STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146037	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Meadows Senior Living	400 West Washington Chrisman, IL 61924

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of verbal abuse to the state survey agency for one of 13 residents (R6) reviewed for staff behavior in the sample list of 21. Findings include:The facility's Abuse Prevention Program dated October 2022 documents visitors are encouraged to report suspected concerns of abuse immediately to the administrator or to an immediate supervisor who immediately reports to the administrator. This policy documents the facility will report allegations of abuse to the Illinois Department of Public Health (IDPH). On 3/16/26 at 11:31 AM R6 stated about a week or so ago a Certified Nursing Assistant (identified as V41 CNA) assisted R6 onto the bedpan during the night. R6 stated R6 told V41 that R6 couldn't decide if R6 was too hot or too cold and V41 told R6 that R6 better make up R6's mind because V41 was not going to keep coming into R6's room every five minutes as V41 is only required to come in every two hours. R6 stated R6 felt like this was scolding in nature and belittling, R6 is an adult and not a child. R6 stated this was a dignity issue but also abuse and R6 did not like being treated like that at all. R6 stated R6 thought R6 reported this to V42 Corporate Marketer last Thursday.R6's Minimum Data Set, dated [DATE] documents R6 as cognitively intact. After reviewing the facility's abuse log on 3/17/26, there were no documented allegations involving R6. R6's abuse allegation was reported to V2 Director of Nursing on 3/17/26 at 12:10 PM. On 3/17/26 at 12:20 PM V2 was asked about any follow up regarding R6's abuse allegation. V2 stated V42 spoke with R6 yesterday and R6 reported that she did not recall the alleged incident and V2 did not report R6's allegation to IDPH (state survey agency) since abuse wasn't suspected. V2 stated V2 reported R6's allegation to V9 Corporate Administrator yesterday.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to restrict an employee from working while investigating an allegation of abuse for one of 13 residents (R6) reviewed for staff behavior in the sample list of 21. The employee had access to R13-R21 during this time period. The facility's Abuse Prevention Program dated October 2022 documents visitors are encouraged to report suspected concerns of abuse immediately to the administrator or to an immediate supervisor who immediately reports to the administrator. This policy documents employees accused of abuse will be removed from resident contact immediately and not permitted to return to work until the results of the investigation have been reviewed by the administrator and determined abuse is unsubstantiated. On 3/16/26 at 11:31 AM R6 stated about a week or so ago a Certified Nursing Assistant (identified as V41 CNA) assisted R6 onto the bedpan during the night. R6 stated R6 told V41 that R6 couldn't decide if R6 was too hot or too cold and V41 told R6 that R6 better make up R6's mind because V41 was not going to keep coming into R6's room every five minutes as V41 is only required to come in every two hours. R6 stated R6 felt like this was scolding in nature and belittling, R6 is an adult and not a child. R6 stated this was a dignity issue but also abuse and R6 did not like being treated like that at all. R6 stated R6 thought R6 reported this to V42 Corporate Marketer last Thursday.R6's Minimum Data Set, dated [DATE] documents R6 as cognitively intact. After reviewing the facility's abuse log provided on 3/17/26, there were no documented allegations involving R6. R6's abuse allegation was reported to V2 Director of Nursing on 3/17/26 at 12:10 PM. On 3/17/26 at 12:20 PM V2 was asked about any follow up regarding R6's abuse allegation. V2 stated V42 spoke with R6 yesterday and R6 reported that she did not recall the alleged incident and therefor abuse was not suspected. V2 stated V2 had not yet spoken to V41 and V41 was not on the schedule to work last night. At 12:30 PM V2 verified which resident rooms are considered Hall 1 on the 200 unit. On 3/17/26 at 1:36 PM V41 CNA stated V41 worked last evening from 6:00 PM until 6:00 AM on Hall 1 of the 200 unit but R41 helped answer call lights on other halls on that unit. V41 stated V41 answered R6's call light last night and assisted R6 onto the bed pan. V41's timecard documents V41 worked on 3/16/26 from 5:47 PM until 5:57 AM. The facility's Resident List Report dated 3/16/26 documents R13-R21 reside on Hall 1 on the 200 unit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review the facility failed to monitor and report changes in condition and follow physician's orders for four of six residents (R1, R2, R6, R11) reviewed for changes in condition in the sample list of 21. Findings include:The facility's Notification of Resident Change in Condition policy dated [DATE] documents the nurse shall inform and consult with the resident's physician and representative regarding significant changes in condition and the nurse should use professional judgement based on assessment and findings or signs and symptoms of changes which could lead to deterioration if not treated. This policy documents to monitor signs and symptoms and vital signs, and notify the family and physician of significant findings. The facility's undated Laboratory Services policy documents the facility must obtain laboratory services to meet the needs of the residents and the facility is responsible for the timeliness of services. 1.) On [DATE] at 11:31 AM R6 stated R6 had a cough, went to the hospital and was diagnosed with acute bronchitis. R6 stated the facility uses agency nurses but the Certified Nursing Assistants (CNAs) have been good about letting the nurses know changes in my health and when R6 should be sent to the hospital. R6 stated R6 feels like they have always sent her to the hospital timely and when needed but R6 didn't remember much about her treatment prior to going to the hospital. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact.R6's Care Plan documents a problem of Congestive Heart Failure (CHF) and altered respiratory status related to difficulty breathing and sleep apnea, with interventions dated [DATE] to monitor/document and report to physician as needed any signs of CHF, including edema, shortness of breath, cool skin, dry cough, distended neck veins, weakness, weight gain, crackles/wheezing upon lung assessment, weakness/fatigue, increased heart rate, lethargy, and disorientation. This care plan also includes interventions to monitor and report symptoms of respiratory distress and abnormal breathing patterns, including increased/decreased respirations, decreased oxygen saturation, restlessness, sweating, headaches, pleuritic pain, use of accessory muscles for breathing, skin color changes, periods of apnea, prolonged deep or shallow breathing, pursed lip breathing and nasal flaring.R6's Progress Note dated [DATE], recorded by V20 Nurse Practitioner, documents R6 presents with increased cough, congestion, inspiratory wheezing noted on lung assessment and increased fatigue. This note includes the following orders: chest x-ray, Complete Blood Count (CBC), Complete Metabolic Panel (CMP), use of spirometer, supplemental oxygen if needed, nebulizer treatments as needed (PRN) and continue to monitor respiratory status. R6's February 2026 Medication Administration Record documents PRN nebulizer treatments were given four times between [DATE] and [DATE] and R6 used oxygen on the evening of [DATE]. There is no documentation in R6's medical record that vital signs or respiratory assessments were completed [DATE]-[DATE]. There is no documentation that chest x-ray and laboratory orders were completed. R6's Nursing Note dated [DATE] [DATE] at 3:40 PM documents R6 was sent to the hospital for shortness of breath and coughing. R6's vital signs were as follows: blood pressure 137/65, Pulse 91, oxygen saturation 95% on 3 liters, temperature 98.3 degrees Fahrenheit. V20 contacted hospital for update and R6 was transferred to transferred to higher level hospital due to R6's oxygen saturation dropping while on bilevel positive airway pressure and Troponin levels were elevated. R6's Hospital History and Physical dated [DATE] documents R6 was direct admit from another hospital emergency room due to concerns for possible Non-ST-segment Elevation Myocardial Infarction, R6 reported symptoms of generalized weakness, fatigue, body aches, wet nonproductive cough, shoulder pain from coughing, severe sore throat, and shortness of breath that progressively worsened over the last four days. While in the emergency room R6 had tachycardia with pulse in the 110s beats per minute, increased respirations of 20-30 per minute, decreased oxygen saturation of 85% which required oxygen via 2 liters per minute. R6 was admitted for sepsis secondary to Pneumonia with Acute Hypoxemic Respiratory Failure with source as seen on admission Chest (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Computed Tomography Angiography showing persistent regions of right lung dependent atelectasis/consolidations. On [DATE] at 4:00 PM V20 stated V20 evaluated R6 on [DATE] and a chest x-ray, CBC, and CMP were ordered for wheeze, shortness of breath and cough. V20 stated the facility's laboratory and x-ray services do not come on the weekends so the orders would have been completed on [DATE]. V20 stated R6 was stable at that time and the nurses should have been monitoring R6's vital signs and completing respiratory assessments every shift and reported any changes to V20. V20 stated depending on the x-ray results and if R6 had any reported changes V20 would have ordered to send R6 to the hospital sooner. V20 reviewed R6's vital signs and nursing notes and confirmed there were no documented assessments or vital signs after [DATE] until R6 was sent to the hospital on [DATE] with sepsis secondary to pneumonia. V20 stated R6 would have required hospital treatment regardless and did not feel R6's sepsis could have been prevented if treated sooner since R6's vitals did not indicate sepsis on [DATE]. If she was notified of any changes during that time prior to results she would have just ordered for her to go to the hospital sooner. On [DATE] at 9:30 AM V37 MDS Coordinator confirmed there were no vital signs or respiratory assessments for R6 from [DATE] until [DATE] when R6 was hospitalized . V37 stated R6 had a prior incentive spirometry order that would have monitored respiratory status that was not resumed after R6 had previously returned from the hospital. V37 stated the x-ray company contacted the facility on [DATE] to schedule R6's x-ray, but R6 had already been transferred to the hospital. 2.) R2's MDS dated [DATE] documents R2 has severe cognitive impairment and is dependent on staff for activities of daily living (ADLs.) R2's care plan documents R2's diagnoses include Hypertension, Peripheral Vascular Disease, Alzheimer's Disease, Heart Failure, and Old Myocardial Infarction. R2's pulse record dated [DATE]-[DATE] documents R2's pulse ranged 60s-80s beats per minute until [DATE] at 5:56 PM when R2's pulse was 106. There are no blood pressures or pulse recorded after this date in R6's medical record. There are no documented assessments, monitoring or notification to R2's Family (V22), V38 Physician or V20 Nurse Practitioner after R2's pulse increased. R2's Nursing Note dated [DATE] at 7:17 AM documents R2 was transferred to the local emergency room for evaluation and treatment per V22's request due to lack of response to stimuli, cold extremities and gurgling. V20 was notified. R2's Emergency Medical Technician report dated [DATE] at 7:21 AM documents upon arrival R2 was unresponsive, flaccid, and cold with mottled extremities, with signs of respiratory distress with rales noted upon lung assessment. Initially unable to obtain blood pressure reading to touch. At 7:36 AM R2's blood pressure was 57/35, pulse was 114 per minute, respirations 10 per minute and oxygen saturation was 51% on room air. R2's Hospital Records dated [DATE] documents R2 died at 9:30 AM. On [DATE] at 1:43 PM V21 Registered Nurse (RN) stated V21 was R2's nurse on dayshift on [DATE] and didn't recall any changes in R2's condition that V21 observed or was reported to V21. V21 did not recall any information regarding R2's 106 pulse on [DATE]. V21 stated V21 would have documented any changes in R2's condition and R2 tapped while the electronic machine obtained R2's pulse and blood pressure, which could have affected the pulse results. V21 stated if she had rechecked R2's pulse manually or did any follow up it would be documented in a nursing note. V21 did not recall reporting any changes in R2 and would have documented this. On [DATE] at 2:39 PM V19 Licensed Practical Nurse stated a CNA came to get V19 after end of shift report, R2 was gurgling and was unresponsive, and nothing had been passed on in the prior shift's report. On [DATE] at 3:18 PM V19 stated a CNA came to get V19 to assess R2 that morning and V19 tried to get oxygen saturation but did not bother with any other vital signs. V19 notified R2's family who wanted R2 sent to the hospital and emergency services was contacted right away. On [DATE] at 12:30 PM V2 Director of Nursing stated physician and family notification is documented in a nursing note. V2 stated for abnormal blood pressure or pulse, the nurse should recheck these vitals manually and look for any symptoms and report to the provider and family. V2 stated if it is a major change for that resident then the nurse should use nursing judgement and send that resident to the hospital right away. On [DATE] at 9:35 AM V34 CNA stated around 5:00 PM-6:00 PM on [DATE], R2 was not acting (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	herself, not verbally responsive, R2's legs were purple up to her knees and cold to touch, and R2 had not swallowed R2's medications that were given earlier. V34 stated V34 reported these things to V21 RN who checked R2's vital signs. V34 stated V34 told the night shift staff to watch R2 closely that night and the next day R2 died at the hospital. On [DATE] at 12:53 PM V20 Nurse Practitioner stated staff should have reassessed and reported R2's pulse of 106. V20 stated the CNAs should report changes to the nurse and then the nurse should have assessed R2 and rechecked vital signs. V20 stated if V20 was notified of these changes, V20 would have deferred to notifying R2's family to determine if they wanted R2 hospitalized , due to R2's age with advanced dementia and Do Not Resuscitate order. V20 stated if V20 was notified V20 would have assessed R2 and checked R2's lungs. 3.) R1's MDS dated [DATE] documents R1 admitted to the facility on [DATE] and had moderate cognitive impairment. R1's Care Plan documents R1's diagnoses included Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Hypertension, and Type 2 Diabetes Mellitus. This care plan documents R1 receives a diuretic and includes interventions to monitor for side effects and effectiveness, and report pertinent laboratory findings, especially sodium and potassium levels, to the physician. R1's Physician's Order dated [DATE], entered by V20, documents CBC and CMP, send the order to the laboratory and place copy in V20's folder. There is no documentation that this order was implemented. R1's Progress Note dated [DATE], recorded by V38 Physician, documents new orders for Spironolactone (diuretic) 25 milligrams (mg) daily and to repeat Basic Metabolic Panel (BMP) in one week. There is no documentation that the order for BMP was entered into R1's medical record and completed. R1's Progress Note dated [DATE], recorded by V20, documents R1 had recent elevated [NAME] Blood Cell count 15.46 on [DATE], and R1 has cellulitis, continue with antibiotics until [DATE] and monitor for improvement.R1's February 2026 Medication Administration Record documents R1 refused 6:00 AM medications on [DATE], recorded by V21 RN. This is the first documented time that R1 refused medications and there is no documentation why R1 refused these medications or any follow up regarding this. R1's Nursing Note dated [DATE] at 11:42 AM documents R1 died at 9:00 AM in the facility. There is no documentation in R1's medical record that R1's family or provider were notified of refusing medications or R1's statements of wanting to die. On [DATE] at 1:43 PM V21 RN stated V21 did not recall much about R1 or when V21 last saw R1 on [DATE] and thought R1's 6:00 AM medications were given by the night nurse and did not recall why R1's medications were refused or any follow up regarding this. V21 stated communication with the providers are documented in a nursing note. V21 confirmed V21 was the nurse who confirmed R1's death on [DATE] at 9:00 AM. On [DATE] at 3:03 PM V31 CNA stated V31 cared for R1 on the evening of [DATE] and R1 had made comments R1 wanted to die, the nurses were aware of this but said it was just R1's anxiety. On [DATE] at 9:35 AM V34 CNA stated V34 started morning rounds on [DATE] and R1 is one of the last ones since R1 liked to sleep in. V34 stated V34 found R1 in bed at approximately 8:00-9:00 AM and got the nurse. On [DATE] at 9:30 AM V37 MDS Coordinator stated V38 gives all his orders to V2 Director of Nursing to enter when V38 rounds at the facility. At 10:34 AM V37 confirmed R1's BMP order from [DATE] was not entered into R1's medical record and there was no documentation that R1's laboratory orders were completed but V37 has contacted the laboratory. At 11:35 AM V37 confirmed R1 did not have laboratory results as scheduled/ordered for [DATE] and 2/10-[DATE]. On [DATE] at 12:53 PM V20 stated the nurses should report refusals of medications and document the reason for refusal, and staff should have reported R1's statements of wanting to die. V20 stated if V20 was notified, V20 would have met with R1 and R1's family to discuss this further. V20 stated V38 Physician saw R1 on [DATE] and ordered Spironolactone and to repeat BMP in one week, which would have been acceptable to draw on the morning of [DATE]. 4.) R11's Hospital discharge date d [DATE] documents R11 was treated for Acute Kidney Injury. R11's CMP dated [DATE] at 7:15 AM documents R11's Blood Urea Nitrogen (BUN) was 32 milligrams per deciliter (mg/dl normal range 5-25), Creatinine was 2 mg/dl (normal 0.5-1.4), Sodium was 135 millimoles per liter (mmol/l normal 135-148) Potassium was 4.5 mmol/l (normal 3.3-5.3) and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Estimated Glomerular Filtration Rate (eGFR) was 24 milliliters per minute per 1.73 meters of body surface area (normal greater than 60). R11's [DATE] Medication Administration Record documents R11 received Spironolactone 25 mg daily, Bumex 1 mg twice daily, and Eliquis 5 mg twice daily starting on [DATE]. R11's Progress Note dated [DATE], recorded by V20, documents hyperkalemia (elevated potassium) likely due to Chronic Kidney Disease Stage 4 and dehydration, intravenous fluids given, and CMP ordered.R11's CBC and CMP dated [DATE] documents R11's WBC was 11.44, BUN was 35, Creatinine was 2.4, eGFR was 19 and Potassium was 4.9. R11's physician's order dated [DATE] documents start date [DATE] and stop date [DATE] for CBC and CMP, send order to the laboratory and place copy in V20's folder. There is no documentation that these orders were implemented. R11's Nursing Notes document R11 was evaluated and treated with antibiotics and pain medications beginning on [DATE] for broken teeth, bleeding gums, and infection. There is no documentation that this was reported to V29, R11's Guardian.On [DATE] at 11:13 AM V29 stated V29 saw R11 the day of the hospice referral but didn't realize R11 had declined that bad until that day. V29 stated V29 was not aware that R11 had dental problems or needed to see a dentist prior to that day since no one had reported this to V29. On [DATE] at 12:53 PM V20 stated R11 had been treated for cellulitis and lymphedema and was hospitalized the end of December and treated for dehydration and Acute Kidney Injury. V20 stated Bumex, Spironolactone and Eliquis can decrease blood pressure and increase work on the kidneys causing elevated BUN and Creatinine and decreased eGFR. V20 stated these levels were improving after intravenous fluids on [DATE] and CBC/CMP were ordered to track WBC, potassium, and kidney function. V20 confirmed CBC and CMP order entered [DATE] but results were never obtained.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately transcribe and follow physician's orders which resulted in multiple significant medication errors for two of six residents (R11, R4) reviewed for change in condition in the sample list of 21.Findings include:The facility's Medication, Treatment, and Other Order policy dated January 2019 documents orders should be entered in the orders section of the resident's electronic health record (EHR) by the licensed personnel receiving the order and changes in dosage or frequency will require a new order to be entered into the resident's EHR. The facility's Medication Administration Policy dated March 2014 documents medications will be administered according to the practitioner's orders, medications will be recorded on the Medication Administration Record (MAR), and the MAR will be verified against physician's orders. 1.) R11's Hospital discharge date d 12/26/25 documents R11 was treated for Acute Kidney Injury and to stop taking Bumex (diuretic) 1 milligrams (mg), Spironolactone (diuretic) 25 mg, and Eliquis 5 mg. These orders document to start taking Eliquis 2.5 mg twice daily. These orders were not transcribed into R11's EHR upon readmission to the facility on [DATE]. R11's Complete Metabolic Panel dated 12/26/25 at 7:15 AM documents R11's Blood Urea Nitrogen (BUN) was 32 milligrams per deciliter (mg/dl normal range 5-25), Creatinine was 2 mg/dl (normal 0.5-1.4), Sodium was 135 millimoles per liter (mmol/l normal 135-148) Potassium was 4.5 mmol/l (normal 3.3-5.3) and Estimated Glomerular Filtration Rate (eGFR) was 24 milliliters per minute per 1.73 meters of body surface area (normal greater than 60). R11's December 2025 and January 2026 MARs document: R11 received Spironolactone 25 mg daily, Bumex 1 mg twice daily, and Eliquis 5 mg twice daily starting on 12/27/25. On 1/1/26 Spironolactone was reduced to 12.5 mg daily. Eliquis was reduced to 2.5 mg BID on 1/14/26. R11's CMP dated 12/29/26 documents BUN was 35, Creatinine was 1.9, eGFR was 22, and Potassium was 5.3. R11's CMP dated 1/3/26 documents R11's BUN was 35, Creatinine was 2.4, eGFR was 19 and Potassium was 4.9. R11's Progress Note dated 12/31/25, recorded by V20 Nurse Practitioner, documents hyperkalemia (elevated potassium) likely due to Chronic Kidney Disease Stage 4 and dehydration, intravenous fluids were given. R11's Progress Note dated 1/13/26, recorded by V38 Physician, documents R11 had recent hospitalization and was treated for acute kidney injury secondary to acute tubular necrosis with slow renal function improvement noted. This note documents R11 was taking Eliquis 5 mg twice daily and to decrease to 2.5 mg twice daily due to renal insufficiency and serum creatinine levels. On 3/18/26 at 12:53 PM V20 stated R11 was hospitalized in December and treated for dehydration and Acute Kidney Injury. V20 stated the facility should follow hospital discharge orders and V20 did not realize that R11's Bumex, Spironolactone and Eliquis orders had changed. V20 reviewed R11's hospital discharge orders and MAR and verified the orders were not transcribed correctly. V20 stated this is a nursing medication error. V20 stated these medications can cause decreased blood pressure and increased work on the kidneys, causing elevated BUN, Creatinine and decreased eGFR. V20 stated based on R11's laboratory results from 12/29/25, R11 was treated with intravenous fluids. V20 reviewed and compared R11's laboratory results from December 2025 and January 2026, and stated R11's BUN, Creatinine and Potassium increased slightly but overall had improved. 2.) R4's Hospital discharge date d 1/23/26 documents to take Keflex (antibiotic) 500 mg by mouth four times daily for four days. R4's January 2026 MAR documents this order was transcribed and administered as only twice daily for two days. R4's Hospital discharge date d 2/15/26 documents to continue taking Losartan 12.5 mg daily. This was never entered as an active order in R4's EHR after returning to the facility on 2/15/26. R4's February and March 2026 MARs document to administer Midodrine Hydrochloride Oral Tablet 5 mg by mouth three times daily related to hypotension and hold if systolic blood pressure is greater than 120. R4 received four doses in February and ten doses in March when R4's documented systolic blood pressure was greater than 120. On 3/18/26 at 12:53 PM V20 stated Midodrine should be held if systolic blood pressure is greater (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than 120, if not this could increase blood pressure.On 3/18/26 at 2:39 PM V2 Director of Nursing stated the nurses are responsible for reviewing, verifying and transcribing admission orders. V2 confirmed a check mark on the MAR indicates the medication was administered. On 3/19/26 at 1:05 PM V20 stated V20 confirmed there were no ordered changes for R4's Keflex and Losartan orders. V20 stated these were also medication errors.