STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225248	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Northbridge	85 Beaumont Drive Northbridge, MA 01534

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that one Resident (#3) out of a total sample of 24 residents, with impaired vision received the proper assistive devices to maintain their vision. Specifically, for Resident #3, the facility failed to ensure that the appropriate corrective lenses were available for the Resident's use when his/her prescription eyeglasses were missing, and he/she was provided with another person's eyeglasses for use. Findings include: Resident #3 was admitted to the facility in March 2021 with diagnoses including Type 2 Diabetes Mellitus with other Circulatory Complications and Schizoaffective Disorder Bipolar Type. Review of Resident #3's most recent Optometry Exam dated 10/29/24, indicated: -Diagnoses of Cataract nuclear, Dry eye, Glaucoma suspect (narrow angle), Hyperopic astigmatism, and presbyopia. -Glasses required, encourage full-time use for distance and reading. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15 possible points -had impaired vision and required corrective lenses Review of Resident #3's Care Plan indicated: -has impaired visual function r/t (related to) Glaucoma and dry eyes, the Resident will have no indications of acute eye problems through the review date.encourage the use of glasses, ensure they (glasses) are clean and unbroken (initiated 6/11/24, revised11/4/25) -requires assist with ADL's (Activities of Daily Living), dependent for glasses (initiated 11/4/25, revised 11/4/25) On 12/3/25 at 9:56 A.M., the surveyor observed that Resident #3 was not wearing any eyeglasses. During an interview at the time, the Resident said he/she haven't had their eyeglasses for weeks, and that the eyeglasses were missing. On 12/4/25 at 2:33 P.M., the surveyor observed Resident #3 wearing eyeglasses. During an interview at the time, Nurse #2 said that the Resident's glasses were kept in the drawer at the nurses' station because the Resident frequently removes the glasses and puts the glasses in random drawers, making it difficult to find the glasses. Nurse #2 further said that the Resident's eyeglasses had gone missing and that the pair of glasses that the Resident was currently wearing had actually belonged to someone else. During an interview on 12/4/25 at 3:42 P.M., Unit Manager (UM) #1 said that it had just been brought to her attention that the Resident's eyeglasses were missing, and she was unaware that the Resident was wearing prescription eyeglasses that belonged to someone else. UM #1 said the staff should have reported the missing glasses to her but had not done so. On 12/8/25 at 9:30 A.M., the surveyor observed Resident #3 sitting up in his/her wheelchair in the unit day room and wearing different glasses than he/she was observed wearing on 12/4/25.ˆ During an interview at the time, Resident #3 said he/she was wearing brand new glasses and they worked well. During an interview on 12/8/25 at 10:00 A.M., UM #1 said she investigated the matter of the Resident's prescription eyeglasses and the glasses were not actually missing but were broken.ˆUM #1 said that one temple piece had been broken off the eyeglasses, but she was unsure how long ago it had happened as she just found out about it.ˆ UM #1 said she did not know how long it had been that the Resident was wearing someone else's glasses as it was never reported to her.ˆUM #1 further said that on 12/5/25 the facility acquired new prescription glasses for the Resident. When the surveyor asked if the facility would have acquired new glasses for the Resident on 12/5/25 if the surveyor had not brought it to the (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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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff's attention, UM #1 said no, we probably still wouldn't have realized the oversight. UM #1 said that she was not aware of any report completed for missing or broken glasses. During an interview on 12/8/25 at 4:27 P.M., UM #1 said that all glasses were typically engraved with the resident's name or the glasses were labeled with a small piece of paper with the resident's name.ˆUM #1 said the eyeglasses that Resident #3 had been wearing had no name identified on them. UM #1 said that she was unaware of when Resident #3's eyeglasses were broken or when the Resident started wearing someone else's glasses.ˆUM #1 said that staff should report to her (the UM) as soon as any glasses were broken or missing but they had not done so.ˆUM #1 also said that the Resident should not have been wearing someone else's glasses.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide foot care and treatment in accordance with professional standards of practice for one Resident (#107) out of a total sample of 24 residents.Specifically, for Resident #107, the facility failed to provide toenail care as required and schedule podiatry services as ordered to assist the Resident in maintaining good foot health and preventing podiatric complications. Findings include:Review of the facility policy titled ADL-Nail Care, not dated, included the following:-The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections.-Nail care includes daily cleaning and regular trimming.-Proper nail care can aid in the prevention of skin problems around the nail bed.-unless otherwise permitted, do not trim the toenails of diabetic residents or residents with circulatory impairments. This nail care should be performed by a Licensed Nurse or Podiatrist.-trimmed and smooth nails to prevent the resident from accidentally scratching or injuring his or her skin.-Resident will be referred to the Podiatrist based on assessment of the resident's toenails by nursing staff and MD. Resident #107 was admitted to the facility in October 2025 with diagnoses including paresthesia (tingling, burning, or numb sensation in the hands, arms, legs or feet) of the skin, vascular Dementia, and alcohol abuse with unspecified alcohol induced disorder. Review of the most recent Minimum Data Set (MDS) Assessment completed 11/3/25, indicated Resident #107:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of possible 15.-required substantial to maximum assistance with personal hygiene. Review of Resident #107's medical record indicated:--Physician's order for Podiatry Consult as needed, dated 10/31/25.- -Request for Podiatry Services, signed by the Resident on 10/31/25.- -Weekly skin checks completed on 11/1/25, 11/8/25, 11/19/25, 11/26/25, and 12/3/25, which failed to indicate that Resident #107's toenails had been trimmed. Review of the Activities of Daily Living (ADL) Care Plan initiated 11/3/25, indicated Resident #107:-requires assist with ADLs due to cognitive loss, decreased attention span, easily distracted, lack of balance, unsteady gait, would not initiate or follow through.-requires moderate assist to complete personal hygiene. On 12/3/25 at 8:48 A.M., the surveyor observed Resident #107's toenails were untrimmed with the free edge of all the toenails on both feet grown significantly past the nail bed. The bilateral great toenails were observed to be thickened and opaque. During an interview at the time, Resident #107 said no one had trimmed his/her toenails or offered to schedule a visit to the Podiatrist. Resident #107 said he/she usually keeps his/her toenails trimmed when they were at home. Resident #107 said he/she would like to have his/her toenails cut if it was offered. During an interview on 12/4/25 at 2:24 P.M., the Unit Secretary said Resident #107 had not been put on the list to be seen when the Podiatrist came to the facility on [DATE]. The Unit Secretary further said Resident #107 was not currently on the list to be seen by the Podiatrist and had no appointment scheduled to go and see a Podiatrist in an outpatient setting. During an interview on 12/4/25 at 2:35 P.M., Nurse #3 said when a resident was identified as needing to see a Podiatrist the Nurse sends a referral to the Unit Secretary, and the Unit Secretary puts the resident on the list to be seen. Nurse #3 said the way it was determined if someone needs to see the Podiatrist was through the resident themselves, a family request, or if it is determined during resident care they need to be seen. Nurse #3 said as far as she knew Resident #107 was not referred to the Podiatrist at any time since his/her admission. During an interview on 12/4/25 at 2:42 P.M., Resident #107 said he/she does have numbness and tingling in both feet and would like to have his/her toenails cut if it was offered. On 12/4/25 at 3:26 P.M., the surveyor and the Director of Nursing (DON) observed Resident #107's toenails. During an interview at the time, the DON said Resident #107 should have been referred to the Podiatrist prior to this observation due to the length of the Resident's toenails. The DON said the length of the Resident's toenails and the need for the toenails to be trimmed should have been identified by the staff during the completion of prior weekly skin checks.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure an environment that was free from accidental hazards for one Resident (#133) out of a total sample of 24 residents. Specifically, for Resident #133, the facility failed to ensure:-that the Resident was provided adequate supervision and assistance during toileting activity to mitigate the risk of a fall.-that a fall sustained by the Resident was investigated, evaluated, and interventions were implemented to reduce fall hazards and risks, and the effectiveness of fall interventions were monitored and modified as required. Findings include: Review of the facility's policy titled Accidents and Incidents, revised October 2022, indicated the following:-It is the policy of the facility to monitor and evaluate all occurrences of accidents or incidents or adverse events occurring on the facility's premises which is not consistent with the routine operation of the facility or care of a particular resident. These occurrences must be evaluated and investigated.-The Nursing supervisor/charge nurse, unit manager, and/or the department director or supervisor shall be promptly notified and then responsible for assessing, reviewing, documenting, and reporting of the incident and/or accident.-Internal report of accidents/incidents regardless of how minor an accident or incident may be, it must be reported to the Nurse Manager or Nursing Supervisor.-Employees witnessing an accident or incidents involving a resident must report occurrence to the nurse manager or nursing supervisor as soon as practical.-The supervisor must assess resident for any injury, completes an occurrence/incident report, and follow-up with interventions.-Should an employee witness an accident, or find it necessary to aid an accident victim, the employee should render immediate assistance. Do not move the victim until he/she has been examined by a nurse for possible injuries.-Examine all residents who may have experienced an accident/incident.-Notify the medical director or the resident's personal attending physician.-Notify the family as soon as possible concerning accident/incident. Resident #133 was admitted to the facility in November 2025 with diagnoses including repeated falls, difficulty walking, obesity, acute on chronic Diastolic Heart failure, and wedge compression fracture of T7-T8 vertebrae. Review of Resident #133's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible score of 15. On 12/3/25 at 9:12 A.M., the surveyor observed the following:-Loud vocal sounds coming from Resident #133's room. -Two staff members were attending to the Resident. -Resident #133 said to the staff that he/she would not allow staff to ambulate him/her to the bathroom because he/she recently had a fall with staff in the bathroom. -Resident #133 said that staff were denying that the fall had occurred. -Resident #133 said that he/she would only use a bed pan. During an interview on 12/3/25 at 9:16 A.M., Unit Manager (UM) #3 said at 9:12 A.M., she and another staff member were attempting to assist Resident #133 to the bathroom, but the Resident consistently indicated that he/she had fallen two days prior in the bathroom and would not allow staff to transfer him/her to the bathroom. UM #3 said Resident #133 was placed on the bedpan in his/her bed per the Resident's request. UM #3 said there was no documentation or evidence that Resident #133 had experienced a fall while being toileted in the bathroom. During an interview on 12/3/25 at 9:24 A.M., Resident #133 said on 12/1/25 around 6:30 P.M., he/she was seated on the toilet in his/her bathroom, and one staff member lifted him/her up and then the Resident's knees gave out, and he/she fell to the floor. Resident #133 said the staff member picked him/her up from the floor and placed him/her back on the toilet and the staff member called for assistance from a second staff member, and both staff members lifted the Resident from the toilet and placed him/her in a wheelchair. Resident #133 said both staff members used a hydraulic lift to transfer him/her from the wheelchair to bed. Resident #133 further said the staff denied that the fall happened, therefore he/she would not allow the staff to assist him/her to the bathroom. During an interview on 12/3/25 at 9:32 A.M., (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Representative #1 (who had arrived in the facility to visit Resident #133) said the facility had not informed him/her of any fall incident on 12/1/25 pertaining to Resident #133. During an interview on 12/3/25 at 9:59 A.M., Nurse #5 said Resident #133 continued to state that he/she had a fall two days ago but there was no documentation and no evidence that the Resident had sustained a fall. During an interview on 12/4/25 at 2:16 P.M., Certified Nurse's Aide (CNA) #2 said Resident #133 was assigned to CNA #3 on 12/1/25 for the 3:00 P.M. to 11:00 P.M. shift. CNA #2 said at 6:30 P.M., CNA #3 reached out to CNA #2 for assistance to ambulate Resident #133 to the bathroom. CNA #2 said he and CNA #3 ambulated Resident #133 with a walker from the Resident's bed into the bathroom and assisted the Resident to sit on the toilet. CNA #2 said he left CNA #3 to monitor the Resident. CNA #2 said CNA #3 reached out to him again because she could not assist Resident #133 to a standing position from the toilet. CNA #2 said he attempted to get Resident #133 to a standing position while holding the Resident's arm and the Resident's knees gave out, and the Resident's knee touched the floor. CNA #2 said he quickly lifted the Resident by grabbing both arms and placed him/her back on the toilet. CNA #2 said he then reached out to Nurse #6 for assistance. CNA #2 said both he and Nurse #6 lifted Resident #133 into a wheelchair and then transferred the Resident to his/her bed using the hydraulic lift. During an interview on 12/4/25 at 2:22 P.M., CNA #3 said she was assigned to Resident #133 on 12/1/25. CNA #3 said Resident #133 requested to use the toilet, but CNA #3 could not transfer the Resident by herself and was not sure of the Resident's transfer status, so she reached out to CNA #2. CNA #3 said CNA #2 assisted with ambulating Resident #133 to the bathroom. CNA #3 said she could not assist the Resident to a standing position to clean him/her, so she called CNA #2 for assistance. CNA #3 said CNA #2 assisted the Resident to a standing position, but the Resident's knees buckled, and CNA #2 lifted the Resident and placed him/her back on the toilet. CNA #3 could not provide any further information as she said she could not recall what happened after the Resident was placed back on the toilet. During an interview on 12/4/25 at 3:30 P.M., Nurse #6 said on 12/2/25, CNA #2 reached out to him to assist Resident #133 back to bed from the toilet. Nurse #6 said he and CNA #2 transferred Resident #133 from the toilet into a wheelchair and then used a hydraulic lift to transfer the Resident to his/her bed. Nurse #6 said CNA #2 did not inform him that the Resident's knees had given out and touched the floor. During an interview on 12/4/25 at 4:26 P.M., the Director of Nursing (DON) said there was no documentation that Resident #133 had sustained a fall on 12/1/25. During an interview on 12/4/25 at 4:55 P.M., the DON said she had not been made aware of any incident related to Resident #133. The DON said she would start an investigation and would notify the survey team of any fall related incident for Resident #133. During an interview on 12/5/25 at 9:14 A.M., the Physical Therapist (PT) said she treated Resident #133 on 12/3/25, and the Resident mentioned he/she had sustained a fall while being assisted in the bathroom. The PT said she spoke with Nurse #5 at the time and Nurse #5 said that the incident did not happen. During an interview on 12/5/25 at 9:53 A.M, the Certified Occupational Therapy Assistant (COTA) said she provided Resident #133 with therapy treatment on 12/2/25. The COTA said Resident #133 requested pain medication before he/she would participate in any therapy sessions and the Resident was observed to have trouble standing. The COTA said during the therapy session, Resident #133 said he/she was stuck in the bathroom the night before and that his/her knees gave out during a transfer off the toilet. The COTA said Resident #133 refused all toilet transfer sessions during therapy on 12/2/25. The COTA said she asked UM #3 if there had been any reported fall or incident related to Resident #133 and UM #3 said there was no incident. During an interview on 12/5/25 at 10:47 A.M., the DON said she started an investigation and found that Resident #133 had been lowered to his/her knees by CNA #2 during a transfer off the toilet on 12/1/25. The DON said the CNA #2 did not report the incident and should have reported it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record reviews, the facility failed to ensure that complete and accurate medical records were maintained for two Residents (#11 and #2), out of a total sample of 24 residents. Specifically,1. For Resident #11, the facility staff documented for ten months that the Resident's Foley (indwelling urinary) catheter was being changed monthly as ordered when the Foley catheter was not being changed monthly.2. For Resident #2, the facility staff documented two medications as being administered during a medication pass when one medication was not offered or administered to the Resident and the second medication was unavailable for administration to the Resident. Findings include: 1.Resident #11 was admitted to the facility in January 2025 with diagnoses including Obesity and obstructive and reflux Uropathy. Review of the Minimum Data Set (MDS) Assessment, dated 11/24/25, indicated the Resident #11: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of a possible score of 15. -had an indwelling urinary catheter. On 12/3/25 at 9:26 A.M., the surveyor observed Resident #11 had an indwelling Foley catheter in place. During an interview at the time, Resident #11 said he/she had been in the facility for a few months. Resident #11 said his/her indwelling Foley catheter had not been changed by the facility staff. Review of Resident #11's December 2025 Physician's orders indicated: -Change (indwelling) Foley catheter using 18 French (Fr) 10 milliliters (ml) balloon every month, change drainage bag with Foley change every month on the 20th, start date 1/27/25. -Monitor Foley catheter 18 Fr/10 ml for patency every shift, start date 1/27/25. Review of Resident #11's Treatment Administration Record (TAR) indicated: - 2/20/25: initialed as Foley catheter changed (8 - indicates other, with no explanation offered) by Nurse #8 - 3/20/25: initialed (8) by Nurse #8 - 4/20/25: check mark by a Nurse - 5/20/25: initialed (8) by Nurse #8 - 6/20/25: initialed (8) by Nurse #8 - 7/20/25: check mark by Nurse #1 - 8/20/25: initialed (8) by Nurse #8 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/20/25: check mark by Nurse #7 - 10/20/25: initialed (8) by Nurse #8 - 11/20/25: check mark by Nurse #5 On 12/4/25 at 9:08 A.M., the surveyor observed that CNA #1 was providing ADL care to Resident #11. During an interview at the time, CNA #1 said the Foley catheter size was 16 Fr and was unable to read the catheter balloon size. On 12/4/25 at 9:18 A.M., the surveyor and Nurse #1 observed Resident #11's Foley catheter. During an interview at the time, Nurse #1 said the Resident's Foley catheter was 16 Fr with 10 ml balloon. The surveyor and Nurse #1 also reviewed Resident #11's December 2025 Physician's orders and Nurse #1 said the Physician's order was for 18 Fr and 10 ml balloon. The surveyor and Nurse #1 reviewed the Resident's TAR and Nurse #1 said she had documented that she changed Resident #11's Foley catheter on 7/20/25 but had not. Nurse #1 said she should not have documented on the TAR that she changed the Foley catheter when she did not. During an interview on 12/4/25 at 11:04 A.M., the Director of Nursing (DON) said Nurses should not initial or sign treatment orders on the TAR when they have not completed treatments. The DON further said it was her expectation that when Nurses provided Foley catheter care, they should ensure the Foley catheter size matched the Physician's order. The surveyor and the DON reviewed the TAR documentation codes, and the DON said Code 8 meant Other, and every time Nurses initialed or signed as other, the Nurses are expected to document what the other meant, but they had not. During an interview on 12/4/25 at 1:44 P.M., Nurse #7 said she had signed/initialed the TAR as having changed Resident #11's Foley catheter on 9/20/25, but she had not changed the Foley catheter. During an interview on 12/4/25 at 1:49 P.M., Nurse #5 said she signed/initialed Resident #11's TAR as having changed the Foley catheter on 11/20/25, but she had not changed the urinary catheter. During an interview on 12/4/25 at 1:50 P.M., Nurse #8 said she had signed/initialed Resident #11's TAR that the Foley catheter was changed on 2/20/25, 5/20/25, 6/20/25, 8/20/25 and 10/20/25, but she did not change the urinary catheter on those dates. During an interview on 12/5/25 at 11:01 A.M., the DON said the Nurses should not have signed/initialed Resident #11's Foley catheter as being changed when the Resident had a history of medical complications in the perineal area and the urinary catheter could only be changed by the Urologist, through interventional radiology. The DON said that the documentation for Resident #11's Foley catheter being changed were inaccurate. 2. Resident #2 was admitted to the facility in February 2025 with diagnoses including Hyperlipidemia, age-related cataracts, other visual disturbances, Diplopia, Exotropia, and Severe Non-proliferative Diabetic Retinopathy with macular edema of the left eye. Review of the facility policy titled Medication Administration Review, revised 1/2023, indicated: -Recheck Medication Administration Records (MAR) to make sure all medications are administered (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	and documented. -When the medication pass is complete, the nurse is to recheck the Medication Administration Records to make sure all medications have been administered and documented appropriately. Review of the Minimum Data Set (MDS) Assessment, dated 11/6/25, indicated Resident #2 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 possible points. On 12/4/25 at 9:14 A.M., the surveyor observed Nurse #4 administering medications to Resident #2 during medication pass. The surveyor did not observe Nurse #4 administer the following medications: -Questran Oral Packet 4 GM (Cholestyramine) give 2 packets by mouth two times a day for diarrhea, to be administered at 8:00 A.M., start date 6/8/25 -Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % (Refresh/Theratears 0.5%) instill 1 drop in both eyes four times a day for dry eyes, to be administered at 9:00 A.M., start date 9/4/25 Review of the December 2025 MAR for Resident #2 after the medication pass indicated that the following medications were administered by Nurse #4 on 12/4/25 during the surveyor observed medication pass: -Questran Oral Packet 4 GM (Cholestyramine) give 2 packets by mouth two times a day for diarrhea, to be administered at 8:00 A.M., start date 6/8/25. -Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % (Refresh/Theratears 0.5%) instill 1 drop in both eyes four times a day for dry eyes, to be administered at 9:00 A.M., start date 9/4/25. During an interview on 12/4/25 at 10:06 A.M., Nurse #4 said she did not administer the Questran 8:00 A.M., and Carboxymethylcellulose Sod PF Ophthalmic Solution and 9:00 A.M. medications during the scheduled medication pass completed at 9:14 A.M. Nurse #4 said she had not offered or administered the Questran medication to Resident #2 and should not have signed the MAR as medication administered. Nurse #4 said that she did not administer the Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % eye drops because the medication was unavailable, and should not have signed off the medication as administered on the MAR. During an interview on 12/4/25 at 10:07 A.M., Resident #2 said that Nurse #4 had not offered the Questran medication during the morning medication pass, but he/she had been refusing the medication and would like it discontinued. During an interview on 12/4/25 at 11:08 A.M., the DON said that Nurse #4 should not have documented the Questran as administered if it was not offered and/or refused. The DON said Nurse #4 should not have documented the Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % as administered if the medication was unavailable. The DON further said that Carboxymethylcellulose Sodium 0.5% strength was unavailable in the facility and Nurse #4 should have called the Physician for clarification on whether to hold the medication or change the order. The DON said Nurse #4 should not have signed the MAR that a medication was administered when it was not.