STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health and Rehabilitation Center	706 Pineywood Road Thomasville, NC 27360

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident #63 was admitted to the facility 7/30/24 with her most recent readmission on [DATE]. Diagnoses for Resident # 63 included stroke and feeding tube. a. Review of the medical record for Resident # 63 revealed a nursing change of condition note dated 10/30/24 at 11:53 PM. The note documented a change of condition for Resident #63 and a physician order was received to transfer her to the hospital for evaluation and treatment. A nursing progress note dated 11/4/24 documented Resident #63 was readmitted to the facility. Review of the medical record revealed no notice of transfer was in the record for the hospitalization from 10/30/24 to 11/4/24. b. Review of the medical record for Resident #63 revealed a nursing progress note dated 11/11/24 at 9:15 PM documented a change in status for Resident #63 and noted a physician order to send Resident #63 to the hospital for evaluation and treatment. A nursing note dated 12/9/24 documented Resident #63 was readmitted to the facility after hospitalization. Review of the medical record revealed no notice of transfer was in the record for the hospitalization from 11/11/24 to 12/9/24. Resident #63's Responsible Party was interviewed by phone on 6/5/25 at 9:40 AM. The Responsible Party reported she had not received a written notice of transfer anytime Resident #63 has been admitted to the hospital. On 6/4/25 at 9:43 AM, an interview was conducted with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the Responsible Party was notified by phone of the reason for the transfer. On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer information for the hospital was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the Responsible Party. (continued on next page)

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

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	The Director of Nursing was interviewed again on 6/5/25 at 10:14 AM and she reported she did not know that a written notice of transfer was required to be sent to the residents and the Responsible Party. The Administrator was interviewed again on 6/5/25 at 12:52 PM and she reported she did not know why the written notice of transfer was not sent to Resident #63 or her Responsible Party, but she expected a written notice to be sent. 4. Resident #87 was admitted to the facility 4/22/25 with diagnoses including hypertension and dementia. Resident #87 was discharged home on 5/27/25. Review of the medical record revealed no discharge summary including a recapitulation of Resident #87's stay. The Social Worker was interviewed on 6/4/25 at 12:01 PM and she reported she did not know who was responsible for completing the discharge summary for residents leaving the facility. The Social Worker explained she did not think she was responsible for the discharge summary. Resident #87's Responsible Party was interviewed by phone on 6/4/25 at 1:24 PM. The Responsible Party reported she had not received a discharge summary for Resident #87 when she was discharged from the facility. The Director of Nursing was interviewed on 6/5/25 at 10:14 AM and she reported she was not aware the facility was not completing a discharge summary. The Administrator was interviewed on 6/5/25 at 12:52 PM and she reported that any resident and Responsible Party should receive a written discharge summary. Based on record reviews and interviews with Resident Representatives (RR) and staff, the facility failed to provide the resident or RR written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization (Residents #32, #59 and #63). In addition, the facility failed to provide a discharge summary to Resident #87 when they were discharged home or complete a recapitulation of a resident stay after discharge for 1 of 1 resident reviewed for a planned discharge. The findings included: 1. Resident #32 was initially admitted to the facility on [DATE]. Her medical record indicated that a family member was her RR. Resident #32 was transferred to the hospital on 3/23/25 for vomiting and on 5/30/25 for respiratory distress. (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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/4/25 at 9:43 AM, an interview occurred with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the RR was notified by phone of the reason for the transfer. On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer notice was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the RR. A phone call was placed to Resident #32's RR on 6/4/25 at 12:34 PM. He stated that he was called when Resident #32 was discharged to the hospital, but he had never received anything in writing regarding the reason for the hospital transfers. An interview was conducted with the Social Worker (SW) on 6/4/25 at 1:30 PM. She stated she had been employed at the facility since the end of February 2025. The SW stated she was unaware a written reason for hospital transfer was to be provided to the resident or mailed to the RR. On 6/4/25 at 1:48 PM, another interview was completed with the Administrator who had been employed at the facility since March 2025. She verified the RR was notified by phone when a resident was transferred to the hospital and a copy of the transfer form was sent in the packet going to the hospital. She was unaware a written reason for the hospital transfer was required to be provided to the resident or RR. 2. Resident #59 was initially admitted to the facility on [DATE]. Her medical record indicated that she had a guardian for her medical and financial concerns. Resident #59 was transferred to the hospital on 2/28/25 for altered mental status. On 6/4/25 at 9:43 AM, an interview occurred with Unit Manager #1, who explained that when a resident was transferred to the hospital a copy of the face sheet, medication administration record, any Do Not Resuscitate (DNR) information if present, change in condition form, transfer form and bed hold policy was sent with the resident. She added that the RR was notified by phone of the reason for the transfer. On 6/4/25 at 12:15 PM, the Director of Nursing and Administrator stated the transfer notice was sent with the resident when they were discharged to the hospital and they did not have anything in writing that was sent to the RR. A phone call was placed to Resident #59's guardian on 6/4/25 at 12:17 PM. She stated that she was called when Resident #59 was discharged to the hospital, but she had never received anything in writing regarding the reason for the hospital transfer. An interview was conducted with the Social Worker (SW) on 6/4/25 at 1:30 PM. She stated she had been employed at the facility since the end of February 2025. The SW stated she was unaware a written reason for hospital transfer was to be provided to the resident or mailed to the RR. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/4/25 at 1:48 PM, another interview was completed with the Administrator who had been employed at the facility since March 2025. She verified the RR was notified by phone when a resident was transferred to the hospital and a copy of the transfer form was sent in the packet going to the hospital. She was unaware a written reason for the hospital transfer was required to be provided to the resident or RR.

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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 Medical Director and staff interviews, the facility failed to prevent Resident #83 from receiving a dose of Lyrica (a medication used to treat nerve and muscle pain) that was prescribed for Resident #13. This affected 1 of 6 residents whose medications were reviewed (Resident #83). The findings included: Resident #83 was admitted to the facility on [DATE] with diagnoses that included neuralgia and neuritis (pain and inflammation of the nerves). An admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #83 had severely impaired cognition. Review of Resident #83's May 2025 physician orders included an order dated 2/18/25 for Pregabalin (Lyrica) 25 milligrams (mg) 1 capsule by mouth twice a day for neuropathic pain. Resident #13 was admitted to the facility on [DATE] with diagnoses that included radiculopathy of the cervical region, bursitis of the left shoulder, and chronic pain syndrome. A quarterly MDS assessment dated [DATE] indicated that Resident #13 was cognitively intact. A review of Resident #13's May 2025 physician orders included an order dated 8/22/24 for Lyrica 100 mg one tablet by mouth three times a day for neuropathic pain. A facility investigational summary dated 5/15/25 indicated that Nurse #2 completed a narcotic count on 5/15/25 at 11:00 PM and found a discrepancy with the count for Resident #83 and Resident #13. Both residents received a dose of Lyrica at 8:00 PM, however there had not been a Lyrica 25 mg removed from Resident #83's blister pack for the 8:00 PM dose and two pills had been removed from Resident #13's Lyrica 100 mg blister pack. The incident was reported to the Medical Director and Resident #83's Resident Representative (RR). A review of Resident #83's May 2025 Medication Administration Record (MAR) indicated Lyrica was provided at 8:00 PM. The MAR didn't indicate the medication was not provided to Resident #83. A nursing progress note dated 5/16/25, written by Nurse #2, revealed that a medication count discrepancy was noted with Residents #83 and #13's Lyrica. The note read that both residents received Lyrica at the same time but at different dosages. Nurse #2 indicated he couldn't recall if had given Resident #83 Lyrica 100 mg that was ordered for Resident #13 but immediately notified the former Assistant Director of Nursing (ADON), began evaluations of Resident #83 and notified the Medical Director and RR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview was completed with Nurse #2 on 6/4/25 at 9:35 PM who recalled the medication error incident. He explained that he had provided medications at 8:00 PM as ordered to Resident #83 and #13. A narcotic count was completed at 11:00 PM and it was noted that Resident #13 had an extra dose of Lyrica 100 mg removed from the medication card while Resident #83's Lyrica 25 mg had the same count as when he started the shift at 7:00 PM. Nurse #2 stated he failed to look at the medication label to ensure the correct medication was pulled for the correct resident. Nurse #2 stated that when he found the discrepancy, he went to assess Resident #83 who was at her baseline, contacted the former ADON, Medical Director and Resident #83's RR. The Medical Director stated to continue monitoring Resident #83 for any side effects. Nurse #2 stated that Resident #83's vital signs remained within normal limits, and she displayed no side effects from receiving the incorrect dosage of Lyrica during the remainder of the night. A review of Resident #83's vital signs from 5/16/25 indicated that at 12:44 AM, 3:04 AM and 6:23 AM they were all within normal limits. On 6/4/25 at 10:57 AM, an interview occurred with the Director of Nursing (DON). She explained that on 5/15/25 Nurse #1 had two residents that received Lyrica at the same time but at different dosages. Resident #83 received 25 mg and Resident #13 received 100 mg at 8:00 PM. Nurse #1 completed his medication pass and completed a narcotic count at 11:00 PM where he found a discrepancy for Lyrica. During the narcotic count he noted that Lyrica 25 mg had not been utilized at 8:00 PM for Resident #83 and two pills had been used out of the Lyrica 100 mg pack for Resident #13. The DON stated that Nurse #2 self-reported the discrepancy, the Medical Director and Resident #83's RR were notified, and Resident #83 was monitored for the rest of the shift. The DON further stated that education was provided to Nurse #2 regarding medication errors and a medication pass observation was completed. A phone interview occurred with the Medical Director on 6/5/25 at 9:00 AM and stated he was notified of the medication error, but didn't feel there would have been any harm caused to Resident #83 from receiving Lyrica 100 mg instead of Lyrica 25 mg one time. He recalled instructing the nurse to monitor Resident #83 throughout the remainder of the shift. Multiple attempts were made to contact the former ADON without success. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/15/25 the nurse noted there was a narcotic count discrepancy on two residents' Lyrica with different dosages. The nurse assessed both residents with no noted adverse outcome identified. The residents and/or responsible party as well as the physician were notified. The nurse received one-to-one education on the Rights of Medication Administration on 5/16/25. 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 the DON/designee initiated a 100% audit of all current residents who receive Lyrica to ensure the right dosage was administered to the resident as per physician order. The DON/designee will notify the physician of all areas of concern identified during the audit. On 5/17/25 the DON/designee initiated an audit of all incident reports for the past 30 days to identify trends and identify any incidents related to medication administration to ensure appropriate interventions were initiated, physician notified, and resident assessed as indicated. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All nursing staff to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Medication Aides received education regarding Rights of Medication Administration on 5/16/25 by the former ADON. Education will be provided to any agency nursing staff before taking an assignment and will be incorporated in the new hire process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when correction action will be completed: The DON/designee will complete random audits of medication administration weekly for 12 weeks. The physician will be notified of any identified areas of concern, and the staff will receive re-training of the Rights of Medication Administration. The Administrator or DON will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for two months. The QAPI committee will meet monthly for two months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. This was reviewed in the QAPI meeting on 5/22/25. The plan alleged compliance on 5/22/25. As part of the validation process, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Education was provided all licensed nursing staff and Medication Aides on the Rights of Medication Administration. A review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with licensed nurses and Medication Aides revealed they had received education on proper medication administration. Medication Administration was observed as part of the recertification survey and no errors were noted. The compliance date of 5/22/25 for the corrective action plan was validated.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to provide treatments as ordered by the physician for a non-pressure wound for 1 of 4 residents reviewed for non-pressure skin integrity (Resident #292). The findings included: Resident #292 was admitted to the facility on [DATE] with diagnoses which included non-pressure chronic ulcer of other part of left foot with unspecified severity, diabetes mellitus with other skin complications, and cellulitis of both right and lower limb. Review of Resident #292's initial nursing assessment dated [DATE] revealed Resident #292 was alert and oriented. Review of Resident #292's care plan initiated 05/27/25 revealed the resident was at risk of skin breakdown related to peripheral vascular disease, chronic venous stasis, changes of lower extremities, diabetic, problems with mobility, and fragile skin. Interventions included observations for changes in skin integrity or skin impairment left great toe ulcer and notify physician as necessary and skin care per facility protocol. Review of physician order dated 05/28/25 revealed Resident #292 was ordered to cleanse left foot second toe with wound cleanser and apply dry gauze daily. A progress note dated 06/04/25 made by Wound Nurse #1 indicated Resident #292's treatment was not completed over the weekend 05/31/25 through 06/01/25. The note further revealed that the Director of Nursing (DON) and the Medical Director (MD) were notified. Review of Resident #292's Treatment Administration Record (TAR) revealed on 05/31/25 and 06/01/25 the resident was checked off for receiving treatment. An interview was conducted with Resident #292 on 06/02/25 at 2:30 PM revealed from 05/31/25 through 06/01/25 the resident did not receive treatment for his toe. It was further revealed he was supposed to have his toe cleaned and new bandage applied daily. Resident #292 stated Wound Nurse #1 was aware because when she changed Resident #292's bandage on 06/02/25 he still had the bandage on that Wound Nurse #1 had applied and dated on 05/30/25. An interview conducted with Wound Nurse #1 on 06/04/25 at 10:15 AM revealed Resident #292 did not receive wound treatment as ordered 5/31/25 through 06/01/25. It was further revealed Resident #292 was supposed to have his ulcer cleaned and bandaged changed over the weekend by the assigned Nurse. Wound Nurse #1 indicated Resident #292 had the same bandage that she had put on 05/30/25. An interview conducted with Nurse #5 on 06/04/25 at 2:30 PM revealed she was assigned to Resident #292 on 05/31/25 and 06/01/25 to complete treatments. It was further revealed she thought she had completed all treatments, but had accidentally overlooked Resident #292 and did not do his. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint interview conducted with the DON and Administrator on 06/05/25 at 12:00 PM revealed they were made aware that Resident #292 had not received treatment on his toe and they expected orders to be followed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide effective supervision for residents with severely impaired cognition that resided on the memory care unit. Resident #91 had a history of wandering and wandered into Resident #92's room and Resident #91 hit Resident #92 in the nose, which caused Resident #92 to sustain a closed fracture of the nasal bone. This was for 1 of 3 residents reviewed for accidents (Resident #92). The findings included: Resident #92 was admitted to the facility on [DATE] and discharged on 07/11/24. Diagnoses included age related osteoporosis, osteoarthritis, dementia, and other behavioral disturbances. Review of Resident #92's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and required limited assistance for most activities of daily living (ADL). The MDS further revealed the resident was not coded for behaviors or wandering. Review of Resident #92's care plan initiated 02/23/24 revealed the resident was at risk expressing emotion, sharing information, and decrease and lack of speech related to impaired memory. Also, the resident was at risk of difficulty understanding speech, difficulty forming thoughts, and requiring cues and directions. The goal was for Resident #92's needs to be met through the next review. Resident #91 was admitted to the facility on [DATE] and discharged [DATE]. Diagnoses included abnormalities of gait and mobility, dementia, anxiety, and cognitive communication deficit. Review of Resident #91's care plan initiated on 12/17/24 revealed the resident had a problematic manner in which resident had ineffective coping such as wandering and wandering into other residents' beds. The goal was Resident #91 would have no episodes through the next review. Interventions included document episodes of wandering per facility protocol, approach wandering resident in non-threatening manner, orient to surrounding and room number as frequently as needed, place familiar objects, furniture, pictures in resident surroundings, and provide assistance in locating own room. Review of Resident #91's quarterly MDS dated [DATE] revealed the resident was severely cognitively impaired. The MDS further revealed the resident was not coded for behaviors or wandering. Review of progress note dated 07/10/24 created by Nurse #4 revealed Resident #92 was in her doorway to her room yelling for help and stated she had been hit in the nose by another resident. Moderate amounts of blood were observed coming from Resident #92's nose and mouth. A compression (pressure on the nose) was used to stop the bleeding followed by cleansing of mouth to check for further injury. The note indicated the Medical Director (MD) was notified and Resident #92 was sent out to the hospital to be further assessed. The note revealed Resident #92's Responsible Party (RP) was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview conducted with Nurse #4 on 06/05/25 at 9:00 AM revealed she was assigned to both Resident #91 and Resident #92 on 7/10/24 when the incident occurred. Nurse #4 indicated Resident #91 had prior behaviors of wandering but had never been aggressive towards other residents. It was further revealed on 07/10/25 around 3:00 AM she was assisting another staff member and Resident #91 wandered across the hall into Resident #92's room. Nurse #4 indicated she had just checked resident rooms 15 minutes prior and Resident #91, and Resident #92 were both asleep in their bed. Nurse #4 indicated she heard Resident #92 yell and found her standing in her doorway with her nose and mouth bleeding. Nurse #4 revealed Resident #91 was in Resident #92's bed asleep. Nurse #4 stated Resident #92's nose was bleeding, there was some swelling, and it appeared to be disfigured. Nurse #4 indicated she contacted the prior DON, MD, and RP and Resident #92 was sent to the hospital to be further assessed. Nurse #4 revealed Resident #91 was directed back to his bed and was assessed and no injuries were found. The Nurse indicated Resident #91 was put on one-to-one care. An initial facility report dated 07/10/24 indicated Resident #91 hit another resident in the face and was removed immediately. It further revealed Resident #92 was observed yelling out and bleeding from her nose. Review of hospital Discharge summary dated [DATE] revealed Resident #92 was seen in the emergency room for a facial injury and was assessed and diagnosed with a closed fracture to the nasal bone. The summary further revealed Resident #92 was to schedule a follow up appointment with an ear, throat, and nose doctor. Review of progress note dated 07/10/24 revealed later that day Resident #92 returned to the facility and was diagnosed with a fracture to the nasal bone. Review of progress note dated 07/12/24 revealed a psychiatrist referral was completed for Resident #91 date and the RP was notified. A 5-day investigation was completed by the facility dated 07/12/24 and revealed Resident #91 had a history of wandering behaviors and will lay down in whatever bed he finds. It was believed Resident #91 got into Resident #92's bed confused and startled Resident #91 which resulted in Resident #91 hitting Resident #92 and injured Resident #92's nose. The investigation indicated nursing staff had left Resident #92's room [ROOM NUMBER] minutes prior to the incident and did not witness Resident #91 wandering. The investigation concluded that staff did not witness the incident but had Resident #91 on one to one for observations of behaviors. A phone interview conducted with the prior Director of Nursing (DON) dated 06/05/25 at 8:50 AM revealed she was the DON at the time of the incident between Resident #91 and Resident #92. The DON further revealed she was not at the facility when the incident occurred but was notified by Nurse #4. The DON indicated she received a call from Nurse #4 that Resident #91 had wandered into Resident #92's room while nursing staff were giving care to another resident. The DON stated she believed Resident #92 yelled at Resident #91 and Resident #91 got startled and struck out at Resident #92. It was reported to her that Resident #92's nose was bleeding, and the RP and MD were notified, and Resident #92 was sent to the hospital. DON revealed Resident #91 had not had aggressive behaviors prior to the incident but was put on one to one for observations and a psychiatrist referral was made. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health and Rehabilitation Center	706 Pineywood Road Thomasville, NC 27360

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the current DON and Administrator on 06/05/25 at 11:50 AM revealed neither one of them worked in the facility at the time of the incident. The interview further revealed they both expected staff to monitor and watch residents in the memory care unit to prevent accidents. The facility provided the following corrective action plan: 1. What corrective action will be accomplished for each resident found to be affected. On 7/10/24 Resident # 91 wandered into Resident # 92's room and was resting on the bed. Resident # 92 came into the room and awakened Resident # 91 startling the resident. Resident # 91 experienced a startle response which resulted in the resident making physical contact with Resident # 92's nose. The facility staff responded immediately by separating Resident # 91 and Resident # 92 and placing Resident # 91 on one-to-one supervision while an investigation of the accident was initiated. A pain and skin assessment on Resident # 92 was completed on 7/10/24. The resident was noted to have a bloody nose and was transferred to the hospital for evaluation. A pain and skin assessment completed on 7/10/24 Resident # 91 revealed the resident had no pain or injury. 2. What corrective action will be accomplished for those residents who have the potential to be affected by the same deficient practice. On 7/10/24 100% of residents progress notes and behavior alerts in the electronic medical record (EMR) were audited by the Quality Assurance Nurse to identify any behavior, to include wandering, that occurred in the last 14 days. The audit was to ensure interventions were in place to address behaviors and interventions were in place on the resident care plan. The audit was completed on 7/10/24. Any identified concerns were addressed during the audit to include updating the care plan and notification of the medical practitioner and resident representative. On 7/10/24 100% skin checks were initiated by the hall nurse for signs and symptoms of injury not previously identified. No signs of injuries were indicated from the assessments. On 7/10/24 the Director or Nursing (DON) reviewed incident reports related to resident-to-resident altercations for the past 30 days to identify patterns and trends. No new areas of concern were identified. 3. What measures are put in place or systemic changes are made to ensure the deficient practice will not re-occur. On 7/10/24 an in-service was initiated, to all staff, by the DON and Staff Development Coordinator (SDC) regarding managing residents with behaviors, utilization of non-pharmacological interventions for behaviors, prevention of resident-to-resident altercations, providing as needed medications/interventions as appropriate to help reduce behavior escalation, and documentation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 a QAPI meeting was held to discuss resident to resident altercations and residents on the memory care unit with dementia. Multiple people including department heads and the Medical Director participated. The in-service was completed by 7/12/24. After 7/12/24 staff that had not completed the in-service were provided with the in-service on their next scheduled shift. This education is provided to newly hired staff ongoing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 100% of all progress notes and behaviors alerts were reviewed by the DON, Unit Manager (UM), Unit Coordinator, SDC and Quality Assurance Nurse 5 days a week for 4 weeks during the daily interdisciplinary team meeting utilizing the Behavior Audit Tool. The purpose of the review was to ensure all behaviors were being addressed to include notification of the medical practitioner, responsible party and that care plans were reviewed/revised as appropriate. The Administrator or DON reviewed and initialed the audits weekly x 4 weeks, then monthly x 1 month to ensure all areas of concern were addressed appropriately. The Administrator and DON presented the findings of the Behavior Audit Tool to the Quality Assurance and Process Improvement (QAPI) committee monthly for 2 months. The QAPI committee met monthly for 2 months and reviewed the Behavior Audit Tool to determine trends and/or issues that needed further interventions and the need for additional monitoring. Corrective Action Plan completion date: 07/13/24 As part of the validation process conducted on 06/04/25, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Education was provided for all nursing staff. A review of the monitoring audits revealed they were completed as stated in the corrective action plan with no concerns identified. Interviews conducted with nursing staff revealed they had received education. The compliance date of 07/13/24 for the corrective action plan was validated.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #2 was admitted to the facility 10/17/2009 with diagnoses including heart failure and diabetes. The most recent quarterly Minimum Data Set assessment dated [DATE] assessed Resident #2 to be moderately cognitively impaired and she received oxygen therapy. A physician order dated 4/3/25 specified for oxygen to be administered at 2 liters per minute by nasal cannula. Resident #2 was observed on 6/2/25 at 1:54 PM. She had oxygen administered by nasal cannula at 2 liters per minute. No oxygen cautionary sign was noted on the door to her room or in her room. Resident #2 was observed with oxygen administered by nasal cannula at 2 liters per minute on 6/3/25 at 8:53 AM. No cautionary oxygen sign was observed. An observation of Resident #2 oxygen administered by nasal cannula at 2 liters per minute was conducted on 6/4/25 at 2:58 PM and no cautionary oxygen sign was observed. Resident #2 was observed with oxygen administered by nasal cannula at 2 liters per minute on 6/5/25 at 8:26 AM with Nurse #3. There was no oxygen cautionary sign observed. Nurse #3 was interviewed at the time of the observation and explained that a sign should be posted outside of the room, and she did not know why there was no oxygen sign for Resident #2. The Director of Nursing (DON) was interviewed on 6/5/25 at 10:14 AM and she reported the facility had completed an audit of all residents using oxygen, and part of the audit was to make certain cautionary signs were posted for oxygen. The DON reported she did not know why there was no sign for Resident #2's oxygen. The Administrator was interviewed on 6/5/25 at 12:52 PM. The Administrator explained the facility had completed a check of residents using oxygen on 6/2/25 and part of the check was ensuring the cautionary signs were in place. The Administrator reported that she did not know why there was no oxygen cautionary sign posted for Resident #2. Based on record reviews, observations, and Medical Director, resident and staff interviews, the facility failed to discontinue an order for the use of supplemental oxygen when a new order was received (Resident #1). In addition, the facility failed to display a cautionary sign indicating the use of oxygen for residents with supplemental oxygen (Residents #2, #18 and #22) and secure a oxygen tank in a Resident's room (Resident #18). This was for 4 of 4 residents reviewed for respiratory care. The findings included: 1. Resident #1 was initially admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). A review of Resident #1's active physician orders included the following orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order dated 8/18/24 for oxygen at 3 liters per minute via nasal cannula. - An order dated 4/3/25 for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact and received oxygen therapy. A review of Resident #1's active care plan, last reviewed 4/21/25, included a focus area for potential for or actual ineffective breathing pattern related to COPD, reflux, dysphagia, asthma, CHF, and hiatal hernia. Interventions included oxygen therapy as ordered. A nursing progress note dated 5/11/25 read that Resident #1 used oxygen at 2 liters per minute via nasal cannula. A review of the May 2025 and June 2025 Medication Administration Records (MARs) revealed an entry for oxygen at 3 liters per minute via nasal cannula. The MARs had a check mark and staff initials for day and night shift. In addition, the MARs had entry for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. The MARs had a check mark and staff initials for day and night shift. On 6/2/25 at 11:40 AM, an observation and interview occurred with Resident #1. She had oxygen flowing at 2 liters per minute via nasal cannula and stated that she used oxygen at 2 liters. Another observation occurred of Resident #1 on 6/4/25 at 9:32 AM who had oxygen flowing at 2 liters. On 6/4/25 at 9:35 AM, an interview occurred with Medication Aide #1 who was familiar with Resident #1 and was assigned to provide medications to her. She stated Resident #1 used oxygen continuously at 2 liters per minute via nasal cannula. After reviewing the June 2025 MAR, MA #1 indicated she checked and initialed both entries for oxygen use but couldn't say why she had not noticed an entry for 2 liters of oxygen and an entry for 3 liters of oxygen. Unit Manager #1 was interviewed on 6/4/25 at 9:43 AM and had been the nurse that created the order for oxygen at 2 liters per minute on 4/3/25. She reviewed Resident #1's active physician orders and verified that there was an order for oxygen at 3 liters and an order for oxygen at 2 liters that were showing as active. She stated when she received the order for oxygen at 2 liters per minute via nasal cannula on 4/3/25 she should have discontinued the order for oxygen at 3 liters per minute via nasal cannula. She felt this was an oversight. The Medical Director was interviewed via phone on 6/5/25 at 9:00 AM and stated that he was aware Resident #1 was using 2 liters of oxygen currently and would have expected the nurse who received the order for oxygen at 2 liters per minute on 4/3/25 to have discontinued the previous order for oxygen at 3 liters per minute. The Administrator and Director of Nursing were interviewed on 6/5/25 at 9:29 AM and stated they would have expected Unit Manager #1 to discontinue the order for oxygen at 3 liters per minute when the new order for oxygen at 2 liters per minute was received on 4/3/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #18 was admitted to the facility on [DATE] with diagnoses which included hypertension and congestive heart failure. Review of resident #18's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was moderately cognitively impaired. Review of a physician order dated 05/21/25 revealed Resident #18 was ordered to start oxygen at 2 liters per minute per nasal cannula for respiratory distress or when oxygen saturation drops under 92%. An observation on 06/02/25 at 11:50 AM revealed Resident #18 had gone to dialysis, but a free-standing (unsecured) oxygen tank, not in a holster or wheeled rack, was sitting in the corner of the resident's room behind his bed. It was further revealed there was no oxygen signage outside of the room or in the room. An observation was conducted in conjunction with an interview with Resident #18 on 06/03/25 at 10:00 AM. The observation revealed there was still a free-standing oxygen tank in Resident #18's room. Resident #18 stated he sometimes used oxygen if he was having issues breathing. It was further observed there was no signage hanging outside of the room, or inside of the room, for oxygen use. An interview conducted with the Unit Manager (UM) on 06/04/25 at 2:00 PM revealed Resident #18 used oxygen as needed. It was further revealed she was not aware Resident #18 did not have oxygen in use signage outside of his room. UM #1 indicated she and all nursing staff were responsible for posting signage, and all oxygen users were expected to have signage posted. An interview conducted with the Director of Nursing (DON) and Administrator on 06/05/25 at 11:50 AM revealed they were unaware Resident #18 did not have oxygen in use signage posted outside of his room. The DON indicated she was aware Resident #18's tank was stored in the corner of his room. It was further revealed both the DON and the Administrator expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms. 4. Resident #22 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease. Review of Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of a physician order dated 05/22/25 revealed Resident #22 was ordered oxygen at 3 liters per minute via nasal cannula. It further read to keep the oxygen saturation greater than 90% every day and night shift. An observation on 06/02/25 at 11:55 AM revealed Resident #22 had gone to dialysis. An oxygen concentrator was observed in the resident's room. It was further revealed no signage of oxygen was posted outside of, or inside, the resident's room. An observation on 06/03/25 at 9:45 AM revealed Resident #22 in his wheelchair with oxygen on and receiving oxygen via a nasal canula and was in the hall talking to another resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted with the Unit Manager (UM) on 06/04/25 at 2:00 PM revealed Resident #22 used oxygen continuously. It was further revealed she was not aware Resident #22 did not have oxygen in use signage outside of his room. UM #1 indicated she and all nursing staff were responsible for posting signage, and all oxygen users were expected to have signage posted. An interview conducted with the Director of Nursing (DON) and Administrator on 06/05/25 at 11:50 AM revealed they were unaware Resident #22 did not have oxygen in use signage posted outside of his room. It was further revealed both the DON and the Administrator expected staff to ensure signage was posted when there was oxygen in use, or in resident rooms.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews and Medical Director and staff interviews, the facility failed to hold blood pressure medications as ordered by the physician (Resident #13). This was for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #13 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), coronary artery disease (CAD), and hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 was cognitively intact. a. Review of Resident #13's active physician orders included an order dated 4/30/25 for Amlodipine (a blood pressure medication) 5 milligrams (mg). Give one tablet by mouth one time a day for hypertension. Hold for systolic blood pressure (SBP) less than 100, diastolic blood pressure (DBP) less than 60 and pulse less than 60. The May 2025 Medication Administration Record (MAR) was reviewed and revealed Resident #13 had received Amlodipine, despite the SBP less than 100 and DBP less than 60. - 5/14/25 SBP was 96 and DBP was 49. - 5/15/25 SBP was 96 and DBP was 49. - 5/28/25 SBP was 97 and DBP was 51. b. Review of Resident #13's active physician orders included an order dated 4/26/25 for Isosorbide Mononitrate Extended Release (a blood pressure medication) 30 mg. Give one tablet by mouth one time a day for CAD. Hold for SBP less than 110 and DBP less than 60. The May 2025 MAR was reviewed and revealed Resident #13 had received Isosorbide Mononitrate Extended Release, despite the SBP less than 110 and DBP less than 60. - 5/7/25 SBP was 102 and DBP was 52 - 5/14/25 SBP was 96 and DBP was 49. - 5/15/25 SBP was 96 and DBP was 49. - 5/16/25 SBP was 96 and DBP was 49. c. Review of Resident #13's active physician orders included an order dated 4/25/25 for Carvedilol (a blood pressure medication) 25 mg. Give one tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and DBP less than 60. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The May 2025 MAR was reviewed and revealed Resident #13 had received Carvedilol, despite the SBP less than 110 and DBP less than 60. - 5/7/25 SBP was 102 and DBP was 52 for the 8:30 AM dose. - 5/14/25 SBP was 96 and DBP was 49 for the 4:30 PM dose. - 5/15/25 SBP was 96 and DBP was 49 for the 8:30 AM dose and SBP was 96 and DBP was 49 for the 4:30 PM dose. - 5/16/25 SBP was 96 and DBP was 49 for the 8:30 AM dose. - 5/28/25 SBP was 97 and DBP was 51 for the 4:30 PM dose. On 6/4/25 at 10:49 AM, a phone call was placed to Medication Aide #2. He had provided medications to Resident #13 on 5/14/25 at 8:30 AM and 4:30 PM. A message was left for a return call that was not received during the survey. On 6/4/25 at 10:50 AM, a phone call was placed to Medication Aide #3. She had provided medications to Resident #13 on 5/28/25 at 8:30 AM and 4:30 PM. A message was left for a return call that was not received during the survey. An interview occurred with Medication Aide #4 on 6/4/25 at 2:44 PM. She had provided medications to Resident #13 on 5/7/25 and 5/14/25. She reviewed the May 2025 MAR and verified Isosorbide Mononitrate Extended Release was signed off as given outside the parameter on 5/7/25 and 5/14/25 as well as Carvedilol on 5/7/25. She felt it was an oversight. On 6/4/25 at 5:20 PM, a phone call was placed to Nurse #1. She had provided medications to Resident #13 on 5/15/25 and 5/16/25. A message was left for a return call that was not received. The Medical Director was interviewed by phone on 6/5/25 at 9:00 AM and stated if Resident #13 had received a few dosages of Amlodipine, Isosorbide Mononitrate Extended Release and Carvedilol outside the parameters it should not have caused any serious harm. The Medical Director added he would expect the nurses to follow the orders for the blood pressure medications parameters as written. The Administrator and Director of Nursing were interviewed on 6/5/25 at 9:30 AM, and stated they expected the nursing staff to follow parameters to hold blood pressure medications per physician orders.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 2. Resident #1 was initially admitted to the facility on [DATE]. A review of Resident #1's active physician orders included the following orders: - An order dated 8/18/24 for oxygen at 3 liters per minute via nasal cannula. - An order dated 4/3/25 for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. A review of the May 2025 and June 2025 Medication Administration Records (MARs) revealed an entry for oxygen at 3 liters per minute via nasal cannula. The MARs had a check mark and staff initials for day and night shift. In addition, the MARs had entry for oxygen at 2 liters per minute via nasal cannula. Keep oxygen saturations greater than 90%. The MARs had a check mark and staff initials for day and night shift. On 6/4/25 at 9:35 AM, an interview occurred with Medication Aide #1 who was familiar with Resident #1 and was assigned to provide medications to her. She stated Resident #1 used oxygen continuously at 2 liters per minute via nasal cannula. After reviewing the June 2025 MAR, MA #1 indicated she checked and initialed both entries for oxygen use but couldn't say why she had not noticed an entry for 2 liters of oxygen and an entry for 3 liters of oxygen. Unit Manager #1 was interviewed on 6/4/25 at 9:43 AM and had been the nurse that created the order for oxygen at 2 liters per minute on 4/3/25. She reviewed Resident #1's active physician orders and verified that there was an order for oxygen at 3 liters and an order for oxygen at 2 liters that were showing as active. She stated when she received the order for oxygen at 2 liters per minute via nasal cannula on 4/3/25 she should have discontinued the order for oxygen at 3 liters per minute via nasal cannula. She felt this was an oversight. The Administrator and Director of Nursing (DON) were interviewed on 6/5/25 at 9:29 AM and stated they would have expected Resident #1's medical record to be accurate. The DON stated the nursing staff should have asked for clarification when they observed the two active orders for oxygen. Based on record review, and resident and staff interviews, the facility failed to maintain complete and accurate medical records related to a resident's wound when a nurse documented the completion of wound care inaccurately for another nurse (Resident #292) and oxygen administration (Resident #1) for 2 of 4 residents reviewed for complete and accurate medical records. The findings included: 1. Resident #292 was admitted to the facility on [DATE]. Review of Resident #292's initial nursing assessment dated [DATE] revealed Resident 292 was alert and oriented. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of physician order dated 05/28/25 revealed Resident #292 was ordered was to cleanse left foot second toe with wound cleanser and apply dry gauze daily. Review of Resident #292's Medication Administrator Report dated 05/31/25 and 06/01/25 indicated Unit Manager #1 checked that treatment was completed on Resident #292's toe. Review of progress note dated 06/04/25 revealed Wound Nurse #1 revealed Resident #292 completed the resident's treatment and it was reported that the treatment was not completed on 05/31/25 and 06/01/25. The note further revealed that the Director of Nursing (DON) and the Medical Director (MD) were notified. An interview was conducted with Resident #292 on 06/02/25 at 2:30 PM revealed over the weekend, give dates the resident did not receive treatment for his toe. It was further revealed he was supposed to have it cleaned and new bandage applied daily. Resident #292 stated Wound Nurse #1 was aware because she changed Resident #292's bandage on 06/02/25 and it still had date and the initials on the bandage that she applied on 05/30/25. An interview conducted with Wound Nurse #1 on 06/04/25 at 10:15 AM revealed Resident #292 did not receive wound treatment as ordered. It was further revealed Resident #292 was supposed to have his ulcer cleaned and bandaged changed over the weekend by the assigned Nurse. Wound Nurse #1 indicated Resident #292 had the same bandage that she had put on 05/30/25, but did not see any outcome of it not being changed, but did notify the DON. An interview conducted with Unit Manager (UM) 1 on 06/04/25 at 2:00 PM revealed on 06/02/25 when she checked treatments, she saw that Resident #292 was not checked off on the MAR. It was further revealed she contacted Nurse #5 who indicated that she had completed all treatments. UM #1 stated she checked off the resident for Nurse #5 but should not have done that because she was not aware the residents' treatment was not completed. UM #1 stated she rarely documented for other nursing staff, but would not do it anymore. An interview conducted with Nurse #5 on 06/04/25 at 2:30 PM revealed she was assigned to Resident #292 on 05/31/25-06/01/25 to complete treatments. It was further revealed she thought she had completed all treatments, but had accidentally overlooked Resident #292 and did not do his. Nurse #5 stated she had told UM #1 she had completed the treatment. An interview conducted with the DON and Administrator on 06/05/25 at 12:00 PM revealed they were made aware that Resident #292 had not received treatment on his toe from Wound Nurse #1 on 06/04/25. It was further revealed they expected documentation to be documented correctly and not to document for other staff.