STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325061	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Dare Wellness & Rehabilitation LLC	3101 North Florida Avenue Alamogordo, NM 88310

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the provider of R #25's blood pressure medication was not available and had a high blood sugar level greater than 400 (normal range of blood sugar levels of 80-130) for 1 (R #25) of 3 (R #1, R #16 and R #25) residents reviewed for neglect. This deficient practice could likely result in residents not receiving necessary care or worsening medical conditions due to lack of or changes in treatment. The findings are: A. Record review of R #25's admission record (no date) revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 had the following diagnoses: a. Essential (Primary) Hypertension. b. Type 2 Diabetes Mellitus without complications. B. Record review of R #25's physician orders, dated 02/13/25, revealed the following: 1. Diltiazem (blood pressure medication) 90 mg oral tablet 1.5 tab oral 2 times per day. 2. Insulin Lispro Injection solution 11 UNIT/ML inject per sliding scale if 0-150=0, 151-200=1, 201-250=2, 251-300=3, 301-350=4,351-400=5, administer 6 units of insulin for blood sugar greater than 400 and call physician, subcutaneously before meals and at bedtime for Diabetes. C. Record review of R #25's MAR, dated February 2025, revealed staff documented the following: 1. On 02/13/25 for diltiazem dose scheduled for Hour of Sleep (HS) administration, staff documented (code 9 other/see nurse note effective). 2. On 02/14/25 for diltiazem dose morning (AM) administration, staff documented code 9. 3. On 02/15/25 for diltiazem morning AM administration, staff documented code 9. 4. On 02/16/25 for diltiazem AM administration, staff documented code 9. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. On 02/17/25 for diltiazem morning AM administration, staff documented code 9. 6. On 02/20/25 at 11:30 AM, for insulin administration, staff documented code 9. 7. On 02/20/25 at 9:00 PM, for insulin administration the nurse administered 6 units of insulin. 8. On 2/21/2025 at 4:30 PM, for insulin administration, staff documented code 9. 9. On 02/22/25 at 11:30 PM, for insulin administration, staff documented code 9. 10. On 2/23/2025 at 11:30 AM for insulin administration no documentation that medication was given to R #25 or physician was not notified. 11. On 02/25/2025 at 4:30 PM for insulin administration, staff documented code 9. 12. On 02/27/25 at 1130 pm, for insulin administration, staff documented code 9. D. Record review of R #25's progress notes for February 2025, revealed staff did not notify the physician of the following: 1. R #25's medication not being available on the following dates: a. 02/13/25, b. 02/14/25, c. 02/15/25, d. 02/16/25, e. 02/17/25, 2. R #25's elevated blood sugar (BS higher than 400) on the following dates: a. 02/20/25 at 11:30 AM, blood sugar level at 402. b. 02/20/25 at 9:00 PM, blood sugar level at 545. c. 02/21/25 at 4:30 PM, blood sugar level at 420. d. 02/22/25 at 11:30 AM, blood sugar level at 406. e. 02/23/25 at 11:30 AM, blood sugar level at 468. f. 02/25/25 at 4:30 PM blood sugar level at 499. E. On 05/29/25 at 2:14 PM, during an interview with DON and regional nurse confirmed the following: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Staff did not document that they contacted R #25's provider for R #25's medications diltiazem not being available and the high blood sugar level. 2. R #25's order indicated that staff are to call physician when blood sugar is greater than 400. 3. Staff should have notified the provider that R #25's Diltiazem was not available. 4. Staff did not call the physician as indicated per order.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Recite from 08/15/24 Based on observation and interview, the facility failed to provide a homelike environment that was in good condition for 1 (R #1) of 1 (R #1) resident randomly sampled by not repairing the wall behind R #1's bed, ensuring electrical outlets have covers, and removing Velcro stuck onto wall. Failure to maintain and provide a comfortable environment is likely to result in residents feeling unimportant and undervalued. The findings are: A. On 05/29/25 at 12:53 PM, during an interview with R #1, she pointed to the wall near her window and stated the velcro had been on the wall since she moved into the room approximately 2 months ago, she also stated that the wall behind her bed was scraped and the electrical outlet behind her bed did not have a cover on it. B. On 05/29/25 at 12:53 AM, an observation of R #1's room revealed the wall near her window had 4 pieces of velcro on it, the wall behind her bed had several deep scratches and missing paint and the electric outlet behind her bed where R #1 had her cell phone charger plugged in did not have an outlet cover on it. C. On 05/30/25 at 2:40 PM, during an interview with the Administrator, he confirmed R #1's wall did have velcro on it, the wall behind her bed was scraped and was missing paint and the outlet did not have a cover on it. The administrator stated the velcro was used to hang an activities calendar, but there was no calendar hanging and stated he was unaware of the wall being scraped or the outlet not having a cover on it.

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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** Recite from 08/15/24 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 1 (R #16) of 6 (R #1, R #2, R #3, R #16, R #25, and R #26) residents reviewed for comprehensive care plans (plan that has measurable goals and timeframes to meet a resident's medical, nursing, mental health and psychosocial needs). This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: A. Record review of R #16's admission record, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 had the following diagnoses: a. Unsteadiness on feet. b. Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing (a break in the neck of the long bone in the leg with normal healing). c. Unspecified fall. d. Other abnormalities of gait and mobility (an unusual walking pattern). e. Need for assistance with personal care. B. Record review of R #16's admission Minimum Data Set (MDS) Assessment (a federally mandated assessment instrument completed by facility staff), dated 01/24/25, revealed R #16 had the following functional abilities for Activity of Daily Living (ADL, fundamental skills needed to take care of oneself): 1. Eating: Setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity). 2. Oral hygiene: Setup or clean-up assistance 3. Toileting hygiene: Partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort). 4. Shower/bathe self: Partial/moderate assistance. 5. Upper body dressing: Setup or clean-up assistance. 6. Lower body dressing: Partial/moderate assistance. 7. Putting on/taking off footwear: Partial/moderate assistance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Personal hygiene: Setup or clean-up assistance. 9. Roll left and right: Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently). 10. Sit to lying: Supervision or touching assistance. 11. Lying to sitting on side of bed: Supervision or touching assistance. 12. Sit to stand: Supervision or touching assistance. 13. Chair/bed-to-chair transfer: Supervision or touching assistance. 14. Toilet transfer: Not Attempted due to medical condition or safety concerns. 15. Tub/shower transfer: Not Attempted due to medical condition or safety concerns. C. Record review of R #16's care plan, dated 01/14/25, revealed staff did not document R #16's functional level and the assistance needed to complete ADL's. D. On 05/29/25 at 2:01 PM, during an interview, the DON confirmed that R #16's care plan did not include the resident's functional abilities. He was unsure whether the care plan should include functional abilities. E. On 05/29/25 at 2:06 PM, during an interview, the corporate nurse confirmed that care plans should include resident's functional abilities.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plan revisions occurred for 1 (R #1) of 3 (R #1, R #2 and R #3) residents when staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: A. Record review of R #1's admission Record (no date) revealed R #1 was admitted to the facility on [DATE]. B. Record review of R #1's shower sheet forms dated 02/22/25 through 05/26/25 revealed the following: 1. R #1 was offered showers twelve times. 2. R #1 refused her showers six of the twelve times showers were offered to her. C. Record review of R #1's care plan dated 02/24/25 revealed the following: 1. R #1 requires partial/moderate assistance with bathing/showering. 2. R #1's care plan was not revised to include residents' refusal of showers and what actions staff could take to encourage her to shower. D. On 05/30/25 at 12:45 PM, during an interview, the Regional Nurse Consultant confirmed that R #1's care plan was not revised to include her refusal of care (refusing to shower) and actions that staff could take to assist her to agree to shower.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards of practice for 2 (R #16 and R #25) of 3 (R #1, R #16 and R #25) residents reviewed for neglect, when staff failed to: 1. Enter an order for urinalysis (a test of your urine. It is often done to check for a urinary tract infection, kidney problems, or diabetes) and urine culture (a test healthcare providers use to check for a urinary tract infection (UTI) by seeing if bacteria or fungi can grow from a sample of your pee. A urine culture test can also identify bacteria or yeast causing a UTI and which drugs work best to treat the infection) for R #16. 2. Collect urine for urinalysis and urine culture for R #16. 3. Administer R #25's blood pressure medication and insulin as ordered by the physician. These deficient practices could likely lead to the resident having worsening of their medical conditions, adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication due to it not being administered. The findings are: R #16 A. Record review of R #16's medical record, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 was discharged from the facility on 02/08/25. B. Record review of R #16's progress note dated 02/07/25, revealed staff documented R #16 had burning during urination. C. Record review of R #16's On-Call physician note dated 02/07/25, revealed the provider ordered a urinalysis and urine culture due to dysuria (pain during urination). D. Record review of R #16's physician's orders, no date, revealed staff did not enter an order for a urinalysis or urine culture. E. Record review of R #16's entire medical record, no date, revealed R #16's medical record did not contain any documentation that urine was collected from R #16. F. On 05/29/25 at 11:17 AM, during an interview, LPN #16 stated the following: 1. She did not remember R #16. 2. She did not remember if she contacted the provider about R #16 having burning during urination. 3. She confirmed R #16 did not have an order for a urinalysis or urine culture. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Staff did not document in R #16's medical record whether urine was collected from R #16. 5. When staff obtain an order from the provider, they are expected to enter the order in the resident's electronic medical record (EMR). G. On 05/29/25 at 11:27 AM, during an interview, the DON and the corporate nurse confirmed the following: 1. The on-call physician's note dated 02/07/25, had an order for a urinalysis and urine culture for R #16. 2. The on-call physician's note was a scanned in document, and staff do not check scanned documents for orders. 3. R #16's EMR did not have an order for a urinalysis or urine culture. 4. R #16's EMR did not contain documentation that urine was collected from R #16. 5. Staff were expected to enter orders that were received from the on-call provider in the EMR. 6. Staff were expected to collect urine from R #16 for the urinalysis and urine culture that were ordered and document in the EMR. R #25 H. Record review of R #25's admission record (no date) revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 had the following diagnoses: a. Essential (Primary) Hypertension. b. Type 2 Diabetes Mellitus without complications. I. Record review of R #25's physician orders, dated 02/13/25, revealed the following: 1. Diltiazem 90 mg oral tablet two times per day. 2. Insulin Lispro Injection solution 11 UNIT/ML inject per sliding scale if 0-150=0, 151-200=1, 201-250=2, 251-300=3, 301-350=4,351-400=5, administer 6 units of insulin for blood sugar greater than 400 and call physician, subcutaneously before meals and at bedtime for Diabetes. J. Record review of R #25's MAR, dated February 2025, revealed staff documented the following: 1. On 02/13/25 for diltiazem dose scheduled for Hour of Sleep (HS) administration, staff documented code 9; (other/see nurse note effective.) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 02/14/25 for diltiazem dose morning (AM) administration, staff documented code 9. 3. On 02/15/25 for diltiazem morning AM administration, staff documented code 9. 4. On 02/16/25 for diltiazem, morning AM administration, staff documented code 9. 5. On 02/17/25 for diltiazem morning AM administration, staff documented code 9. 6. On 02/20/25 at 11:30 AM for insulin administration, staff documented code 9. 7. On 02/20/25 at 9:00 PM for insulin administration the nurse administered 6 units of insulin. 8. On 2/21/2025 at 4:30 PM for insulin administration, staff documented code 9. 9. On 02/22/25 at 11:30 PM for insulin administration, staff documented code 9. 10. On 2/23/2025 at 11:30 AM for insulin administration no documentation that medication was given to R #25 or physician was not notified. 11. On 02/25/2025 at 4:30 PM for insulin administration, staff documented code 9. 12. On 02/27/25 at 1130 PM for insulin administration, staff documented code 9. K. Record review of R #25's progress notes for February 2025, revealed staff did not notify the physician of the following: 1. R #25's diltiazem medication not being available on the following dates: a. 02/13/25, b. 02/14/25, c. 02/15/25, d. 02/16/25, e. 02/17/25, 2. R #25's elevated blood sugar (BS higher than 400) on the following dates: a. 02/20/25 at 11:30 AM, blood sugar level at 402. b. 02/20/25 at 9:00 PM, blood sugar level at 545. c. 02/21/25 at 4:30 PM, blood sugar level at 420. d. 02/22/25 at 11:30 AM, blood sugar level at 406. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. 02/23/25 at 11:30 AM, blood sugar level at 468. f. 02/25/25 at 4:30 PM blood sugar level at 499. L. Record Review of R #25's entire record, multiple dates, revealed that the provider was not notified of medication not given to R #25 and blood sugar levels higher than 400. M. On 05/29/25 at 2:00 PM during an interview with LPN #27, she stated that anytime there is medication not available, and a resident has high blood sugar the physician is to be notified. N. On 05/29/25 at 2:14 PM, during an interview with DON and regional nurse confirmed the following: 1. Staff did not document that they contacted R #25's provider for R #25's medications diltiazem not being available and the high blood sugar level. 2. R #25's order indicated that staff are to call physician when blood sugar is greater than 400. 3. Staff should have notified the provider that R #25's Diltiazem was not available. 4. Staff did not call the physician as indicated per order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths or showers for 1 (R #16) of 3 (R #16, R #25, and R #26) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #16's medical record, no date, revealed the following: 1. R #16 was admitted to the facility on [DATE]. 2. R #16 was discharged from the facility on 02/08/25. 3. R #16 had the following diagnoses: a. Unsteadiness on feet. b. Fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing (a break in the neck of the long bone in the leg with normal healing). c. Unspecified fall. d. Other abnormalities of gait and mobility (an unusual walking pattern). e. Need for assistance with personal care. B. Record review of R #16's admission Minimum Data Set (MDS) Assessment (a federally mandated assessment instrument completed by facility staff), dated 01/24/25 revealed R #16 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for showers/baths. C. Record review of R #16's documentation summary report (spreadsheet for staff to document resident's ADL's), dated January 2025, revealed the following: 1. On 01/22/25, R #16 received a shower/bath. 2. On 01/28/25, R #16 received a shower/bath. D. Record review of R #16's documentation summary report dated February 2025 staff documented Not Applicable (NA) for R #16's shower/bath on 02/07/25. E. Record review of R #16's shower sheets, multiple dates, revealed the following: 1. On 01/14/25, R #16 refused shower and said she had one the day before. 2. On 01/22/25, R #16 received a shower. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 01/28/25, R #16 received a shower. F. Record review of the shower schedule, no date, revealed the following: 1. Residents housed in even numbered rooms are supposed to receive showers on Mondays, Wednesdays, and Fridays. 2. Residents housed in odd numbered rooms are supposed to receive showers on Tuesdays, Thursdays, and Saturdays. 3. Residents are to be showered on an as needed basis. 4. All shower refusals are to be documented in the electronic medical record progress notes. G. Record review of R #16's progress notes, multiple dates, revealed the following: 1. On 01/14/25, staff documented that R#16 refused a shower. 2. On 01/22/25, staff documented that R #16 received a shower. 3. On 01/28/25, staff documented that R #16 received a shower. H. On 05/29/25 at 12:46 PM during an interview, the DON confirmed the following: 1. R #16 refused a shower on 01/14/25. 2. R #16 received a shower on 01/22/25 and 01/28/25. 3. According to the documentation R #16 only received 2 showers between her admission on [DATE] and her discharge on [DATE]. 4. CNA's are responsible for completing resident showers according to the shower schedule. 5. Based on the shower schedule, residents are expected to receive showers three times a week. 6. CNA's are expected to document showers in the EMR and on shower sheets. 7. CNA's are supposed to document when a resident refuses a shower and notify the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325061	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Betty Dare Wellness & Rehabilitation LLC	3101 North Florida Avenue Alamogordo, NM 88310

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	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 interview, the facility failed to ensure medical records were complete and accurate for 1 (R #16) of 1 (R #1, R #16, and R #25) residents reviewed for neglect. This deficient practice has the potential to negatively impact on the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are: A. Record review of R #16's admission record, no date, revealed R #16 was admitted to the facility on [DATE]. B. Record review of R #16's progress note dated 02/07/25 revealed staff documented R #16 had burning during urination. C. Record review of R #16's On-Call physician note dated 02/07/25 revealed the provider ordered a urinalysis and urine culture due to dysuria (pain during urination). D. Record review of R #16's entire medical record, no date, revealed the following: 1. Staff did not document that the provider was notified about R #16 having burning during urination. 2. Staff did not enter any orders that were received when the provider was contacted about R #16 having burning during urination. E. On 05/29/25 at 11:17 AM during an interview, LPN #16 stated the following: 1. She did not remember R #16. 2. She did not remember if she contacted the provider about R #16 having burning during urination. 3. She confirmed that R #16's electronic medical record (EMR), did not have documentation that the provider was notified about R #16 having burning during urination. 4. She confirmed R #16's EMR did not have an order for a urinalysis or urine culture. 5. Staff are expected to document contact with the provider in the resident's EMR, document what the provider said, enter any orders in the EMR, and complete any orders that were ordered. F. On 05/29/25 at 11:27 AM, during an interview, the DON and the corporate nurse, confirmed the following: 1. Staff documented that R #16 had burning during urination. 2. The on-call physician's note dated 02/07/25 had an order for a urinalysis and urine culture for R #16. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325061	A. Building B. Wing	05/30/2025

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Betty Dare Wellness & Rehabilitation LLC	3101 North Florida Avenue Alamogordo, NM 88310

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The on-call physician's note was a scanned in document that staff would not see (the nurse contacted the on-call provider and the provider provided the note for the medical record after the conversation). 4. R #16's EMR did not contain documentation that the provider was contacted regarding R #16 having burning during urination. 5. R #16's medical record did not have an order for a urinalysis or urine culture. 6. Staff were expected to document any contact with the provider in the EMR. 7. Staff were expected to enter orders that were received from the on-call provider in the EMR. 8. Staff were expected to collect urine from R #16 for the urinalysis and urine culture that were ordered and document in the EMR.