STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205067	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cove's Edge Inc	26 Schooner Street Damariscotta, ME 04543

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's care plan was developed to reflect the current needs of the resident for 2 of 16 residents reviewed for care planning (Resident #3, #35).Findings:1. Resident #3 was admitted in January 2025 with diagnoses to include complete heart block and presence of cardiac pacemaker.Review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 10/19/25, indicates presence of cardiac pacemaker. Review of Resident #3's physician orders revealed an order with a start date of 7/31/25 for St. [NAME] pacemaker.A review of Resident #3's care plan, revised on 11/3/25, lacked evidence that goals and interventions were developed and implemented for the pacemaker. On 1/7/2025 at 12:07 p.m. during an interview, Registered Nurse (RN) #5 reviewed Resident #3's care plan and confirmed that it had not been developed or implemented in the area of the pacemaker. 2. Resident #35 was admitted in November 2025 with diagnoses to include chronic obstructive pulmonary disease (COPD), heart failure, and chronic lower extremity edema.On 1/5/26 at 9:05 a.m. observation of Resident #35 seated in his/her recliner chair located next to his/her bed. Resident #35's bed was neatly made, and the surface of the bed was covered with various personal belongings. During an interview at this time, Resident #35 stated he/she needs help from the staff applying his/her compression socks each day because he/she loses his/her balance easily.On 1/7/26 at 11:40 a.m., a surveyor observed Resident #35 seated in his/her recliner with Tubigrips (a tubular bandage that provides compression for swelling) in place on his/her bilateral lower legs. During a follow-up interview at this time, Resident #35 stated that he/she wears the Tubigrips every day and that the Certified Nursing Assistant (CNA) helps him/her apply them each morning and remove them before bed.On 1/7/26 at 11:44 a.m. during an interview, CNA #6 stated Resident #35 sleeps in his/her recliner and that he/she wears compression stockings every day.On 1/7/26 at 11:50 a.m. during an interview, Registered Nurse (RN) #8 and CNA #5 stated that Resident #35 wears Tubigrips daily. Review of Resident #35's clinical record revealed a Quality Review progress note dated 12/4/25 that states, . chooses to sleep in [his/her] recliner.Review of Resident #35's care plan states, I have an ADL [Activities of Daily Living] self-care performance deficit.Will have no injuries from use of side/enabler rail device.BED MOBILITY: I use an enabler to maximize independence repositioning in bed. and I have potent [potential] for skin integrity r/t [related to] decreased mobility.pressure relieving device on bed. Further review of the care plan revealed, Altered cardiovascular status r/t CHF.chronic lower leg edema. and lacked evidence of Resident #35's daily use of Tubigrips.On 1/7/26 at 12:37 p.m. during an interview, the above finding was discussed with RN #5 and the DON. At this time, RN #5 reviewed Resident #35's care plan and stated that Resident #35 has slept in his/her recliner since admission and confirmed that the bed mobility and side/enabler rail interventions on Resident #35's care plan do not reflect his/her current care needs. RN #5 then stated that the Tubigrips should have been included on Resident #35's care plan.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner and failed to ensure foods were labeled and dated in the reach in refrigerator for 2 of 2 kitchen tours. (1/5/26 and 1/5/26)Findings:1. On 1/5/26 at 9:06 a.m., observation of the kitchen with the Dietician and the Food Service Director (FSD) the following findings were observed and confirmed.- The walk-in freezer ceiling had built up ice in front of the fans, the floor was littered with food and bagged food/packages including French fries, frozen yogurt/ice cream single serve cup and several packages of an unknown food product. Under the shelving unit was a built up ice mound in the right back corner. There were open unlabeled/dated bag of waffles and a bag of personal pizzas.- The stand up mixer had dried food/debris on the mixing arm, the protective cage and the shield. At this time the FSD and the cook stated the last time the mixer was used was Friday (3 days ago) for making cinnamon buns.- The 3 bin plastic storage containers for flour, panko and sugar had food/debris particles covering the container and lids.- The Cook's cooler had a pan of sliced deli meat (roast beef) with an orange sticker/label with a used by date of 1/4/26.2. On 1/6/26 at 8:20 a.m., during a follow up observation of the kitchen with the FSD, the walk-in freezer ceiling had built up ice in front of the fans and under the shelving unit was the built up ice mound in the right back corner. The FSD stated I didn't realize it was that harsh.We will probably be hitting it by the end of the week.On 1/6/26 at approx. 3:30 p.m., observation of the built up ice in the walk in freezer was removed.The facilities Food and Supply Storage policy revised 1/25 states, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Most, but not all, products contain an expiration date. The words sell by, best by, enjoy by, or use by should precede the date. The sell-by date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the use-by, sell-by, best-by, or enjoy-by date should be discarded. Cover, label ad date unused portions and open packages. Use the Medvantage/Freshdate labeling system or complete all sections on the [NAME] orange label. Products are good through the close of business on the date noted on the label.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to apply appropriate interventions including Transmission Based Precautions (TBP) and Enhanced Barrier Precautions (EBP). In addition, facility failed to demonstrate staff competency for Infection Control in the areas of TBP and EBP in 2 of 2 units (Periwinkle and hummingbird). Findings: 1. On 1/6/26 at 9:52 a.m., during a medication administration observation for Resident #6 on the Periwinkle Unit with Certified Nursing Assistant-Medication Tech (CNA-M) #7, a Contact Precautions sign that indicated a gown and gloves are to be worn when entering the room and a Personal Protective Equipment (PPE) storage bag was hanging on the front of the door. At this time, the surveyor asked CNA-M #7 to verify the type of precautions in place, and CNA-M #7 stated Resident #6 is not on precautions but that his/her roommate is on precautions for urine. When the surveyor asked to clarify what type of precautions are in place for Resident #6's roommate, CNA-M #7 sanitized his hands, donned (put on) a mask and gloves and stated he is wearing a mask because Resident #6 is coughing but could not tell the surveyor what type of precautions were in place. The surveyor donned PPE according to the instructions on the Contact sign. On 1/6/26 at 2:13 p.m. the surveyor and the Director of Nursing (DON) observed the contact sign and PPE bag hanging on outside of Resident #6's door. At this time, the DON stated neither Resident #6 or his/her roommate is on Contact precautions and that the Contact sign was placed in error. The DON then stated Resident #6's roommate is on EBP and that the PPE and an EBP sign should have been placed on the back of the door. 2. On 1/6/26 at 11:21 a.m. observation of room [ROOM NUMBER] with a Personal Protective Equipment (PPE) bag hanging on the back of the room door, there was no visible EBP sign or TBP posted instructing staff on what to wear during care or which resident in the room required the PPE. On 1/6/26 at 11:21 a.m. the above was confirmed with RN#3, who stated that they know who is on EBP or TBP by looking at the Treatment Administration Record (TAR). 3. On 1/5/26 at 12:21 p.m., observation of room [ROOM NUMBER] with a PPE bag hanging on the back of the room door, there was no visible Enhanced Barrier Precautions sign or TBP posted instructing staff on what to wear during care or which resident in the room required the PPE. At this time, during an interview with the resident, he/she stated he/she has a supra pubic (SP tube) catheter. He/she was asked if staff wear personnel proactive equipment when providing direct care for his/her SP tube. He/she stated some do some don't. On 1/6/25 at approx. 1:55 p.m., the DON and 3 surveyors discussed the lack of EBP posting on several rooms and a TBP (Contact) posted on a room that was not required. The DON stated that the EBP rooms should all have Contact precaution sign posted, stating EBP is contact precautions If the resident did not have an active infection and was on EBP then the PPE bag will be on the inside of the door until the resident is discharged . The surveyor asked if there was posted EBP signage for those residents, the DON stated no. At this time, the DON and the surveyors went to the Hummingbird unit and observed room [ROOM NUMBER]. On the back of the door was the hanging PPE bag now with a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Droplet Precaution (TBP) sign posted. At this time, DON was asked which resident was on droplet precautions. The DON stated neither resident was on droplet precautions and that the posted TBP was incorrect. The surveyor asked how does staff or visitors know which resident is on TBP or EBP. The DON stated there is a list at the station. The DON was unable to find the list in the wall hanging station on the Hummingbird unit and then asked the Certified Nurses Aide (CNA#2) where the list of EBP residents is located. After ruffling through papers CNA#2 found an undated paper that contained a list of residents. On this list it had nonpharmacological interventions, which resident required a daily weight, and who was on EBP. At this time CNA #2 stated she doesn't know how old the list is or when it was made but one of the residents on the list was discharged a while ago.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to provide care for a resident in a dignified manner when a Certified Nursing Assistant (CNA#1) was observed transporting a resident in a shower chair when a resident wasn't provided a cover in a dignified manner exposing their bottom in a facility hallway (Resident #3). Findings: On 1/5/26 at 11:39 a.m., observation of CNA #1 transporting Resident #3 in a shower chair from Periwinkle Place unit, past the front entrance of the facility and nurses station down onto the adjacent unit shower room. Resident #3 had a sheet over his/her lap; however, his/her bottom was visible/exposed, hanging out from under the commode seat as well as his/her foley catheter. At this time, the surveyor intervened, discussing that Resident #3 was left exposed during the transport. CNA #1 stated he/she must have moved the sheet from his/her lap.On 1/5/26 at approx.11:45 a.m., the above observation was discussed with the Director of Nursing.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record reviews and interview, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 1 of 16 residents reviewed for care planning (Resident #35).Finding:Review of Resident #35's clinical record revealed an MDS admission Assessment was completed on 11/25/25. Further review of Resident #35's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment.On 1/7/26 at 12:46 p.m. the above finding was discussed during an interview with the Director of Nursing (DON) and Registered Nurse (RN) #5. At this time, RN #5 stated that she documents the IDT meeting notes in the resident's electronic medical record (EMR). RN #5 then reviewed Resident #35's EMR and confirmed that an IDT meeting was not held following the above assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of medication administration and treatments for 2 of 19 sampled residents (Residents #35 and #2).1. On 1/6/26 at 11:56 a.m. observed Registered Nurse (RN#3) push the medication cart to R#2's room, proceeded to pull the medications out of the cart and then crushed them without verifying the medications to the resident's chart. The surveyor questioned the practice, but RN#3 stated she did it by memory and that the order is on the resident's Treatment Administration Record (TAR). Even after surveyor intervention RN#3 did not review the TAR before giving the resident the medications. On 1/6/26 at 12:00 p.m. the above finding was confirmed with RN#3. 2. Resident #35 was admitted in November 2025 with diagnoses to include heart failure and chronic lower extremity edema. On 1/5/26 at 9:05 a.m. during an interview, Resident #35 stated he/she needs help from the staff applying his/her compression socks each day because he/she loses his/her balance easily. On 1/7/26 at 11:40 a.m., a surveyor observed Resident #35 seated in his/her recliner with Tubigrips (a tubular bandage that provides compression for swelling) in place on his/her bilateral lower legs. During a follow-up interview at this time, Resident #35 stated that he/she wears the Tubigrips every day and that the Certified Nursing Assistant (CNA) helps him/her apply them each morning and remove them before bed. On 1/7/26 at 11:44 a.m. during an interview, CNA #6 stated Resident #35 wears compression stockings every day. On 1/7/26 at 11:50 a.m. during an interview, Registered Nurse (RN) #8 and CNA #5 stated that Resident #35 wears Tubigrips daily. A review of Resident #35's active physician orders lacked evidence of an order for the Tubigrips. On 1/7/26 at 12:44 p.m., the above finding was discussed with the Director of Nursing (DON).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 residents reviewed for respiratory care (Residents #24, #35, and #41). In addition, the facility failed to ensure physician orders were obtained and provided proper monitoring for 1 of 5 residents (Resident #6) receiving oxygen therapy and failed to ensure that physician orders were followed for 1 of 4 residents (Resident #24) receiving oxygen therapy.2. On 1/5/26 at 9:33 a.m. and on 1/6/26 at 8:14 a.m. a surveyor observed the following: Resident #24 seated in his/her recliner chair, wearing nasal cannula (NC) oxygen tubing, dated 1/3/26, with the oxygen concentrator set to 2.5 liters per minute (L/min). Resident #24's unbagged, undated NC oxygen tubing attached to a portable oxygen tank stored in the pocket on the back of his/her wheelchair. The nasal cannula prongs were in direct contact with the surface of the wheelchair. A review of Resident #24's clinical record revealed the following active orders: An order with a start date of 2/25/25 for Oxygen: Continuous Oxygen via NC, 1-2 L/ min Maintain 02 [oxygen] Sat [saturation] > 92% Check 02 SAT: Q shift Titrate: SP02 [oxygen saturation] greater than 92% every shift for Dyspnea [shortness of breath] An order with a start date of 9/5/25 for Change oxygen tubing. once weekly on Friday per facility protocol. *REMEMBER TO DATE TUBING. On 1/5/26 at 9:35 a.m., during an interview, Resident #24 stated that he/she uses oxygen continuously and uses the portable oxygen quite often when he/she goes to the bathroom or leaves his/her room. On 1/6/26 at 9:01 a.m. during an interview, Registered Nurse (RN) #2 stated nursing staff apply Resident #24's portable oxygen when he/she transfers to his/her wheelchair and that Resident #24 just used the portable oxygen last night when he/she went to the dining room for the evening meal. On 1/6/26 at 1:20 p.m. during a follow-up observation, Resident #24 was asleep in his/her recliner, and his/her oxygen tubing was draped behind the oxygen concentrator, with the nasal cannula in direct contact with the floor. The oxygen concentrator was off. On 1/6/26 at 1:21 p.m. during an interview, RN #3 stated that Resident #24 needs continuous oxygen at 2L/min and that his/her oxygen saturation drops to 88% without it. At this time, the surveyor discussed the above observation with RN #3. At 1:24 p.m., the surveyor, RN #3, and CNA #8 entered Resident #24's room and observed his/her nasal cannula touching the floor. RN #3 proceeded to pick up the oxygen tubing and turn on the oxygen concentrator. Despite surveyor intervention, RN #3 continued to place the nasal cannula in Resident #24's nose. The surveyor then asked how oxygen tubing is stored when it is not in use. RN #3 stated that she usually just hangs it on the concentrator. CNA #8 stated she wraps the tubing with a tissue. On 1/6/25 at 2:05 p.m. the above concerns, including the oxygen flow rate being set outside of the physician's order parameters, the unbagged and undated tubing, and RN #3 placing the nasal cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on Resident #24 after it was in direct contact with the floor, were discussed with the Director of Nursing (DON). At this time, the surveyor and the DON observed Resident #24's concentrator set to 2.5 L/min and his/her unbagged oxygen tubing connected to the portable tank on the back of the wheelchair, and the DON stated that to her knowledge, the facility does not have a process in place for storing oxygen tubing when it is not in use. 3. On 1/5/26 at 9:09 a.m., a surveyor observed Resident #35's unbagged nebulizer tubing and mouthpiece connected to a nebulizer machine, stored on top of Resident #35's bed. The mouthpiece was in direct contact with a pile of papers on top of the bed. On 1/6/26 at 1:16 p.m. during a follow-up observation, Resident #35's nebulizer machine with attached tubing and mouthpiece was stored on top of Resident #35's bed, and the mouthpiece was in direct contact with his/her bed linens. Review of Resident #35's clinical record revealed active physician orders for Ipratropium-Albuterol Inhalation Solution. inhale orally every 6 hours as needed for wheezing and Nebulizer Disinfect daily: in clean container/ bowl, soak items in three parts hot water, to one part white vinegar for 30 mins. [minutes] remove items from disinfectant sol. [solution], rinse under hot tap water. air dry, store Review of Resident #35's January 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) lacked evidence that the Nebulizer is disinfected and stored according to the above order. On 1/6/26 at 1:20 p.m. during an interview, the above observations were discussed with RN #6. At this time, RN #6 stated Resident #35 has Chronic Obstructive Pulmonary Disease and has used nebulizer treatments since he/she was admitted to the facility and that his/her nebulizer machine and mouthpiece should not be stored on his/her bed. RN #6 then stated that after use, the mouthpiece should be cleaned and air dried and stored on a surface but that she is not sure exactly how it should be stored. On 1/6/26 at 2:00 p.m., the surveyor discussed the finding with the DON. At this time, the DON stated she thinks nebulizer tubing and mouthpieces may have been stored in a plastic bag at one point but that she is not sure if the facility has a consistent practice now. 4. On 1/5/26 at 9:42 a.m. a surveyor observed Resident #41's oxygen concentrator next to his/her bed with unbagged and undated nasal cannula oxygen tubing coiled up with the nasal cannula prongs in direct contact with the surface of the concentrator. On 1/6/26 at 1:23 p.m., a surveyor observed Resident #41 seated in his/her wheelchair in the hall, and a portable oxygen tank was stored in the pocket on the back of his/her wheelchair with unbagged, undated nasal cannula oxygen tubing coiled up on top of the tank. At this time, Resident #41 stated that he/she stated never uses the concentrator anymore but sometimes uses this tank, gesturing toward the tank stored in the back of his/her wheelchair. Review of Resident #41's clinical record revealed documented vital signs indicating the last time Resident #41 used oxygen was 11/19/25. Review of Resident #41's November Medication Administration and Treatment Administration Record (MAR/TAR) indicated, Check O2 sat every shift. Titrate oxygen to be >91% every shift for was on (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen at the hospital. The MAR/TAR indicated this order was discontinued 12/9/25. On 1/6/26 at approximately 2:10 p.m., the surveyor and the DON observed Resident #41's oxygen concentrator and the surveyor discussed the above finding. At this time, the DON stated Resident #41's oxygen concentrator and tank should have been removed when the oxygen was discontinued. On 1/6/26 at 2:44 p.m., the above findings were discussed with the Administrator. Findings: On 1/06/2026 at 9:52 a.m., a surveyor observed Resident #6 wearing oxygen via nasal cannula (n/c) during a medication administration observation. On 1/06/2026 at 12:11 p.m., during an interview with Resident #6, a surveyor observed an oxygen concentrator set at 2 liters and the nasal cannula tubing dated 1/1/26. Resident #6 stated he/she wears oxygen all the time. Record review for Resident #6 revealed an admission in November, 2025, with diagnoses that included COPD (Chronic Obstructive Pulmonary Disease). On 1/3/25, Resident #6 was evaluated in the emergency department for difficulty breathing and diagnosed with COPD exacerbation and pneumonia. A review of provider orders lacked a current order for oxygen use. admission orders, dated 10/24/25, included PRN (as needed) Orders, which stated Oxygen 2 liters per minute via nasal cannula as needed for dyspnea, comfort and/or an oxygen saturation below 90. Resident #6's record did not specify the amount of oxygen in use or staff documentation of regular monitoring of oxygen saturation. On 1/6/25 at 12:50 p.m., in an interview with the Director of Nursing and the Long Term Care Unit Manager, a surveyor discussed that Resident #6 has worn oxygen continuously since his/her return from the emergency room on 1/3/25. The surveyor discussed the clinical record lacked a current provider's order for oxygen use. In addition, the clinical record lacked evidence of staff documentation of amount of oxygen in use and the results of oxygen saturation monitoring. The Director of Nursing acknowledged the findings and stated she would have the provider clarify the orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205067	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cove's Edge Inc	26 Schooner Street Damariscotta, ME 04543

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for positioning and mobility (Resident #3).Finding:Resident #3 was admitted to the facility in January 2025 with diagnoses to include left hip fracture and left hip surgical repair.A review of Resident #3's clinical record revealed the following active physician orders:An order with a start date of 1/16/25 for Elevate affected extremity to prevent swellingAn order with a start date of 1/16/25 for Incentive Spirometer 10 x QH [every hour] while awake An order with a start date of 1/16/25 for Call for persistent or worsening drainage . Review of Resident #3's baseline care plan, initiated 1/17/25 states, L [left] hip surgical incision r/t [related to] Left femur fracture [NAME] gamma nail.my surgical incision will heal .by review date. A review of Resident #3's revised care plan indicated the focus, goal, and interventions were resolved on 7/2/25.On 1/7/26 at 11:59 a.m. during an interview, the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated that the order for persistent drainage should have been discontinued because Resident #3 no longer has a surgical wound but that she is not sure about the other orders and the nurse would know better.On 1/07/2026 at 12:07 p.m. during an interview with Registered Nurse (RN) #5 and RN #6, RN #6 stated Resident #3's left leg is no longer being elevated and that the Incentive spirometer is no longer being used and that the above orders are no longer accurate. At this time, RN #5 stated the nurse should have asked the provider to discontinue the orders.