STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed assess and determine safety for 1 of 1 resident (R3) reviewed for self-administration of medication. Findings include: R3's care plan initiated 6/8/24, included the resident had a swallowing problem. Interventions included the resident would have small bites alternated with sips of fluid and use a teaspoon for eating. The resident was to eat only with supervision and was to be instructed to eat in an upright position. R3's electronic medical record (EMR) included a nursing note dated 6/9/24 which included the resident was on a dysphagia diet with thick nectar liquids. Medication was to be given whole in a spoonful of puree or applesauce. R3's Self Administration of medications assessment dated [DATE], indicated the resident did not want to self-administer medications. R3's EMR was failed to include an order for self-administration of medications. R3's medication administration record (MAR) for June included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give 1/2 a tab twice a day by mouth. Parameters were included indicating to hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the June 27th blood pressure reading was marked NA or not applicable. The metoprolol tartrate was marked as being given. During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did not remember staff taking his blood pressure prior to giving his morning medications. (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: 245028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated she left R3's pills in his room the morning of June 27th to retrieve a pain medication he requested. The medications were gone when she returned to the room. LPN-A stated an assessment should be in the chart if a resident could self-administer medications. LPN-A stated there was not an order which stated R3 could self-administer medications. LPN-A stated she should have stayed with R3 while he was taking his medications. During interview on 6/27/24 at 12:18 p.m., nurse practitioner (NP)-A confirmed the resident would need to be assessed prior to being allowed to self-administer medications and would need an order to self-administer. NP-A confirmed R3 did not have a self-administration order and would not have been appropriate for one because of his dysphagia (difficulty swallowing). During interview on 6/27/24 at 3:24 p.m., director of nursing (DON) stated if a medication was left in a resident's room and was taken without supervision, it was self-administered. DON stated an assessment by an interdisciplinary team (IDT) would be needed to assess the resident's safety and ability and an order from the resident's provider would be needed prior to any self-administration of medications. The DON confirmed R3 did not have an order to self-administer medications. The DON stated this was important to ensure resident safety. A facility policy titled Administering Medications dated 12/13/21, included Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to develop a baseline care plan for 2 of 3 residents (R1, R3) reviewed for wounds, pain, and respiratory concerns. Findings include: R1's Nurse Admission/Readmission assessment dated [DATE], included under the respiratory status section, R1 was short of breath while lying, with exertion, and he received oxygen with a concentrator or liquid oxygen via a nasal cannula. Under the pain section, R1's pain was listed at 8/10, described as chronic pain. Ice, pain medication and rest were marked for alleviating factors to reduce R1's pain. The admission summary included Resident had knee [pain] prior to total knee replacement. Continues to have pain, post op. R1's MDS Pain Assessment V5 dated 6/10/24, R1 rated his pain frequency in the past 5 days as almost constantly. R1 answered pain effects his sleep frequently, interference with therapy activities occasionally. R1 rated his pain as a 10 on a 1-10 pain scale, with 10 being the worst pain you can imagine. R1's hospital after discharge orders dated 6/9/24, included respiratory medications of Albuterol HFA inhaler (a fast acting medication to relax the muscles around the airway to make it easier to breath), levalbuterol nebulizer solution (a medication to prevent wheezing, shortness of breath and coughing), roflumilast (a medication to prevent bronchospasms), and Trelegy Ellipta inhaler (a long lasting medication to treat breathing problems) to treat chronic obstructive pulmonary disease (COPD). R1's discharge medications included acetaminophen, ibuprofen, and hydromorphone to treat pain for total knee arthroplasty (replacement) and osteoarthritis (inflammation in a joint). Provider visit note dated 6/10/24, included R1 was limited by post-surgical pain, his right knee incision was covered with a dressing, had nebulizers four times a day, and was on oxygen via nasal cannula. R1's care plan closed 6/21/24, included an identified focus of acute pain related to recent knee replacement. Care plan interventions that addressed how pain was alleviated was incomplete. Care plan failed to address respiratory needs including continuous oxygen, nebulizers and inhalers. Care plan failed to address surgical incision. R3's electronic medical record (EMR) included an admission summary note dated 6/8/24 at 12:03 p.m., included R3 complained of pain to his right lower abdomen where drain tube was located and his low back where a tube was removed. R3's Order Summary Report printed 6/27/24, included an order placed 6/8/24 to change dressing around cholecystostomy tube (a tube placed to drain excess bile from the gallbladder after surgery) every evening and to empty bag as needed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's new patient provider visit note dated 6/10/24, included under the plan and order section to flush cholecystostomy tube daily, refer to pain management for [cholecystostomy] tube pain, and to refer to general surgery for follow up in regard to cholecystostomy tube. R3's care plan intervention for skin integrity dated 6/8/24 noted an actual skin impairment. Care Plan interventions failed to include specifics on cholecystostomy tube, wound care, monitoring, and risk for infection. During in interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated the managers normally completed the care plans. She would expect to find wound care to be identified on the care plan. During interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-B stated she would have expected to find information about a wound and wound care to be identified on the resident's care plan. During an interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated all care plans were in Point Click Care, the facility electronic medical record charting system. She stated the care plan should be updated as concerns were identified. The DON stated for R1, additional clarification should have been included for his skin integrity since he was admitted with a surgical wound. R1's pain intervention should include how his pain was relieved, both pharmacologically and non-pharmacological measures. R1's should have had a respiratory problem identified which included his oxygen, nebulizers, and diagnosis of heart failure and COPD. The DON confirmed R3's care plan did not address his old chest tube site nor his cholecystostomy site. The DON stated she did not feel these were complete and individualized care plans and the identified issues should have been added within the first 48 hours. Facility policy Care Plans - Baseline dated 11/30/21, included the baseline care plan was to meet the resident's immediate needs and would be developed within 48 hours of admission. The immediate needs of a resident included but were not limited to physician orders including routine treatments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review, the facility failed to assess and monitor 2 of 3 residents (R1, R3) reviewed for monitoring. Findings include: R1's Nurse Admission/Readmission assessment dated [DATE], included under the respiratory status section, R1 was short of breath while lying and with exertion, and received oxygen with a concentrator or liquid oxygen via a nasal cannula. The skin integrity section listed the resident's skin was intact and the resident had right total knee. The admission summary included Resident had knee [pain] prior to total knee replacement. Continues to have pain, post op. The assessment failed to document any skin impairments or surgical incisions. R1's New Patient provider visit note dated 6/10/24, included under the skin section; R1 had a right knee incision covered with dressing. R1's electronic medical record (EMR) indicated admitted [DATE]. However, the record lacked a comprehensive skin assessment or formal wound observation/assessment or documentation. R1's oxygen saturation was documented in R1's EMR on two occasions during his stay: 6/9/24 at 12:55 p.m. at 97% at 2 liters per minute via nasal cannula, 6/10/24 at 3:30 a.m. at 93% at 2 liters per minute via nasal cannula. R1's pulse was documented twice during his stay: 6/9/24 at 12:55 p.m. at 97.7 degrees Fahrenheit, 6/10/24 at 3:30 a.m. at 97.7 degrees Fahrenheit. R1's pulse rate was also only documented on two occasions during his stay: 6/9/24 at 12:55 p.m. at 99 beats per minutes, 6/10/24 at 3:30 a.m. at 90 beats per minute. R1's progress notes dated 6/12/24 at 10:05 a.m., indicated the right knee is erythematosus (red) and hot to the touch. The skin is so warm that it melted the ice packs put on just an hour before. Nursing progress note at 11:32 a.m. included re-assessed knee, which remains erythematosus, hot, and painful. The progress notes lacked any documentation prior to 6/12/24 acknowledging surgical incision. R3's nurse practitioner visit note dated 6/24/24, included monitor BP closely for two days and check vital signs every 4 hours for 48 hours for a diagnosis of hypotension (low blood pressure). R3's order summary report printed 6/27/24, included an order for vital signs every 4 hours for 48 hours for hypotension with a start date of 6/24/24 and an end date of 6/26/24. Active order for Metoprolol Tartrate 25 mg, give 1/2 tab twice a day with the parameters to hold if systolic blood pressure is less than 100 and diastolic blood pressure is less than 60. R3's medication administration record (MAR) for June had an entry of NA for blood pressure on 6/27/24. MAR indicated Metoprolol Tartrate was given on 6/27/24. R3's EMR included an order for vital signs every 4 hours for 48 hours which was marked off on 6/24/24. EMR includes the following vital blood pressure readings from 6/24/24 to 6/26/24: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/24/24 at 4:57 p.m. 104/76 mmHg 6/25/24 at 8:29 a.m. 97/71 mmHg 6/25/24 at 6:49 p.m. 111/64 mmHg 6/26/24 at 9:07 p.m. 112/73 mmHg No reading for temperature, pulse, respiration rate or oxygen saturation recorded after 6/24/24. R3's nurse progress note dated 6/24/24, included vital signs stable during the shift, however did not include specific vital sign readings. R3's nurse practitioner visit note from 6/27/24, included vital signs were ordered every 4 hours for 48 hours to start on Monday (6/24/24), however no vitals were documented in Point Click Care (the facility EMR system). During interview on 6/27/24 at 9:52 a.m., nurse practitioner (NP)-A stated R1 had a non-removable surgical dressing in place on 6/10/24 during NP visit. NP-A described slight shadowing (darker area caused by bleeding or drainage on a dressing), but not enough that she was concerned. NP-A stated she expected to see typical shift documentation were abnormalities, like shadowing, increased pain, redness, swelling) to be noted. NP-A expected daily oxygen monitoring with the rest of the vitals for residents recieving oxygen therapy. Further, NP-A stated R3 was hypotensive with mild tachycardia (fast heart rate) on Monday. NP-A ordered vital signs every 4 hours for 48 hours to confirm if R3 continued to be hypotensive. A complete set of vitals would include blood pressure, heart rate, pulse, oxygen saturation, respiratory rate, and temperature. NP-A stated the facility had missed an opportunity to identify a change in condition. During interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated a full set of vitals included blood pressure, temperature, respirations, pulse, oxygen and pain. A full set should be taken weekly for long term residents, and daily or every shift for residents on the transitional care unit (TCU). RN-I stated the MAR directed how often vitals were ordered. RN-I stated there were certain medications that required specific vital signs to be checked prior to giving the medication. During interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-A stated vital sign frequency would be in a resident's physician orders. LPN-A stated she liked to check vital signs once a day or more if needed, like if a resident was non-verbal or receiving certain medications. LPN-A stated vital signs were documented in the MAR and included temperature, pain, heart rate, blood pressure, and respirations. During interview on 6/27/24 at 10:35 a.m., assistant director of nursing (ADON) stated if someone came in with a surgical wound, there should have been documentation every shift or at least once a day that the wound was assessed. ADON stated she expected to see documentation on the type of dressing in place, what the surrounding skin looked like and the type of wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated a full set of vitals should be completed every shift for TCU residents for the first 3 days. Staff should complete any specific provider order for vitals, such as every 4 hour for 48 hours. A full set of vitals included blood pressure, pulse, oxygen, temperature, respirations, and pain. The DON confirmed a full set of vitals was not completed as expected for R1. The DON confirmed the order for R3 to have a full set of vitals ever 4 hours for 48 hours was not completed. She stated this would be important to establish a baseline and to monitor for change in condition. During interview on 6/27/24 at 3:23 p.m., DON stated it was important to have baseline assessment on skin and wounds so nursing could monitor for changes. DON confirmed R1 did not have a baseline assessment and progress notes failed to describe wound. R3's admission summary note dated 6/8/24 at 12:03 p.m., which included R3 complained of pain to his right lower abdomen where drain tube was located and his low back where a tube was removed. R3's Order Summary Report printed 6/27/24, included an order placed 6/8/24 to change dressing around cholecystostomy tube (a tube placed to drain excess bile from the gallbladder after surgery) every evening and to empty bag as needed. R3's new patient provider visit note dated 6/10/24, included order to flush cholecystostomy tube daily, refer to pain management for [cholecystostomy] tube pain, and to refer to general surgery for follow up in regard to cholecystostomy tube. Wound Care progress note dated 6/19/24, included measurements of tube site on lower right back and treatment instructions to use wound cleanser and protect with a small foam dressing which should be changed daily. R3's EMR lacked an order for wound care from 6/19/24 wound care visit. R3's Skin and Wound Evaluation dated 6/26/24, failed to include assessment of periwound (skin surrounding wound). Pain section and treatment section of evaluation were not complete. During interview on 6/27/24 at 10:40 a.m., RN-I stated wound care information was located in the MAR and progress notes. RN-I stated skin assessments were completed weekly and the admission assessment should have documented any skin impairment. Wound documentation should have included wound size, drainage, how the wound looked and any odor present. During interview on 6/27/24 at 11:00 a.m., LPN-A stated orders for wound have care and dressing changes were on the MAR. Skin was evaluated on bath days and a progress note added with any findings. During interview on 6/27/24 at 11:45 a.m., R3 stated he had a wound on his right side and believed there should be a dressing over it. R3 believed the nurses only changed his dressing twice since he had been admitted and believed it was the wound nurse who completed the dressing change. During interview on 6/27/24 at 3:23 p.m., DON confirmed wound care orders were placed on 6/19/24 for daily dressing change for R3. DON confirmed there was no documentation of wound care being completed and therefore could not say it was done as ordered. DON stated it was important to complete wound care as ordered to prevent infection and to promote healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility provided policy titled Acute Condition Changes - Clinical Protocol dated 11/30/21, included the nurse should have assessed and documented the following baseline information: vital signs, current pain level and any recent changes, onset, duration and severity, all active diagnoses. Facility provided policy titled Standing Orders for Skilled Nursing Facilities revised 2023, included for vital signs to be obtained weekly for four weeks and then monthly thereafter unless otherwise directed for long term care residents. For transitional care or TCU residents, daily vitals should be completed unless otherwise directed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on interview and document review, the facility failed to properly assess and obtain orders for 1 of 1 residents (R1) receiving oxygen therapy. Findings include: R1's admission record dated 6/27/24, include diagnosis of chronic congestive heart failure (a serious condition where the heart cannot effectively pump blood to meet the body's needs) and emphysema (a condition where there is damage to the air sacs in the lungs making it difficult to breathe). R1's hospital discharge orders dated 6/9/24, failed to include orders for oxygen. R1's hospital records prior to admission to facility reviewed. A nursing shift care plan summary note from 6/8/24 at 6:33 p.m. included R1 wears 2 liters of oxygen via nasal cannula. A Nursing Shift Care Plan Summary Note from 6/9/24 at 6:30 a.m., included R1 was on 2 liters of oxygen via nasal cannula, which was his baseline. R1's electronic medical record (EMR) included a nursing note dated 6/9/24 at 12:15 p.m., included resident arrived with oxygen on via nasal cannula at 2.5 liters. An oxygen concentrator was set up in his room. R1's Occupational Therapy evaluation dated 6/10/24, included R1 has chronic obstructive pulmonary disease (COPD) and was chronically on 2.5 liters of oxygen. R1's nurse admission/readmission assessment dated [DATE], included R1's oxygen saturation was 97% on oxygen via nasal cannula. The respiratory status section of the assessment included R1 was on an O2 concentrator or liquid oxygen. R1's care plan reviewed and failed to address oxygen use or respiratory problems. R1's provider visit note dated 6/10/24, included vital sign review of oxygen saturation which listed it at 93% on room air. Provider note failed to include orders or indication for use of oxygen. During interview on 6/27/24 at 9:52 a.m., nurse practitioner (NP)-A stated administration of oxygen was a medication and would need a prescription. During interview on 6/27/24 at 10:40 a.m., registered nurse (RN)-I stated an order for oxygen was needed and if someone was admitted from the hospital with oxygen, she would have called the hospital provider for clarification if there was not an order on the paperwork. RN-I stated it was not within her scope to order oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 11:00 a.m., licensed practical nurse (LPN)-A stated the facility had standing orders for 2 liters of oxygen for pretty much everyone, but the provider would have needed to be updated if oxygen was used. LPN-A stated if someone was admitted with oxygen, they should have come with an order. If they did not, she would call the hospital to obtain one. LPN-A stated she would not feel comfortable keeping a resident on oxygen without an order. During interview on 6/27/24 at 1:05 p.m., LPN-B stated she remembered R1 being on continuous oxygen. LPN-B stated the admitting nurse was responsible for ensuring proper orders for oxygen were in the chart. During interview on 6/27/24 at 6/27/24, director of nursing (DON) confirmed oxygen was a medication and an order would need to be obtained to administer it. DON confirmed she did not see an order for oxygen in R1's EMR. It was her expectation that staff followed up with either the hospital or the new primary provider to obtain an order. The DON stated it was important because there are resident's who should not be on oxygen, and it should be evaluated by the provider. Facility policy titled Oxygen Administration dated 11/1/21, listed staff should have verified that there is a physician order for administration as the first step in preparation to administer oxygen. Step two would have been to review the resident's care plan to assess for any special needs of the patient.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49035 Based on observation, interview and document review, the facility failed to accurately obtain blood pressure reading prior to administering blood pressure medication per provider orders for 1 of 1 resident (R3) reviewed for medication administration in accordance with physician instructions. Findings include: R3's medication administration record (MAR) for June 2024, included an order for Metoprolol Tartrate (a medication to lower blood pressure) Oral Tablet 25 mg, give 1/2 a tab twice a day by mouth. Parameters were included indicating to hold the medication if R3's blood pressure had a systolic (the top number on a blood pressure) reading below 100 or a diastolic (the bottom number on a blood pressure) reading below 60. The blood pressure reading for the 6/27/24 was marked NA or not applicable. The metoprolol tartrate was marked as being given. During interview on 6/27/24 at 11:45 a.m., R3 stated he assumed his blood pressure pill was mixed in with his morning medications. R3 did not remember staff taking his blood pressure prior to giving his morning medications. R3 stated he worked with physical therapy for about an hour after taking his medications. He started to feel sweaty and got dizzy after sitting down. R3 stated he attempted to go to his room because it was ice cold and he wanted to lay on the bed and let the air blow on him, but he fell over outside of the elevator. During interview on 6/27/24 at 12:00 p.m., licensed practical nurse (LPN)-A stated R3 took Metoprolol and there were parameters for holding the medication if his blood pressure was below a specific reading. LPN-A confirmed R3's blood pressure should have been taken prior to him taking his blood pressure medication, however, she did not take it that morning prior to giving him his blood pressure medication. LPN-A confirmed she also did not take R3's blood pressure after he took his medication. LPN-A stated she did not check R3's blood pressure prior to administering the medication because she left his medication in his room in a medication cup when she went to get a saline flush and pain medication. LPN-A stated R3 took his medications while she was out of the room prior to her being able to check his blood pressure. During interview on 6/27/24 at 11:29 a.m., nurse practitioner (NP)-A confirmed R3 had parameters for his blood pressure medication and his blood pressure was not documented prior to has medication being given the morning of 6/27/24. NP-A stated the facility checked R3's blood pressure after he fell and his systolic blood pressure was 77. When the blood pressure was rechecked it was 81/59 mmHg. During observation and interview on 6/27/24 at 11:43 a.m., R3 was sitting in wheelchair next to medication cart in the common room with blood pressure cuff on arm and reading on the blood pressure machine of 78/51 mmHg with a heart rate of 95 beats per minute. NP-A approached R3 and informed him she was going to send R3 to the hospital. NP-A stated she thinks the low blood pressure was related to the metoprolol he was given in the morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/27/24 at 3:23 p.m., director of nursing (DON) stated R3 was a fall risk due to his hypotension. DON confirmed R3 was taking blood thinners which did increase the risk of injury from a fall due to an increased risk of bleeding. The DON confirmed R3 took Metoprolol and he was supposed to have his blood pressure checked prior to administering his blood pressure medication. The DON stated failure to follow this order include R3 falling. The DON does count this as a medication error as it was given incorrectly, and a medication error report was completed. Facility policy titled Administering Medications dated 12/13/21, included medication were to be administered in accordance with prescriber orders. Vital signs and allergies were to be checked and verified for each resident prior to administering medication if necessary.