STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals who have a serious mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care, requires that all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability, be offered the most appropriate setting for their needs, and receive the services they need in those settings) Level II was completed on a resident with a serious mental disorder for 1 of 1 resident's reviewed (Resident 6). The facility identified a census of 81. Findings are: Record review of Resident 6's PASARR Level I screening determination notification dated 6/1/2023 revealed the following statement: There were no signs of a serious mental illness, intellectual disability or a related condition found during the Level I screen. No further clinical review or onsite evaluation is needed. Record review of Resident 6's Census Sheet revealed an admitted to the facility on [DATE]. Record review of Resident 6's Medical Diagnosis Sheet revealed the Diagnosis of Bipolar Disorder dated 6/7/2023. Bipolar Disorder is a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania) to extreme lows (depression). Bipolar Disorder therefore was missed during the initial Level I PASARR screening. Record review of Resident 6's Minimum Data Set (MDS, a federally mandated assessment tool used for care-planning) revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) with a score of 15. A BIMS score of 15 indicated the resident was cognitively intact. The MDS also revealed Resident 6 was independent with eating, transfers, bed mobility, and toileting. Under Section I of the MDS, the following diagnoses were marked: Anxiety, Depression, and bipolar disorder. Interview on 7/23/24 at 09:13 AM with facility Social Services Director confirmed the resident had a diagnosis of Bipolar Disorder upon admission but was not identified on the initial PASARR Level I screening. Social Service Director also confirmed a referral should have been made for a PASARR level II once the facility identified the omission. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy entitled Pre-admission Screening and Resident Review dated 9/25/2023 revealed the following: -The facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to PASARR level I and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or Intellectual Disability (ID) arises later. A possible Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. Federal Regulations F644 A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: Incorporating the recommendations from the PASARR Level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for level II resident review upon significant change in status assessment. Preadmission screening for individuals with a mental disorder and individuals with intellectual disability. A nursing facility must notify the state mental health authority or state intellectual disability authority (SMH or ID), as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental illness or intellectual disability for resident review. Procedure 1. Ensure Level I PASARR screening has been completed on potential admissions prior to admission. 2. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. 3. A record of the pre-screening should be retained in the resident's medical record. 4. A positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR level II, which must be conducted prior to admission to nursing facility. 5. When a Level II PASARR screening is warranted it must be obtained as well as determination letter prior to admission. The Level II PASARR cannot be conducted by the nursing facility. 6. With respect to the responsibilities under the PASARR program, the state is responsible for conducting the screens, preparing the PASARR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The state is required to provide a copy of the PASARR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide. 7. The Level II PASARR determination and the evaluation report specify services to be provided by the facility and/or specialized services defined by the State. 8. Recommendations from the PASARR Level II determination and PASARR evaluation report are to be incorporated in the person-centered care plan as well as in transitions of care. 9. As part of the PASARR process, the facility is required to notify the appropriate SMH/ID authority when a resident with a mental disorder or intellectual disability has a significant change in their physical or mental condition. This will ensure that residents with a mental disorder or intellectual disability continue to receive the care and services they need in the most appropriate setting. 10. Referral to the SMH/ID authority should be made as soon as the criterial indicative of a significant change are evident. a. Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements. 11. Facilities should look to their state PASARR program requirements for specific procedures. PASARR contact information for the SMH/ID authorities and the State Medicaid Agency. 12. The State must provide or arrange for the provision of specialized services to all nursing facility resident with MD or ID in accordance with 483.120, whose needs are such that continuous supervision, treatment, and training by qualified mental health or ID personnel is necessary, as identified in the resident's PASARR level II. Examples of individual who may not have previously been identified by PASARR to have MD, ID or a related condition include, but is not limited to: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted , or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment. Interview on 7/23/24 at 09:13 AM with facility Social Services Director confirmed the resident had a diagnosis of Bipolar Disorder upon admission but was not identified on the initial PASARR Level I screening. Social Service Director also confirmed a referral should have been made for a PASARR level II once the facility identified the omission.

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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** 47733 Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record review and interview, the facility failed to complete a baseline care plan (a person-centered plan developed and implemented to meet the resident's needs) on admission for 1 (Resident 79) of 29 sampled residents. The facility identified a census of 81. Findings are: Record review of Resident 79's (Electronic Medical Record) EMR revealed the admitted [DATE]. Record review of Resident 79's baseline care plan that was initiated in (Point Click Care, a system for documenting clinical information on residents) PCC on 06/21/2024 revealed the facility staff had not developed a baseline care plan for Resident 79. Interview concluded on 07/18/2024 at 1:29 PM with the (Assistant Director of Nursing) ADON confirmed that baseline care plans should be completed within 48 hours of admission. The ADON confirmed Resident 79 baseline care plan in PCC were blank and had no information about Resident 79's physical or medical needs, goals or interventions to maintain or improve Resident 79's health or physical needs. Record review of the facility's policy Person Centered Care Planning dated 08/22/2023 revealed; Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Further review of the facility's procedure revealed: 1. The facility will develop a person-center care plan that addresses the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline. 2. The care plan will include measurable goals, timeframe's to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs. 3. The care plan will reflect interventions that are person-centered, measurable, and include time frames to achieve the desired outcome. Record review of facility's: Area of focus: Care Planning, Baseline, Comprehensive. and Routine Updates, Clinical Leadership Resource Pathway, Dated 12/05/22. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Baseline Care Plan: Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. -Why-The baseline care plan must include the minimum health care information necessary to properly care for each resident immediately upon admission and a summary must be presented to the resident or their representative that includes the initial goals of the resident, a summary of the resident's medications and dietary instructions, services, and treatments to be administered by the facility, and any updates. -When-The baseline care plan must be developed within 48 hours of a resident's admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47733 Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview, the facility staff failed to complete a Comprehensive Care Plan (CCP, the plan of care is developed from a comprehensive assessment to ensure the resident achieves optimal functional status.) for Resident 79 after the completion of the comprehensive assessment. This affected 1 (Resident 79) of 29 sampled residents. The facility identified a census of 81. Findings are: Record review of Resident 79's (Electronic Medical Record) EMR revealed the admitted [DATE]. Record review of Resident 79's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 06/28/2024 identify Resident 79 used a wheelchair and a walker. The MDS section GG-Functional Abilities and Goals, identified Resident 79 needed setup or clean-up assistance with oral hygiene. Further review of Resident 79's MDS revealed Resident 79 was dependent for showering, toileting, and lower body dressing. Resident 79 required substantial/maximal assistance with transferring from one surface to another per the MDS. Record review of Resident 79's CCP dated 06/22/2024 revealed there was 1 focus area identified was on relating to Advanced Directives. Further review of Resident 79's CCP dated 06/22/2024 there was no information on the CCP that identified the care needs of the resident. Interview conducted on 7/18/24 at 1:29 PM with the (Assistant Director of Nursing) ADON confirmed Resident 79's CCP had not been completed. Record review of the facility's policy Person Centered Care Planning dated 08/22/2023 revealed; Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Further review of the facility's procedure revealed: 1. The facility will develop a person-center care plan that addresses the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline. 2. The care plan will include measurable goals, timeframe's to meet the patient's cultural, nursing, mental, and psychosocial needs including services being provided to meet those needs. 3. The care plan will reflect interventions that are person-centered, measurable, and include time frames to achieve the desired outcome. Record review of the facility's Area of Focus: Care Planning-Baseline, Comprehensive, and Routine Updates Clinical Leadership Resource Pathway. Dated 12/05/2022. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan (What) -Developed after the (Minimum Data set) MDS assessment is completed to address the resident's goals and preferences, contain measurable objectives and timeframe, interventions to assist the resident' meets their goals, additional follow-up and clarification, items needing additional assessment, testing, and review with the practitioner, items may require additional monitoring but do not require other investigations, and the resident's preferences and potential for future discharge plan. -Comprehensive Care Plan: (Why) Federal Regulation 483.21(b) requires the facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframe to meet the residents medical nursing, and mental and psychosocial needs that are identified in comprehensive assessment (MDS). -The comprehensive Care Plan cannot be completed until the MDS, the Care Area Triggers are addressed through the Care Areas Assessment Process. -The Comprehensive Care Plan is to be completed within 7 days of Care Area Assessments. -Comprehensive Care Plan: (How) -The Comprehensive Care Plan cannot be completed until the MDS, Care Area Triggers are addressed through the Care Area Assessment Process. -The Comprehensive Care Plan must include a problem/focus statement, measurable goals, and interventions. -Comprehensive Care Plan: (When) -The Comprehensive Care Plan is to be completed within 7 days of Care Area Assessments. -The Comprehensive Care Plan must be updated with each MDS assessment and periodically.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 006.09(H)(vi)(2) Based on observation, interview, and record review, the facility failed to ensure activities were provided to meet resident needs and interests for 1 [Resident 63] of 1 sampled resident. The facility had a total census of 81 residents. Findings are: A review of Resident 63's electronic medical record revealed Resident 63 was admitted on [DATE] with a diagnosis of dysphagia, oropharyngeal phase [difficulty swallowing], and anoxic brain damage [brain injury caused by lack of oxygen]. A review of Resident 63's annual MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 5/17/24 identified the following: -Brief Interview for Mental Status was not completed -Resident 63 was identified as having short-term and long-term memory problems -The following activities were identified as being very important to Resident 63: listening to music, doing things with groups of people, going outside to get fresh air when the weather is good A review of annual activities evaluation for Resident 63 dated 5/31/24 revealed the following preferences: -music -television -frequency of activities 1-2 weekly in own room A review of Resident 63's care plan identified of focus area dated 8/14/23 of Resident 63 being dependent on staff for meeting emotional, intellectual, physical and social needs related to immobility with a goal of participation in activities at least 1-2 times weekly when up in Resident 63's chair. Interventions were as follows: -All staff to converse with Resident 63 while providing care -Resident 63 needs 1:1 bedside/in-room visits and activities if unable to attend out of room events -Resident 63 prefers the following radio stations: country music -Establish and record Resident 63's prior level of activity involvement and interests by talking with Resident 63, caregivers, and family on admission and as necessary (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Thank Resident 63 for attendance at activity function Observations on 7/17/24 at 9:33 AM, 10:53 AM and 11:47 AM revealed Resident 63 in bed in room with no activities going on. Observations on 7/18/24 at 7:49 AM revealed Resident 63 up in wheelchair in common area in front of TV. Observations on 7/22/24 at 7:23 AM, 9:18 AM, 9:30 AM, 11:51 AM, 2 PM, and 4:06 PM revealed Resident 63 in bed in Resident 63's room with no activities going on. In an interview on 7/22/24 at 2:06 PM, Nurse Aide C confirmed Resident 63 had not been gotten out of bed during the day shift on 7/22/24. A review of Resident 63's Individual Resident Daily Participation Record revealed the following activity participation: -Between 7/1/24-7/18/24, Resident 63 accepted one 1-1 visit and was unavailable for one 1-1 visit. No other activity participation was documented. -For the month of 6/2024, Resident 63 accepted 3 1-1 visits and was unavailable for 2 1-1 visits. Resident 63 accepted 1 exercise activity. -For the month of 5/2024, Resident 63 accepted 3 1-1 visits and was unavailable for 3 1-1 visits. In interviews on 7/22/4 at 9:13 AM and 7/23/24 at 9:07 AM, the Activity Director reported that more 1-1 visits may have been provided than are recorded on the participation record. The Activity Director reported that if Resident 63 is up and available, Resident 63 will be brought to activities. The Activity Director reported that Resident 63 is not always out of bed to come to activities. A review of undated list of Activity Ideas for Low-function, Bedbound Residents revealed the following: -Arts and Crafts: yarns, paper, coloring, cloth, pillow-toy stuffing, painting -Bedside Music -Correspondence: assist in letter writing, read mail -Games and Exercises: checkers, cards, ball throwing, ring toss -Reality Orientation: environmental awareness, weather, time of the day, place, who they are, how they are, news -Religious activities: Bible reading, music, singing, prayer -Miscellaneous: nail care

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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** 04577 Licensure reference: 175 NAC 12-006.09(I) Based on observation, interview, and record review, the facility failed to ensure interventions to prevent potential falls were implemented for 1 [Resident 63] of 3 residents sampled for falls. The facility had a total census of 81 residents. Findings are: A review of Resident 63's electronic medical record revealed Resident 63 was admitted on [DATE] with a diagnosis of dysphagia, oropharyngeal phase [difficulty swallowing], and anoxic brain damage [brain injury caused by lack of oxygen]. A review of Resident 63's annual MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 5/17/24 revealed Resident 63 has had 2 falls with no injury since admission/entry or reentry or prior assessment whichever is more recent. A review of Resident 63's care plan identified of focus area dated 5/17/23 of being at risk for falls related to confusion, incontinence, and unaware of safety needs with a goal of Resident 63 not sustaining a serious injury that required hospitalization . Interventions were as follows: -Assist with activity of daily living as needed. -Resident 63 will move closer to the nurses' station. -Call light within reach. -Fall mat at bedside when in bed. -Frequent checks on resident to ensure proper bed positioning. -Low bed when resident is asleep or when appropriate for resident safety. -Mechanical lift. -Medication review. -Educate staff to do frequent incontinence monitoring. -New orders for Urinalysis and labs. -Perimeter mattress to assist resident in identifying edge of bed. -Positioning pillows to assist in proper bed positioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Urinalysis with culture and sensitivity if indicated. -Will evaluate for floor mattress. -Will have medication review. Resident will have lab draw for therapeutic level. -Will place in large bed to assist with position. A review of Incident Report dated 6/4/24 at 4:45 AM for Resident 63 revealed Resident 63 was found on mat next to bed. Resident 63 was conscious and upset hollering out. Resident 63 had no observed injuries at time of incident. A review of Incident Report dated 7/22/24 at 6:30 AM for Resident 63 revealed Resident 63 was found lying on left side on the fall mat. Resident 63 had no observed injuries at time of incident. Observations on 7/22/24 at 7:23 AM revealed Resident 63 in bed with head of bed at 45-degree angle. A fall mat was in place on floor next to bed and bed in medium position. Observations on 7/22/24 at 9:30 AM revealed Resident 63 with feet off edge of bed. Resident 63 had no wedges in place to assist with keeping Resident 63 in bed. Resident 63's nurse was alerted to Resident 63's position. Observations on 7/23/24 at 6:40 AM revealed Resident 63 with brief and gown off. Resident 63 had no wedges in place to keep Resident 63 in bed. A whole-body pillow was observed on side of bed next to wall. Resident 63's bed was in a medium position and mat was in place on floor next to bed. In an interview on 7/23/24 at 6:40 AM, LPN B [Licensed Practical Nurse] confirmed wedges were not in place and Resident 63's bed was in a medium position. In an interview on 7/23/24 at 9:25 AM, the ADON confirmed that wedges were being used in placed of a peripheral mattress and need to be in place for Resident 63. A review of facility policy titled Fall Management dated 12/4/23 revealed the following: -The facility will assess the resident upon admission/readmission, quarterly, with change in condition and with any fall event for any fall risk and will identify appropriate interventions to minimize the risk of injury related to falls.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 12-006.09(H)(vi)(3) Based on observation, interview, and record review, the facility failed to ensure enteral feeding was provided in accordance with physician order for 1 [Resident 63] of 1 resident sampled for enteral feeding. The facility had a total census of 81 residents. Findings are: A review of Resident 63's electronic medical record revealed Resident 63 was admitted on [DATE] with a diagnosis of dysphagia, oropharyngeal phase [difficulty swallowing], and anoxic brain damage [brain injury caused by lack of oxygen]. A review of Resident 63's annual MDS [Minimum Data Set; a comprehensive assessment used for care planning] dated 5/17/24 revealed Resident 63 received greater than 51% of total calories from enteral tube feeding. A review of Resident 63's 7/2024 MAR [Medication Administration Record] revealed the following orders: -Jevity 1.5 [tube feeding formula] 300 cc [cubic centimeters] bolus via G-tube [a tube inserted in resident's stomach], flush with 50 ml [milliliters] water before and after bolus 4 times per day with scheduled times of 12 AM, 6 AM, 12 PM and 6 PM. -300 cc water via G-tube at 9 AM, 3 PM, and 9 PM. Observations on 7/18/24 at 9:12 AM revealed Registered Nurse A administering tube feeding of 300 cc Jevity 1.5 with 50 ml water flush. Registered Nurse A checked for residual which was 60 cc then flushed tube with 25 cc water. Registered Nurse A poured 2 oz. [ounces] of Jevity 1.5 formula into syringe and began to administer feeding via gravity. Registered Nurse A then added water to syringe and continue gravity feeding. Registered Nurse A reported having difficulty administering the tube feeding. Registered Nurse A left the room to call Resident 63's Nurse Practitioner regarding difficulty with administering tube feeding. Registered Nurse A then checked orders in electronic medical record and determined Resident 63 had orders for 300 cc water flush at 9 AM and orders for Jevity tube feeding every 6 hours. Registered Nurse A returned to Resident 63's room and flushed tube with another 10 cc water. Registered Nurse A reported Registered Nurse A will follow up with Nurse Practitioner. A review of Progress Note for Resident 63 dated 7/18/24 revealed the following: -Resident 63 received an extra feeding of Jevity 1.5 bolus 150 cc at 9:10 AM with 50 cc of water. Feeding was not due until 12 PM. APRN [Advanced Practice Registered Nurse] was notified with order to listen to bowel sounds and continue 12 PM feeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/22/24 at 3:16 PM, the ADON [Assistant Director of Nursing] confirmed that the timing for administration of Resident 63's tube feeding was not followed. A review of gastric Enteral Tube Feeding 2024 Checklist revealed the first step is to verify the practitioner's order.