STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105690	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Rehabilitation Center	1111 S Highland Ave Clearwater, FL 33756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure physician orders were followed in a timely manner, related to wound care treatment for one resident (#19) out of three residents sampled. On 10/20/2025 Resident #10 sustained an injury to his right pinky finger. On 10/20/2025 orders were given by the provider for wound care treatment and medications to fight infection. The facility staff failed to enter the orders until 10/22/2025. Resident #10 continued to experience pain and go without medications for the infection for two days. Resident #10 was transferred to a higher level of care and had to have his right pinky finger amputated. Findings Included:During an interview on 02/25/2026 at 10:41 AM, Staff A Licensed Practical Nurse (LPN), stated she went to give Resident #10 medication on 10/20/2025 and noticed the resident had an injury to the right pinky finger. Staff A stated she asked Resident #10 what happened to the finger and was told the finger was caught in his wheelchair spokes. Staff A stated the resident was a brittle diabetic and anything could have caused the injury. Staff A stated It was pretty bad when I saw it. Staff A stated the right pinky was swollen, necrotic, pussy, and had a blister. Staff A said she could tell the finger was infected. Staff A stated it would have taken a few days to develop to the condition it was in. Staff A stated no treatment was provided to Resident #10 until 10/22/2025. Staff A stated the expectations would have been to place the resident on antibiotics. Staff A stated a nurse would have entered the order. Staff A stated she would have immediately notified the provider after seeing the resident's finger like that, and stated I don't know why I didn't.During an interview on 02/25/2026 at 11:39 AM, Staff B, LPN, Unit Manager (UM), stated she was a wound care nurse at the facility. Staff B stated she had seen Resident #10 often due to previously providing wound care for the resident. Staff B stated on 10/21/2025 she provided wound care for Resident #10 for a double below knee amputation. Staff B stated Resident #10 said he had injured his right pinky by getting it caught in his wheelchair. Staff B stated the area was swollen, discolored, with a little drainage, and a blister. Staff B stated Resident #10 did not have neuropathy. Staff B stated there was a late note on 10/22/2025 that the provider had been contacted. Staff B stated the note was created on 10/23/2025. Staff B stated the provider was contacted gave orders for an x-ray. Staff B stated the results of the x-ray were received on 10/23/2025, which suggested osteomyelitis, and recommended an Magnetic Resonance Imaging (MRI) test. Staff B stated the x-ray also revealed subtle bone loss at the fifth DIP (distal interphalangeal joint), with joint swelling. Staff B stated Resident #10's right pinky finger injury should have been identified sooner.During an interview on 02/25/2026 at 01:39 PM, Staff C, Regional Nurse Consultant (RNC), stated having been the Director of Nursing (DON) at the facility in 10/2025. Staff C stated if a resident was observed with an open area, the nurse should have notified the provider immediately. Staff C stated the notification to the provider would have been documented in a progress or evaluation note. Staff C explained being familiar with Resident #10 and stated the resident had a bilateral leg amputations. Staff C stated Resident #10 had a pinky injury on 10/20/2025. Staff C stated according to an evaluation on 10/20/2025, Resident #10 stated his finger was caught in a wheelchair. Staff C stated no treatment was noted at the time. Staff C stated an assessment and evaluation was conducted for Resident #10. Staff C stated an order for Doxycycline was generated for 10 days 100 mg (milligrams) starting (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 0684 Level of Harm - Actual harm Residents Affected - Few	10/22/2025 for Resident #10. Staff C stated the provider was notified of Resident #10's condition on 10/22/2025. Staff C stated not having saw anywhere, that Resident #10 was seen by the provider on 10/22/2025. Staff C stated having expectations for the nurse who found the injury to start a treatment plan, notify the provider, and notify the family immediately. Staff C stated from what she could see, the process was not followed. Staff C stated Resident #10 received an x-ray for his hand on 10/22/2025. Staff C stated Bacitracin was ordered and discontinued on 10/22/2025. Staff C stated staff should have identified the condition of Resident #10's finger prior to 10/20/2025. During a phone interview on 02/27/2026 at 03:43 PM, A family member of Resident #10 stated Resident #10 had injured his finger about a week prior to being sent to the hospital on [DATE]. A family member of resident #10 stated the resident had explained injuring his finger in a wheelchair, by getting it caught in the wheelchair. The family member explained not being notified about Resident #10's pinky injury, until 10/23/2025, and had expectations of being notified prior. The family member stated the resident's finger had to be amputated.During an interview on 03/04/2026 at 11:01 AM, Staff B, LPN, UM, explained not having notified the provider of Resident #10's injury on 10/20/2025 and stated I let the floor nurse do her job. Staff B stated not being aware, the floor nurse had not contacted the provider. Staff B stated the provider saw Resident #10 on 10/20/2025, in person at the facility. Staff B stated not knowing why orders from the provider were not entered into the system until 10/23/2025. Staff B stated Resident #10's right pinky had a white bubble at the top, purple bruising, and dried torn skin. Staff B stated Resident #10's right pinky was so dry that nothing could be put on it. Staff B stated she used normal saline and gauze on the right pinky, on 10/20/2025. During an interview on 03/04/2026 at 11:22 AM, Staff I, Registered Nurse (RN), stated the response process for a skin tear was to notify the family and physician, get orders for care, measure disrupted skin area, make an incident report, notify the unit manager, put in treatment orders from the physician, make post event charting for 72 hours, and notify wound care. Staff I stated the process would have been completed immediately upon discovery of the skin tear.During an interview on 03/04/2026 at 11:25 AM, Staff J stated the response process for a skin tear was to notify the provider and get orders, enter the orders, do a change in condition, notify the family, monitor the area and do daily dressing changes, and notify wound care. Staff J stated the process would have been implemented immediately, upon knowledge of a skin tear.During an interview on 03/04/2026 at 12:09 PM, Resident #10's Primary Care Physician, (PCP), stated she was the primary provider for Resident #10. Resident #10's PCP stated she was rounding at the facility on 10/20/2025 and received a call, related to Resident #10. Resident #10's PCP told staff to order antibiotics and an obtain an x-ray for Resident #10. Resident #10's PCP stated Resident #10 declined the x-ray and she had to go back to the resident's room to insist that the resident receive the x-ray. Resident #10's PCP explained having seen Resident #10 twice on 10/20/2025. Resident #10's PCP stated orders should have went into the system the same day they were given to facility staff. Resident #10's PCP stated orders are supposed to be pulled and completed the same day. Resident #10's PCP explained not knowing the orders given on 10/20/2025 were not put in, the same day they were given. Resident #10's PCP stated the x-ray completed on 10/23/2025, would have revealed suspicions of osteomyelitis, which would have required a higher level of care. Resident #10's PCP stated the treatment for Resident #10 would have been changed, because Doxycycline could not have penetrated the bone. Resident #10's PCP stated IV (intravenous) antibiotics would have been given if the x-ray was received earlier, and hospitalization may have been an option. Resident #10's PCP stated it was not appropriate for the orders to be put in two days later and should have been put in the day she gave the orders.During an interview on 03/04/2026 at 12:35 PM, Staff B, LPN, UM stated not having received orders from the provider on 10/20/2025. Staff B stated there was no reason orders would have been received on 10/20/2025 and not entered until 10/22/2025, unless the nurse entered a later start date and it should have been caught if so.During a phone interview on 03/04/2026 at 02:02 PM, Staff K, LPN, stated having called Resident #10's PCP on 10/22/2025, and stated having explained the condition of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #10's right pinky. Staff K stated the resident needed to be sent to the hospital. Staff K stated she received and entered orders for Resident #10, x-rays and antibiotics, on 10/22/2025, the same day she spoke to the PCP. Staff K stated she was not told by the PCP, that orders were given days prior for the same injury. Staff K stated there was no reason she would have waited to enter orders as typically, she entered orders the same day they were given. Staff K stated not knowing about the right pinky injury prior to discovering it on 10/22/2025, while performing a blood pressure check for blood pressure medication.Record review for Resident #10 revealed the resident had been admitted to the facility on [DATE]. Medical diagnosis revealed the following: acquired absence of right leg below knee, acquired absence of left leg below knee, muscle wasting and atrophy, chronic congestive heart failure, Type 2 Diabetes Mellitus with diabetic chronic kidney disease, need for assistance with personal care, altered mental status, and delusion disorder.Review of Resident #10's physician orders revealed:X-ray to the right hand dated 10/22/2025 at 07:45 PM,Bacitracin External Ointment 500 UNIT/GM (Bacitracin (Topical)) Apply to Right 5th digit topically one time a day for Wound Healing Apply cream to 5th digit and cover with dry dressing, dated 10/23/2025 at 09:00 AMDoxycycline Hyclate oral tablet 100 MG, dated 10/23/2025 at 09:00 AMOK to send to ED for assessment and treatment, revised 10/24/2025Review of Resident #10's evaluations revealed a skin evaluation, dated 10/16/2025, which revealed no new areas of skin impairment. A skin evaluation, dated 10/20/2025, reveled bruising to Resident #10's right hand pinky, and an open area.Review of Resident #10's Minimum Data Set, section C revealed the resident had a Brief Interview of Mental Status score of 11, which indicated moderate cognitive impairment. Section GG revealed the resident had impairment on both sides of the lower extremity.Review of progress notes for Resident #10, revealed:10/20/2025 11:11 Skin Issue: #001: Skin issue has not been evaluated. Location: Left rear below knee - amputation site. Issue type: Abrasion. Wound acquired in-house. Wound is new. Undermining: No. Tunneling: No.#002: New skin Issue. Location: Right Dorsum 5th Digit (Small Finger). Laterality / Orientation: Right. Issue type: Skin tear. Wound acquired in-house. Painful: No. Length (cm): 2.23 Width (cm): 2.48 Depth (cm): 0 Area (cm2): 4.19 Undermining: No. Tunneling: No.Skin Issues Note: Resident stated he got finger caught in W/C (wheelchair) no pain noted resident stated he didn't think he needed to tell anyoneAdditional skin issue education documentation: Educated resident that if something else happens like this to alert the nurse when it happens so we can do all necessary actionsA review of the progress notes for Resident #10 revealed: -10/20/2025 15:12 Progress Note (general) Note Text: Writer observed resident with open area noted to right hand pinky finger, UM and wound care team notified. resident stated that his finger accidently became tangled up in wheelchair wheel. No complaints of pain and or discomforts noted at this time.-10/21/2025 08:00 #001: Skin issue has been evaluated. Location: Left rear below knee - amputation site. Issue type: Abrasion. Progress: Monitoring: Wound healed or closed with continued monitoring. Wound acquired in-house. Wound is new. Length (cm): 0.7 Width (cm): 0.56 Depth (cm): 0 Area (cm2): 0.31 Undermining: No. Tunneling: No.#002: Skin issue has not been evaluated. Location: Right Dorsum 5th Digit (Small Finger). Laterality / Orientation: Right. Issue type: Skin tear. Wound acquired in-house. Undermining: No. Tunneling: No-10/22/2025 13:48 Progress Note (general) Note Text: Late entry for 10/22/25: call placed out to Dr, regarding resident right hand pinky finger infectious, swelling, and bruising. Awaiting return call back. Writer spoke with UM regarding the call out. Dr. will be rounding sometime today and will exam resident status. Resident remains alert and oriented x2 with forgetfulness, denies pain and or discomforts at this time.-10/23/2025 11:22 Physician Order Note Text: X-ray to right hand one time only for X-ray for 3 Days D/C once completed-10/23/2025 17:15 Transfer Note Text: Resident and family requested to be sent out to a hospital. Vitals stable, alert and oriented, ambulatory.Review of Resident #10's care plan revealed the following:Focus: WOUND RISK: The resident is at RISK of developing a wound Impaired Mobility, initiated 06/20/2025. The goal was to minimize wounds from developing, initiated: 06/20/2025. The interventions were to: observe for any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care; report to nurse if (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	noted, nurse will report to medical doctor if noted, initiated 06/20/2025.Review of Resident #10's hospital records revealed the resident had presented to the hospital from the facility for evaluation of right small finger injury, on 10/23/2025. The records revealed it was reported the resident injured his finger in a wheelchair as the wheelchair was in motion. The records revealed initial hand x-rays demonstrated signs of cellulitis and osteomyelitis. The records revealed Rocephin and Vancomycin were initiated for Resident #10. The records revealed Resident #10 was taken to an operating room for resection of right small finger on 10/28/2025.Review of Resident #10's medical records showed an untitled document, dated 02/25/2025, for a service date of 10/20/2025. The note revealed Resident #10's primary care provider saw the resident at the facility on 10/20/2025 and gave orders for x-rays, Doxycycline, and topical Bacitracin.Review of Resident #10's medical records showed an untitled document, signed 03/04/2026 by the resident's primary care provider, which revealed a statement: I came to the building and I saw the patient in person on 10.20.2025.Review of a document titled Radiology Report, revealed x-ray results, dated 10/22/2025, as follows:HAND 2 View, RIGHTResults: Subtle bone loss at the 5th DIP joint with swelling. Conclusion: findings suggest osteomyelitis, recommend MRI.Signed 10/23/2025 at 08:52 AM.During an interview on 03/04/2026 at 04:07 PM, the DON stated when nurses respond to reports of resident skin tears, the nurses should contact the provider, get orders, and then implement the orders. The DON stated orders should be added to the system as soon as they are given by the provider. The DON stated Resident #10's primary care provider suspected osteomyelitis related to Resident #10's right pinky finger. The DON stated the x-ray results revealed osteomyelitis for Resident #10's right pinky.Review of a facility policy titled Physician Orders, dated 02/2026, revealed:Policy: Nurses, therapists and pharmacists may take verbal and/or telephone orders as permitted by their state licensure board.Procedures:11. Note Physician's Order (recaps/renewals, telephone/verbal, or fax orders, etc.) by writing noted, dating, and signing with the name and title.12. Confirm the accuracy of orders. Review orders daily in the Clinical meeting to confirm the accuracy in transcription and identify errors of omission.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure urinary catheter care and services were provided in accordance with professional standards of practice for two residents (#16, #7) out of three residents sampled for catheter care.Findings Include:1. On 03/04/2026 At 9:27 AM Resident #16's urinary catheter bag was observed detached from the bed and resting directly on the floor. Urine appeared slightly cloudy.On 03/04/2026 At 12:32 PM the urinary catheter bag was observed on the floor. On 03/04/2026 At 1:35 PM the urinary catheter bag was observed on the floor.Record review of the March 2026 (Treatment Administration Record) TAR indicated Resident #16 received urinary catheter care as ordered on the day shift of 03/04/2026.Review of Resident #16's admission Record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease (Stage 4) and obstructive uropathy.The Care Plan for Resident #16, initiated 10/24/2025, directed staff to keep drainage bags below level of bladder and ensure catheter bag is not on the floor.During an interview on 03/04/2025 at 1:03 PM with Staff D, Certified Nursing Assistant (CNA), stated she checks the assigned residents every two hours and ensures the catheter tubing is secured and that the drainage bag is always hanging on the bed frame, kept off the floor to prevent infection.During an interview on 3/4/26 at 2:01 p.m. Staff G, Licensed Practical Nurse (LPN) stated if she has a resident with an indwelling catheter she would check the catheter bag throughout the day to make sure the resident has urine output and what it looks like. She stated the urine should be yellow and clear. She stated if the urine is cloudy or a different color like brown, red or dark she would notify the doctor. She stated if the resident is not having a lot of output, she would notify the doctor. She stated the cnas usually provide care and empty it but will empty the catheter bag when necessary. Upon arriving at Resident #16's room, Resident#16's catheter bag was observed on the floor. Staff G stated the catheter bag was on the floor. She stated the catheter bag should not be on the floor because it could cause an infection.During an interview on 3/4/26 at 4:07 p.m. The Director of Nursing (DON) stated the CNAs are responsible for catheter care. She stated urinary catheter bags should not be on the floor.2. Review of Resident #7's admission record revealed a readmission on [DATE] with diagnoses including obstructive uropathy, renal disease, communicating hydrocephalus, altered mental status, dementia, and acidosis.Review of the Daily Skilled Nursing Notes revealed the following: 10/21/25 urine clear and yellow. Abdomen is non-tender. Bowel sounds presented in all quadrants. 10/23/25 urine is clear and yellow. Abdomen is non-tender. Bowel sounds presented in all quadrants. 10/24/25 urine is clear and yellow. Abdomen is non-tender. Bowel sounds presented in all quadrants.Review of the care plan for Resident #7, initiated 10/21/2025, indicated the resident used a urinary catheter with risk for infection and complications. Staff were directed to change drainage bag routinely and as needed and provide catheter care daily & as needed.Review of a Nursing Progress note dated 10/26/2025 showed Upon entering room [ROOM NUMBER] resident was observed lethargic and not responding to verbal stimuli. 11-7 Nurse called 911 EMS arrived at bedside. Resident sent to ER for evaluation and treatment. On call md was notified. Responsible party called left message to call facility. DON was notified.Review of the Hospital admission record from 10/26/2025 for Resident #7 indicated the resident was admitted with Severe Sepsis secondary to Urinary Tract Infection (UTI), Life-Threatening Hypernatremia (>170), and Acute Kidney Injury. Computed Tomography (CT) scan findings revealed the catheter balloon was inflated in the urethra rather than the bladder, causing a significant distended bladder (1250 mL urine) and bilateral hydroureteronephrosis.During an interview on 02/25/2026 at 10:05 AM with Staff G, Licensed Practical Nurse (LPN), stated she did not specifically recall the resident's catheter status. She noted the resident visually looked clean but remembered he wasn't responding normally prior to transfer. Despite this observed change in condition, no assessment of the urinary catheter patency was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented.During Interviews on 03/04/2026 at 1:42 PM with Staff F, Certified Nursing Assistant (CNA), stated she had no recollection of the resident or whether he had an indwelling catheter. She described her standard care as frequent hourly rounding, reporting urinary catheter related abnormalities to nurses, and emptying the urinary bag every shift.During Interviews on 03/04/2026 at 2:01 PM with Staff E, Certified Nursing Assistant (CNA), stated she had no recollection of the resident having an indwelling catheter. She described her standard care as frequent rounding of every two hours, reporting urinary catheter related abnormalities to nurses, and emptying the urinary bag once to twice a shift.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure pain management was provided as ordered for two residents (#11 and #13) out of two residents sampled. Findings included:1) An interview on 2/24/2026 at 12:25 P.M with Resident #11 was conducted. Resident #11 said she does not receive her medication as scheduled. Resident #11 said when she does not receive her pain medication as scheduled, she has pain for the rest of the day.A review of Resident #11's admission Record showed she was admitted to the facility on [DATE] with diagnoses including contusion of right knee, muscle weakness, and need for assistance with personal care.A review of Resident #11's Minimum Data Set (MDS), Section C, dated 12/11/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. A review of Resident #11's MDS Section J, dated 12/11/2025 revealed the resident was experiencing pain with an average pain intensity of 07 over the last five days. The numeric pain rating scale was indicated by asking the resident to rate the pain on a scale of 00-10 over the last five days with zero being no pain and ten as the worst pain imagined.A review of Resident #11's physician orders revealed an order for Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 8 hours for chronic pain.A review of Resident #11's Medication Administration Record (MAR) for January 2026 revealed the resident did not receive pain medication as ordered on 1/11/2026 at 6:00 A.M. and 1/15/2026 10:00 P.M.2) An interview on 2/24/2026 at 12:31 P.M with Resident #13 was conducted. She said she there are times she does not receive her pain medication leading to her having severe pain. Resident #13 said she is one a schedule pain medication regimen.A review of Resident #13's admission Record showed she was admitted to the facility on [DATE] with diagnoses including generalized anxiety disorder, age-related osteoporosis, and unspecified abdominal pain.A review of Resident #13's Minimum Data Set (MDS), Section C, dated 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating cognitively intact. A review of Resident #13's MDS Section J, dated 1/14/2026 revealed the resident was experiencing pain with an average pain intensity of 07 over the last five days. The numeric pain rating scale was indicated by asking the resident to rate the pain on a scale of 00-10 over the last five days with zero being no pain and ten as the worst pain imagined.A review of Resident #13's physician orders revealed an order for monitoring pain every shift and recording pain number on a 0-10 scale. A review of Resident #13's MAR for January 2026 revealed her pain level was not recorded on 1/10/2026 on night shift and Resident #13's pain level on 1/11/2026 on day shift was recorded as 10/10 indicting severe pain. On 1/14/2026 evening shift her pain level as recorded as 5/10 indicting moderate pain.A review of Resident #13's physician orders revealed an order for oxycodone HCl oral tablet 5 MG; Give 1 tablet by mouth every 8 hours for pain.A review of Resident #13's MAR for January 2026 revealed the resident did not receive the medication on 1/29/2026 at 2:00 P.M.A review of Resident #13's physician orders revealed an order for Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 1 tablet via g-tube every 6 hours for pain.A review of Resident #13's MAR revealed the resident did not receive the medication on 1/11/2026 at 12:00 A.M. or 1/11/2026 at 6:00 A.M.A review of Resident #13's physician orders revealed an order for Hydrocodone-Acetaminophen oral tablet 7.5-325 MG, give 1 tablet via g-tube every 6 hours for pain.A review of Resident #13's MAR revealed documentation of NA on 1/14/2026 at 6:00 P.M. and documentation of 9 (indicting to see progress notes) on 1/20/2026 at 12:00 A.M.A review of Resident #13's progress notes on 1/20/2026 revealed no documentation related to the resident receiving pain medication.An interview on 2/25/2026 at 11:00 A.M. with the Activities Director (AD) was conducted. The AD said she remembered a few months ago Resident #11 filed a grievance regarding not receiving her medications. The AD does not know the outcome of that grievance.An interview on 2/25/2026 at 3:25 P.M. with the Regional Nurse Consultant (RNC) was conducted. The RNC said Resident #11 should have received the medication as ordered by the physician. The RNC said Resident #11 does experience a high pain level often and the (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident receives scheduled pain medication. The RNC stated the documentation of Resident #13's MAR does not make any sense. The RNC said Resident #13 should have received the medications as ordered by the physician; noting a reason in the progress notes if the medication was not given. A review of the facility policy, dated 2007, titled Medication Administration General Guidelines revealed the following:Medication Administration: 1: Medications are administered in accordance with written orders of the prescriber . 2: Obtain and record any vital signs necessary prior to medication administration. 14: Medications are administered within 60 minutes or scheduled time. Documentation: 1: The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.