STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115570	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens of Life Care	804 South Broad Street Box 1959 Thomasville, GA 31792

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35847 Based on observations and interview, the facility failed to provide housekeeping and/or maintenance services to maintain a clean and orderly environment on four of six nursing units/floors including resident rooms (Resident Rooms 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 27, 31, 32, 34, 35, 37, 38, 39, and 43) and failed to ensure the cleanliness of the carpet. Findings include: During an environmental tour of the facility on 4/29/2025, starting at approximately 10:50 am, the following was observed: In Resident room [ROOM NUMBER], there were paint chips on the wall of the bathroom which exposed the drywall. In Resident room [ROOM NUMBER], scuff marks were on the floor, and paint chips which exposed the dry wall were in the bathroom. A cable coming out of the drywall in the room did not have a face plate. Resident room [ROOM NUMBER] had paint chips on the wall of the bathroom exposing the drywall. A cable with a face plate in the room was hanging out of the wall. Brown, black stains were on the privacy curtain. In Resident room [ROOM NUMBER], a cable came out of the drywall in the room, and scuff marks and paint chips exposed the dry wall in the room and bathroom. A ceiling electrical outlet was hanging out of the ceiling tile. In Resident room [ROOM NUMBER] had paint chips that exposed the dry wall in the room and bathroom. A wire was coming out of the PTAC (packaged terminal air conditioner) unit on the wall. Resident room [ROOM NUMBER] had paint chips on the wall of the bathroom which exposed the drywall. The toilet paper holder was broken off the wall. Resident room [ROOM NUMBER] had scuff marks and paint chips exposing the dry wall in the room and bathroom, the head of bed was broken and hanging off, and a ceiling electrical outlet was hanging out of the ceiling tile. (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 - Some	Resident room [ROOM NUMBER] had scuff marks and paint chips exposing the dry wall in the room and bathroom, and the bathroom door handle was loose. Resident room [ROOM NUMBER] had a ceiling electrical outlet that was hanging out of the ceiling tile and there was a tear in the flooring under the toilet which exposed the wooden subflooring. In Resident room [ROOM NUMBER], the bathroom door handle was loose. Resident room [ROOM NUMBER] had scuff marks and paint chips exposing the dry wall in the room, and there were brown, black stains on the privacy curtain. The toilet paper holder was broken off the wall. In Resident room [ROOM NUMBER], the bathroom wall molding was separated off the wall, and there was a tear in the flooring near the toilet. The nightstand composite wood was worn away and crumbling at the base. Resident room [ROOM NUMBER] had scuff marks on the floor. Resident room [ROOM NUMBER], floor tile missing behind the bed and missing paint in the bathroom. Resident room [ROOM NUMBER], missing paint in the bathroom and the bathroom wall had holes, entry and bathroom doors with scrapes, handle of bed B's nightstand with only one screw and handle hung downward. Resident room [ROOM NUMBER], entry door and bathroom doors scraped, walls with missing paint. Resident room [ROOM NUMBER], entry and bathroom doors with scrapes and paint missing in the bathroom. Resident room [ROOM NUMBER], entry and bathroom door with scrapes. Resident room [ROOM NUMBER], floor tile missing under bed A, holes in bathroom wall, paint missing on the bathroom and bedroom walls, facing missing on the lower drawer of bed B's nightstand, stained ceiling tile, and entry room and bedroom doors was scraped. Resident room [ROOM NUMBER], floor tile missing under bed A, paint/scrapes/missing in bathroom and across from bed B, and entry room and bathroom drawers scraped. Resident room [ROOM NUMBER], air conditioner cover missing and noted to be under a chair in the room, paint missing on wall by bathroom sink, across from commode the wall paint was bubbled outward, missing sheetrock, ceiling tile bowing downward in room and bathroom doors scraped. Resident room [ROOM NUMBER], bed pan with feces and urine in the bathroom, paper and urine colored liquid in commode and paint missing behind bed A. Carpet going down the ramp from dining room had black/brown stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second environmental tour of the facility, on 5/2/2025, at approximately 9:15 am, accompanied by Maintenance Director (MD) GG, he confirmed the above observations and stated the resident environment was to be maintained in a clean, safe, and homelike manner.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35847 Based on observations, staff interviews, record review, and review of facility policy, the facility failed to provide interventions as planned for the prevention of falls for one of three residents reviewed for falls (Resident (R) #26). Findings include: Review of the facility policy titled, Incident and Reportable Event Management dated September 2025, revealed Policy - The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. The policy further revealed, Procedure - The Five I's to Event Management - To help reduce the risk of an event, all residents receive assistance and supervisions as addressed in their care plan. Review of R#26's clinical record revealed an admitted [DATE] and the diagnoses included dementia, anxiety, contracture of left thigh muscle, fracture of the right femur, and history of falling. Review of R#26's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. The MDS revealed R#26 required set-up/supervision with ambulating 10 feet and the activity of ambulating 50 or 150 feet did not occur during the assessment period. The MDS revealed the resident had not fallen since the previous assessment. Review of R#26's at risk for falls care plan dated 3/21/2025 revealed the interventions of bed in lowest position when in bed and reposition signage to a more visible location to ask for assistance. Review of R#26's hospital Discharge Summary revealed the resident was transferred to the hospital on 4/20/2025. The resident admitted to the staff she had a fall from the wheelchair approximately three days prior, which she denied telling the nursing staff. The resident admitted that her hip was persistently hurting and she was transferred to the hospital. R#26 was diagnosed with a right femur fracture and did not want surgical intervention. The resident was discharged back to the facility on [DATE]. Observation of R#26 on 4/29/2025 at 12:02 pm revealed the resident lying in bed and the bed was at the regular height. Observations of R#26 on 4/30/2025 at 8:07 am and 12:10 pm, revealed the resident lying in bed and the bed was not in the lowest position. Observations of R#26 on 5/1/2025 at 9:20 am and 2:00 pm revealed the resident lying in bed and the bed was not at the lowest position and there was no sign in the room to instruct the resident to call for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/1/2025 at 2:03 pm of R#26's room and an interview with Registered Nurse (RN) DD revealed after the surveyor asked about if the bed was in the lowest position, RN DD lowered the resident's bed approximately 12 inches to the lowest position. RN DD at that time confirmed there was no sign in the room to instruct the resident to call for assistance. In an interview with MDS Coordinator FF on 5/2/2025 at 9:08 am, she stated the Interdisciplinary Team made sure the interventions on the care plan were put in place. The team used an informal process to ensure the intervention was in place, just by completing observations and talking with the staff, but not documented as completed. In an interview with the Director of Nursing (DON) on 5/2/2025 at 9:42 am, she stated the staff should follow the care plan as much as possible. The DON stated the direct care staff found out about the residents' care interventions by reviewing the Kardex, during Grand Rounds, or verbal reports.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35847 Based on observations, interviews, record review and review of facility's policy titled Activities of Daily Living (ADLs), the facility failed to provide assistance and provide accurate documentation of meal intake for one of five residents (R) (R26) reviewed for nutrition status. Findings include: Review of the facility's policy titled Activities of Daily Living (ADLs) dated 9/10/2024, revealed Policy - The resident will receive assistance as needed to complete activities of daily living (ADLs). Any change in the ability to perform ADLs will be reported to the nurse. Review of R26's clinical record revealed diagnoses that included but not limited to dementia, anxiety, disorder of plasma-protein metabolism, emphysema, and chronic ulcer of left lower leg. Review of R26's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment; Section GG (Functional Abilities and Goals) revealed R26 required set-up/supervision with eating, weighed 108 pounds, experienced weight loss, and was on a mechanically altered diet. Review of R26's hospital Discharge Summary revealed the resident was transferred to the hospital on 4/20/2025 and discharged on [DATE] with the diagnoses of a right femur fracture. Review of R26's care plan for unplanned/unexpected weight loss revised 4/4/2025 revealed the intervention to record food intake at each meal. Review of R26's care plan for ADL Assistance and Therapy Services revealed the staff should assist the resident with mobility and ADLs as needed. Review of R26's Physician Orders revealed an order for a regular diet/regular texture with the start date of 4/23/2025. Review of R26's Mini Nutritional Assessment revealed a score of seven with a score of zero to seven identified the resident as malnourished. Observations of R26 on 4/29/2025 revealed: 12:10 pm - the lunch tray was on the overbed table, and the overbed table was on the right side of the bed and R26 was lying on their right-side fidgeting with the napkin and not eating. Staff was not present with the resident. 12:20 pm - no staff with R26 and the resident not eating. 12:28 pm - a staff member entered the room and asked R26 if she had it. Staff left the room without cueing or assisting the resident to eat. 12:43 pm - Observation revealed R26 only ate the meat off one side of the chicken leg. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:56 pm - R26 was lying in bed with her eyes closed and had not eaten anything else. Review of the Meal Intake report revealed staff documented the resident ate 51 to 75 percent (%) of the meal. Observations of R26 on 4/30/2025 revealed: 8:07 am - the breakfast tray was on the overbed table, positioned to the right side of the bed. A staff member entered the room and asked R26 if she was going to eat and stated, it is right here, you didn't eat anything. Staff did not attempt to assist or encourage the resident to eat. 8:58 am - the breakfast tray was observed on the overbed table, and R26 had not eaten anything. 12:10 pm - staff served R26 her lunch tray and placed it on the overbed table on the right side of the bed. The resident was lying on her right side with the head of the bed elevated approximately 45 degrees. The resident was picking at the food. Staff was not present in the room. 12:22 pm - staff had not entered the resident's room to queue or assist R26 and the resident was not eating her lunch meal. 12:44 pm - staff picking up the trays from the residents' rooms. A staff member from the hall asked, You not going to eat? Staff entered the room and then came back out without the tray and stated the resident had changed her mind. 12:47 pm to 12:49 pm - two staff members entered the resident's room, one staff member left and then returned with a package of incontinence briefs. 12:51 pm - the staff removed the tray from the resident's room and the resident ate 0% of the lunch meal. Review of the Meal Intake report revealed staff documented the resident ate 51 to 75% of both the breakfast and lunch meals. An observation of R26 on 5/1/2025 at 9:20 am revealed the resident's breakfast tray was on the overbed table. The coffee mug and the Styrofoam bowl were empty. The plate still contained a piece of toast, bacon, and grits. In an interview with Registered Nurse (RN) DD on 5/1/2025 at 2:03 pm, revealed R26 required extensive assistance with ADLs, but she could feed herself. Staff should set her tray and herself up and either position the tray in front of her or to her side. RN DD also stated the staff should queue R26 to eat if she did not eat on her own. In an interview with Certified Nursing Assistant (CNA) HH on 5/2/2025 at 9:13 am, she stated the resident required extensive assistance with all ADLs except eating, which required supervision and set-up. CNA HH stated they documented meal intake by the percentage eaten of the entire meal served. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 5/2/2025 at 9:42 am, she stated the meal intake was the percentage of the entire meal eaten and the CNAs completed that documentation. The DON stated if a resident was not eating, the staff should queue, encourage, and try to get the resident to eat. Staff should also offer the resident alternatives.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on interview, record review, and review of the facility's policies titled Administration of Medications and Pain Assessment and Management, the facility failed to provide nursing services consistent with professional standards of practice by failing to follow physician orders for pain management for two of three sampled Residents (R) (R51 and R5) reviewed for pain. Findings include: A review of facility's policy titled Administration of Medications last reviewed on 9/16/2024, revealed Policy; the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Procedure; 2. Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration. g. Right Assessment; note the resident's history and any parameters around drug administration. A review of facility's policy titled Pain Assessment and Management last reviewed on 9/5/2024, revealed Policy; based on the comprehensive assessment of a resident, this facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pain Management Procedure; 2. The facility will address/treat the underlying causes of the pain, to the extent possible; a. Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both. Review of clinical records revealed that R51 was most recently admitted to the facility on [DATE], with diagnoses to include acute pain due to trauma, spinal stenosis without neurogenic claudication, and T5, T6 vertebra wedge compression fracture. Review of R51's Admission Minimum Data Set assessment (MDS) dated [DATE] for Section J, Pain Management, indicated that the resident had frequent pain within the last 5 days, and the pain intensity, rate pain (0 to 10), 0 being no pain and 10 as the worst pain you can imagine, he responded as a 10, for the most severe pain. Review of R51's Care Plan revealed the resident expresses (pain/discomfort) r/t [related to] neuropathy, date-initiated 4/16/2025. Interventions included to anticipate the resident's need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, observe and report to nurse any s/sx [signs/symptoms] of non-verbal pain. Observe for pain characteristics: quality (e.g. sharp, burning); severity (1 to 10 scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors, and relieving factors. Pain medications as ordered, provide the resident with reassurance that pain is time limited. Encourage (resident) to try different pain-relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, report to nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx [signs or symptoms]or c/o [complaints of] pain or discomfort. And the resident is able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain, with date initiated on 4/16/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R51's physician orders dated 4/22/2025 revealed, hydrocodone-acetaminophen (an opioid - narcotic pain medication) Oral Tablet 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed for Severe pain 7-10 for 7 Days. The order was completed 4/29/2025. A review of Physician Orders dated 4/29/25, hydrocodone-acetaminophen oral tablet 2.5-325 mg. Give 1 tablet by mouth every 6 hours as needed for Severe pain 7-10. The order was discontinued 5/1/2025. A review of R51's April 2025, Medication Administration Record (MAR), revealed that nursing administered the as needed hydrocodone-acetaminophen oral tablet 5-325 mg, for a total of 15 doses, from 4/22/2025, through 4/29/2025. Continued review of the April 2025 MAR revealed the pain scale (0-10 [0 indicating no pain, and 10 the worst pain]) nursing staff had documented the opioid pain medication, hydrocodone-acetaminophen, 5-325 mg, was provided to the resident for a pain scale of five (5) and six (6), [which is below the physician ordered Severe pain 7-10], for a total of 10 out of 15 doses, from 4/22/2025, through 4/29/25. A further review of R51's April 2025, Medication Administration Record (MAR), revealed that nursing administered the as needed hydrocodone-acetaminophen oral tablet 2.5-325 mg, for a total of 2 doses, on 4/30/2025. Continued review of the April 2025 MAR revealed the pain scale nursing staff had documented the opioid pain medication, hydrocodone-acetaminophen, 2.5-325 mg, was provided to the resident for a pain scale of five (5), [which is below the physician ordered Severe pain 7-10], for a total of 1 out of 2 doses, on 5/30/2025. In review of R51's clinical record revealed, lack of documentation of non-pharmacological interventions (NPI) attempted prior to the administration of the opioid pain medication, Hydrocodone-Acetaminophen. During an interview on 5/1/2025, at 11:38 am with the Director of Nursing she confirmed that nursing staff had administered 11 out of 17 doses, below the physician ordered severe pain range, and was unable to provide the documentation of the NPIs used prior to the administration of the opioid - narcotic pain medication, Hydrocodone-Acetaminophen. Review of clinical records revealed that R5 was admitted to the facility with diagnoses that included bilateral primary osteoarthritis of knee, pain in right hip, right knee, and contracture of the right knee. Review of R5's Quarterly Minimum Data Set assessment (MDS) dated [DATE], revealed for Section J (Pain Management), indicated that the resident had occasional pain within the last 5 days, and that the resident's pain intensity was moderate as noted by the resident's response of 5 on a pain scale of zero (0) to 10, with zero (0) being no pain and 10 as the worst pain you can imagine. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R5's pain care plan revised 10/19/2023 revealed the resident expressed (pain/discomfort) r/t [related to] OA [osteoarthritis] and CVA [cerebral vascular accident - stroke]. Interventions included: Evaluate the effectiveness of pain interventions, pain medications as ordered, date-initiated 9/21/2023. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe and report to nurse any s/sx [signs/symptoms] of non-verbal pain, observe for pain characteristics: Quality (e.g. sharp, burning); Severity (1 to 10 scale); Anatomical location; Onset; Duration (e. g., continuous, intermittent); Aggravating factors; Relieving factors. Provide the resident with reassurance that pain is time limited, and to encourage resident to try different pain-relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application. And the resident is able to: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain, date Initiated, 2/25/2025. A review of R5's current Physician Orders (PO) dated 2/16/2025, revealed hydrocodone-acetaminophen (an opioid - narcotic pain medication) oral tablet five (5)-325 milligrams (mg). Give one (1) tablet by mouth every six (6) hours PRN for moderate pain 4 -6, and severe pain 7-10. A review of R5's March 2025, Medication Administration Record (MAR) revealed that nursing staff administered the PRN hydrocodone-acetaminophen oral tablet 5-325 mg, for a total of 34 doses, from 3/1/2025, through 3/31/2025. Continued review of the March 2025 MAR revealed the pain scale (zero [0]-10 [0 indicating no pain, and 10 the worst pain]) nursing staff documented the opioid pain medication, hydrocodone-acetaminophen 5-325 mg, was administered to the resident for a pain scale of 2 and 3 , [which was below the physician ordered moderate pain 4 - 6, and severe pain 7-10], for a total of four (4) out of 34 doses, from 3/1/2025, through 3/31/2025. A review of R5's April 2025, MAR, revealed that nursing staff administered the PRN hydrocodone-acetaminophen oral tablet 5-325 mg, for a total of 43 doses, from 4/1/2025, through 4/30/2025. Continued review of the April 2025 MAR revealed the pain scale (zero [0]-10) nursing staff documented the opioid pain medication, hydrocodone-acetaminophen, 5-325 mg, was administered to the resident for a pain scale of 3, [which was below the physician ordered moderate pain four (4) - six (6), and severe pain seven (7) -10], for a total of seven (7) out of 43 doses, from 4/1/25, through 4/30/2025. In review of R5's clinical record revealed the record lacked documentation of non-pharmacological interventions (NPI) attempted prior to the administration of the opioid pain medication, hydrocodone-acetaminophen. Documented evidence of NPIs were not provided to the survey team prior to the survey's exit on 5/2/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 5/1/2025, at approximately 11:40 am, confirmed that the current physician order for the hydrocodone - acetaminophen (as prescribed, included pain levels of moderate, and severe, and in addition, that nursing staff administered the narcotic pain medication below the physician ordered parameter, which did not include administering the pain medication for mild levels of pain. This practice was not consistent with facility policy or standards of practice for pain management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115570	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens of Life Care	804 South Broad Street Box 1959 Thomasville, GA 31792

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35847 Based on observations, interviews, record reviews, and review of facility's policies titled Administration of Medications, Nasal spray instillation, Metered-dose inhaler use, and Eyedrop administration, the facility failed to provide medications accurately and as ordered for two of four Residents (R) (R28 and R29) observed during medication pass. The medication pass included 45 opportunities with five errors which resulted in an error rate of 11.11 percent (%). Findings include: Review of the facility's policy titled, Administration of Medications dated 9/16/2024 revealed, Procedure . 2. Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration a. Right Drug . b. Right Resident . c. Right Dose . d. Right Route . e. Right Time and Frequency . f. Right Documentation . g. Right Assessment . h. Right to Refuse . i. Right Evaluation/Response . j. Right Education and Information. Review of the facility's policy titled, Nasal spray instillation dated 5/20/2024 revealed Implementation . Occlude one of the patient's nostrils with your finger to prevent air from entering the nasal cavity, allowing the medication to flow properly. Review of the facility's policy titled, Metered-dose inhaler use dated 5/20/2024 revealed, Implementation . When administering inhaled corticosteroids, such as beclomethasone, budesonide, ciclesonide, flunisolide, fluticasone, or triamcinolone, instruct the patient to rinse and gargle with water and then to expectorate using an emesis basin after each dose (if necessary) to help prevent an infection in the mouth. Review of the policy facility's titled, Eyedrop administration dated 5/20/2024 revealed, Instilling Eyedrops . After instilling the eyedrops, instruct the patient to close the eyes gently and to keep them closed. Closing the eyes tightly or squeezing them shut may force some medication out of the eye, resulting in the absorption of an inaccurate dose. Repetitive blinking may push out the medication. If necessary, gently press your thumb or a gauze pad on the inner canthus for 2 [two] to 3 [three] minutes while the patient keeps the eye closed to prevent systemic absorption of medication. 1. Review of R28's Physician Orders included the following orders: Fluticasone Nasal Suspension (Flonase) 50 micrograms (mcg)/activation (act), one spray in both nostrils two times a day for allergies with the ordered date of 3/13/2025; Toprol XL oral tablet, extended release 25 milligrams (mg) one time a day for hypertension and atrial fibrillation, scheduled for 9:00 a.m., with the start date of 3/14/2025; and Olopatadine ophthalmic solution 0.2 percent (%), instill one drop in both eyes one time a day for cataract surgery, scheduled for 9:00 a.m. with the ordered date of 3/14/2025. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 4/30/2025 at 8:11 a.m., revealed Registered Nurse (RN) AA administered medications to R28. Observation revealed the resident's blood pressure (BP) was 100/59. RN AA removed the Toprol from the medication cup and did not administer it to the resident. No parameters were noted on the Medication Administration Record (MAR). Observation revealed RN AA handed the resident the fluticasone nasal suspension and did not instruct the resident on how many sprays to instill. R28 administered two sprays into each nare. RN AA did not observe the resident administer the fluticasone nasal spray. Further observation revealed RN AA did not administer the olopatadine ophthalmic eye drops as ordered. In an interview with RN AA on 4/30/2025 at 12:17 p.m., regarding the parameters for holding the Toprol, RN AA revealed she could not find the parameters, but she held it because R28's BP was 100. Asked the nurse if the facility had standing orders for holding medications regarding BP results and she stated yes. RN AA and two other nurses looked for the standing orders but could not find them. RN AA also stated they did not observe the resident administer two sprays of the Flonase and stated she did not see the eye drops in the cart and was going to look for them. RN AA had R28's BP taken at this time and stated it was 109/70 so she just gave the Toprol, three hours after it was scheduled to be given. The clinical record lacked evidence that the physician was notified the physician. 2. Review of R29's Physician Orders revealed orders for: Breo Ellipta Inhalation Aerosol 100-25 mcg/act, one puff inhaled orally one time a day for shortness of breath, scheduled for 9:00 a.m., with the ordered date of 3/20/2025;Flonase Allergy Relief Nasal Suspension 50 mcg/act, two sprays in both nostrils one time a day for allergies, scheduled for 9:00 a.m. with the ordered date of 3/15/2025; and Latanoprost solution 0.005%, instill one drop in both eyes one time a day related to open-angle glaucoma bilaterally with the start date of 12/10/2024. An observation on 4/30/2025 at 9:11 a.m., revealed Licensed Practical Nurse (LPN) BB administered medications to R29. An observation revealed LPN BB administered one drop of latanoprost into each eye but did not instruct the resident to close their eyes and did not hold the inner canthus to increase absorption and decrease systemic absorption. Continued observation revealed LPN BB handed the resident the Flonase Nasal Spray, did not instruct the resident to hold the opposite nare when instilling the nasal spray and the resident administered two sprays into each nostril without holding the opposite nare, to increase absorption of the Flonase. Further observation revealed the resident administered the fluticasone inhaler, but LPN BB did not offer or provide assistance for the resident to rinse out their mouth. In an interview with LPN BB on 4/30/2025 at 2:46 p.m., she stated she did not have the resident to rinse their mouth after the Breo Ellipta inhalation and said, the resident's daughter said she didn't have to. LPN BB also stated R29 said she received more of the Flonase by not holding the opposite nare when administering it. Review of the Federal Drug Administration (FDA) label dated 1/7/2019 revealed, Breo Ellipta, After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis. An interview with the Director of Nursing (DON) on 5/1/2025 at 9:00 a.m., revealed she did not know if the facility had standing orders for the holding parameters for BP medications. She stated the staff usually just follow the physician's orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 5/1/2025 at 10:42 a.m., revealed staff should assist the resident with rinsing their mouth after they received an inhaler. The DON stated the nurse should put those instructions on the orders. The DON also stated the staff did monthly reviews to make sure instructions like that were on the orders. The DON stated the staff should instruct the resident on how many inhalations they should take and to hold the opposite nare when administering nasal spray. The DON further stated staff should follow the facility's policy which followed the [Name] nursing book and professional standards when administering medications. If a steroid eye drop was administered, the staff should hold the inner canthus of the eye. Regarding BP parameters, the DON stated typically the physician will order the parameters as to when to hold the medication. If the staff held the medication, they should notify the physician.