STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to ensure drug records were in order and an account of all drugs was maintained and periodically reconciled for 4 out of 12 residents who received narcotic medications, out of the total sample of 23 residents. The findings include: Review of the facility policy titled, [NAME] Healthcare Medication Administration Policy, dated 01/05/2025, revealed the facility was to follow the five rights of medication administration. Per review the five rights included the: right resident, right medication, right dose, right route, right time and must be confirmed at the following stages during medication administration. Continued review revealed the stages included: before removing the medication from the container, matching the label against the medication administration order, after preparing the dose and before returning the medication to storage, and double checking that all information was accurate and properly documented. During observation on 01/07/2026 at 9:08 AM, of a medication cart located on the Northeast hallway of the facility, the State Survey Agency (SSA) Surveyor requested a narcotic medication reconciliation of the cart be performed, and Licensed Practical Nurse (LPN) 1 agreed to do that. Per observation, LPN 1 looked at the cards that held the narcotic medications and stated how many tablets were left for each resident with the SSA Surveyor verifying the count in the narcotic binder, located on the medication cart. Continued observation revealed the most current remaining count for each resident receiving narcotic medication on the facility's Northeast hallway was performed. Observation revealed the following: R15's Oxycodone drug card contained 15 tablets; however, the narcotic form noted 16; R17's Gabapentin 400 milligram (mg) pill bottle contained two pills; however, the narcotic form stated one, R17's Oxycodone 15 mg drug card contained 16 tablets; however, the narcotic form noted 17. Further observation revealed R33's Lorazepam 1mg drug card contained 15 tablets; however, the narcotic sheet noted 16; and R39's Oxycodone/Acetaminophen 5/325mg drug card contained 20 tablets; however, the narcotic sheet noted 21. In interview with LPN 1 on 01/07/2026 at approximately 9:30 AM, he stated he had not documented the accurate narcotic count prior to administering the narcotic medication and that was why the count was off. He reported the standard procedure was to document the narcotic drug count on the narcotic sheet inside the binder once the medication had been administered to the resident to reflect an accurate amount when comparing the narcotic drug card and narcotic book. In interview on 01/08/2026 at 5:35 PM, the Director of Nursing, (DON) stated the narcotic binder was to be compared to the actual narcotics for reconciliation daily. He stated the unit managers and nurses were to do a narcotic count every time the cart key was passed from one nurse to another. The DON reported the unit managers went behind the nurses to ensure reconciling was being done correctly on a daily basis. He said if a nurse found the narcotic count did not match the narcotic binder count, the nurse should try to find the medication and/or try to account for it on the narcotic sheet. The DON stated if the nurse was unable to find the medication or was unable to account for it, then the nurse should call him. He explained he would call the facility's Nurse Consultant, and we would open up an investigation. The DON said a nurse should look to ensure they followed the doctor's medication order by checking the resident's medication (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
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administration record (MAR). He reported the standard procedure for administering residents' medications was to verify the five rights and check the medication against the MAR. The DON stated the nurse should document having given a resident's narcotic medication after administration. He further stated a negative outcome for not properly reconciling narcotics to the narcotic documentation form in the binder was possible drug diversion. In interview on 01/08/2026 at 5:46 PM, the Administrator stated how often the narcotic binder was be compared to the narcotic medication was according to facility policy. She stated reconciling of the narcotic medications was also according to facility policy. The Administrator said the DON or designee would be the staff member to ensure the reconciling of narcotic medications was being done correctly. She explained she expected staff to follow the policy if a narcotic count did not match the amount documented in the binder. The Administrator reported the standard procedure for administering medications, including narcotic medication, was to administer the medication to the resident according to the physician's order in the facility's electronic point click care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to ensure all medications and wound care products used in the facility were stored and labeled in accordance with professional standards, with the potential to affect 25 out of 25 residents receiving wound care. The findings include: Review of the facility's policy titled, Medication Storage, undated, revealed drugs and biologics were to be stored in the packaging, containers or other dispensing systems in which they were received. Per policy review, only the issuing pharmacy was authorized to transfer medications between containers. Continued review revealed the nursing staff were responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. Further review revealed the facility was not to use discontinued, outdated, or deteriorated drugs or biologics, and all such drugs should be returned to the dispensing pharmacy or destroyed. During observation on 01/06/2026 at 2:30 PM, of a wound care treatment cart located on the rear hallway by nurses' station revealed the following: one tube of Mupirocin ointment with no opened date and not in an individualized bag; one tube of Fluorouracil 5% topical chemotherapy cream with no opened date, no cap on it, and it was not stored in an individualized bag. Continued observation revealed one tube of Medihoney ointment with an expiration date of 09/01/2025, which was not stored in an individualized bag. Per observation, there was also one bottle of sterile water with no opened date or expiration date; one package of Gentell collagen wound filler, opened, unsealed, exposed to air, undated; and one package of lemon glycerin swab sticks, that had expired 06/2024. Further observation revealed four packages of Skintegrity hydrogel impregnated 4x4 gauze with an expiration of 11/2022; one bottle of Dakin's Solution quarter strength undated; one container of Sani Cloth super large wipes with an expiration of 07/2025; one package of Calcium Alginate dressing that was opened, unsealed with no opened date; and one package of Kerrafoam gentle border with an expiration of 10/01/2024. In interview on 01/06/2026 at 2:42 PM, the Wound Care Nurse (WCN) stated she was the person responsible for maintaining the treatment cart; however, she was new to the position and was being trained by the former WCN this week on how to manage the treatment cart. She reported she did not know how often the treatment cart was to be gone through to ensure there were no expired medications or products and that all medications/products were properly labeled. The WCN further stated she thought the treatment cart should be gone through weekly or daily. She further stated the expired medications, wound care products and undated items stored in the treatment cart was not acceptable. In interview on 01/06/2026 at 2:48 PM, the Minimum Data Set (MDS) Nurse stated she was the former WCN and was currently precepting the new WCN on her new role. She stated it was the current WCN's duty to manage the treatment cart and ensure all medications and wound care products were labeled and stored unexpired as according to professional standards. The MDS Nurse said she did not know how often the treatment cart was to be gone through because she also worked two to three other additional roles at the facility. She further stated it slipped her mind to check the treatment cart because she did not look at products she did not use. In interview on 01/08/2026 at 5:35 PM, the Director of Nursing, (DON) stated his expectation for maintaining the treatment carts was for them to be gone through and restocked regularly, with all residents medications individually bagged and clean, and the necessary items easily accessible. He said the staff member responsible for maintaining treatment carts was technically the current WCN. The DON stated the WCN was to ensure the treatment carts did not have expired items, or opened medications and products without dates which were not contained in a protective bag. He said the treatment carts should be checked daily, and a negative outcome for residents who needed wound care and received administration of expired wound care products to their wounds would be potential infection to the resident's wound. The DON said the wound care products were not guaranteed past their expiration dates, and all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medications and wound care products should have opened dates on them. In interview on 01/08/2026 at 5:46 PM, the Administrator stated the expectation for maintaining the treatment carts was to follow a standard we could use, find their guidance and follow whatever that was. She said the nurses were responsible for maintaining the treatment carts and ensuring they did not have expired items or opened medication and products without dates and that all were contained in a protective bag. The Administrator reported she was not a clinician and did not know what a potential negative outcome for residents who needed wound care and received administration of expired wound care products to their wounds would be as that was out of her scope of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of facility policy and procedure, the facility failed to ensure resident participation in the development of the comprehensive care plan for 3 of 8 residents (Resident (R)16, R94, and R72) out of the total sample of 23 residents. The findings include:Review of the facility policy titled, Care Planning - Comprehensive Person -Centered, undated revealed, To the extent practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process. Per policy review All reasonable efforts were to be made for the resident/resident representative to be informed in the language he/she could understand regarding his/her total health status, including but not limited to, his or her medical condition. Review of the facility policy titled, Resident's Rights, dated 11/01/2024, revealed residents had a right to be fully informed of, and participate in, his/her treatment. Further policy review revealed those rights included: the right to be fully informed in a language he/she could understand about his/her total health status, including but not limited to his or her medical condition.1). Review of R16's clinical record revealed the facility admitted the resident on 09/16/2025. Further review revealed however, no documented evidence in the comprehensive care plan, progress notes and signature noting R16 had been present at care plan meetings. The facility was unable to provide documented signature sheets of those in attendance at care plan meetings or proof that translation service was provided to update R16's care plan. During interview on 01/07/2026 at 10:52 AM, via translation by Translator 1 via a telephonic translation service, R16 stated she was from [NAME]. She reported she had not received any documents from the facility written in the Spanish language and said the care team did not use the translation line to speak with her. R16 said the documents she had been given were written in English, and she had to ask a Spanish speaking aide to help her translate the documents. She stated she had not attended any care plan meetings. R16 further stated Spanish speaking staff or a translator application (app) through a web browser on her phone was how she communicated her needs. She additionally said communication was an issue, and she felt frustrated.During interview on 01/05/2026 at 10:40 AM, CNA 1 stated she tried to translate documents for R16 because the documents were written in English. She reported the business office person and the Social Worker tried to explain the forms to her so she could explain the documentation to R16. She further stated she dis not always know how to translate the forms though.2). Review of R94's clinical record revealed the facility admitted the resident on 12/18/2025. Continued review revealed however, no documented evidence in the comprehensive care plan, progress notes and signature noting R94 had been present at any care plan meetings. The facility was unable to provide documentation of those in attendance at care plan meetings or proof that translation services were provided to update R94's care plan. During interview on 01/07/2026 at 11:08 AM, translated by Translator2, R94 stated the documents he received from the facility had been written in English. He said, I cannot see well, even if I could read English. R94 reported it would help if the written documentation he received was written in Spanish and/or read to him. He further stated he had never been in a care plan meeting, and said he felt overlooked due to the communication barriers.3). Review of R72' s clinical record revealed the facility admitted the resident on 05/25/2025. Additional review revealed however, no documented evidence in the comprehensive care plan, progress notes and signature sheet noting R72 had been present at care plan meetings. The facility was unable to provide documented signature sheets of those in attendance at care plan meetings or proof that translation service was provided to update R72's care plan. During interview on 01/07/2026 at 11:22 AM, translated via telephonic translator the resident representative of R72 stated she had not been consulted regarding the resident's care plans. She said the documents she signed and/or had received regarding her husband's care had only been written in English. She stated she had given verbal consents for things on the phone. She stated staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not use the translation line for communicating with her. R72's representative explained she usually communicated via the translator app on her phone. She further stated she would like more communication from the facility via a translator and written in her own language. During interview on 01/08/2026 at 10:24 AM, the admission Coordinator stated at times she had Certified Nurse Aide (CNA) 1 translate English written documents for Spanish speaking residents. She stated if someone signed something they did not understand they could receive inadequate care or could be exploited. When the SSA Surveyor asked her if the facility tested bilingual aides they used to interpret for Spanish speaking residents on things such as vocabulary, medical, and legal terms, before they used those aides, she stated she did not know if that was being done. During interview with Registered Nurse (RN) 1 on 01/08/2026 at 2:20 PM, when asked how she communicated with non-English speaking residents, she stated I use Google translate, bilingual staff and sometimes family. She reported she had not had a situation where the communication was in an emergency. The RN said she rarely worked on that hall and had not really been told anything about using the interpreter until yesterday. During interview on 01/08/2026 at 11:56 AM, the MDS Coordinator stated the Minimum Data Set (MDS) was a checks and balance system. She said staff should ask questions of the residents or responsible party each time the MDS Assessment was performed, and the assessments could be modified as necessary. The MDS Coordinator stated, Everybody plays a part in it. (the MDS Assessments). She further stated, when asked how she communicated with non-English speaking residents, she would use a translator service provided by the facility when conducting MDS Assessments with non-English speaking residents going forward. The MDS Coordinator also stated, This will make sure everything is correct.During interview on 01/08/2026 at 4:49 PM, with the Director of Nursing (DON), he stated The MDS Coordinator does the comprehensive care plan. The floor nurses have the ability to make changes, but it is usually the interdisciplinary (IDT) team or MDS nurse will change it. He said the care plan was changed with any change in a resident's condition or care. When asked how staff communicated with non-English speaking residents, he stated There are several bilingual staff members. We have had a translation line in place, and a lot of family members come in and insist on doing this. The DON reported We do not allow the bilingual staff to translate medical or legal documents. He stated, when asked if bilingual staff had to do competency testing for medical and legal vocabulary, he stated no testing was done to check competency for translation. The DON further stated he would not be using staff to translate going forward. The DON additionally said a possible negative outcome of not using a translation service for non-English speaking residents, was misinterpretation in communication of necessary information. During interview with the Administrator on 01/08/2026 at 5:50 PM, she stated, nursing was responsible for residents' care plans. She said We have communicated with the residents that are not English speaking in a manner according to our policy. The Administrator explained the facility had a translation service, staff used cue card, pantomime, and some residents preferred to use family and staff members. She stated the negative outcome for not being able to communicate with non-English speaking residents was process failure. The Administrator further said, Every system we have is policy. My expectations is that the policy is followed. She reported the facility had systems that monitor compliance over our policies to ensure they are being followed, and everything that did not follow policy is not desirable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, the facility failed to ensure resident assessments accurately reflected a resident's status for 1 of 3 residents reviewed for MDS accuracy out of the total sample of 23 residents, (Resident (R)16).The findings include:Review of the CMS MDS 3.0 RAI Manual version 1.20.1, revealed the instructions for completing the ethnicity category was to ask the resident to select the category or categories that most closely corresponded to their ethnicity from the list in question A1005. Review further revealed, Only use medical record documentation to code A1005, Ethnicity if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.Review of R16's Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/22/2025, revealed the facility assessed the resident's ethnicity as Mexican; however, R16's ethnicity was Cuban. During interview on 01/07/2026 at 10:52 AM, R16 stated she came to the United States on a visa from [NAME] and had not received any documents from the facility in the Spanish language. R16 said the care team did not utilize the translation phone to speak with her about her care or during the assessments. She reported she had not attended any care plan meetings. The resident stated she made her needs known as well as she could through bilingual staff if they were available but mainly relied on a translator app on the phone if bilingual staff were not working. She further stated she wanted to communicate in a method she understood, so she could understand what information was being given her, and so she could be understood. During interview with the admission Coordinator on 01/08/2026 at 10:24 AM, she stated the demographic information the electronic health record (EHR) had in it was pulled directly from the hospital paperwork received. She further stated the MDS was updated as each member of the care team completed their assessment portions of the RAI. During interview on 01/08/2026 at 11:56 AM, the MDS Coordinator stated, MDS is a checks and balance system. Questions should be asked each time the assessment is performed, and the assessments can be modified. Everybody plays a part in it. She said she was now going to look at the MDS of each resident to ensure their demographics were correct. The MDS Coordinator reported while she had been transitioning to the role of MDS Coordinator, many people had been assuming parts of the role until she could fully step into the position. She further stated, I am auditing for correct documentation. [NAME] issues, continuity of care can be greatly impacted by incorrect information.During additional interview on 01/08/2026 at 12:35 PM, the MDS Coordinator stated upon investigating R16's inaccurate ethnicity information she, pulled off the old social services form the facility used to use. She said however, the social services (SS) employee who completed that form was no longer an employed at the facility. The MDS Coordinator further stated the demographic information now pulled from an MDS form rather than the social SS form due to the updates in the electronic health record computer program. When the State Survey Agency (SSA) Surveyor asked her if a proper MDS Assessment should include an actual face to face interview with the resident, she did not provide an answer.During interview on 01/08/2026 at 4:49 PM, the Director of Nursing (DON) stated, The MDS Coordinator does the comprehensive care plan. The floor nurses have the ability, but it is usually the interdisciplinary (IDT) team or MDS nurse who made changes. He said the MDS was changed with any change in the resident's condition or care. The DON reported he was not familiar with the MDS processes, as the MDS Coordinator handled that. He stated he expected the MDS nurses to review all documentation and assess the resident in person. The DON further stated if a MDS was not filled out correctly and was inaccurate, it could cause incorrect billing, or medical services which would cause me to go to prison.During interview with the Administrator on 01/08/2026 at 5:50 PM, she stated, I do not do anything with editing residents' MDS Assessments; however, I do use data. She said We ensure the data is correct by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185096	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Health & Rehabilitation	900 Gagel Avenue Louisville, KY 40216

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following our data and process. We have a triple check system. The Administrator explained the negative outcome if an MDS was inaccurate was process failure. She reported Every system we have is policy. My expectations that the policy is followed. We have systems that monitor compliance over our policies to ensure they are being followed. The Administrator further stated the facility had a process and a policy, and everything that did not follow the policy was not desirable.