood glucose level of 101, and code 13 (no insulin required) was documented on [DATE] at 4:30 PM for blood glucose level of 112. Review of Resident #122's MAR for [DATE] showed code 4 (vitals outside of parameters for administration) was documented on [DATE] a 4:30 PM for blood glucose level of 147, code 9 (other/see progress notes) was documented on [DATE] at 6:30 AM for blood glucose level of 78, code 9 (other/see progress notes) was documented on [DATE] at 6:30 AM with no blood glucose level documented, code 4 (vitals outside of parameters for administration) was documented on [DATE] at 6:30 AM for blood glucose level of 141, and no entry was documented on [DATE] at 6:30 AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:53 AM, the Medical Doctor #2 stated, The nurses communicate with me and tell me when they are going to hold insulin. I would have to go back to my notes and review which days. [Resident #122's name] A1C is 6.9 which is stable. Holding is the right thing to do. He does not even need insulin. I have instructed the Director of Nursing to place him on oral medication. During an interview on [DATE] at 9:55 AM, Staff I, LPN, stated, Nurses are expected to follow the parameters in the medication and document why they have held the medication. During an interview on [DATE] at 10:31 AM, Staff O, LPN, stated, I would have to look at my notes. I do not know why the entry would be blank because I check all my blood sugars and administer the insulin based on the parameters. During an interview on [DATE] at 3:10 PM, the DON stated, I would expect nurses to document in the system the notifications and conversations with the provider. During an interview on [DATE] at 8:38 AM, Staff J, LPN, stated, I do not recall not giving the insulin. Maybe it was an error on my part and documented the wrong code. That was an error. I would normally call the provider if there was a question, or I needed to hold a medication. I would make a note in the progress note. During an interview on [DATE] at 8:51 AM, Staff N, LPN, stated, If the medication is being held, I contact the provider. I only come to the facility on ce a week or every two weeks. If I have any questions on medication, I contact the provider or the unit manager and write the notification in a nursing note. During an interview on [DATE] at 9:14 AM, Staff Q, LPN, stated, I don't remember much about that day. I think his blood sugar was low, and I was trying to get it up. I normally put it in a progress note. Not sure why it is not there. Review of the facility policy and procedure titled Documentation of Medication Administration with the last review date of [DATE] showed it read, Policy Statement: A medication administration record is used to document all medication administered. Policy Interpretation and Implementation: 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication record (MAR). 2. Administration of medication is documented immediately after it is given. Review of the facility policy and procedure titled Administering Medications with the last review date of [DATE] showed it read, Purpose: To ensure that medications are administered in a safe and timely manner, and as prescribed. General Guidelines . 19. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall enter the correct code into the bos [Sic] on eMAR [electronic Medication Administration Record] followed by nursing note if indicated. 49846 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Review of Resident #15's physician order dated [DATE] showed it read, Humalog KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Lispro), Inject as per sliding scale: if ,d+[DATE]=2 units; , d+[DATE]=4 units; ,d+[DATE]=6 units; ,d+[DATE]=8 units; ,d+[DATE]=10 units; subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy, unspecified for bg >400 or <60 [blood glucose greater than 400 or less than 60], call MD. Review of Resident #15's MAR for [DATE] for administration of Humalog showed no entries documented on [DATE] at 9:00 PM, on [DATE] at 6:30 AM and 9:00 PM, on [DATE] at 6:30 AM and 4:30 PM. During an interview on [DATE] at 3:30 PM, the [NAME] Director of Nursing stated, I could not find any other supporting document for the missing entries on the medication record. The nurses will also document blood sugars on the blood sugar vital sign task. During an interview [DATE] at 3:34 PM, the DON stated, There should have been documentation of blood sugars when it was done, and any coverage that would have been given. During an interview on [DATE] at 8:59 AM, the Medical Doctor #1 stated, [Resident #15's name] diabetes is well managed. The staff is usually very good at contacting me in regards to insulin, medications and parameters. I think there is more concern with documentation not with the care provided. He is on two other oral diabetic medications and his A1C is 6.6. [Resident #15] is stable. During an interview on [DATE] at 10:15 AM, Staff O, LPN, stated, [Resident #15's name] I don't recall not taking blood sugars or providing coverage if needed. I worked on [DATE] and [DATE]. I do not know why there are blanks in the system. 50695 6) During an observation on [DATE] at 9:47 AM, Resident #28 was in bed. The resident was not receiving oxygen. During an observation on [DATE] at 10:34 AM, Resident #28 was lying in bed with eyes closed and glasses on. Resident #28 was receiving oxygen via nasal cannula at 3.5 liters per minute. During an observation on [DATE] at 12:18 PM, Resident #28 was receiving oxygen via nasal cannula at 4.5 liters per minute. Review of Resident #28's physician orders showed an order dated [DATE] for administration of oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath. Review of Resident #28's Treatment Administration Record (TAR) for February 2025 showed the resident received oxygen at the rate of 2 liters per minute on [DATE] on both twelve-hour shifts, [DATE] on both twelve-hour shifts, and on [DATE] on the first twelve-hour shift. During an interview on [DATE] at 12:25 PM, Staff D, Registered Nurse (RN), stated, I signed off on [Resident #28's name] oxygen this morning. We are supposed to check that he has O2 [oxygen] on, and I think we just have to check his O2 [oxygen saturation] level. I didn't know that the rate was there too when I signed it. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:50 PM, the DON stated, I expect the nurses to confirm all the rights, including the right rate and the number of hours they are receiving oxygen. Review of the facility policy and procedure titled Nursing- Oxygen Administration with the last review date of [DATE] showed it read, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record . 3. The rate of oxygen flow, route, and rationale.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47275 Based on observation, interview, and record review, the facility failed to ensure infection control standards were followed for catheter care to prevent the possible spread of infection and communicable diseases for 1 of 3 residents reviewed for indwelling urinary catheters, Resident #136. Findings include: During an observation on 2/3/2025 at 10:58 AM, Resident #136's catheter bag was lying on the floor. During an interview on 2/3/2025 at 11:05 AM, Staff C, Licensed Practical Nurse (LPN), stated, That bag should absolutely not be lying on the floor. During an interview on 2/4/2025 at 11:30 AM, the Director of Nursing stated that it was her expectation for the nurses on the floor to check the catheter bags during medication pass. Review of the facility policy and procedure titled Nursing- Catheter Care- Urinary with the last review date of 1/13/2025 showed it read, General Guidelines . Infection Control: 1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag . b. Be sure the catheter tubing and drainage bag are kept off the floor.