STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northchase Nursing and Rehabilitation Center	3015 Enterprise Drive Wilmington, NC 28405

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and family interviews, the facility failed to honor a resident's choice to receive a shower for 1 of 1 resident reviewed for choices (Resident #172). Findings included: Resident #172 was admitted to the facility on [DATE]. Diagnoses included vascular dementia, anxiety, depression, and insomnia. The Minimum Data Set admission assessment dated [DATE] revealed Resident #172 was moderately cognitively impaired and demonstrated no behaviors or refusals of care. She required substantial / maximal assistance with one staff physical assistance with bed mobility and transfers, and substantial / maximal assistance with one staff physical assistance with personal hygiene. She had no functional impairments with range of motion, used a walker and a wheelchair and required one staff physical assistance with bathing/showering. Resident #172 was frequently incontinent of bowel and bladder. A review of Resident #172's care plan dated 06/04/25 revealed a plan of care for Activities of Daily Living/Personal Care will be completed with staff support as appropriate to maintain or achieve highest practical functioning through the next review. Resident required substantial/maximal assistance with personal hygiene. An observation was conducted on 06/09/25 at 12:33 PM of Resident #172' s shower schedule posted on her wall which revealed she was to be offered a shower on Wednesdays and Sundays during the 7:00 PM to 7:00 AM shift. Review of the Activity of Daily Living (ADL) shower sheet from 06/01/25 through 06/08/25 revealed there was no evidence that Resident #172 had received a shower since admission to the facility on [DATE]. The documentation revealed the following: - 06/01/25 no documentation of bathing - 06/02/25 bed bath - 06/03/25 no documentation of bathing - 06/04/25 no documentation of bathing (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 06/05/25 full bed bath documented by Nurse Aide #9 - 06/06/25 full bed bath documented by Nurse Aide #9 - 06/07/25 no documentation of bathing - 06/08/25 no documentation of bathing Review of the nursing progress notes from 06/01/25 through 06/08/25 revealed there was no documentation to support the nurse aides offered Resident #172 a shower and she refused. An observation of Resident #172 on 06/09/25 at 12:33 PM revealed an alert resident sitting upright in her chair at the bedside. She was appropriately dressed, was without odors, and appeared to be well groomed. An interview was conducted with Resident's # 172's family member on 06/09/25 at 12:33 PM. The Family Member stated she arrived at the facility at 7:30 AM and stayed with Resident #172 until 11:30 PM every day since her admission. The Family Member stated she did not understand why Resident #172 has not had a shower since her admission. The Family Member stated that since the resident arrived on 06/01/25 she was present when Resident #172 got a bed bath on 06/02/25. The Family Member stated she requested to a staff member (unknown) that Resident #172 would like a shower and the staff member told her that Resident #172's shower days were Wednesday (06/04/25) and Friday (06/06/25) during the 7:00 PM to 7:00 AM shift. The Family Member stated on Wednesday evening 06/04/25 she asked the Nurse Aide assigned to Resident #172 (Nurse Aide #9) if the resident was going to get her shower today and she stated that Nurse Aide #9 replied Resident #172 would get a shower on 06/05/25. The Family Member stated on 06/05/25, Resident #172 did not receive her shower during her stay up until 11:30 PM. The Family Member stated she was told by Nurse Aide #9 that Resident #172 would get a shower on 06/06/25. She stated 06/06/25 came and went and Resident #172 was not offered nor did she receive a shower. The Family Member stated on 06/07/25 a staff member (Nurse Aide #12) provided her with a shower schedule of when Resident #172 should receive a shower and posted the shower schedule in the resident's room. The schedule revealed Resident #172 should get a shower on Wednesday and Sundays. The Family Member stated it had been 9 days since her admission and she knew that Resident #172 would really like a shower. An interview was conducted with Nurse Aide #12 on 06/09/25 at 1:10 PM. Nurse Aide #12 reviewed the shower schedule and confirmed Resident #172 was to get a shower on Wednesdays and Sundays on the 7:00 PM to 7:00 AM shift. She stated she provided a schedule to the Resident and the family on 06/07/25 and posted the schedule in her room on 06/07/25. Nurse Aide #12 reported that whenever she gave showers, she would document in the electronic record if a shower or bed bath was given to a resident and would let the nurse know if the resident refused. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse Aide #9 via phone on 06/11/25 at 4:45 PM. Nurse Aide #9 stated she did not recall her work activities on Wednesday 06/04/25. She stated if Resident #172 did not get a shower, there was a reason and she would have documented it in the electronic record and let the nurse know. The ADL sheet was reviewed with Nurse Aide #9 which indicated no shower or bed bath was given on 06/04/25 or 06/05/25 and she stated she did not recall giving Resident #172 a shower on 06/04/25 or 06/05/24. The shower schedule was reviewed with Nurse Aide #9 and revealed the Resident was scheduled to be offered a shower on third shift beginning on Wednesday 06/04/25 and ending on Thursday 06/05/25. Nurse Aide #9 stated if Resident #172 got a shower she would have documented it in the electronic record. Nurse Aide #9 stated if she did not document that the resident received a shower then the resident did not get one. Nurse Aide #9 stated she could not remember all her activities and conversations with residents that occurred during her shifts. An interview was conducted with the Director of Nursing on 06/12/25 at 4:00 PM. The Director of Nursing stated she expected her nursing staff to be offering and giving showers to all residents according to the shower schedule. The Director of Nursing stated if a resident refused the shower, the nurse aides should be notifying their nurse to see if the nurses could encourage the resident to have a shower and document any continued refusals. The Director of Nursing stated it was important to make sure residents were at least being offered a shower to maintain their personal hygiene.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Nurse Practitioner (NP), Medical Director interviews, and Consultant Pharmacist interviews, the facility failed to protect a resident's right to be free from neglect, when a nurse (Nurse #1) disregarded a severe drug-to drug interaction alert sent from the pharmacy to the resident's electronic medical record (EMR), regarding a newly prescribed antibiotic and a heart medication the resident (Resident #30) was currently prescribed. Nurse #1 neglected to read a severe drug-to-drug interaction alert received from the pharmacy regarding a newly prescribed antibiotic and did not notify the physician of the alert. The resident was administered the antibiotic by the nurse and there was no significant harm to the resident. This deficient practice occurred for 1 of 1 resident reviewed for neglect. The findings included: Resident #30 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), obstructive pulmonary disease (COPD), lymphedema, kidney disease, Stage 3, and paroxysmal atrial fibrillation (a type of atrial fibrillation (Afib) (irregular heart rhythm episodes that are intermittent and short lived), hypertension (high blood pressure), and history of transient ischemic attacks (TIA's are often a warning sign that a major stroke may occur). The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact, and she was receiving oxygen therapy as needed. Her primary diagnosis was listed as congestive heart failure (CHF). The care plan for Resident #30 dated 2/5/25 revealed a plan of care for risk for cardiac complications related to diagnoses that included peripheral vascular disease, hypertension, history of transient ischemic attacks, and paroxysmal atrial fibrillation. Interventions included administering oxygen as needed, monitoring for signs and symptoms of respiratory distress. An Encounter note written by the NP on 5/30/25 at 1:00 PM read in part the visit to Resident #30 was to evaluate her pulmonary status due to an acute episode of dyspnea (shortness of breath) at rest with associated increased oxygen demands and wheezing on 5/28/25. The note read that a chest x-ray was obtained on 5/29/25 and the results revealed she had consolidation in the right lower lung. The NP diagnosed Resident #30 with right lower lobe pneumonia due to infectious organism and ordered ceftriaxone 1 gram intramuscularly times one dose, then azithromycin 250 mg for 5 days. The physician's orders for Resident #30 revealed the following orders: 1. An order dated 5/30/25 at 12:42 PM for azithromycin (antibiotic prescribed for bacterial infections) 250 milligrams (mg) tablets. Give 500 mg by mouth one time a day for infection for one day and then a 250 mg tablet one time a day for 4 days. 2. An order dated 3/14/25 for amiodarone hydrochloride tablet 200 mg. Give one tablet by mouth one time a day for abnormal heart rhythm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's EMR revealed a Physician's Order Note alert was sent by the Pharmacy to the nursing staff on 5/30/25 at 3:11 PM. The note read in part, The order you have entered azithromycin 250 mg tablet, give 500 mg by mouth one time a day for infection for 1 day then give 250 mg one time a day for infection for 4 days has triggered the following drug protocol alerts/warnings: Drug-to-drug interaction. The system has identified a possible drug interaction with the following orders: Amiodarone 200 mg, give one tablet by mouth one time a day for abnormal heart rhythm. Severity: Severe. Interaction: additive QT interval prolongation may occur during coadministration of azithromycin, a moderate-risk QT-prolonging agent and amiodarone hydrochloride oral tablet 200 mg, a high-risk QT prolonging agent. The alert was acknowledged by Nurse #1. According to Resident #30's MAR the first dose of Azithromycin 250 mg, give 500 mg by mouth one time day for infection day 1 was administered on 5/31/25 at 8:00 AM by Nurse #1. An interview was completed with Nurse #1 on 6/11/25 at 11:53 AM. Nurse #1 stated that the NP entered the orders herself on 5/30/25 for the ceftriaxone and the azithromycin. She further stated that the NP usually entered her own orders. Nurse #1 indicated that she thought it was the responsibility of the NP to check allergies and contraindications. Nurse #1 indicated that she had seen the alert for the azithromycin, but she had just acknowledged it without reading it. She stated that Resident #30 was acting like herself on both 5/30/25 and 5/31/25. Nurse #1 further stated that Resident #30 was outside smoking most of the day and her vital signs were within normal limits on both days. An interview with the Consultant Pharmacist was conducted on 6/12/25 at 12:50 PM. The Consultant Pharmacist stated that when the pharmacy received the order for azithromycin for Resident #30 on 5/30/25, the pharmacy had immediately sent an electronic alert to Resident #30's EMR concerning the severe drug-to-drug interaction for azithromycin and amiodarone. He indicated the alert must be acknowledged by the nurse prior to administering the medication ordered. The Consultant Pharmacist stated that the nurses were supposed to read the pharmacy alerts and notify the physician of the drug-to-drug interaction to check if the Provider wanted the medication administered or wanted to prescribe a different medication. An interview was completed with the Director of Nursing (DON) on 6/12/25 at 3:31 PM. The DON stated she expected the nurses to read the pharmacy alerts regarding medication interactions and to notify the provider to see if they still wanted the medication to be given. An interview with the Medical Director was conducted remotely on 6/23/25 at 1:30 PM. The Medical Director stated that the drug-to-drug interaction regarding the azithromycin should have been identified by the nurse that received the alert. He further stated that Nurse #1 should not have administered the azithromycin without notifying the provider and obtaining a baseline electrocardiogram (EKG) and close monitoring for irregular heart rhythms. The Medical Director indicated that another option would have been to order a different antibiotic for Resident #30. The facility did provide a plan of correction to the state agency, but it was not accepted due to being unable to validate on site.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Consultant Pharmacist, and Pharmacy Manager, the facility failed to prevent misappropriation of a resident's controlled medication (30 hydrocodone/acetaminophen 5-325 milligrams (mg) pills and 30 oxycodone hydrochloride 10 mg pills) prescribed by the physician for pain for 1 of 1 resident reviewed for misappropriation of property (Resident #267). Findings included: Resident #267 was admitted to the facility on [DATE] with diagnoses to include dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and mood disturbance, history of falls, atrial fibrillation. She was receiving hospice care at the time of the misappropriation. The physician's orders for Resident #267 included: - Hydrocodone/Acetaminophen 5-325 mg oral tablet every 8 hours for pain ordered on [DATE]. - Oxycodone hydrochloride oral tablet 10 mg. Give 10 mg by mouth every 6 hours as needed (PRN) for pain ordered on [DATE]. The pharmacy packing slips for Resident #267's controlled medications were reviewed and revealed the following information: 1. On [DATE] 30 oxycodone 10 mg tablets were delivered from the pharmacy. 2. On [DATE] 90 hydrocodone-acetaminophen 5-325 mg tablets and 30 oxycodone tablets were delivered from the pharmacy. 3. On [DATE] 30 oxycodone 10 mg tablets were delivered from the pharmacy. Review of Resident 267's [DATE] Medication Administration Record (MAR) from [DATE] through [DATE] revealed she was administered 93 doses of scheduled hydrocodone-acetaminophen 325 mg and 32 doses of PRN oxycodone 10 mg. Review of Resident #267's February 2025 MAR from [DATE] through [DATE] (the record indicated Resident #267 expired in the facility on [DATE]) revealed she was administered 65 doses of scheduled hydrocodone-acetaminophen 325 mg tablet and 32 doses of PRN oxycodone 10 mg. A telephone interview was conducted with the Consultant Pharmacist on [DATE] at 12:50 PM. The Consultant Pharmacist stated the pharmacy received a refill request for Resident #267's for hydrocodone-acetaminophen 5-325 mg tablets from the facility on [DATE]. He further stated the pharmacy delivered a 30-day supply of 90 pills on [DATE]. The Pharmacist indicated that on [DATE] the pharmacy had faxed a notification to the facility that it was too early to dispense the medication. He further indicated that [DATE] was the earliest the pharmacy would have refilled the medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Initial Allegation report dated [DATE] at 4:59 PM revealed the facility became aware of the possible misappropriation of a controlled medication for Resident #267 and a proactive investigation was initiated to determine if there were missing pills of hydrocodone/acetaminophen due to an early refill request that was sent by the facility to the pharmacy on [DATE]. The facility re-ordered the medication at the facility's expense and no missed doses were identified. Law Enforcement was notified on [DATE] at 4:40 PM. An Occurrence Investigation Report Summary for drug diversion dated [DATE] completed by the Director of Nursing (DON) was provided by the facility. The report revealed that on [DATE] the nurse on the 500-hall noted that Resident #267's hydrocodone-acetaminophen was not delivered yet, the pharmacy and the Hospice Provider were contacted. The facility was notified by the pharmacy Resident #267's hydrocodone-acetaminophen was ordered too early. Facility staff were utilizing the emergency kit to ensure Resident #267 was administered her pain medication. An investigation was initiated by the DON. On [DATE] the facility received 90 hydrocodone-acetaminophen tablets and the three medication blister packs were added to the shift count sheet by the assigned nurse. On [DATE] card #1 was initiated and completed on [DATE]. Card #3 of 3 was initiated on [DATE]. Between [DATE] and [DATE] 10 doses were documented on the MAR as given but no declining count sheet was found for card #2 of 3 and potentially 30 hydrocodone-acetaminophen pills were unaccounted for. The facility Nurse Practitioner (NP) then electronically prescribed hydrocodone-acetaminophen to replace the missing medications that were valued at $13.85 and paid for by the facility. Appropriate regulatory agencies were contacted to include the state, Adult Protective Services (APS), law enforcement and the Drug Enforcement Agency. During the investigation it was also noted that the resident had unaccounted for oxycodone 10 mg tablets. On [DATE] the resident received a new refill of oxycodone 10 mg tablets and another refill on [DATE] for an additional 30 tablets were received from the pharmacy. The oxycodone refill for [DATE] was requested by Nurse #7. Multiple attempts were made to contact Nurse #7 but were unsuccessful. It was determined that 24 doses were documented on the MAR as given from [DATE] and believed they were given from the refill delivered on [DATE]. There was no declining count sheet to review, and no evidence the medication was returned to the pharmacy. There was no evidence that any medication was administered from the oxycodone card filled on [DATE] and no return of drug or declining count sheet were available for review. By reviewing declining count sheets and staff schedules, both staff members (Nurse #5 and Nurse #7) noted to last be in possession of the medication and were suspended pending an investigation. Resident #267 was assessed for pain to ensure the pain regimen in place was effective with no negative findings. There was no harm to the resident because she did not go without pain medication. After a thorough investigation the facility was unable to determine the root cause of missing medications, the allegation of misappropriation was not substantiated. A new system process was initiated for monitoring receiving/returning controlled substances and shift to shift count. Review of the Nursing Assignment Sheets on [DATE] revealed Nurse #7 was the nurse working the 500 hall on the 7:00 PM to 7:00 AM and Nurse #5 was the nurse working the 7:00 AM to 7:00 PM shift 500 hall on [DATE]. A telephone interview was completed with Nurse #7 on [DATE] at 12:50 PM. Nurse #7 stated that she didn't know anything about missing medications at the facility. She further stated that she had stopped working at the facility in February 2025. Nurse #7 indicated due to personal issues she was unable to return to work. Nurse #7 stated she was never contacted by the Director of Nursing (DON) in regard to missing narcotic medications. She further stated that she was not aware she was terminated from the facility. Nurse #7 stated she couldn't remember anything about Resident #267's narcotic medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #5 on [DATE] at 3:15 PM. Nurse #5 stated she had worked at the facility for 2 years. Nurse #5 stated that she had suspected Nurse #7 of diverting narcotics and had reported it to the DON on [DATE] right before Nurse #7 never came back to work. She further stated she and Nurse #7 were the 2 nurses involved in the investigation for missing medications. Nurse #5 indicated that the narcotic counts were always right. She indicated that on [DATE] she was not aware of the missing declining narcotic count sheets and missing medications. Nurse #5 further indicated she was allowed to return to work when the facility was unable to reach Nurse #7 after she left for personal reasons. Nurse #5 stated she was not the person who diverted the narcotic medications. The Investigation Report submitted to the stated agency on [DATE] completed by the DON revealed Resident #267 did not miss any doses of medication. A declining count sheet could not be located to verify the sign out of meds for hydrocodone/acetaminophen and oxycodone. The facility will replace unaccounted for medications. The report further read that an audit of controlled substance count sheets, audit of declining count sheets, audit of packing slips from pharmacy, audits of returned medication, witness statements, state registry check, education to all nurses on drug diversions and narcotic process. A telephone interview with the Pharmacy Manager occurred on [DATE] at 2:30 PM. The Pharmacy Manager stated he was aware of an incident that occurred at the facility on [DATE]. He further stated the facility had reached out for invoice slips and the names of the nursing staff who ordered the medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the DON on [DATE] at 1:26 PM. The DON confirmed Nurse #5 had come to her [DATE] with some concerns regarding narcotic medication and Nurse #7. She further stated before she could begin an investigation to confirm the allegation, she was notified by the Unit Manager working on the 500 hall on [DATE] that Resident #267's narcotic medication had not been delivered to the facility that evening. She further stated she instructed the nurse to obtain the medications from the emergency kit, so Resident #267 would receive her scheduled medication. The DON stated the next day she had started an investigation as to why the medication was not delivered. She indicated that she had tried to order the medication from the pharmacy and was told it was too early. The DON stated she had requested the packing slips and the names of the staff ordering the medication. During the investigation they discovered the narcotic shift change sheet and the declining pill count sheet for Resident #267's narcotic medications were missing from the narcotic book on the 500 hall and a new count sheet had been started by Nurse #7 on [DATE]. She further stated that one of the blister packs containing 30 hydrocodone-acetaminophen 5-325 mg tablets and the declining count sheet and the blister pack for 30 oxycodone 10 mg tablets delivered by the pharmacy on [DATE] were missing. The DON indicated that a refill of 30 oxycodone 30mg tablets were delivered on [DATE] and Nurse #7 had requested a refill for the medication on [DATE]. She stated that Nurse #7 had started a new declining count sheet, and the old one was missing. She further indicated that Nurse #7 left a note under her door on the morning of [DATE] stating she was out of state for personal reasons. The DON indicated Nurse #7 never returned to the facility after [DATE]. She stated she had tried to call and text message Nurse #7 multiple times, but the only response she received was that Nurse #7 was busy with personal issues. The DON indicated that the facility was unable to prove who took the medication, but they did substantiate that drug diversion occurred for Resident #267's narcotic medication. The DON stated Resident #267 never missed any scheduled narcotic medication doses. She further stated the facility had initiated pain assessments on non-alert residents for signs and symptoms of pain and interviews were conducted with alert and oriented residents to ensure they were not experiencing pain. The DON indicated the facility reviewed 60 days of packing slips, narcotic shift change sheets, narcotic declining count sheets and return of drug forms, and an audit of the residents' Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication carts. She further stated they had inspected the blister packs for evidence of tampering and none was noted. The DON indicated an audit of all nurses' and medication aides license verification was completed and with no negative findings. She further stated the facility conducted in-services with all the nurses and medication aides regarding Controlled Substance Diversion and initiated a Narcotic Management Process. The DON indicated they facility was continuing to perform audits and reconciliation of all the narcotics in the facility. An interview was completed with the Administrator on [DATE] at 4:13 PM. The Administrator stated she expected no misappropriation from the staff regarding medications, especially narcotic medications. The facility provided a Plan of Correction (POC) that was not acceptable to the state agency, due to there was no evidence of how the facility would prevent future misappropriatoin, and it did not address the suspicion that the nurse diverted the medication and was not reported to the Board of Nursing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of Preadmission Screening and Resident Review (PASRR) for 2 of 26 residents reviewed for MDS assessments (Resident #14 and #16). Findings included: 1. Resident #14 was admitted to the facility on [DATE]. Diagnoses included anxiety, depression, and bipolar disorder. Review of Resident #14's electronic health record revealed Resident's PASARR was completed on 02/12/21 and indicated Resident #14 was screened as Level II (a person centered evaluation that is completed for residents identified as having a mental illness diagnoses. It helps to determine appropriate placement and the need of specialized services). A review of Resident #14's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was not coded as a Level II PASRR. A review of Resident #14's care plan dated 05/29/25 revealed a plan of care for a Level II Preadmission Screening and Resident Review (PASRR) recommendations related to mental illness diagnoses of bipolar disorder, anxiety and depression and treated with psychotropic medications. The goal for the plan of care was that the Resident would receive recommended care and/or services as determined appropriate by Level II Preadmission Screening and Resident Review (PASRR) through next review. Interventions included provide a referral for new and updated PASSR as indicated, psychiatric services, close observation and assessments with corresponding documentation due to medications, provide daily care related to severe medical conditions which are debilitating or chronic illness and that cannot be given adequately at lower care levels, behavioral problems related to a medical condition (Depression, Anxiety, Bipolar), and requires treatment or observation by skilled professional personnel, to extent deemed appropriate for a nursing facility. An interview was conducted with the Social Worker on 06/11/25 at 4:22 PM. The Social Worker stated she had a list of the residents that were Level II PASRR and she answered the question on the MDS assessments regarding PASRR. The Social Worker stated she did not know why Resident #14 was not coded as a Level II PASRR on the 12/08/24 annual MDS assessment. The Social Worker stated she must have missed it. An interview was conducted with the Administrator on 06/12/25 at 4:00 PM. The Administrator indicated that she expected that the MDS assessments would be completed accurately and this included the coding of PASRR status for each resident. 2. Resident #16 was admitted to the facility on [DATE]. The resident's diagnoses included psychosis and hallucinations. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's electronic health record revealed the resident had a PASARR screening completed on 3/7/21 and Resident #16 was screened as a Level II (a person-centered evaluation that is completed for residents identified as having a mental illness diagnosis. It helps to determine appropriate placement and the need for specialized services). A review of Resident #16's annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was not coded as a Level II PASRR. A review of Resident #16's care plan revealed a plan of care dated 6/10/25 for a Level II Preadmission Screening and Resident Review (PASRR) with recommendations related to psychoses and hallucinations. The goal for the plan of care was that the residents would receive recommended care and/or services as determined appropriate by Level II Preadmission Screening and Resident Review (PASRR) through next review. Interventions included provide a referral for new and updated PASSR as indicated, psychiatric services, close observation and assessments with corresponding documentation due to medications, provide daily care related to severe medical conditions which are debilitating or chronic illness and that cannot be given adequately at lower care levels, behavioral problems related to a medical condition (psychoses and hallucinations) and requires treatment or observation by skilled professional personnel, to extent deemed appropriate for a nursing facility. An interview was conducted with the Social Worker on 06/11/25 at 4:22 PM. The Social Worker stated she had a list of the residents that were Level II PASRR, and she answered the question on the MDS assessments regarding PASRR. The Social Worker stated she did not know why Resident #16 was not coded as a Level II PASRR on the 12/5/24 annual MDS assessment. The Social Worker stated she must have missed it. An interview was conducted with the Administrator on 06/12/25 at 4:00 PM. The Administrator indicated that she expected that the MDS assessments would be completed accurately and this included the coding of PASRR status for each resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner (NP), and Consultant Pharmacist interviews, the facility failed to prevent the administration of unnecessary medication when a resident (Resident #30) a) received a dose of ceftriaxone (an antibiotic used to treat bacterial infections) as a one-time dose by intramuscular injection. Resident #30 had a documented allergy to ceftriaxone documented on the allergy list in the electronic medical record (EMR) and b) administered azithromycin (an antibiotic used to treat bacterial infections) that had a drug to drug interaction alert not to be administered with amiodarone without a baseline electrocardiogram (EKG is a test that measures the electrical impulses in the heart for abnormal rhythms because of risk of long QT syndrome (prolonged QT interval on the EKG (which increases the risk of a dangerous heart rhythm). This deficient practice occurred for 1 of 6 residents reviewed for medication errors. The findings included: a).The hospital discharge summary sent to the facility on 1/30/25 for Resident #30 listed her allergies as: 1. Sulfa drugs with the reaction listed as 12/22/22 script for Bactrim (sulfa antibiotic) led to severe thrombocytopenia. She also received a dose of ceftriaxone. 2. Ceftriaxone with the reaction listed as 12/22/22 dose of ceftriaxone led to severe thrombocytopenia but could not exclude that it was from the sulfa antibiotic script given the same day. We would need to review her prior exposure to antibiotics and balance risks/benefits. 3. Statins (cholesterol reduction inhibitor) with the reaction of feeling faint and jittery. 4. Theophylline (medication used to treat symptoms of chronic obstructive pulmonary disease [COPD]) with the reaction of restlessness, and insomnia. Resident #30 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF), obstructive pulmonary disease (COPD), lymphedema, kidney disease, Stage 3, and paroxysmal atrial fibrillation (a type of atrial fibrillation (Afib) where the irregular heart rhythm episodes are intermittent and short lived), peripheral vascular disease (PVD), hypertension (high blood pressure), and history of transient ischemic attacks (TIA's are often a warning sign that a major stroke may occur). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Unit Manager on 6/12/25 at 2:02 PM. The Unit Manager stated she was the nurse that entered the allergies into the EMR for Resident #30 when she was admitted to the facility. She further stated that she had obtained the information from the discharge summary sent by the hospital. She indicated that she had documented the allergies from the allergy section, but she had not seen the reactions listed for the allergies on a different page. The Unit Manager stated she had just read the top section of the summary but didn't read the reactions. She further stated that when the allergies were entered into the electronic medical record (EMR) they would show up in the banner in the record and they were transmitted automatically to the pharmacy and added to the medication administration record (MAR) screen. The Unit Manager indicated that it was important for the nursing staff to know the residents' allergies prior to the administration of medication. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact, and she was receiving oxygen therapy as needed. Her primary diagnosis was listed as congestive heart failure (CHF). The care plan for Resident #30 dated 2/5/25 revealed a plan of care for risk for cardiac complications related to diagnoses that included peripheral vascular disease, hypertension, history of transient ischemic attacks, and paroxysmal atrial fibrillation. Interventions included administering oxygen as needed, monitoring for signs and symptoms of respiratory distress. An Encounter note written by the NP on 5/30/25 at 1:00 PM read in part the visit to Resident #30 was to evaluate her pulmonary status due to an acute episode of dyspnea (shortness of breath) at rest with associated increased oxygen demands and wheezing on 5/28/25. The note further read that the chest x-ray obtained on 5/29/25 results revealed she had consolidation in the right lower lung. The NP diagnosed Resident #30 with right lower lobe pneumonia due to infectious organism and ordered ceftriaxone 1 gram intramuscularly times one dose, then azithromycin 250 mg for 5 days. An interview was conducted with the NP on 6/12/25 at 2:18 PM. The NP stated that her process for entering orders involved using the EMR and putting the orders in herself or by giving a nurse a verbal order. She further stated that she had to list the name of the medication, the route, dosage, and the frequency of the medications or the pharmacy would not accept the order. The NP indicated that she usually checked the residents' allergies by clicking on the tool bar in the EMR. She stated that if she forgot to check the allergies and the resident was allergic to a medication she would expect the nursing staff to call and confirm the medication. She stated that the order for ceftriaxone 1 gm for Resident #30 was ordered in error. She further indicated that it was also contraindicated to administer azithromycin and amiodarone at the same time. The NP stated that she would have expected the nurse who received the alert from the pharmacy would call her to clarify the order. The physicians' orders for Resident #30 revealed an order dated 5/30/25 at 12:42 PM written by the NP for ceftriaxone one gram (gm) intramuscularly times one dose for pneumonia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Nurse #1 on 6/11/25 at 11:53 Nurse #1 stated she was the nurse who signed off the order dated 5/30/25 at 12:42 PM written by the NP for ceftriaxone one gram intramuscularly times one dose for pneumonia for one day. Nurse #1 further stated that the NP entered the orders in the computer herself on 5/30/25 for the ceftriaxone and the azithromycin. She further stated that the NP usually entered her own orders. Nurse #1 indicated that she thought it was the responsibility of the NP to check the allergies. Nurse #1 indicated she was not aware of Resident #30's allergy to ceftriaxone when she had signed the order off. She further indicated that she had obtained the ceftriaxone from the emergency kit and filled out a slip and faxed it to the pharmacy. Nurse #1 stated she had attempted to give Resident #30 the ceftriaxone injection, but that she had refused to come inside from smoking to get the injection. She further stated that she was not the nurse that administered the medication and that Nurse #6 administered the injection on the next shift beginning at 7:00 PM. Nurse #1 stated that since she had obtained the ceftriaxone from the emergency kit, it had not triggered an alert stop from the pharmacy. She stated she had not checked Resident #30's allergies prior to removing the ceftriaxone from the emergency supply kit. The May 2025 Medication Administration Record (MAR) for Resident #30 revealed she was administered ceftriaxone sodium injection by intramuscular injection by Nurse #6 on 5/30/25 at 9:45 PM. An interview with Nurse #6 was completed on 6/12/25 at 4:37 PM. Nurse #6 stated that she was given report on the residents on 5/30/35 at 7:00 PM by Nurse #1. She further stated that Nurse #1 had informed her that she had received an order for Resident #30 for ceftriaxone 1 gm intramuscularly and she had pulled the medication from the emergency kit. Nurse #6 indicated that Nurse #1 had not administered the medication because Resident #30 had refused to come into the facility while she was outside smoking. She further indicated that she didn't believe she had received an alert from the pharmacy indicating Resident #30 had an allergy to the ceftriaxone. Nurse #6 stated that she usually does check for allergies prior to administering a medication. She further stated that it was a mistake that she hadn't checked the allergies prior to administering the medication. An interview with the Consultant Pharmacist was conducted on 6/12/25 at 12:50 PM. The Consultant Pharmacist stated that when the ceftriaxone was ordered for Resident #30 on 5/30/25 the pharmacy had sent a faxed alert to the facility concerning the allergy to ceftriaxone. He further stated that since the medication was removed from the emergency kit, the nurse would have to fill out a slip listing the residents' name, date, time, and the medication removed from the emergency kit and fax it to the pharmacy, so the medication could be replaced. The Consultant Pharmacist indicated that the reason the nurses faxed it to the pharmacy was so the resident could be charged and the medication that was used could be replaced the next day. The Consultant Pharmacist stated the pharmacy would have called the facility if the reaction listed was anaphylaxis but that was not listed as a reaction on her allergies list. An interview was conducted with the Medical Director on 6/12/2025 at 2:42 PM. The Medical Director stated that he was aware of the medication error related to Resident #30 receiving ceftriaxone and she had a documented allergy to it. He further stated that she was also administered a sulfa medication at the same time that the allergic reaction occurred and it had not been determined which medication had caused the reaction, which was thrombocytopenia (low platelets). The Medical Director stated that it would take longer than one day to develop thrombocytopenia He indicated that they didn't know if she truly had an allergy to ceftriaxone. The Medical Director acknowledged that the medication should not have been ordered because she was possibly allergic (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 6/12/25 at 3:31 PM. The DON stated that during the review of the chart on 6/2/25 they had discovered Resident #30 was administered a medication that she had a documented allergy to. The DON indicated that an investigation was conducted regarding the issue. She further indicated that the facility had noted that she was administered sulfa medication at the same time an allergic reaction had occurred, and that it was undetermined which medication had caused the reaction. The DON stated that she was unaware if the facility had received a fax alert from the pharmacy on the date it was ordered. She indicated that she expected the nurses to check the resident's allergies prior to administering a medication and to respond appropriately to pharmacy alerts regarding medications. The DON further indicated that the nurses should call the provider and verify the allergies and medication prior to administering the medication. She stated that the chart was reviewed on Monday 6/2/25 and that was how the error was discovered. The DON indicated the facility had immediately enacted a plan of correction involving a 100% check of all the allergies for every resident. She further indicated that they had entered the allergic reaction to the medications if they were able to identify them from the record or their former provider. The DON stated the all the nurses had received education and in-services regarding checking residents' allergies prior to administration of medications. She further stated that the facility had conducted an ad hoc Quality Assessment and Performance (QAPI) meeting regarding the medication error and that the facility was continuing to monitor and audit the charts for medication errors. An interview was conducted with the Administrator on 6/12/25 at 4:11 PM. The Administrator stated that she expected the nurses to check the allergies prior to administering a medication, especially new medications. The facility provided the following corrective action plan with a completion date of 6/4/25. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/2/25, during the morning QAPI Meeting the resident's chart was reviewed. Resident #30 received a medication she had potential sensitivity to. An investigation revealed Resident #30 was experiencing a change in condition with cough and decreased oxygen saturation on room air on 5/28/25. The Provider was notified and an order for a chest x-ray. The chest s-ray was obtained on 5/29/25 and resulted in the diagnosis of pneumonia. The resident was evaluated by the facility NP on 5/30/25 and she was prescribed ceftriaxone for this change in condition. The provider entered the order for the ceftriaxone and the day nurse confirmed the order. The medication was administered on the night of 5/30/25 by the night shift nurse with no side effects or adverse signs and symptoms noted. Resident #30 was at baseline the following day and was noted by staff throughout the day, up and out of bed and went outside multiple times to smoke. Upon review of the allergies in EPIC (hospital electronic medical record sofware) the allergy for ceftriaxone was added as precaution from a health event in 2022 and downgraded from severe. Allergies were validated with alert and oriented residents and there were no concerns from the audit. Residents' families were contacted to validate allergies of non-alert and oriented residents. A care plan audit was completed of all allergies and no concerns were identified. A 30-day look back of progress notes was performed and any concerns were addressed with the doctor. Medication allergies and policy changes were provided for both providers and nursing staff. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25, the Social Worker and Unit Manager initiated interviews with all alert and oriented residents regarding allergies including medication allergies. The purpose of the interviews was to ensure the allergy is reflected in Point Click Care (PCC) and in the care plan. The Social and Unit Manager updated the resident's clinical record accordingly for all identified areas of concern. The interviews were completed on 6/3/25. On 6/3/25, the Quality Improvement (QI) Nurse from a sister facility initiated interviews with all residents' representatives for non-alert and oriented residents regarding allergies, including medication allergies. The purpose of the interviews was to ensure the allergy was reflected on the residents' dashboard in PCC and in the care plan. The QI Nurse updated the residents' clinical records accordingly for all areas of concern identified. The interviews were completed on 6/3/25. On 6/3/25, the Pharmacy Manager obtained a list of facility notifications of drug alerts from pharmacy in the past 7 days. The purpose of the audit was to ensure the physician was notified of the alert with documentation in the clinical record. The Pharmacy Manager notified the physician of all identified areas of concern. The audit was completed on 6/3/25. On 6/3/25, the Director of Nursing from a sister facility initiated 100% audit of all current residents' medication allergies listed on the resident's dashboard in the EMR including ceftriaxone and the residents' care plans. All residents' medications allergies were compared to the residents' physician orders to ensure the resident was not receiving any medication that may cause an allergic reaction. The facility's DON contacted the physician for all identified areas of concern. The audits were completed on 6/3/25. On 6/3/25, the DON from a sister facility initiated an audit of all residents' progress notes for the past 30 days to identify any documented acute change in condition that may have been related to the resident receiving the medications with known allergies. The purpose of audit was to ensure the acute change was addressed to include physician notification. The audits were completed on 6/3/25. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 6/3/25, an in-service was initiated with 100% of all nurses, medication aides, Medical Director regarding the following: 1. Nurses are to check all admission paperwork for resident's allergies upon admission. 2. Nurses are to ensure all resident allergies are reflected on the resident's dashboard in PCC and on the care plan upon admission 3. The residents' allergies should be reviewed on the dashboard in the EMR or the MAR for allergies every time a new medication is ordered. This should be done prior to nurses or medication aides administrating new medications. 4. If the provider orders medication and the resident has a known allergy on the dashboard in the EMR or the MAR to the medication, immediately contact the provider to verify whether they intend to proceed with the order or want an alternative. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5.The provider must be immediately notified of all fax or verbal allergy notices received from the pharmacy. 6. When a medication is entered into PCC and an alert is received from the pharmacy regarding an allergy, the nurse must immediately contact the provider to verify whether they intend to proceed with the order or want an alternative. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. On 6/3/25, the DON delegated the Unit Managers to audit all new residents' orders 5x per week times 4 weeks then monthly times 1 month and compare them to the resident's allergies on the dashboard in the EMR to ensure the resident is not receiving any medications that may cause an allergic reaction utilizing an allergy/order audit tool. The DON will notify the physician of any identified areas of concern. The Administrator or DON will review and initial the audits weekly times 4 weeks then monthly times 1. The QAPI committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need for additional monitoring. The POC for allergies will be presented at the QAPI meeting on 6/17/25. The facility implemented all corrective actions and was in compliance on 6/4/25. As part of the validation process on 6/12/24, the plan of correction was reviewed and included a sample of nursing staff, the Unit Managers, Administrator, and Medical Director regarding in-services and training related to deficient practice. The nursing staff verified the education and in-service training. The Unit Managers confirmed the audits and monitoring tools. The Medical Director confirmed that nursing staff were to notify him or the NP to verify orders if an allergy was identified. The Administrator stated that the investigation would be included in the QAPI meeting on 6/17/25. The completion date of 6/4/25 was validated. b). An Encounter note written by the NP on 5/30/25 at 1:00 PM read in part the visit to Resident #30 was to evaluate her pulmonary status due to an acute episode of dyspnea (shortness of breath) at rest with associated increased oxygen demands and wheezing on 5/28/25. The note further read that the chest x-[NAME] obtained on 5/29/25 results revealed she had consolidation in the right lower lung. The NP diagnosed Resident #30 with right lower lobe pneumonia due to infectious organism and ordered ceftriaxone 1 gram intramuscularly times one dose, then azithromycin 250 mg tablets for 5 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the NP on 6/12/25 at 2:18 PM. The NP stated that her process for entering orders involved using the EMR and putting the orders in herself or by giving a nurse a verbal order. She further stated that she had to list the name of the medication, the route, dosage, and the frequency of the medications or the pharmacy would not accept the order. The NP stated that it was contraindicated to administer azithromycin and amiodarone at the same time. The NP stated that she would have expected the nurse who received the alert from the pharmacy to call her to clarify the order. She further stated that if the nurses had called her about the pharmacy alert and the drug-to-drug interaction she would have obtained a baseline EKG and then another one in about a week to compare for changes or ordered another antibiotic. The physician's orders for Resident #30 revealed the following orders: 1. An order dated 5/30/25 at 12:42 PM for azithromycin (antibiotic prescribed for bacterial infections) 250 milligrams (mg) tablets. Give 500 mg by mouth one time a day for infection for one day and then 250 mg tablet one time a day for 4 days. 2.An order dated 3/14/25 for an amiodarone hydrochloride tablet 200 mg. Give one tablet by mouth one time a day for abnormal heart rhythm. According to Resident #30's MAR she received the initial dose of Azithromycin 250 mg, give 500 mg by mouth one time day for infection day one, and it was administered on 5/31/25 at 8:00 AM by Nurse #1. Review of Resident #30's EMR revealed a Physician's Order Note alert was sent by the Pharmacy to the nursing staff on 5/30/25 at 3:11 PM. The note read in part, The order you have entered azithromycin 250 mg tablet, give 500 mg by mouth one time a day for infection for 1 day then give 250 mg one time a day for infection for 4 days has triggered the following drug protocol alerts/warnings: Drug to drug interaction. The system has identified a possible drug interaction with the following orders: Amiodarone 200 mg, give one tablet by mouth one time a day for abnormal heart rhythm. Severity: Severe. Interaction: additive QT interval prolongation may occur during coadministration of azithromycin, a moderate-risk QT-prolonging agent and amiodarone hydrochloride oral tablet 200 mg, a high-risk QT prolonging agent. The alert was acknowledged by Nurse #1. An interview was completed with Nurse #1 on 6/11/25 at 11:53 AM. Nurse #1 stated that the NP entered the orders herself on 5/30/25 for the ceftriaxone and the azithromycin. She further stated that the NP usually entered her own orders. Nurse #1 indicated that she thought it was the responsibility of the NP to check allergies and contraindications. Nurse #1 indicated that she had seen the alert for the azithromycin, but she had just acknowledged it without reading it. She stated that Resident #30 was acting like herself on both 5/30/25 and 5/31/25. Nurse #1 further stated that Resident #30 was outside smoking most of the day and her vital signs were within normal limits on both days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Consultant Pharmacist was conducted on 6/12/25 at 12:50 PM. The Consultant Pharmacist stated that when the pharmacy received the order for azithromycin for Resident #30 on 5/30/25, the pharmacy had immediately sent an electronic alert to Resident #30's EMR concerning the severe drug-to-drug interaction for azithromycin and amiodarone. He indicated the alert must be acknowledged by the nurse prior to administering the medication ordered. The Consultant Pharmacist stated that the nurses were supposed to read the pharmacy alerts and notify the physician of the drug-to-drug interaction to check if the Provider wanted the medication administered or wanted to prescribe a different medication. An interview was completed with the DON on 6/12/25 at 3:31 PM. The DON stated she expected the nurses to read the pharmacy alerts regarding medication interactions and to notify the provider to see if they still wanted the medication to be given. A follow-up interview with the DON was conducted remotely on 6/23/25 at 9:26 AM. The DON stated the facility had a plan of correction for Nurse #1 failing to read the drug-to-drug interaction alert the pharmacy sent to Resident #30's EMR regarding the azithromycin and the amiodarone. She further stated that the audits for the drug-to drug interaction and education were completed at the same time as the audits were conducted regarding Resident #30's drug allergy. The DON indicated the facility had conducted audits of the charts to identify any alert notifications of drug interactions sent by the pharmacy. She stated education was provided regarding nurses responding to drug notifications sent from the pharmacy to the EMR. An interview with the Medical Director was conducted remotely on 6/23/25 at 1:30 PM. The Medical Director stated that the drug-to-drug interaction regarding the azithromycin should have been identified by the nurse that received the alert. He further stated that Nurse #1 should not have administered the azithromycin without notifying the provider and obtaining a baseline electrocardiogram (EKG) and close monitoring for irregular heart rhythms. The Medical Director indicated that another option would have been to order a different antibiotic for Resident #30. The facility provided the following corrective action plan with a completion date of 6/4/25. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25, during the morning QAPI Meeting the resident's chart was reviewed. Resident #30 received a medication that had a severe drug-to-drug interaction alert with a medication she was currently prescribed. An investigation revealed Resident #30 was experiencing a change in condition with cough and decreased oxygen saturation on room air on 5/28/25. The Provider was notified, and she ordered a chest x-ray. The chest s-ray was obtained on 5/29/25 and resulted in the diagnosis of pneumonia. The resident was evaluated by the facility NP on 5/30/25 and she prescribed azithromycin for this change in condition. The provider entered the order for the azithromycin and the day nurse confirmed the order. The nurse received a Pharmacy severe drug-to-drug interaction alert on 5/30/25 and she acknowledged it without reading it. The medication was administered on the morning of 5/31/25 by the nurse with no side effects or adverse signs and symptoms noted. Resident #30 was at baseline the following day and was noted by staff throughout the day, and up and out of bed. A review of the residents EMR's was conducted for drug interaction alerts sent by the pharmacy to ensure the physician was notified of the alert. Audits of all pharmacy alerts for the last 30 days were completed to ensure the physician was notified of all drug-to-drug interactions alerts, and no concerns were identified. Drug-to-drug interaction education and policy changes were provided for both providers and nursing staff. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/3/35, the DON from a sister facility initiated an audit of all residents' electronic medical records for the past 30 days to identify any alert notifications of drug interactions. The purpose of the audit was to ensure the physician was notified of the alert. The physician was notified by the facility's DON with documentation in the clinical record for all identified areas of concern. The audits were completed on 6/3/25. On 6/3/25, the Pharmacy Manager obtained a list of facility notifications of drug interaction alerts from pharmacy in the past 7 days. The purpose of the audit was to ensure the physician was notified of the alert with documentation in the clinical record. The Pharmacy Manager was to notify the physician of all identified areas of concern. The audits were completed on 6/3/25 On 6/3/25, the Staff Development Coordinator (SDC) from a sister facility initiated quizzes with 100% of nurses to ensure knowledge and understanding of what to do when there was an alert of a drug interaction. All nurses that do not successfully pass the quiz after 3 attempts will be retrained and removed from the schedule until they achieve a passing score. The quizzes were completed on 6/3/35 for all nurses that worked. The DON will monitor staff completion. After 6/3/25 any nurse that has not worked or received the quiz will complete it upon starting their next scheduled work shift. This was completed on 6/3/25. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 6/3/25, an in-service was initiated by the SDC from a sister facility with 100% of all nurses and the Medical Director regarding drug interactions: 1.When an order is entered into the EMR and an alert is triggered for a drug interaction (physicians order risk note) the nurse must immediately contact the provider to verify whether they intend to proceed with the order or want analternative. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The provider must immediately be notified of all fax or verbal drug interaction notifications received from the pharmacy. 3. Do not administer medications with a severe level alert drug interaction without first speaking to the physician. The in-service will be completed by 6/3/25 for all nurses that worked. The DON and/or the Administrator will monitor staff completion. After 6/3/25 any nurse who has not received the in-service will complete upon starting their next scheduled work shift. All newly hired nurses will receive education during orientation. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. On 6/3/25, the Unit Managers will audit the physician order risk notes 5 times per week for 4 weeks, then monthly for 1 month to ensure the physician was notified of all drug interaction alerts with documentation in the clinical record utilizing a drug interaction tool. The Unit Manager will notify the physician of any identified areas of concern. The Administrator or DON will review and initial audits weekly for 4 weeks then monthly for one month to ensure all areas of concern were addressed appropriately. The QAPI committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need for additional monitoring. The POC for drug interactions will be presented at the QAPI meeting on 6/17/25. The facility implemented all corrective actions and was in compliance on 6/4/25. As part of the validation process on 6/12/24, the plan of correction was reviewed and included a sample of nursing staff, the Unit Managers, Administrator, and Medical Director regarding in-services and training related to deficient practice. The nursing staff verified the education and in-service training. The Unit Managers confirmed the audits and monitoring tools. The Medical Director confirmed that nursing staff were to notify him or the NP to verify orders if a drug-to-drug interaction alert was identified. The Administrator stated that the investigation would be included in the QAPI meeting on 6/17/25. The completion date of 6/4/25 was validated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to discard expired medications on 2 of 4 medication (med) carts observed (200 hall and 100 hall med carts) and date medications when they were opened to allow for the determination of their shortened expiration date for medications stored on 3 of 4 med carts (100 hall, 200 hall, and 400 hall) med carts reviewed for medication storage. Findings included: 1 a. An observation was conducted on 6/11/25 at 9:46 AM of the 200 hall med cart in the presence of Nurse #8. The observation revealed the following medications were stored on the cart. - An opened box of ipratropium bromide 0.5 milligrams (mg) and albuterol sulfate 3 mg (inhaled medications used to treat chronic obstructive pulmonary disease (COPD) nebulizer treatments containing 3 vials dispensed for Resident #23 with an opened date 2/6/25. The manufacturer's instructions included discarding medication 2 weeks after it was opened. - An open bottle of floor stock zinc sulfate (a supplement) 50 mg tablets with a manufacturer's expiration date of 1/25. - An opened box of ipratropium bromide 0.5 mg and albuterol sulfate 3mg (inhaled medications used to treat COPD) 7 vials dispensed for Resident #8 with an opened date of 2/1/25. The manufacturer's instructions included discarding medication 2 weeks after opening. 1 b. An observation of the 100 hall med cart was conducted on 6/11/25 at 10:15 AM in the presence of Nurse #9. The observation revealed the following medication was stored on the cart. - An opened box of ipratropium bromide 0.5 mg and albuterol sulfate 3 mg (inhaled medications used to treat symptoms of COPD) containing 7 nebulizer vials dispensed from the pharmacy for Resident #13 with an opened date of 2/4/25. The manufacturer's instructions included discarding the medication 2 weeks after opening. 2 a. An observation of the 200 hall med cart was conducted on 6/11/25 at 9:46 AM in the presence of Nurse #8. The observation revealed the following medications were stored on the med cart. - An opened umeclidinium 62.5 mcg powder inhaler (medication used to treat symptoms of COPD) with 17 out of 30 doses left dispensed for Resident #23 with no opened date. - An opened box with 3 vials of ipratropium bromide 0.5 mg and albuterol sulfate 3mg dispensed to Resident #11 were laying out of their package with no date opened on the package. - An opened package of fluticasone furoate 10 mcg (a powdered corticosteroid used to treat allergies) inhaler dispensed to Resident #23 on 5/28/25 with no date opened on the package. The manufacturer's instructions included discarding the medication 6 weeks after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 b. An observation of the 100 hall medication cart was conducted on 6/11/25 at 10:15 AM in the presence of Nurse #9. The observation revealed the following medications were stored on the cart. - An opened package containing 6 vials of ipratropium bromide 0.5 mg and albuterol 3 mg (medication used to treat symptoms of COPD) dispensed for Resident #110 with no opened date. The manufacturer's instructions included discarding the medication 6 weeks after opening. - An opened inhaler of fluticasone furoate 10 micrograms (mcg) inhalations powder with 24 of 30 doses remaining dispensed on 5/28/25 for Resident #13 had no date opened on the package. The manufacturer's instructions included discarding 6 weeks after opening. 2 c. An observation of the 400 hall med cart occurred on 6/11/25 at 10:50 AM in the presence of Nurse #10. The observation revealed the following medication was stored on the cart. - An opened inhaler containing fluticasone furoate 110 mg and vilanterol 25 mcg (medication used to treat symptoms of COPD) inhalation powder with 20 of 30 doses remaining was without a label and no dated opened. An interview was conducted with the Director of Nursing (DON) on 6/12/25 at 3:45 PM. The DON stated she expected the nursing staff to label and date medications when they were opened and to discard them before their expiration date. She further stated she expected the nursing staff to follow manufacturer's instructions for labeling and storage of medications An interview was completed with the Administrator on 6/12/25 at 4:15 PM. The Administrator stated she expected the nursing staff to properly label and store medications and to dispose of medications prior to their expiration date.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to honor a resident's food preferences. This deficient practice was for 1 of 3 residents reviewed for food preferences (Resident #14). Findings included: Resident #14 was admitted to the facility on [DATE]. A physician order dated 02/12/21 revealed Resident #14 had an order to receive a regular diet, with regular texture, and thin consistency. A diet communication slip dated 05/15/25 revealed resident requests grits in the morning and no orange juice. This slip was signed by Nurse #11. Review of a nursing note written on 05/17/25 by Nurse #11, revealed Resident approached nurse and stated that she needed nurse to go to the kitchen and reiterate that she wants grits for breakfast every morning and no orange juice. This nurse let resident know that she wrote a dietary slip the other day, as resident requested, and handed it to the kitchen staff herself. Nurse will again let kitchen know the residents' request. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #14 was cognitively intact and was independent with eating. Resident #14 received a regular diet and had no weight loss or gain. An interview was conducted with Resident #14 on 06/09/25 at 11:10 AM. Resident #14 stated she has been at the facility for 4 years and she did not ask for much. She stated she had been requesting to the staff to get a bowl of grits every morning and no orange juice for over 3 weeks and every morning she received orange juice on her tray and had to ask for a bowl of grits because it was never served on her tray. Resident #14 stated she preferred to have just a bowl of grits in the morning and was frustrated that she had to ask a staff member every single morning for her grits. Resident #14 stated this morning on her food tray she received orange juice, scrambled eggs, bacon and 1 piece of toast. A diet communication slip dated 06/09/25 (unsigned) revealed Grits for breakfast, and no OJ (orange juice). An interview with Resident #14 on 06/10/25 at 12:17 PM revealed she was not served grits again this morning and had to ask for them and she was given orange juice again. An observation of Resident #14's breakfast tray on 06/11/25 at 8:35 AM revealed she had no grits on her tray and was served orange juice. Resident stated she did not understand why she was not getting what she preferred served to her and then would have to wait for the staff to bring her what she wanted even though the kitchen was informed. Resident #14 stated she cannot drink orange juice and yet it was put on my tray every morning. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the dietary slip provided on Resident #14's meal tray on 06/11/25 at 8:35 AM revealed: prefers sausages, likes boiled and scrambled eggs, 1 piece of toast, prefers lemonade and dislikes cranberry juice. While reviewing and discussing Resident #14's likes and dislikes, Nurse Aide #7 entered the room and Resident #14 requested a bowl of grits at this time and reminded the Nurse Aide she did not like orange juice. Nurse Aide #7 removed the tray and stated she would get Resident #14 a bowl of grits. An observation of Resident #14's breakfast tray on 06/12/25 at 8:15 AM revealed she received grits on her meal tray with eggs and sausage and 1 piece of toast. She was also served apple juice. An interview with the Dietary Manager on 06/12/25 at 8:50 AM revealed she reviewed the dietary communication slips that were in a pile in her desk drawer and located the slips that were written on 05/15/25 and 06/09/25. She stated she used to have a system whereby she would initial the slip after she entered the information in the electronic record for meal trays to know that preferences were updated. She stated she stopped doing that and probably should not have because both of these slips were over looked. She stated she changed the revised the breakfast likes and dislikes on the evening of 06/11/25 to prefers grits, sausage, scrambled eggs, and 1 piece of toast and dislikes OJ after Nurse Aide #7 returned Resident #14's breakfast tray on 06/11/25 and stated Resident #14 just wanted grits and no orange juice. The Dietary Manager stated she would visit Resident #14 today and discuss her likes and dislikes again since it had been almost a year since she updated her preferences. An interview with the Administrator on 06/12/25 at 4:10 PM revealed she would expect the Dietary Manager to have a system in place to ensure resident preferences were being updated and the residents' choices were being honored.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observations and staff interviews, the facility failed to remove expired food items stored for use in 1 of 1 walk-in refrigerator and 1 of 2 nourishment rooms and failed to label and date leftover food in 1 of 2 nourishment rooms observed (Rehabilitation Hall nourishment room). This deficient practice had the potential to affect the food served to the residents. The findings included: 1. An observation in the kitchen on 6/9/25 at 11:00 AM revealed the following items in the walk-in refrigerator: - an opened bag of Swiss cheese with no opened date. - a metal container with pureed mixed fruit with no label and no opened date. - a metal container with stewed tomatoes with an opened date of 5/28/25 and a use by date of 5/29/25. - a metal container with pimentos with a label with an open date of 6/4/25. - an opened plastic bag of deli turkey with no opened date. - an opened plastic bag of deli ham with no opened date. - an opened half full box of muffins with no opened date. - an opened carton of honey thick tea with no opened date. - an opened carton of honey thick orange juice with an opened date of 5/29/25. The manufacturer label for the honey thick tea and orange juice indicated the products were good for 7 days after they were opened if stored in the refrigerator. An interview was conducted with the Dietary Manager on 6/9/25 at 11:00 AM. The Dietary Manager stated she expected all items to be labeled with an opened date and expired items to be discarded. The Dietary Manager stated it was challenging to keep up with ensuring that all items were dated due to frequent staff turnover in the dietary department. The Dietary Manager stated she tried to conduct audits of the refrigerator and freezer to check dates and labeling of food items, but she had fallen behind on this. An interview was conducted with the Administrator on 6/12/25 at 4:00 PM. The Administrator indicated that she expected that all food items in the kitchen would be labeled and dated properly and that foods that were passed the used by date would be discarded. 2. An observation of the Rehabilitation Hall nourishment room on 6/9/25 at 11:30 AM with the Dietary Manager present revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- an opened carton of a nutritional supplement with no opened date. - an opened carton of a nutritional supplement with an opened date of 5/30/25. - a glass bowl of rice and vegetables with no date. - a large plastic bag with leftover food in it dated 5/8/25. - a plastic bag with a plastic container and a foil container with unidentifiable, food items with no name or date. - an opened plastic container of hummus with no name or date that it was opened. The manufacturer label for the nutritional supplement indicated the product was good for 4 days after it was opened if stored in the refrigerator. An interview was conducted with the Dietary Manager on 6/9/25 at 11:30 AM revealed she observed the expired food items in the plastic bags and stated she did not know why the expired items were in the nourishment room refrigerator and that they should have been discarded. The Dietary Manager stated that the dietary staff checked the nourishment room refrigerators daily, made sure they were clean and stocked them with items such as juice and soda for the residents. The Dietary Manager stated the dietary staff should have discarded the expired items and informed the nursing staff that there were items in the refrigerator that were not labeled with the resident name and date they were brought in. An interview was conducted with the Administrator on 6/12/25 at 4:00 PM. The Administrator stated she expected that items in the nourishment room refrigerators would be labeled with a resident name and the date when the item was brought in. The Administrator indicated that she expected that expired items would be discarded. The Administrator revealed the refrigerators should be free from expired items. The Administrator further stated she expected that all out-of-date items would be discarded immediately.