STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165346	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Village	345 Parriott Street Aplington, IA 50604

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review, the facility failed to ensure medications were not diverted for 5 of 5 residents reviewed (Residents #1, #2, #3 #4 and #5). Resident #1, #3, #4, and #5 all had a narcotic pain pill missing from one of the facility's medication cart's controlled substance locked drawer. Resident #2's Controlled Substance card was missing when the count was checked. The medication card contained clonazepam (Klonipin) (an antianxiety medication) that was to be administered daily at noon. The card that was to be counted showed this once a day medication was given at 7:40 a.m. This card also showed there was 1 pill missing. There was no reason documented that showed this resident received the medication early. Nor is a medication to be given prior to the time it is to be received without a doctor's order. The facility reported a census of 34.Findings include:1. A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #1 included anxiety, reduced mobility, and diabetic polyneuropathy (nerve damage caused by high blood sugar levels over time). A Brief Interview for Mental Status (BIMS) revealed a score of 7 out of 15, which indicated severe cognitive impairment. Resident #1 had pain frequently in the past 5 days. Pain occasionally made it hard for Resident #1 to sleep and pain frequently limited Resident #1's participation in rehabilitation therapy sessions in the past 5 days. It documented that over the past 5 days the resident was frequently limited in her day-to-day activities due to pain. A Minimum Data Set (MDS) dated [DATE], documented that diagnoses for Resident #1 included anxiety. A Brief Interview for Mental Status (BIMS), documented a score of 15 out of 15, indicating Resident #1 had intact cognition. Resident #1 had pain occasionally in the past 5 days. Pain occasionally made it hard for #1 to sleep in the past 5 days. It documented that over the past 5 days the resident was occasionally limited in her day to day activities due to pain. A Care Plan with a target date of 11/7/25, documented that Resident #1 had complaints of pain described as chronic greater than 3 months related to sacrum (tail bone area) pressure ulcer and osteoarthritis to right hips. The interventions included to administer pain medications per physician orders and encourage/assist to reposition frequently to position of comfort. A Medication Administration Record/Treatment Administration Record (MAR/TAR), for the month of May 2025, directed staff to do a pain evaluation daily. The beginning date was 5/6/25. On 5/29/25, Staff A, Licensed Practical Nurse (LPN), documented that Resident #1's pain level was at an 8 out of 10, which indicated severe pain.This MAR documented that hydrocodone-acetaminophen oral tablet 5mg(milligrams)-325mg could be given by mouth, 1 tablet every 6 hours as needed for pressure ulcer of sacral region. It documented that Staff A administered 1 tablet on 5/29/25 at 7:33 a.m. for a pain level of 9 and again administered 1 tablet at 2:13 p.m. for a pain level of 6.Progress Notes reviewed for 5/29/25 through 5/30/25. No mention of pain was documented. A Controlled Substance Medication Record for Resident #1, was signed by Staff A on 5/29/25 at 7:30 a.m., 5/30/25 at 3:30 p.m., and on 5/30/25 at 7:04 a.m. Bringing the count from 23 to 20. An FRI (Facility Reported Incident) of suspected controlled substance diversion, investigation report dated 6/16/25, Resident #1, had an order for Hydrocodone/APAP Tab 5-325 mg every 8 hours as needed. A 42-tab card was received from pharmacy on 5/15/25. 22 doses were signed off as administered on the Controlled Substance Medication Record as of the morning of 5/30/25. There (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were 19 tablets in the card leaving one tablet unaccounted for. 10/8/25 at 4:00 p.m., A Certified Nurse Aide (CNA) went into the resident's room and shut the door. The CNA said ?Cares' then gave permission for this writer to go into the room. The CNA left and stated she needed to get another staff person. Talked with Resident #1 after CNA left the room. When asked if she was in pain, Resident #1 stated she was feeling some pain, that's why she had turned on her call light to be repositioned. She felt this would help with the pain. She felt she was on the appropriate pain medications and felt she received this medication when she needed it.2. An MDS dated [DATE], documented diagnoses for Resident #2 included anxiety disorder, intellectual disabilities, and mood disorder. A BIMS revealed a score of 0 out of 15, which indicated severely impaired cognitive functioning. the resident had behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 4-6 days, but less than daily in the 7 day observation period prior to this MDS.A MAR dated May 2025, directed to administer Klonopin (clonazepam) 0.5 mg 1 tablet at noon. The start date for this medication was 5/5/23. The MAR documented that Staff A administered this medication on 5/30/25 at noon. The MAR did not document this medication was administered out of the accepted and prescribed time. The MAR directed staff starting on 5/30/25 at 2:00 p.m., to monitor the use of psychotropic medications. The staff's initials indicate the absence of signs and symptoms of side effects and sedation (difficult to arouse, sleeping more than normal). This medication is treating the targeted behaviors noted in the care plan. Use code NN (other/see nurses notes) if side effects are present and complete documentation every shift.A Care Plan for Resident #2 directed the following: Resident #2 utilizes psychotropic medication related to generalized anxiety disorder for targeted behavior of excessive anxiety and worry occur most days for at least six months; difficulty controlling the worry restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep problems, striking out at staff and others. The goal with a target date of 1/15/26, documented that Resident #2 would remain free of complications related to use of psychotropic medications.This care plan directed staff to:administer medications as ordered.Assess for side effects and complications such as abnormal involuntary movements.Attempt nonpharmacological interventions prior to use of psychotropic medications.Monitor behaviors per facility protocol.Monitor for changes in cognition, mood and behavior.It documented to try the following non-pharmacological interventions: going for a walk or stroll outside when nicemusic therapyoffer a snack offer to lay down and restoffer toileting or anticipating the needs of the residenttalk therapy ask about life events or interests.Progress Notes (to include nurses notes) for Resident #2, lacked documentation to support early administration of clonazepam for anxiety or behaviors on 5/30/25. There was no documentation at all in these progress notes from 5/21/25 to 6/18/25.A Controlled Substance Medication Record for Resident #2, documented this record was for the administration of clonazepam tab 0.5 mg-1 tablet by mouth daily at noon for anxiety wear gloves. Staff A had documented on 5/30/25 at 7:20 a.m., 1 clonazepam tab had been given, bringing the count from 1 left in the card to 0 left in the card. This card also revealed that on 5/29/25 at 10:00 a.m., Staff A had administered a clonazepam 1 tab, bringing the count from 3 to 2. The following two entries signed and lined through by Staff A documented that Clonazepam 1 tab was given bringing the count from 2 to 1. Staff A wrote ?error' by the struck through entries and then signed her initials. On 5/29/25 at 10:00 p.m., this count sheet was signed as ?count' 1 tab by Staff B, LPN, and Staff C, Registered Nurse (RN). On 5/30/25, Staff A signed the card at 7:20 a.m., putting the count from 1 to 0. An FRI of suspected controlled substance diversion, investigation report dated 6/16/25, documented that during the count, it was noted that Resident #2 had an order for Clonazepam tab 0.5 mg daily at noon and this card was missing from the drawer. Staff A reported that she had given the medication early, even though she knew she wasn't supposed to do that and signed it out on the Controlled Substance Medication Record as administered at 7:20 a.m. on 5/30/25. On 10/15/25 at 11:16 a.m., the Director of Nursing (DON) stated that on 5/30/25 at around 9:30 a.m., she (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	went through the controlled medication cards with Staff A to ensure the count was correct for the controlled medications. The DON noted that Resident #2's medication card containing clonazepam was missing. She then looked at Resident #2's Controlled Substance Medication Record count sheet and noted the clonazepam was given at 7:20 a.m. on 5/30/25. The medication was not supposed to be given until noon. DON stated that Staff A said that she knew she wasn't supposed to give the medication early, but gave no reason as to why she administered the clonazepam outside of the parameters.3. A MDS dated [DATE], documented diagnoses for Resident #3 included chronic pain syndrome and postlaminectomy syndrome (persistent pain following spinal surgery). A BIMS revealed a score of 14 out of 15, which indicated intact cognition. the resident had pain almost constantly during therapy activities, sleep, and day to day activities in the past 5 days. A Care Plan for Resident #3 with a target date of 6/10/25, directed that the resident had complaints of pain described as chronic pain related to arthritis and postlaminectomy syndrome. Resident #3 utilized opioids for pain management. The interventions included to administer pain medications per physician orders and encourage/assist to reposition frequently to position of comfort. The Census page for Resident #3, revealed he was discharged to the hospital on 6/3/25. The resident did not return to the facility. Resident #3's MAR for the month of May 2025, directed that Oxycodone 20 mg tablets could be given 1 tablet every 6 hours as needed for pain. This MAR documented that Staff A administered 1 dose to Resident #3 at 9:47 a.m. for a pain level of 9 on 5/29/25 and another dose at 6:16 a.m. on 5/30/25 for a pain level of 9. Staff A documented that the effectiveness of the dose given on 5/30/25 was unknown.There was nothing documented in the resident's progress notes on 5/29/25 nor on 5/30/25.On a Controlled Substance Medication Record for Resident #3's as needed oxycodone, Staff A documented that she had given 1 tab at 6:35 a.m. and again at 1:45 p.m. on 5/29/25. Both of these entries had scribbles over the numbers and were difficult to read. The MAR documented only one dose was given by Staff A on 5/29/25. Staff A documented that she had given Resident #3 a dose of Oxycodone 20 mg at 6:16 a.m., bringing the countdown to 26. An FRI of suspected controlled substance diversion, investigation report dated 6/16/25, Resident #3 had an order for Oxycodone tab 20 mg every 6 hours as needed. A 30-tab card was received from pharmacy on 5/19/25. Four doses were signed off as administered on the Controlled Substance Medication Record as of the morning of 5/30/25. There were 25 tablets in the card leaving one tablet unaccounted for.4. A MDS dated [DATE], documented diagnoses for Resident #4 included fracture of right humerus (long bone of the upper arm). A BIMS revealed a score of 8 out of 15, which indicated moderately impaired cognitive functioning. Resident #4 had pain almost constantly. It documented that Resident #4 had pain frequently while sleeping, participating in therapy activities, and during day to day activities in the past 5 days.A Care Plan with a target date of 11/22/25 documented that Resident #4 had complaints of pain described as acute. 1 month related to fracture of right humerus. Resident utilizes scheduled APAP (acetaminophen/Tylenol), as needed opioids, and ice packs. Interventions included administer pain medication per physician orders and encourage/assist to reposition frequently to position of comfort. A MAR, for the month of May 2025, documented that oxycodone 5 mg could be given, 1 tablet every 6 hours as needed for pain. It documented that Staff A administered 1 tablet on 5/29/25 at 7:16 a.m. for a pain level of 7 and again administered 1 tablet at 2:13 p.m. for a pain level of 8.The resident did not have any entries in her progress notes on 5/29/25.A Controlled Substance Medication Record for Resident #4's as needed oxycodone, documented that Staff A gave tablets on 5/26/25 at 7:30 a.m., bringing the count from 9 to 8. The following entry is difficult to read as it is scribbled over. Off to the side it is documented ?dropped' with initials by Staff A. On 5/29/25 at 2:13 p.m., Staff A documented that she gave one tablet, bringing the number from 7 to 6.An FRI of suspected controlled substance diversion, investigation report dated 6/16/25, Resident #4 had an order for Oxycodone tab 5 mg every 6 hours as needed. A 28-tab card was received from pharmacy on 5/14/25. 22 tabs were signed off as administered on the Controlled Substance Medication Record as of the morning of 5/30/25. There were 4 tablets in the card leaving two tablets unaccounted for.5. A MDS dated (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], documented diagnoses for Resident #5 included chronic pain. The BIMS documented that resident was rarely/never understood and staff assessment documented that he was severely impaired. The staff assessment for pain or possible pain for the past 5 days, documented that none of the following signs were observed or documented: non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning); vocal complaints of pain (e.g., that hurts, ouch, stop); facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), or protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement).A MAR for the month of May 2025, documented that Hydrocodone/Acetaminophen 5-325 mg 1 tablet could be given every 8 hours as needed for pain. Staff A administered 1 tablet on 5/19/25 at 3:55 p.m., and one tablet on 5/29/25 at 6:50 a.m. A Controlled Substance Medication Record for Resident #5 documented that Staff A gave one as needed Hydrocodone/APAP 5-325 mg tab on 5/29/25 at 6:30 AM, which brought the count from 6 to 7 (instead of 8 to 7). The last number on this form was 7 tabs were to be in the medication pack. This Controlled Substance Medication Record also had a date that was illegible that brought the count from 9 to 8. It was given in between a dose that was given on 5/28/25 by another nurse and the dose that was given by Staff A on the morning of 5/29/25. This was not signed out as given on the MAR. There was a dose signed out on 5/11/25 by Staff A as well that at that time brought the number from 13 to 12. Staff A did not sign the MAR for administering this medication on that day. (Staff A signed for administering 4 doses on this Controlled Substance Medication Record but only signed as administering this medication twice on the MAR. An FRI of suspected controlled substance diversion, investigation report dated 6/16/25, Resident #5 had an order for Hydrocodone/APAP Tab 5-325 mg every 8 hours as needed. A 30-tab card was received from pharmacy on 3/10/25. 23 tabs were signed off as administered on the Controlled Substance Medication Record as of the morning of 5/30/25. There were 6 tablets in the card leaving one tablet unaccounted for. On 10/7/25 at 4:45 p.m., Staff B stated that Staff A had seemed distracted during the controlled substance count at 2:00 p.m. on 5/29/25. This count was done when Staff B arrived for her shift and Staff A was ending her shift. Staff B stated she couldn't remember the exact residents or medications but Staff A had signed a pill out, then crossed one out that she had given. Staff B stated Staff A was discombobulated that day. Staff B said that by the time they finished counting everything, all medication was accounted for. Staff B said that Staff A thought she had dropped a pill, but then said she had not dropped the pill but had actually given it to a resident. On 10/13/25 at 1:29 p.m., Staff C stated that she counted the controlled substances at the end of her shift and the beginning of Staff A's shift on 5/29/25 at 6:00 a.m., and the count was correct. Staff C stated she counted the controlled substances again when she came back into work on 5/29/25 at 10:00 p.m., with Staff B and it was not correct. Staff C stated along with Staff B, they then made sure all the count was correct at that time. Staff C stated there were entries that were lined through and it didn't appear right. She stated that she went through all the medications in the count with Staff B and made sure the count reflected/was correct at that time and left a note for the DON. Staff C stated she asked Staff A what she had done on Resident #5's controlled substance card, and Staff A said she just didn't really know why she had done that. Staff A's balance was all off and she fell over when she was trying to tie her shoe. Staff C said the morning of the 29th, Staff A came in and pulled out the roller chair. Staff A sat down to tie her shoe on the roller chair and fell off the chair and was lying on the floor and she was tugging at her shoe. Staff C stated that Staff A then got up and went to the shower to get a towel for a med cart and stumbled into the wall. Staff C asked Staff A what was wrong, and Staff A said she thought she had a sinus infection. Staff C said that Staff A then came up to the medication cart and was standing with her feet together and almost fell over again. She then widened her stance and was fine. On 5/29/25 at 10:00 p.m., Staff C stated she was counting with Staff B and they noted that Staff A had changed the number from the day before on one of the resident's card. Staff A had just scribbled everything out and changed the number, didn't put a new date or anything new, she had just changed the number. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She didn't put a new line and sign and subtract any of that. Resident #5 should have had one or two pills given that day. Staff C stated that on the morning of 5/30/25, Staff A was fine, she was her normal self again. After Staff C wrote her note (to the DON), Staff B did remind Staff C that Staff A did take sleeping pills. Staff C stated she could not remember exactly if the count was on for the other residents. The whole thing was just wrong. Staff C stated she did kind of remember that there might have been other residents with one pill missing. Staff C stated she wrote down Resident #5's because of the scribbling on the count sheet.On 10/9/25 at 2:20 p.m., the DON stated that Staff C, the night shift nurse, had notified The DON via a post it note in her mailbox. The DON found the note around 9/9:30 a.m. on 5/30/25. The DON went out and asked Staff C to do the controlled substance count with the DON. The DON stated the very first resident's card they checked was not right. The DON pulled that card out and put it to the side. The DON went through the rest of the cards pulling out ones that weren't right and set them aside. The DON stated that they started counting and Staff A kept laughing. The DON told Staff A that this (the count being off) was serious and not okay. The DON didn't know if it was a nervous laugh or what. The DON stated they were counting maybe Resident #5's card and Staff A started to mark on the sheet. The DON told Staff A to stop marking on the sheet. Staff A didn't give an explanation to any of the cards when the DON told Staff A the count was off on the cards that the DON was setting aside. The DON took the medication cart keys from Staff A and went into the office. The DON pulled up the resident's MARs and started comparing the MARs to the count sheet. They were all lining up except for the day before on 5/29/25. The DON asked Staff A when she last gave a controlled medication to Resident #5. Staff A stated it had been about 2 days. The DON said that Staff A had signed that she had given him a hydrocodone that morning. The DON brought all the cards and the sheets up to the administrator's office and showed the administrator what the DON had found. Staff A was then sent home. On 10/14/25 at 3:55 p.m., the Licensed Nursing Home Administrator (LNHA)(Administrator), stated that on 5/30/25, the DON had come to the LNHA mid morning. The DON had seen a note, and did a controlled substance count with Staff A. The DON had seen that there were a few discrepancies. The DON then took the keys and the cards and tried to figure out where the discrepancies were. The DON took Staff A off of the medication cart. After the DON and the LNHA looked at the count together, they noticed that the discrepancies were coming from Staff A. When we asked her about these, Staff A was unable to explain anything. Staff A did say she had a sinus infection and she did sound congested. They ended up sending her home. They then called Staff B. Staff B said that the count was different. Staff B told them that she didn't realize the count was off until she counted the meds with Staff C that evening. That's how they discovered the count was off. The LNHA reviewed video the following week and saw some strange and concerning things. The LNHA stated in the video she saw Staff A open the narcotic drawer and pop several pills into a medication cup. They then brought Staff A back in and showed her the videos of her popping the pills out into the med cup and a video of when Staff A took a pill out of the drawer with her hand. The LNHA stated that Staff A's eyes got kind of big when she saw both videos, like she couldn't believe what she was seeing and looked surprised. Staff A stated she didn't know why she would have done that, Staff A could give no reason behind it.An FRI of suspected controlled substance diversion, investigation report dated 6/16/25, included the following documentation:On 6/4/25, the Administrator reviewed camera footage from 5/29/25 - At approximately 6:45 AM, Staff A was observed standing at the South medication cart. She flips through several pages of the Controlled Substance Medication Record binder and writes on two pages. She unlocks the narcotic drawer and pulls the back card and dispenses one pill into a medication cup. The back card in the drawer is Oxycodone tab 20 mg for Resident #3. Staff A then pulls the front card and appears to dispense two pills into the same medication cup. The front card in the drawer is Hydrocodone/APAP Tab 5-325 mg for Resident #1. Staff A pulled another card towards the middle of the stack and appears to dispense two pills into the same medication cup, and then pulls one more card and dispenses one pill into the same medication cup. She writes one entry in the Controlled Substance Medication Record. She (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accompanying controlled medication sheet indicating the medication is takenAfter administration of the controlled medication, the nurse/medication aide will sign off the eMAR (electronic Medication Administration Record)If the controlled medication needs to be wasted, a second nurse should witness the wasting of the controlled medication and both nurses will sign the medication sheet (a certified medication aide and licensed nurse can waste controlled medication) NOTE: 2 certified medication aides are NOT authorized to waste controlled medicationsAny narcotic count discrepancy will be immediately reported to the Director of NursingNarcotic counts are completed at the beginning and end of each shift or at the time when there is an exchange of medication cart keysRequires two nurses (or one nurse and one certified medication aide)Oncoming nurse validates medication count on the medication card, off-going nurse validates medication count on the paper documentBoth nurses are required to sign off on the shift-to-shift count record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165346	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Village	345 Parriott Street Aplington, IA 50604

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to discontinue medication per discharging hospital physician's orders for 1 out of 3 residents reviewed (Resident #1). Resident #1 received 4 doses of Eliquis (an anticoagulant medication (treats and prevents blood clots)) after returning to the facility following a hospitalization. The orders from the hospital were to no longer administer Eliquis. The facility reported a census of 34. Findings include: A Minimum Data Set (MDS) dated [DATE], documented that diagnoses for Resident #1 included anemia and anxiety. A Brief Interview for Mental Status (BIMS), documented a score of 15 out of 15, indicating Resident #1 had intact cognition. The resident was always incontinent of stool. Resident #1 was taking an anticoagulant medication. A Hospitalist Discharge Summary printed on 9/22/25 at 1:43 p.m., documented that Resident #1 was admitted to the hospital on [DATE] and was discharged on 9/22/25 at 12:05 p.m. The Discharge Final Diagnosis was [NAME] (a form of blood in stool which refers to the dark black, tarry feces that are commonly associated with upper gastrointestinal bleeding). The Discharge Medication List directed to stop taking Eliquis 2.5 mg. A Medication Administration Record (MAR) for the month of September, directed that Resident #1 was to receive Eliquis oral tablet 2.5 mg twice a day (a.m. and supper) related to atrial fibrillation (an irregular and often very rapid heart rhythm. An irregular heart rhythm is called an arrhythmia. AFib can lead to blood clots in the heart. The condition also increases the risk of stroke, heart failure and other heart-related complications.) with a start date of 5/17/25. This MAR documented that starting with the supper dose on 9/17/25 through the morning dose on 9/22/25, Eliquis was not given due to the resident being hospitalized . It documented that Resident #1 was administered her supper dose of Eliquis upon her return on 9/22/25. She received two doses of Eliquis on 9/23/25 and the morning (a.m.) dose on 9/24/25 for a total of 4 doses. The medication was discontinued on 9/24/25 at 9:01 a.m.On 10/8/25 at 4:00 p.m., Resident #1 stated she guessed she shouldn't be taking a blood thinner for another 3 months. She stated she did not want to have a stroke. On 10/8/25 at 4:31 p.m., the Director of Nursing (DON), stated she was the one that wrote the Eliquis order. She stated it was a mistake. She was taking down the information from the hospital discharge and she didn't see the discontinuation order for the Eliquis, she only saw the Eliquis order. She stated she somehow skimmed right over the discontinuation wording as it was in smaller letters. The medications that were to be given were right above this and she thought the Eliquis was in with the medications to give directions. A Physician Orders/Transcription of Orders policy revised July 2023, directed the following: PURPOSE: To correctly and safely receive/transcribe physician's orders so correct order can be followed/administered. To ensure that patient medications, treatments, and plan of care are in accordance with the licensed providers orders.PROCEDURE:Physician's orders will be received by a licensed nurse, therapist, or dietitian.Orders may be received through written communication in the resident's chart, verbally or per telephone, via fax, or electronically entered in PCC (resident's electronic health record).When receiving a telephone or verbal order, the order should be repeated back to the Physician (MD)/Nurse Practitioner (NP)/Physician Assistant (PA) to assure accuracy.The order should be entered into the resident's medical record exactly as it was stated/written by MD/NP/PA.Orders must contain name, strength, route, dose, quantity, diagnosis/indication for use, and specific duration of therapy indicated. Order must contain specific and clear parameters if parameters indicated by MD/NP/PA. Orders for treatments must contain location for treatment if indicated. If for any reason, the attending physician in not available or cannot be reached by the nurse, the facility appointed medical director may be contacted for orders. Orders will be signed by the MD/NP/PA in accordance with state and federal guidelines. Medication and treatment orders will be entered in electronic medication administration record (eMAR) or electronic treatment administration record (eTAR) accordingly.Active orders should be followed and carried out as written/transcribed.