STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105810	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Hill Nursing & Rehabilitation Center, Inc	1329 Abraham Street Tallahassee, FL 32304

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** room [ROOM NUMBER] On 06/02/2025 during the tour of the facility, it was noted that the floor in room [ROOM NUMBER] was sticky and a dried brown substance was noted on the floor and wall of the room in the corner left side of the doorway facing the hallway. (Photographic evidence obtained) On 6/3/26 a follow up observation was made of room [ROOM NUMBER] at approximately 12:00 PM, which revealed the dried brown substance in the left corner of the doorway had been removed from the floor, however remained on the wall. On 6/4/25 at approximately 2:45 PM, another observation was made of room [ROOM NUMBER]. The wall remained with a dried brown substance and the floor remained sticky. An interview was conducted with Nurse B, a Licensed Practical Nurse (LPN), who was responsible for the residents on this hallway. Nurse B confirmed that the floor was sticky and the wall with the dried brown substance needed to be cleaned. Based on observations and interviews, the facility failed to provide a sanitary, orderly, and comfortable environment in 2 of 90 occupied rooms. (rooms [ROOM NUMBERS]) The findings include: room [ROOM NUMBER] An observation in room [ROOM NUMBER] was conducted with Staff M, Maintenance, on 6/4/25 at approximately 9:00 am. The following was observed: One of the resident's bedside table was missing paint with particle board showing along edges and at the top of the drawers. The top drawer was missing a knob used to open the drawer. The paint on the wall beside the head of the bed was scraped and scratched showing various layers of paint and gouged down to the plaster underneath. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wall behind the head of the other bed had deep metal grey colored scratches in the paint all along where the bed was positioned. An interview was conducted with Staff M about the walls and dresser conditions. He stated the bed is positioned against the wall and, whenever the head of the bed is raised, it scrapes against the wall. He states he has attempted to repaint it, but it keeps getting scratched up while the bed remains flush against the wall. When asked about the bedside table's poor condition, he acknowledged it needed replacing.

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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** Based upon record review and interviews, the facility failed to identify and properly code an assessment correctly upon admission to facility. (Resident #27) The findings include: Resident #27 was admitted to the facility on [DATE] with an admitting diagnosis of end stage renal disease, dependence on renal dialysis, Type 2 diabetes with neuropathy, Atherosclerotic Heart disease, Chronic ischemic heart disease, Hypertension, Cardiac pacemaker, Cirrhosis of the liver, Heart Failure, AFIB, Osteoarthritis, and Pneumonia. The Minimum Data Set (MDS) assessment with a date of 04/28/25 reveals these diagnoses were not coded on the admission comprehensive assessment. An interview was conducted on 6/4/25 at 10:26 AM with the MDS Coordinator. The MDS Coordinator acknowledged that the admission diagnoses of Resident #27 was not coded correctly on the MDS assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record reviews and interviews, the facility failed to forward a resident for a level 2 Preadmission Screening and Resident review (PASARR) for 1 of 2 residents residents sampled for PASARR. (Resident #51) The findings include; On 6/3/25, a record review was conducted for Resident #51. The resident had a PASARR form, dated 7/16/20. The formed had depression checked off at that time and had dementia checked off at that time. On the PASARR Completion sections, it was checked the facility needed to request a level 2 screening due to suspicion of serious mental illness. There was no documentation in the record for a level 2 screening. On 06/03/25 at approximately 12:15 PM an interview was conducted with staff development staff, a Registered Nurse (RN) who stated she assists with compliance with the PASARR being accurate and up to date. Stated when she started in 2021 has not updated his PASARR and it should have been done but she will start working on it today. 06/03/25 at approximately 02:40 PM an interview was conducted with the Administration who stated they do not have a specific policy for PASAAR they just follow the regulation. The Administrator returned later and present a policy but the policy did not address the timing of the PASARRS or the completeness.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to update the Preadmission Screening and Resident Review (PASARR) for 1 of 2 residents sampled for PASARR. (Resident #51) The findings include: On 6/3/25, a record review was conducted for Resident #51. The resident had a PASARR form dated 7/16/20. The form listed depression and dementia as diagnoses at the time. On the PASARR Completion section, it was recommended that the facility needed to request a level 2 screening due to the suspicion of serious mental illness. There was no documentation in the record for a Level 2 screening. A diagnosis of bipolar disorder was added on 7/21/23. Anxiety disorder was diagnosed on [DATE]. However, no further actions on a Level 2 PASSAR review were noted. On 06/03/25 at approximately 12:15 PM, an interview was conducted with the Staff Development Nurse, who stated she assists with compliance with the PASARR being accurate and up to date. She stated when she started in 2021 and acknowledged the PASARR was not followed up as required. On 06/03/25 at approximately 02:40 PM, an interview was conducted with the Administrator, who stated they do not have a specific policy for PASARR, they just follow the regulations. The Administrator returned later and presented a policy but the policy did not address the timing of the PASARR.

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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** Resident #27 Resident #27 was admitted to facility on 04/22/25 with admitting diagnoses of End stage renal disease, dependence on renal dialysis, Type 2 diabetes with neuropathy, Atherosclerotic Heart disease, Chronic ischemic heart disease, Hypertension, Cardiac pacemaker, Cirrhosis of the liver, Heart Failure, AFIB, Osteoarthritis, and Pneumonia. Resident 27's plan of care revealed he has a risk for falls, complications of anticoagulant medication use, activity involvement, ADL self-care performance, potential for complications related to dialysis, potential for complications related to diabetes, and the potential for complications related to cardiovascular disease with a pacemaker. No goals or interventions are documented for each focus problem identified. An interview with Staff Member Q was conducted on 06/04/25 at 10:26 AM. She revealed that they have 14-21 days to complete a care plan that was initiated from the admission assessment. She acknowledged Resident #27 had incomplete care plans in his medical records since his admission to the facility on [DATE]. Based on interview and record review, the facility failed to complete a plan of care for 2 of 5 residents sampled for care plans. (Resident #28 and #27) The findings include: Resident #28 On 6/3/25 a record review was conducted for Resident #28. The comprehensive care plan for Resident #28, dated 2/10/25, was left incomplete. The care plan under the focus point for activities contained directions to SPECIFY: Independent/dependent on staff etc for meeting the resident's emotional, intellectual, physical, and social needs. This was not completed as instructed. The care plan included instructions to SPECIFY i.e. 3-5 times weekly the goal for the number of times resident will participate in activities weekly. This was not completed as instructed. On 6/4/25 at approximately 10:33 AM an interview was conducted with Staff Q, Licensed Practical Nurse, Minimum Data Set Coordinator (LPN/MDS), about the care plan for Resident #28 being incomplete for activities. She agreed the care plan is incomplete and stated that it would be fixed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Resident #50 On 6/02/25 at 1:17 PM, an interview was conducted with Resident #50. The resident looked disheveled and had her hair was unbrushed and oily. She stated she had only two showers since she was admitted to the facility. She further stated that both showers happened with Occupational Therapy (OT) staff members. A review of Resident #50's medical record was conducted. This resident was admitted on [DATE] with diagnoses that included needing assistance with Activities of Daily Living (ADL). The plan of care included ADL self-care deficit related to decreased functional mobility and activity tolerance and generalized weakness. Interventions included nursing staff providing ADL care to ensure daily needs. A review of documentation related to bathing indicated Resident #50 was scheduled for showers on Tuesdays, Thursdays, and Saturdays. Bathing documentation revealed OT provided bathing services on 5/1/25 and 5/16/25 and Certified Nursing Assistants (CNAs) provided bathing on 5/16, 5/22 and 5/25. On 6/03/25 at 2:38 PM, an interview was conducted with Staff A, Registered Nurse (RN) and a unit manager. She stated Resident #50's shower documentation had not been properly documented. Staff A agreed that, if it had not been documented, it had not been done. A review of Facility policy: Activities of daily living (ADL) supporting dated 2001 stated: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing dressing, grooming, and oral care). Based on record review, staff interviews, observations, and family interviews, the facility failed to provide the necessary services to maintain good grooming and personal hygiene on 3 of 3 residents. (Residents #13, #44, and #50) The findings include: Resident #13 On 06/02/25 at 11:04 AM, Resident #13 was observed with her hair matted and tangled around the back of the head. When asked about this, Resident #13 was unable to communicate. A second observation on 6/03/25 at 10:30 AM revealed her to be in the same state. On 06/04/25 at 10:30 AM , Staff G, a Certified Nursing Assistant (CNA) was asked how she documents baths/showers. She stated that they log them into the electronic medical record and stated she documents tasks every shift. She stated she also documents on bath sheets located in the binder at nurse's station. A record review of Resident #13 showed no documentation of bathing for the past 30 days. The bath book was reviewed and no bath was indicated for Resident #13 for June. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/04/25 at 11:19 AM, an interview was performed with the Unit Manager. The Unit Manager brought bath sheets from May 2025. The bath sheets indicate that Resident #13 has had only 4 clearly documented baths in the month of May on 5/5/25, 5/16/25, 5/22/25, and 5/23/25. No other documentation of baths or attempts to bathe were noted. On 06/04/25 at 12:06 PM, an interview was performed with the Assistant Director of Nursing (ADON). The ADON stated that refusals should also be charted in the progress notes. Resident #44 On 06/02/25 at 01:34 PM, a strong smell of urine was noted coming from the resident's body. During a phone interview with the responsible family member on 6/2/25 at 5:00 PM, the family member stated Resident #44 has not had a shower since November. She stated, He only has sponge baths and sits in urine soaked clothes. She states that has she made grievance reports and talked to the staff. On 06/03/25 at 10:29 AM, an interview with the resident indicated that he had a bath on 06/02/2025. Per the grievance logs, on 12/02/2024, the family member stated that staff are not providing bathing care for her loved one. The form stated that the issue had been resolved on 12/5/24 and the family was informed they could call anytime. Then on 02/05/2025, the family member again informed the administrator that CNAs did not care for Resident #44 properly and she had to step in and do some of the resident's care. The form indicated that the staff would be encouraged to complete all personal care on a daily basis. On 06/04/25 at 10:30 AM, the bath sheets were requested for May 2025 for Resident #44. The sheets revealed that he received showers on 5/7/25, 5/16/25, 5/21/25, and 5/28/25. The sheets also indicated he refused personal care on 5/2/25, 5/5/25, and 5/12/25.

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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 observation, interviews, and record reviews, the facility failed to ensure that a resident was free from harm and neglect when it failed ensure that residents with diabetes mellitus receive their insulin and/or blood glucose monitoring as ordered for 1 of 16 residents diagnosed with diabetes mellitus. (Resident #90) The findings include: A medical record review was conducted on Resident# 90, who was admitted in the facility on 11/10/2024. Resident #90 was noted to have an elevated blood glucose of 583 mg/dl and elevated A1C of 11.4% on 12/23/2024. There was no documented intervention or orders to address the elevated blood glucose level and elevated A1C. Record review showed no nursing actions and no medical orders had taken place on these laboratory results. Hospital records were reviewed and on 02/24/2025, the resident was transported to the hospital emergency room due to altered mental status. Resident #90 was diagnosed with diabetic ketoacidosis, encephalopathy, and a urinary tract infection (UTI). Resident #90 was readmitted to the same facility on 02/26/2025 with a new diagnosis of diabetes mellitus showing on the doctor's notes. Per the record review on 06/04/2025, Resident #90 had a glucose level of 593 mg/dl and an elevated A1C of 16.9%. The night shift nurse called the advance practice nurse and reported the laboratory results. Orders of insulin and additional blood glucose checks were received from the medical provider. On 06/05/2025 at 09:15 am, Resident #90 was transported by two Emergency Medical Staff (EMS) personnel to the hospital's emergency room (ER) for altered mental status. Staff P, a Certified Nursing Assistant, was asked about the current blood glucose level. The staff responded that the resident is not diabetic. The two EMS personnel did not check the blood glucose level. The resident was transported to the hospital ER. Staff O, a Licensed Practical Nurse, was asked about the reason for the previous hospitalization of Resident# 90 on 02/24/25. She stated it was due to a UTI. She verified that there has never been blood sugar checks since Resident #90 was re-admitted on [DATE]. Record reviews showed the Minimum Data Set (MDS) did not have the active diagnosis of diabetes mellitus. The care plan reviewed on 06/02/2025 showed the care plan for diabetes mellitus was noted by dietary but not nursing. There was no diabetes in the diagnosis list, no diabetes medications, and no glucose check in the medication administration record. Progress notes of the Advance Practice Registered Nurse (APRN) did not document a diabetes diagnosis and post hospitalization history and assessment of Resident #90. On 06/05/25 at 11:30 AM an interview with Staff H, Unit Manager, confirmed that nightly chart checks have to be performed by night shift nurse on duty. Then the Assistant Director of Nursing (ADON) and Staff H checked if nightly chart checks are being done. Staff H said she just started as unit manager in April 2024 and the diabetes mellitus assessment and doctor's order for Resident #90 was missed on 02/26/2024. Chart checks were not completed nightly including on 06/04/2025. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon further record review, the orders from medical director to start the insulin and blood glucose checks orders were found in the physical chart and were not carried out by the nursing staff. Staff S, the MDS nurse, performed the nursing admission screening history and documented new onset diabetic. During interview with facility administrator on 06/05/2025 at 1:55pm, he said unfortunately the nurses who were there at the time are no longer here. So, we can only move forward and try to ensure this never occurs again. The Administrator agreed the process failed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview, observation, and record review, the facility failed to consistently perform services to prevent pressure ulcers for 1 of 1 residents observed for pressure ulcers. (Resident #50) The findings include: On 06/02/25 at 1:17 PM, an interview was conducted with Resident #50. During the interview, she stated she had developed a pressure ulcer because staff was not helping her enough during incontinence episodes. A review of Resident #50's medical record was conducted on 6/4/25. The resident was admitted on [DATE]. The plan of care included a risk of skin breakdown due to decreased mobility, incontinence, and fragile skin. Interventions included weekly skin checks. The physician's orders included a skin assessment every week and to notify the physician of any breakdown. The most recent skin assessment was documented on 5/24/25 and stated groin, buttocks and perineal area redden with excoriation. There were no new orders or progress notes indicating resident's skin issues had been addressed. On 6/04/25 at 12:58 PM, an interview was conducted with Director of Nursing (DON). DON reviewed resident #50's skin assessment documentation and stated last assessment was supposed to be done on 5/31. She further stated the treatment administration record was signed off on that day, but the skin assessment was not completed. DON stated that the expectation was to order a barrier cream if there was an excoriation noted, and further assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record reviews, observations, and interviews, the facility failed to properly assess and provide services for 1 of 1 residents reviewed for range of mobility care. (Resident #40) The findings include: Observations of Resident #40 on 6/2/25, 6/3/25, and 6/4/25 revealed a contracture to her left upper extremity. Resident #40 was observed with her left arm and hand contracted to her upper chest and abdomen area. Resident #40 stated she has not had any therapy or restorative services since she has been at the facility. Record review on 6/3/25 revealed Resident #40 was admitted to the facility with impairment to left upper and left lower extremities related to contractures. Resident #40 admitting diagnosis to the facility revealed a contracture to her left hand. Her care plan included alteration in musculoskeletal status related to contracture with a goal that Resident #40 will remain free of complications related to contracture and immobility. Further review of the medical record reveals no therapy screening or restorative program was initiated for her. An interview with the Director of Therapy on 6/4/25 at 2:00 pm revealed that a therapy screen was conducted on 5/2/25, 4/1/25, and 1/15/25. No documentation of screening was observed and provided by the Director of Therapy. A progress note was obtained by the Director of Therapy that was dated 11/18/24 revealed that a physical therapy screening was completed and that Resident #40 presented with contracted left upper and lower extremity in a flexor pattern with no change in functional mobility at this time due to the resident being bedbound. A progress note was obtained from the Director of Therapy dated 5/14/24 revealing the resident was admitted to the facility and had a contracted left hand to her chest. The Director of Therapy confirmed that the only screening that was conducted for Resident #40 was after she had falls, but no documentation was completed or could be provided at this time. When asked about the restorative program and if Resident #40 was on the case load, the Director stated that, to his knowledge the resident was not on any restorative program but that I would need to check with the restorative nurse. Upon asking who was over the restorative program and who makes referrals to the restorative program he revealed that nursing was overseeing the restorative program, and the therapist / therapy department would make referrals to the program if it was indicated at the time of screening or discharge from therapy services. An interview with restorative nurse on 6/4/25 at 03:00 PM reveals resident 40 has not received any services from restorative for splinting or range of motion since her admission on [DATE].

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide care and services for 2 out 2 residents receiving hemodialysis. (Resident #27 and #82) The findings include: Record reviews of Resident #27 and Resident #82 revealed no physician orders for dialysis care, services, and treatments. No physician orders were in place to monitor the Permacath (a special intravenous device that medical professionals insert into a blood vessel that allow less interrupted access to the bloodstream over an extended period) for Resident #27. A physician's order was written on 04/23/25 for Resident #27 to receive dialysis on Monday, Wednesday, and Friday at 8:00 am. However, the physician's order does not reveal where Resident #27 receives dialysis, what time Resident #27 is to be transported to the dialysis center, or to hold medications while the resident is at the dialysis center since his admission to facility on 4/22/25. Resident #82 also has no physician's orders to indicate the resident is receiving dialysis services and treatments. There were no physician orders initiated to monitor fistulas site for bruit and thrill, monitor for signs of infection, bleeding, pressure bandage, swelling at site, and what time and what facility Resident #82 was to receive his dialysis treatments from. No physician's orders were observed to hold medications while at the dialysis center since admission on [DATE]. An interview was conducted on 6/4/25 at 11:18 AM with Staff Member H, a Licensed Practical Nurse (LPN). She revealed that staff nurses on the unit are to monitor and assess a dialysis resident prior to going to their treatments and upon returning to the facility after their treatments. The nurses assess the dialysis port site for signs of infection and bleeding, assess the bruit and thrill, and document in the medical record their assessment and findings in a progress note. She also revealed that morning medications for Resident #27 are not administered on the days he goes to dialysis due to Resident #27 leaving the facility prior to administration time. Staff member H was asked if physician's orders should be in the medical chart for residents receiving dialysis and for monitoring fistula and port sites before and after treatments. Staff Member H agreed that there should be physician's orders in the medical record. Staff Member H reviewed the physician orders and confirmed that no physician orders for dialysis care and treatments are in the medical chart for neither Resident #27 nor Resident #82. An interview was conducted with the Director of Nursing on 6/4/25 at 01:00 PM. She agreed that physician's orders for dialysis care and treatments should be documented in the medical record and staff nurses should be monitoring dialysis port and fistulas prior to going for their dialysis treatments and upon their return from dialysis treatments. A review of the facility's policy and procedures revealed the facility is responsible for verifying physician orders, measure blood pressure and pulse, and observing shunt sites prior to transporting to dialysis center. Upon return from dialysis the facility is responsible for verifying orders, measure blood pressure and pulse, observe and assess the dressing at the access site.

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	105810	A. Building B. Wing	06/05/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and record reviews, the facility failed to provide medications as ordered for 2 of 5 residents observed during medication administration observations. (Resident #79 and #21) The findings include: On 6/3/25 at approximately 9:12 AM, a medication administration observation was conducted with Nurse C, a Licensed Practical Nurse (LPN), for Resident #79. Nurse C indicated that the medication Zoloft (a medication used to treat depression), which was ordered for Resident #79, was not in the cart. After informing the resident that the medication had not come in from the pharmacy, Nurse C went to the facility's emergency medication supply Omnicell to see if the medication was available. The medication Zoloft was not stored in the Omnicell. Nurse C indicated that she would notify the physician, and the pharmacy to have it sent in. On 6/4/25 at approximately 9:25 AM, a medication administration observation was conducted with Nurse D, a Registered Nurse (RN), for Resident #21. During the medication administration observation, it was noted that the medication Coreg 12.5 mg oral tablet (a medication used to treat heart failure) that was ordered for Resident #21 was not on the cart. Nurse D checked the facility's emergency medication supply Omnicell to see if the medication was available, but the Omnicell did have Coreg 3.125mg, however only 3 tablets were available, which was not enough to reach the correct dose of 12.5mg. Nurse D indicated that she would notify the pharmacy and the physician of the medication not being available. On 6/4/25 at approximately 10:15 AM, an interview was conducted with the Director of Nursing (DON), who indicated that it is her expectation for routine medications that all nurses on the hall reorder the medications from the pharmacy 7 days prior to running out of the medication. If the medication does not arrive, then for the nurse to check to see if it is available in the Omnicell. If not in the Omnicell, then they are to notify the pharmacy and have sent in from our back up pharmacy. The DON further indicated that the medications should be available and not run out.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and facility policy review, the facility failed to store medications in accordance with currently accepted professional principles and include the appropriate expiration date when applicable for 2 of 2 medication carts reviewed for medication storage. The findings include: On 6/4/25 at approximately 1:30 PM, an observation was made of the Northwest 18 hall medication cart with Nurse C, a Registered Nurse (RN). When Nurse C opened the medication cart, in the top drawer, 3 medication cups were sitting in the top drawer with medications inside. The medication cups were noted to have numbers written on the outside of the cups. Nurse C indicated that one of the residents was not in their room when she pulled up their medications to administer them. Nurse C went on to indicate that she then labeled the cup and set it in the cart to administer when the resident returned. Nurse C indicated that the other 2 cups of medications were for 2 other residents that she had pulled up to give as well. When asked Nurse C what the facility policy is for medications that are prepared and the resident is not available, Nurse C indicated that the policy is to discard the medications if not given in the discard solution, and to not pre-pull medications. Further inspection of the medication cart revealed 4 bottles of eye drops without an opened date indicated on the labeled bag and one bag of nebulizer medication without an opened date indicated on the labeled bag. Nurse C confirmed that the medications should be dated when opened due to shortened expiration dates once opened. On 6/4/25 at approximately 1:50 PM, an observation was made of the East 45 hall medication cart with Nurse B, a Licensed Practical Nurse (LPN), which revealed 2 bottles of eye drop medications without an opened date indicated on the bag label and one narcotic card of Tramadol (a medication used to treat pain) in the narcotic box with 9 tablets remaining. Upon review of the narcotic sign out sheet, the count indicated that there should be 10 tablets remaining in the card. A review of the resident's medication administration record revealed no sign out on the record for the tramadol by the nurse. An interview with Nurse B at approximately 1:55 PM was conducted. Nurse B indicated that he had medicated the resident approximately an hour ago and had forgotten to sign the medication out at the time. (Photographic evidence obtained) On 6/4/25 at approximately 1:58 PM, an interview was conducted with the Administrator and the Director of Nursing (DON). The DON indicated that it is her expectation that medications should be dated at the time of opening the medication to ensure the discard of medications per pharmaceutical recommendations, and that narcotics should be signed out on the narcotic count book and on the Electronic Medication Administration Record at the time of administering. Review of the facility policy titled 5.3 Storage and Expiration Dating of Medications and Biologicals (effective date 12/01/07, last revised 08/01/24), revealed the following: Applicability: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes, and needles. Procedure: General Storage Procedures 11. Once any medications or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once open or opened. 11.1 Facility staff may record the calculated expiration date based on date opened on the primary medication container. 11.4 When an ophthalmic solution has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. Review of the facility policy titled 5.4 Inventory Control of Controlled Substances (effective date 12/01/07 last revised 8/01/24), revealed: Applicability: Policy 5.4 sets forth the procedures for inventory control of controlled substances. Procedure: 1. With respect to Schedule II controlled substances: 1.1 Facility should maintain separate individual controlled substance records on all schedule II medications and any medication with a potential for abuse or diversion in the form of a declining inventory using the Controlled Substances Declining Inventory Record. These records should include: 1.1.1 Resident Name, 1.1.2 Prescription number 1.1.3 Medication name, strength, dosage form, dosage 1.1.4 Total quantity received by facility 1.1.5 Date and time of administration 1.1.6 Quantity remaining, and 1.1.7 Name and Signature of person administering the medication.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observations, interviews and record reviews, the facility failed to ensure the Quality Assurance and Program Improvement Program (QAPI) identified and prioritized problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information and corrective actions addressed gaps in systems, and were evaluated for effectiveness. Specifically the facility failed to provide medications to meet the needs for 2 of 5 residents observed during medication administration observations. (Resident #79, and #21). The findings include: On 5/23/25, a complaint survey conducted at the facility revealed the facility failed to ensure medications were available and administered to two residents. A plan of correction was submitted to the State Agency which stated, .2. In order to identify if there were any other residents affected by the alleged deficient practice, the DON, ADON, and Unit Managers were assigned with reviewing all current resident charts to ensure physicians orders are being followed and all medications were appropriately administered and documented in the MAR. 3. To ensure systematic change, the Unit Managers were assigned to review the MARS weekly to ensure compliance with facility policies. If the Unit Manager was not in the building, then the ADON and DON would review to ensure compliance. If a concern is detected by the reviewer, it will develop ways to immediately remediate any outstanding issues to ensure that the alleged deficient practice does not recur. 4. In order to endure that the alleged deficient practice does not recur, the ADON and DON will report the findings of their audits of the MARs to the Quality Assurance Committee. The QA Committee and the facility clinical team will monitor findings monthly. Based on the QA review, additional training should be implemented if necessary or disciplinary action should be taken regarding a nurse who fails to consistently comply with facility policies regarding medication administration and following physician orders. On 6/3/25 at approximately 9:12 AM, a medication administration observation was conducted with Nurse C, a Licensed Practical Nurse (LPN), for Resident #79. Nurse C indicated that the medication Zoloft (a medication used to treat depression), which was ordered for Resident #79, was not in the cart. After informing the resident that the medication had not come in from the pharmacy, Nurse C went to the facility's emergency medication supply Omnicell to see if the medication was available. The medication Zoloft was not stored in the Omnicell. Nurse C indicated that she would notify the physician, and the pharmacy to have it sent in. On 6/4/25 at approximately 9:25 AM a medication administration observation was conducted with Nurse D, a Registered Nurse (RN), for Resident #21. During the medication administration observation, it was noted that the medication Coreg 12.5 mg oral tablet (a medication used to treat heart failure) that was ordered for resident #21, was not on the cart. Nurse D checked the facility's emergency medication supply Omnicell to see if the medication was available, the Omnicell did have Coreg 3.125mg, however only 3 tablets were available which was not enough to reach the correct dose of 12.5mg. Nurse D indicated that she would notify pharmacy and the physician of the medication not being available. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at approximately 10:15 AM, an interview was conducted with the Director of Nursing, (DON), who indicated that it is her expectation for routine medications that all nurses on the hall reorder the medications from pharmacy 7 days prior to running out of the medication. If the medication does not arrive, then for the nurse to check to see if it is available in the Omnicell, if not in Omnicell to then notify the pharmacy and have sent in from our back up pharmacy. The DON further indicated that the medications should be available and not run out. 06/05/25 11:09 AM, an interview was conducted with the Nursing Home Administrator and the Director of Nursing. When they were presented with these concerns and others found during thesurvey, the Administrator stated they do not have current QA plans related to these deficiencies but they did have a plan for the Pharmacy related to thyroid medication. When advised that we had more than one resident who didn't receive pharmacy medications due to them being unavailable, the Administrator agreed that they QAPI plan was ineffective and that it should have addressed more than just thyroid medications. The root cause is medications not being available. The facility only reviewed and audited thyroid medications.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and staff interview, the facility failed to provide documentation that 2 of 5 residents received education and were offered a Influenza immunizations. (Residents #41 and #83) The findings include: A review of Resident #41's medical record provided by the Director of Nursing (DON) indicated that influenza immunization was administered on a future date of 11/06/25. A review of Resident #83's documentation provided by the DON also shows that the influenza immunization was administered on a future date of 11/06/25. An interview with the Director of Nursing (DON) was conducted on 06/05/25 at 12:52 pm inquiring how often the Flu, Pneumonia, and COVID vaccines should be offered. The DON stated they are offered yearly in the fall. The DON was made aware of the issues with the documentation with Residents #41 and #83. Upon exit, the facility was not able to provide current information of the influenza vaccines for these two residents.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to provide documentation that 2 of 5 residents received education and were offered a COVID immunization. (Resident #83 and #44) The findings included: A review of Resident #83's documentation shows that the COVID immunization was refused however no signature of the resident or a responsible party was present. Resident #44's medical record was missing Education and Consent or Declination of COVID immunization. The Director of Nursing (DON) was conducted on 06/05/25 at 12:52 pm inquiring about the COVID vaccine process. The DON stated they are offered yearly in the fall. The DON and Administrator were informed of the missing information for Residents #44 and #83. This information was not presented prior to the exit of the survey.